PALLIATIVE CARE IN LEBANON Where are we now? Where are we going?

SETTING PRACTICE STANDARDS for PALLIATIVE CARE in LEBANON • Recommendations of the Subcommittee on Practice - National Committee for Pain Control and Palliative Care

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ABSTRACT : Palliative care is in the early stages of development in Lebanon. The National Committee for Pain Control and Palliative Care (NCPCPC) was established under the Ministry of Public Health to work towards the development of palliative care. This paper summarizes the recommendations of the Subcommittee on Practice of the NCPCPC regarding hospital standards and provider competencies in palliative care. The authors propose actions that should be taken to implement these recommendations to help move palliative care forward in the country.

Keywords: palliative care, Lebanon, certification, health services

INTRODUCTION

Palliative care is new to the health care field in Lebanon. The concept was first introduced in 1995 at the WHO National Cancer Control Workshop and later at the Middle East Oncology Congress in 1999. These workshops helped launch the first efforts to establish palliative care services in the country [1]. Studies among nurses and physicians in Lebanon have demonstrated a need for establishing such services in Lebanon [2]. Until recently there were no hospital-based palliative care programs and palliative care services were often provided ad hoc based on hospital and health care providers perceived needs. The American University of Beirut Medical Center launched the first hospital-based palliative care service in August 2013.

The National Committee for Pain Control and Palliative Care (NCPCCPC) was launched under the Ministry of Public Health in May 2011 with the aim of creating a road map for establishing palliative care services in Lebanon. The proposed targets include the introduction of changes to the health care system to facilitate and improve pain management and palliative care.

The NCPCPC is chaired by the Director General of the Ministry of Public Health. Members of the Committee include physicians, nurses, mental health professionals and pharmacists from various backgrounds including academia, professional and community-based organizations. The work of the committee was delegated to four subcommittees: Policy, Practice, Education and Research. The subcommittees were composed of individuals from various disciplines who had been active in pushing the agenda of palliative care in Lebanon.

This paper summarizes the recommendations of the Subcommittee on Practice of the NCPCPC. This subcommittee represented a number of specialties including palliative care, geriatrics, family medicine, anesthesiology, pediatric oncology, nursing and mental health. The nurses had backgrounds in oncology, pain, and palliative care. The mandate of the subcommittee was:

1. To develop national standards and competencies for pain relief and palliative care.
2. To develop strategies to engage professionals from different disciplines in the care process such as the use of multidisciplinary care pathways.
3. To recommend models for service delivery such as home care and residential care and the use of palliative care teams in hospitals.
4. To develop mechanisms to empower the family and the patient to be actively involved in the care process emphasizing the importance of family and patient-centered care.

To date, the work of the subcommittee has focused on setting standards for hospitals and competencies for palliative care providers (Item 1 of the mandate). This paper presents the recommendations of the Subcommittee on Practice and proposes steps to implement these recommendations in the context of the Lebanese health system.

METHODOLOGY

Hospital standards and provider competencies were developed based on guidelines established in the United States, Europe, Canada and Australia. European and North American guidelines were selected for review as most hospitals in Lebanon follow either European or American standards for their regulation. A review of current hospital standards

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and provider competencies from leading organizations in hospice and palliative care as well as health care management in Europe and United States of America was completed.

Hospital standards were based primarily on the following documents: • the White Paper from the European Association of Palliative Care (EAPC) [3] • the National Consensus Project (NCP) Guidelines (Second edition) [4] • “Crosswalk of JCAHO Standards and Palliative Care Policies, procedures and assessment tools - Joint Commission on Accreditation of Healthcare Organization, procedures and assessment tools” [5]. We also reviewed the French Haute Autorité de Santé (HAS) guidelines and the recommendations of the Center of Advance Palliative Care (CAPC) for the joint commission certification process.

Nursing competencies were based on guidelines from the National Hospice and Palliative Care Organization (NAPCO) [6] and the Canadian Hospice and Palliative Care Association for both Registered Nurse and Advanced Practice Nurse [7]. Physician competencies were based primarily on competencies established by CAPC [8]. Social workers competencies were based on guidelines from the National Association for Social Workers (NASW) in the USA [9]. Competencies were revised to ensure that they reflected the four dimensions of palliative care: the physical, social, psychological and spiritual and that they were appropriate for the Lebanese context.

The first draft of these recommendations was circulated and reviewed by subcommittee members. Subcommittee members met to discuss the recommendations and made changes and adjustments to the original document. A second draft was circulated and final comments were solicited by email. The recommendations were then submitted to the NCPCPC and presented for review and comments. The comments of members of the NCPCPC were incorporated into the recommendations and the final draft was presented at a national workshop on palliative care organized by the Ministry of Public Health on World Palliative Care Day in October of 2012.

RECOMMENDATIONS

Research has supported the need for establishing palliative care services. Palliative care services lead to a decrease in overall hospital costs (decrease in length of stay, decrease in ICU stay and better coordination of care), decrease in symptom intensity, increase in staff satisfaction thus retention of staff, and increase in patient and family satisfaction.

Several studies have examined the impact of hospital-based palliative care programs on patient outcomes [10-15]. Clinical outcomes of palliative care have shown an improvement in pain control [16]; relief of symptoms such as nausea, shortness of breath, fatigue, depression, and anxiety; improved nutrition; better family and patient support especially in relation to making difficult decisions and treatment plans, improvement in adherence to treatments; increased overall patient and family satisfaction with care; and increased referral to other care settings [15].

To that end, the Subcommittee on Practice focused on setting hospital standards for palliative care and looking for ways to encourage hospitals to incorporate these standards into their current systems.

Hospital standards

Three levels of care were defined to reflect the degree of focus on and expertise in palliative care that a hospital may wish to have. These include:

1. ESSENTIAL PALLIATIVE CARE • These regulations reflect a basic minimum standard in palliative care that should be present in all hospitals regardless of the scope of care in the specific hospital. This is necessary to ensure that all patients receive a minimum level of palliation that respects their rights as human beings including their rights to make informed decisions regarding their health care, to be free from pain and to receive respectful care that preserves their dignity. These standards define the beneficiaries of palliative care and their rights. They identify proper communication and adequate pain management as essential tools to achieve appropriate care. In order to achieve this, hospitals must:
a. Provide training to all physician and nursing staff in pain assessment, documentation, and management. Training may be waived for health care providers who demonstrate previous training or competence in pain management.
b. Provide training in communication skills and end of life discussions to physicians and nurses working in units that commonly deal with terminal illness and death such as Intensive Care Units (ICU), Oncology, Respiratory Care Units (RCU), and acute geriatric care units.

2. PALLIATIVE CARE PROGRAMS • These regulations were defined for hospitals choosing to develop a palliative care program or service within the institution. Hospitals wishing to provide palliative care services must meet the Essential Palliative Care standards required of all hospitals. In addition to these standards, a hospital with a palliative care program should have the following:
a. Palliative care services provided by an interdisciplinary team which includes a physician, a nurse and a mental health specialist. Additionally, teams could include a social worker, a clinical pharmacist, and a spiritual consultant. Supporting disciplines such as physiotherapists and dieticians may serve as consultants or team members. Volunteers could also play active supporting roles to the interdisciplinary team.
b. Symptom management, advanced care planning and goal setting are primary functions of the palliative care team. The duties, responsibilities and
functions of this team are further defined in the recommendations.

3. **Centers of Excellence**: These regulations were defined for hospitals wishing to deliver advanced palliative care services and play a leadership role in the provision and advancement of palliative care. In addition to all the components necessary in hospitals with Palliative Care Programs, Centers of Excellence should provide the following:

a. **Bereavement support services**: Palliative care offers support to family and other close caregivers during the patient’s illness, helps them prepare for loss and continues to provide bereavement support after the patient’s death. Bereavement services are recognized as a core component of palliative care service provision. Centers of Excellence should ensure that bereavement services and follow-up support are made available to the family after the death of the patient. They have a process to identify patients at high risk of complicated grief and a referral mechanism to insure that they receive appropriate care.

b. **Inpatient palliative care unit**: Palliative care units (PCUs) provide specialist level palliative care to patients. They are usually wards within or adjacent to a hospital, but they can also exist as stand-alone services. They provide crisis intervention for patients with complex symptoms and problems or end-of-life care for patients where home care is no longer possible. The aim of palliative care units is to alleviate disease and therapy-related discomfort and, if possible, to stabilize the functional status of the patient and offer patient and caregivers psychological and social support in a way that allows for discharge or transfer to another care setting.

c. **Technical support**: Centers of Excellence should serve as referral centers. They network with medical centers, hospital, and health providers in the community to provide technical support.

d. **Training center**: Regardless of whether they are part of a teaching institution or nonacademic, Centers of Excellence must serve as training centers in palliative care.

e. **Bioethics committee**: Given the ethical issues commonly associated with decision making in serious illness, Centers of Excellence should have bioethics committees to help resolve disagreements and support staff and families in making important decisions.

f. **Spiritual support**: Spiritual support is an integral aspect of palliative care. Centers of Excellence should employ staff dedicated to the spiritual support of patients and their families. These individuals should also play a role in supporting patient care teams when necessary in their own internal processes related to dealing with death on a regular basis. This is essential in a multi-confessional country like Lebanon in order to insure community buy-in and collaboration.

g. **Volunteers**: Volunteers can play an important role in supporting the work of the palliative care team. Centers of Excellence should have volunteer services to expand the resources available to patients and their families.

h. **Research**: Centers of Excellence play an important role in the advancement of a discipline. As such, an active research program is an important component of a Center of Excellence in palliative care.

**Provider competencies**

Competencies and responsibilities for the different members of the palliative care team were defined as follows:

1. **Physicians**
   
a. All physicians, regardless of their background, should have a basic knowledge in communication about prognosis and advance care planning. Primary care physicians should also have a basic knowledge of pain assessment and pain management.
   
b. Palliative Care Specialists provide specialist palliative care services including inpatient and outpatient consultations. They lead the interdisciplinary team and their role includes education and training of staff. They also participate in developing standards of care for quality palliative care and facilitating access of patients to supportive care services.
   
c. Palliative care specialists must hold a current active license to practice in Lebanon and be registered in the Lebanese Order of Physicians. Additional qualifications include:
      
i. Board certification in Hospice/Palliative Medicine or equivalent or
   
ii. Doctor of Medicine with two (2) years experience in PC beyond completion of residency training.

   For example:
   
   * Adequate training and experience in palliative medicine in their country of training or
   
   * Involvement in the care of patient with chronic disease with active symptoms management by providing care to at least 100 terminally ill patients requiring palliative care as well as experience of at least two years working in an interdisciplinary team in hospice and palliative care.

   Palliative care specialists must demonstrate 10 hours of Continuing Medical Education in palliative care annually and 1 hour specifically related to medical ethics.

2. **Nurses**
   
a. A palliative care nurse (RN) can provide palliative care to patients in various settings. Palliative care nurses must hold a valid license to practice nursing...
in Lebanon and be registered in the Lebanese Order of Nurses. In addition, they should hold a minimum of a Bachelor’s degree in nursing with at least 2 years of clinical experience preferably in oncology or geriatrics and training in palliative care.

b. Clinical Nurse Specialists (CNS) in palliative care are members of the palliative care team. They provide palliative care and related health care services to patients and families. They also provide training and continuing education about palliative care for nurses and assist in the development of clinical practice guidelines or policies for palliative care. A CNS in palliative care must hold a valid license to practice nursing in Lebanon and be registered in the Lebanese Order of Nurses. CNS should also hold a Masters Degree in a clinical nursing track with a focus on palliative care. Additional qualifications include:

i. Certification as an advanced hospice and palliative care nurse (ACHPN) from the National Board for Certification of Hospice and Palliative Nurses (NBCHPN) or equivalent or

ii. Completion of 500 supervised palliative care patients contact hours as well as a minimum of 2 years nursing experience; clinical nursing care in oncology, geriatrics, or intensive care is preferred.

3. Mental Health Specialists play a vital role within the interdisciplinary team. They guide other team members in communicating and supporting patients and their families. They also identify high-risk patients and families, assess their psychological needs, encourage verbalization of fears and worries, and teach patients and families coping strategies. In addition, they assist patients and their families in resolving problems. A mental health specialist should hold a degree in psychiatry, clinical psychology or mental health nursing. In addition they should have a minimum of 2 years clinical experience with terminally ill patients, grief/bereavement and family dynamics.

FUTURE STEPS

The Subcommittee on Practice has proposed the following steps to move the above recommendations forward.

1. Hospital accreditation is new to the Lebanese health care system and has played an important role in setting standards for hospitals in Lebanon. However, to date the accreditation system has focused primarily on issues of patient safety and quality improvement [17]. The accreditation system has not yet addressed issues of patient rights or the issue of pain management. The current hospital accreditation criteria are in the process of being updated and revised. The standards for Essential Palliative Care must be incorporated into the new hospital accreditation criteria to ensure that all hospitals in Lebanon are providing a minimum level of palliative care to their patients regardless of their diagnosis or where in the disease process they may be.

2. Standards for Palliative Care Programs and Centers of Excellence in Palliative Care should be published to allow hospital administrators to work towards these goals should they wish to establish more advanced palliative care services and become Centers of Excellence that can serve as resources to health providers in the country as well as the region.

3. A Primary Palliative Care curriculum should be introduced into medical and nursing schools and primary care residency programs to ensure that all primary care physicians can provide a basic level of palliative care to the community.

4. Palliative care was recently recognized as a medical specialty by the Ministry of Public Health. The Physician Competencies established by the NCPCP should be used to set the requirements for palliative care physicians. They should also be publicized to allow physicians with an interest in palliative care to seek the training and certification necessary to qualify as palliative care providers.

5. Current laws restrict the prescribing of opioid analgesics to Oncologists and Pain Specialists. The recognition of palliative care as a specialty should be accompanied with the right of palliative care providers to prescribe opiates to ensure that adequate pain management is accessible to patients who need it regardless of their diagnosis or the cause of their pain.

6. Adequate reimbursement for services is essential if palliative care programs are to be established. To this end, insurance reimbursement by the National Social Security Fund (NSSF) as well as private insurance companies for the provision of palliative care services should also follow soon after the recognition of the specialty. This will allow the expansion of palliative care services, and will also encourage physicians in training to consider careers in palliative care. The expansion of the pool of palliative care providers is an essential step towards ensuring that palliative care services are available to anyone who may need them in the future.

7. Nurses play a major role in the provision and delivery of appropriate palliative care. This role should be recognized and rewarded appropriately. As the Order of Nursing moves towards establishing fields of specialty within nursing the above competencies should be used as the standards for Palliative Care Nurses.

This can be accompanied by recognition and compensation that is commensurate with additional training and skills associated with a nurse specialized in palliative care.

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