

Editorial

Setting Higher Standards in Cancer Care: Experiences at the First Palliative Moroccan Care Congress Casablanca, Morocco, March 2022

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Since the implementation of the first National Cancer Prevention and Control Plan (PNPCC1) in 2010, palliative care in Morocco has been a strategic approach in its own right, alongside the prevention, early detection and cancer management approaches. Since then, several measures have been put in place to facilitate the deployment of the actions representing this axis, i.e. the development of the palliative care network, pain management, palliative care research, as well as social and family support for palliative cancer patients.¹

Palliative care units have been established in seven regional oncology centers, four of which have mobile home teams, in addition to outpatient and inpatient activities.

Palliative care activity is, therefore, centralised at the tertiary level of care, ensuring care for advanced palliative cancer patients only in urban areas, through home visits, outpatient or inpatient care. However, they are inaccessible to patients living in peri-urban or rural areas, unless they can physically travel to the regional oncology centre where specialised palliative care teams operate. Unfortunately, this is not the case for most patients in advanced or terminal palliative situations.

It is in this context of inaccessibility to palliative care that the palliative care strategic axis of the second National Cancer Prevention and Control Plan (PNPCC2 2020-2029) was designed, emphasising the community approach to palliative care, the proposal of regulatory texts in line with the principles of bioethics, as well as the reinforcement of the training of health professionals in palliative care to achieve full coverage of patients in need of palliative care.²

In fact, the lack of awareness and training in basic palliative care among oncologists, specialists and general practitioners is

one of the obstacles to access to palliative care, in general, and its decentralisation towards primary care.^{3,4}

“I don't know how to prescribe morphine” or “how are we going to manage a stockpile of opioids? This must really be a source of trouble?” or “what if the patient goes into respiratory distress while taking morphine?”.

These are the main fears of healthcare professionals regarding cancer patients in advanced palliative care due to lack of training.⁵ This indirectly raises a second question about the situation of palliative care in Morocco, which is the inaccessibility to opioids. Their supply is limited to regional oncology centres and they are only sold in pharmacies in the cities where these specialised centres are located, despite the fact that Moroccan law allows their prescription by all doctors, regardless of their status as specialists or not.

There is no sense of responsibility, obligation or ethical duty in the caregiving community to “not abandon” a patient at the end-of-life (EoL). On one hand, this is due to a lack of training; on the other hand, this is due to the lack of an “integrated palliative care process (IPC-PC)”. Organisational models are arbitrary, “everyone does what they can”, scenarios are unclear and the patient is lost in an unfocused and complicated system. This biased community approach can be represented as a chain of disconnected rings, though, in reality, it has only two rings at the end of the two extremes: the tertiary level and the community represented only by the patient's family. It does not incorporate all the intermediate rings which should contribute to a coordinated system of palliative care and its good integration in the community: liaison nurses, support teams at the primary care level, volunteer teams, social workers, respite hospitalisations at the provincial hospital level, etc.,³ especially when the patient lives in the periphery or in a rural area.

The development of the IPC-PC model such as the IPC-PC could guarantee good coordination aimed at the continuity of care for cancer patients in palliative care by assigning each healthcare professional, each level of care and all the components of our healthcare system “a well-defined role” in the care of cancer patients from the moment the patient is identified as being in a palliative situation until death. In other words, to define in an institutionalised way the what, who, when, how and where of interventions aimed at the care of these patients.⁶

This will allow patients to benefit from “timely” palliative care. Timely palliative care is early palliative care tailored to the patient’s biopsychosocial and spiritual needs, and delivered at the optimal time and place.^{7,8}

However, the philosophy of palliative care has yet to be promoted among the various actors in the healthcare system. This is a real challenge to which the Lalla Salma Foundation for the Prevention and Treatment of Cancer (FLSC) is committed, not only through the development of the PNPCC in partnership with the Moroccan Ministry of Health, but also through the creation of palliative care units in almost all oncology centres supported by the FLSC (nine centres in total supported by the FLSC, seven of which have a specialised palliative care unit). The FLSC has also provided training for palliative care teams by setting up continuing education courses for nursing staff working in palliative care or general cancer care at the national level. Theoretical training is complemented by practical training at the Palliative Care Unit of the Mohammed VI Centre for Cancer Treatment at the University Hospital of Casablanca, which is currently considered the reference centre for training, organisation and quality management in palliative care at the national level.

Towards this goal of raising awareness of palliative care among health professionals, the Moroccan Association of Palliative Care (AMSP) was formed in 2019, with the main objective of promoting the philosophy of palliative care and to permeate health professionals. In order to cover the training of the maximum number of healthcare professionals, the AMSP has, since its creation, periodically organised certificates in palliative care, webinars accessible to all types of healthcare professionals and, most recently, the first International Congress on Palliative Care under the motto “Cancer Pain in all its States”. The motto chosen is not a trivial one. Through their presentations, national and international speakers have broken all taboos related to cancer pain, addressed to more than 250 participants. The topics of the Congress included: the use of opioids in daily practice, neuropathic pain in cancer, analgesic radiotherapy, breakthrough cancer pain, breaking bad news and spiritual pain in the cancer patient.

Thus, the message conveyed to participants of different profiles was not limited to interdisciplinary participants, was not focused on the medicinal approach to pain, but to the holistic approach to care. Participants were invited to reflect on the depth of the dimensions of humanity, dignity and quality of life, which are intimately linked to person-centered care. The often neglected un-

spoken aspects of medicine, such as the spiritual pain often associated with physical and psychosocial distress⁹ and the awakening of the community of caregivers to compassion is the ultimate key to active and authentic intervention in patients at end-of-life.

CONFLICTS OF INTEREST

The authors declare that they have no conflicts of interest.

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