



TURKISH JOURNAL OF  
EMERGENCY MEDICINE

Access this article online

Quick Response Code:



Website:

[www.turkjemergmed.com](http://www.turkjemergmed.com)

DOI:

10.4103/2452-2473.336105

## Invited Review Article

# The end-of-life care in the emergency department setting with respect to the Middle East countries and comparison with the Western countries

Alamgir Ahmed Qureshi, Jassim Mohammad, Ali Elhaj Mohammed Elkandow, Jagannath Hanumanthappa, Ashok Kumar Ariboyina, Süha Türkmen\*

Department of Emergency Medicine, Hamad Medical Corporation, Doha, Qatar

\*Corresponding author

### Abstract:

Patients who are affected with severe chronic illness or in need for end-of-life care (EOLC), they are mainly treated in the emergency departments (EDs) to provide the utmost amount of care for their condition. The major aspects which impact the accessibility of care in the ED include the clinical, social, and economic factors in different regions of countries. In recent years as the EOLC has been provided, it has been observed that patients experiencing EOL and dealing with a dying process do not always achieve the experience what resonates with a good death. The main cause of concern for these patients is the problem that in the ED they do not have access to palliative care options, mainly the ones who are suffering from noncancer ailments. These patients are provided palliative care at a very later stage in the ED when they could have been provided with palliative management at home in an earlier manner. EOLC plays a very critical role in ensuring that terminally ill patients are given a proper and adequate amount of care. The present article aims to highlight the EOLC in the ED in the Middle-Eastern regions. We aim to present a broader view that has impacted the current situation of EOLC in the Middle East regions and demonstrate a description of the EOLC in an ED setting between the Middle Eastern regions and western culture focusing on the following five important factors: Situation acceptance in the ED, cultural compatibility of bioethics, treatment perspective, skills among clinical providers and physician's attitude. In this literature review, we present the evidence associated with the EOLC in the ED setting with respect to the Middle East countries and bring out their differences in the religious, clinical, social, ethical, and economic aspects in comparison with the Western countries. We also tried to determine the differences between the two regions in terms of the principle of explaining the fatal diagnosis or poor prognosis, family relations, and do-not-resuscitate decision. This comparative analysis will help to bring out the gaps in the quality of care in the ED in the Middle East countries and promote the development of well-assessed policies and strategies to improve EOLC. The findings of this study and the future interventions that can be implemented to improve the structure and design of the EOLC that will act as a guiding force to execute evidence-based quality improvement program.

### Keywords:

Emergency medicine, end-of-life care, intensive care, palliative care

## Introduction

The main goal of emergency medicine (EM) is to treat the situation

or the condition that demands immediate attention such as resuscitate and stabilize them in a time-restricted environment and finally establish a definitive line of treatment where the patients are admitted to an

This is an open access journal, and articles are distributed under the terms of the Creative Commons Attribution-NonCommercial-ShareAlike 4.0 License, which allows others to remix, tweak, and build upon the work non-commercially, as long as appropriate credit is given and the new creations are licensed under the identical terms.

**How to cite this article:** Qureshi AA, Mohammad J, Mohammed Elkandow AE, Hanumanthappa J, Ariboyina AK, Türkmen S. The end-of-life care in the emergency department setting with respect to the Middle East countries and comparison with the Western countries. Turk J Emerg Med 2022;22:1-7.

For reprints contact: [WKHLRPMedknow\\_reprints@wolterskluwer.com](mailto:WKHLRPMedknow_reprints@wolterskluwer.com)

Submitted: 02-08-2021

Revised: 01-09-2021

Accepted: 01-09-2021

Published: 20-01-2022

### ORCID:

AAQ: 0000-0002-6946-1310

JM: 0000-0002-0012-9635

AE: 0000-0003-0949-7722

JH: 0000-0002-7020-7598

AKA: 0000-0002-8113-4039

ST: 0000-0002-8010-4453

### Address for correspondence:

Prof.Süha Türkmen,  
Department of Emergency  
Medicine, Hamad Medical  
Corporation, Doha, Qatar.  
E-mail: [drsuhaturkmen@hotmail.com](mailto:drsuhaturkmen@hotmail.com)



appropriate facility. However, in the case of patients at the end-of-life (EOL), all these methodologies cannot be implemented as these patients do not have a health status similar to the patient who does not have any terminal condition. In addition, the emergency procedures such as resuscitation and other active treatments cannot be performed on these terminally ill patients especially if they are not willing to undergo such treatments. The patients at EOL may comprise of different characteristics including a variety of demographic, social, clinical, and psychosocial factors related to the time and location of the death.<sup>[1]</sup> The main cause of concern for these patients is the problem that in the Emergency departments (ED) they do not have access to palliative care options, mainly the ones who are suffering from noncancer ailments.<sup>[2]</sup>

These patients are provided palliative care at a very later stage in the ED when they could have been provided with palliative management at home in an earlier manner. Patients who are affected with severe chronic illness or in need for EOL care (EOLC), they are mainly treated in the EDs to provide the utmost amount of care for their condition.<sup>[3]</sup> In recent years as the EOLC has been provided, it has been observed that patients experiencing EOL and dealing with a dying process do not always achieve the experience what resonates with a good death despite five-fold increase in inpatient cost.<sup>[4]</sup>

In Middle East countries, there is a range of demographic, socioeconomic, and political diversity. There is the growing number of the aging population despite the occurrence of "Youth Bulge." The increased longevity of the people among the Middle East countries is not necessarily associated with ill health, but it denotes that a higher proportion of the population is having high life expectancy which means a larger fraction of the population will require more care and support as they approach the EOL stage demanding greater EOLC. To assess the level of palliative care among different regions of the world, Clark and Wright divided these countries into four main groups, namely: (1) countries that do not have any palliative care activity, (2) countries that are in the process of developing palliative care facility, (3) countries that have the facility of palliative care at specific locations only, (4) countries where the facility of palliative care is directly associated with the maintenance of the public health system. Among all these groups, Clark and Wright were unable to identify any Middle East country in Group 4.<sup>[5]</sup> This projects that the EOLC lacks the level of quality as well as a well-defined system that is seen in many Western countries.

In this literature review, we present the evidence associated with the EOLC in the ED setting with respect to the middle east countries and bring out their differences in the religious, clinical, social, ethical, and economic

aspects in comparison with the Western countries. This comparative analysis will help to bring out the gaps in the quality of care in the ED in the middle east countries and promote the development of well-assessed policies and strategies to improve EOLC.

## Review of the Literature

A computerized literature search was performed in MEDLINE (PubMed), the Cochrane Library, and Scopus databases by using specific keywords to identify all relevant articles. The articles were identified by using the following keywords in different combinations: "terminal care," "Middle East," "Western," "end-of-life," "quality of life," "palliative care," "emergency department," "intensive care," "last year of life," "death," or "dying."

Out of the 180 articles indicated in Table 1, 115 articles did not meet the relevance of the topic as observed by screening the content of the title and abstract. The rest of the 65 articles were evaluated properly, reviewed for the level of quality and whether it met the literature review requirements. After a detailed examination, it was found that 39 articles did not specifically assess the level of EOLC in the Western or the Middle Eastern regions and were therefore excluded. Finally, 26 articles were selected and included as they fulfilled the review articles demands linked with the ED setting.

After including the 26 articles that were selected for the literature review, we identified that majority of the articles had a low score of citation level as compared to the articles that were based on different topics in the same journal. The majority of the journals had articles published on the EOLC topic in an ED setting in the past few years. A large proportion of published research was undertaken in the past 5 years accounting for its less citations. Out of the total 26 articles, 4 articles had <10 citations,<sup>[6-9]</sup> 11 articles<sup>[10-20]</sup> had citations between 10 and 50, 4 of the articles<sup>[21-24]</sup> had between 51 and 100, only 2 articles<sup>[25-27]</sup> had more than 100 citations and 5 of the included articles<sup>[28-30]</sup> had no citations.

**Table 1: Keywords used in the literature review**

Strategy	MeSH	Results
1	Terminally ill	11,769
2	Terminal care and hospice care and palliative care and end of life care	5696
3	Terminally ill/or place of death/or middle east	996
4	Terminally ill/or place of death/or western	3718
5	1 and 2 and 3	403
6	1 and 2 and 4	1078
7	Emergency/or emergency department	427,183
8	5 and 6 and 7	102
9	Replicated steps 1-8 using MEDLINE (PubMed), and the Cochrane library	180

MeSH=Medical subject headings

It was observed after evaluating the articles that in the majority of the Middle Eastern regions the hospital and community-based palliative services are present, however, the level of delivery is quite low as they attend to only 10%–15% of the population needs.<sup>[14]</sup>

### End-of-life care difference between the middle east and western regions

In the ED people who have been admitted for chronic and terminal illness usually tend to develop various other ailments displaying severe symptoms after their long stay at the hospital. In general, most of these care institutions follow conservative treatments and methodologies that consist of medications providing pain relief and targeting the physical symptoms. The main aim is to make the patients comfortable and treat their physical symptoms.<sup>[14]</sup> After careful analysis, we have identified the comparative approach that will help highlight the differences in social, cultural, religious, clinical, and ethical aspects between the Western and Middle Eastern regions.

#### Social aspects

The reason for the social difference between the two regions is the difference in “accepting the situation in the ED.” Most of the Middle Eastern regions follow the principle of disclosing the fatal diagnosis or poor prognosis to any of the close family members instead of sharing it with the patient himself.<sup>[31]</sup> It is assumed by the family members of the Middle Eastern countries that sharing the reality of the patient’s condition will further make the patient hopeless, create a sense of anger and disappointment and promote his mental and physical suffering hastening his death. More than 70% of the physicians and patients in Middle Eastern countries agree that withholding medical information associated with the patient’s condition is more humane and ethical.<sup>[32]</sup>

The situation is completely different in Western culture. In their autonomy-dominant paradigm, truth-telling about any medical situation is very important. They believe that clear communication and initial phase of sadness is necessary so that the patient, as well as the family members, can address their unspoken fears, discuss all possibilities of treatment and support options and therefore the patients, family members and the physician can plan for the future in a better way.<sup>[33]</sup>

The majority of the Muslim patients believe that it is God who decides death and therefore, any loss of hope is judged as an indication to loss of faith in God. Hence, they find it disrespectful to their culture and religion if they discuss even the probability of death as it is in God’s hands according to their belief.<sup>[34]</sup>

#### Cultural aspects

In the Middle Eastern regions, the families and communities are very concerned about each other’s well-being.<sup>[35]</sup> The family provides a support system, source of strength, positivity, and hope to each other. Due to close association between all the family members, as compared to many Western families the principle of autonomy is not frequently followed. The family is the key holder to make decisions on behalf of each other. In the Middle Eastern regions, the family members are given the complete medical information regarding the patient’s illness and it is decided by them whether sharing the information is helpful for the patient.<sup>[36]</sup>

In the Western culture, it is totally dependent on the patient’s willingness and needs what needs to be done further to improve his/her condition. The physician closely coordinates the situation with the patient and ensures that he is provided the best possible treatment if the condition allows. The family also makes suggestions and jointly they work toward an approach what is best for the patient. The autonomy of decision-making is not solely on the family members. This helps in allowing a medical practitioner to follow a systematic approach for providing EOLC instead of only following what the family members feel.

In the Middle Eastern regions, the cultural background plays a strong part in following the guidelines whenever any decision needs to be made. However, it is considered that any medical practices should be considered well enough instead of blindly adapting to cultural values.

#### Religious aspects

The religious “perspective on treatment” is different in the two regions. In the Islamic religion, it is believed that God is the sole creator who decides the death of any human being.<sup>[37]</sup> Therefore, the people of the Middle Eastern regions believe that medical professionals should ensure that the patient is given maximum care to prevent premature death and save life.<sup>[34]</sup> The physician in such situations does all in his power to promote the care and provide pain relief by opting for the suitable treatment modality.<sup>[31]</sup> In the quest to prolong the life of the patient family members often advocate to continue futile treatment.<sup>[38]</sup> On the other hand, many Islamic scholars also believe that if the treatment is going to impose pain and suffering on the patient it is completely unacceptable in Islam as mentioned in the Qur’an that a human body has its own limitations.<sup>[39]</sup> There are very few hospitals in Middle Eastern regions that allow to undergo a “Do Not Resuscitate” (DNR) protocol so that the patient could die peacefully.<sup>[40]</sup> It represents that the process of delaying death is just a painful experience for the patient and also compromises the resources that could be used for others.

In Western cultures, the concept of medical futility is accepted in a much better way. According to their guidelines, it is stated that medical professionals do not need to provide any futile treatment as it is not an ethical obligation.<sup>[41]</sup> In countries such as the UK, the balance between futile and beneficial treatment is always weighed upon. The family members are clearly explained the reasons behind the option that is chosen considering the patient well-being at all times. Therefore, the medical professionals do not ask for permission to either continue or stop any given treatment but act logically and inform the family members what decision will be in the best interest for the patient and the reason behind that.

### Clinical aspects

“Skills Among Clinical Providers” also differ between the two regions. It is very important that regular training and educational courses should be planned in such a way that it promotes the skills of the clinicians and other health-care providers. EOLC for the critically ill patients in the ED demands quality service that ensures all the patient’s needs are adequately met. Therefore, it should be the main goal of all the palliative service providers in the Middle Eastern regions.<sup>[42]</sup> In places like Israel and other Middle Eastern countries, there are frameworks designed specifically for providing training and education related to EOLC services. Usually, the programs that were developed were the short term and dependent on funding and donations.<sup>[4]</sup> Even though the curriculum associated with the training programs is designed for undergraduate and postgraduate, but it provides very little training that is actually needed for palliative care. The topics relating to suffering and terminal illness included for the nursing or medical students are highlighted as a general topic with no specific guidelines.<sup>[43]</sup> The education and different training programs for making the young medical professionals aware about the illness and care provided at the EOL exist, but they are not properly arranged or systematically integrated into the education system. This results in a lack of skills and proper attitude of the healthcare providers who were not guided into the process of providing palliative care initially.

In the Western nations, there has been a lot of training and education programs that have focused on the development of palliative services.<sup>[42]</sup> There are numerous fellowship programs in the US that are targeting the EOLC and palliative services. There is a systematic and integrated approach for the medical specialist to obtain the knowledge related to the management and care of a terminally ill patient.

### Ethical aspects

Differences in the ethical aspect are the “attitude of physicians.” The direction to withhold the patient’s

cardiac and pulmonary resuscitation denotes the DNR medical instruction. This DNR was passed by the fatwa (Islamic ruling) issued on 30/6/1409 (1988/1989), No. 12086. It mentions that the DNR is medically decided when three specialists and competent physicians agree that the treatment is futile for severely ill patients whose condition has worsened.<sup>[44]</sup>

Even though in the Western countries also, it is believed that DNR should be based on patient’s situation as assessed by the medical professional similar to that followed in Islamic cultures. It is the attitude and the communication to the family members that make a huge difference. In the western nations, the families are informed and shared the reasons so that they also understand why it is done. This is not conducted properly in the Middle Eastern countries so that it leads to dissatisfaction and lack of trust among the family members.<sup>[45]</sup>

It has been observed that 60%–70% of the people who are admitted to the hospital are aware of their chronic disease and expect that at the EOL they will be staying in the ED and the modern therapeutics and treatment cannot change their condition.<sup>[46]</sup> The best approach to make the dying stage of such patients comfortable is to organize and implement care services. The care for these patients will need a lot of patience, will be time-consuming, and demands interaction with the family members regularly.

## End-of-Life Care Improvement Recommendations

It needs the development of specific guidelines and policies that will help to build stronger and better quality care services in the Middle Eastern countries. Following is a list of policy and practice recommendations: specialized training, systematic planning and decision making, Improvement in the infrastructure and strategic planning, evidence-based research related to EOLC in an ED setting, and Public awareness.

### Specialized training

To provide a quality EOLC, systematically abide by all the guidelines and implement the palliative care services it is very important that the physicians should be trained effectively and efficiently by bringing out a modification in their approach towards education and training. The Middle Eastern nations do not have a separate and standard curriculum for providing EOLC and palliative care training in the graduation or postgraduation level for the medical and nursing colleges. Therefore, a structured curriculum should be designed that is not only academically oriented but also provides a thorough clinical perspective to the medical students, clinicians, and other healthcare professionals.

### Systematic planning and decision making

Majority of the elderly people during their admission in the ED present with multiple problems and comorbidities such that it results in the collaboration of different specialists and medical team members to get involved. However, it is seen that there is no coordination or a sense of leadership among the members to discuss regarding the patient's situation and the treatment options to be offered. Overall, a systematic approach should be followed, and clear steps should be planned in an ED setting. The numerous factors that will impact the EOLC such as prognosis, life stage of the patient, expectations, and goals of care. This will help to provide palliative care that meets all the demands of the patient as well as the family members.

### Improvement in the infrastructure and strategic planning

There is a lack of palliative care services in the Middle Eastern countries as the resource allocation is not done adequately to ensure quality EOLC in the hospital organizations. There is huge gap in the kind of medical care and attention given to the densely populated location than that of the sparsely populated areas in the Middle Eastern countries. Additionally, it has been observed that people with varied socioeconomic characteristics are also given an unequal EOLC. Therefore, the government, as well as the private organizations, should make sure that the palliative care services are distributed evenly with proper resources allocated to the people who are most in need of it.<sup>[47]</sup>

### Evidence-based research related to end of life care in an emergency department setting

In the Middle Eastern countries, as the palliative care organizations are still getting structured and designed there is no systematic framework that can provide collaborative research. There have been few individual researches that were updated and revised such as the impact of morphine in the management of pain caused due to cancer after the involvement of the Expert Working Group of the Steering Committee of the Research Network of the European Association of Palliative Care. In many of the Middle Eastern countries research has mainly targeted cancer patients and methods to provide effective EOLC. However, the palliative care needs and guidelines for other chronic conditions should also be taken into consideration. Due to changing patterns in life, death, and disease occurrence, it is necessary now that research should be conducted to provide an evidence-based public health policy.<sup>[48,49]</sup>

### Public awareness

As the population in the Middle Eastern countries is not properly aware of the role of palliative care facilities,

therefore, they do not even consider it for their near and dear ones. A large-scale campaign should be implemented to raise awareness and attention regarding the importance of palliative care that can improve the quality of life and make the patient comfortable surrounded by his friends and families.

It is observed that with growing cultural diversity, varied religious beliefs, and different socioeconomic infrastructure the EOLC facilities will also differ. It is difficult for health care professionals to adopt to specific guidelines that could meet the needs of the medical practice as well as the cultural and ethical model. Even though cultural and religious beliefs will always play a very important role in ensuring EOLC in the Middle Eastern countries but the training and level of education should be provided to the young medical students in such a way that they communicate with the patient and family members openly and honestly. In the present review paper, we have demonstrated a comparative description of the EOLC in an ED setting between the Middle Eastern regions and Western culture. The findings of the study and the future interventions that can be implemented to improve the structure and design of the palliative services will act as a guiding force to execute evidence-based quality improvement program.

### Acknowledgment(s)

We verify and confirm that everyone who contributed to this manuscript is either listed as an author or acknowledged as a contributor in the acknowledgment section and that the title page details any professional writing assistance or others paid to provide manuscript support.

### Author contributions statement

AAQ, JM, AEME; Conceptualization – Data curation – Formal analysis – Investigation – Methodology.

AAQ, JH, AKA, ST; Software – Supervision – Validation – Visualization – Writing – original draft – Writing – review and editing.

### Conflicts of interest

None Declared.

### Funding

None.

## References

1. Small N, Gardiner C, Barnes S, Gott M, Payne S, Seamark D, *et al.* Using a prediction of death in the next 12 months as a prompt for referral to palliative care acts to the detriment of patients with heart failure and chronic obstructive pulmonary disease. *Palliat Med* 2010;24:740-1.
2. Shanley C, Whitmore E, Khoo A, Cartwright C, Walker A, Cumming RG. Understanding how advance care planning is approached in the residential aged care setting: A continuum model of practice as an explanatory device. *Australas J Ageing* 2009;28:211-5.
3. Hillman K. Dying safely. *Int J Qual Heal Care* 2010;22:339-40.

4. Kardamanidis K, Lim K, Da Cunha C, Taylor LK, Jorm LR. Hospital costs of older people in New South Wales in the last year of life. *Med J Aust* 2007;187:383-6.
5. Clark D, Wright M. The international observatory on end of life care: A global view of palliative care development. *J Pain Symptom Manage* 2007;33:542-6.
6. Masood UR, Said A, Faris C, Al Mussady M, Al Jundi A. Limiting intensive care therapy in dying critically ill patients: Experience from a tertiary care center in United Arab Emirates. *Int J Crit Illn Inj Sci* 2013;3:200-5.
7. Al-Yateem N, Al-Tamimi M, Brenner M, Al Tawil H, Ahmad A, Brownie S, *et al.* Nurse-identified patient care and health services research priorities in the United Arab Emirates: A Delphi study. *BMC Health Serv Res* 2019;19:77.
8. Di Leo S, Alquati S, Autelitano C, Costantini M, Martucci G, De Vincenzo F, *et al.* Palliative care in the emergency department as seen by providers and users: A qualitative study. *Scand J Trauma Resusc Emerg Med* 2019;27:88.
9. Reuter Q, Marshall A, Zaidi H, Sista P, Powell ES, McCarthy DM, *et al.* Emergency department-based palliative interventions: A novel approach to palliative care in the emergency department. *J Palliat Med* 2019;22:649-55.
10. Kranidiotis G, Gerovasili V, Tasoulis A, Tripodaki E, Vasileiadis I, Magira E, *et al.* End-of-life decisions in Greek intensive care units: A multicenter cohort study. *Crit Care* 2010;14:R228.
11. ur Rahman M, Abuhasna S, Abu-Zidan FM. Care of terminally-ill patients: An opinion survey among critical care healthcare providers in the Middle East. *Afr Health Sci* 2013;13:893-8.
12. Bentur N, Emanuel LL, Cherney N. Progress in palliative care in Israel: Comparative mapping and next steps. *Isr J Health Policy Res* 2012;1:1-13.
13. Forero R, McDonnell G, Gallego B, McCarthy S, Mohsin M, Shanley C, *et al.* A Literature review on care at the end-of-life in the emergency department. *Emerg Med Int* 2012;2012:1-11.
14. Damghi N, Belayachi J, Aggoug B, Dendane T, Abidi K, Madani N, *et al.* Withholding and withdrawing life-sustaining therapy in a moroccan emergency department: An observational study. *BMC Emerg Med* 2011;11:12.
15. Miller AC, Ziad-Miller A, Elamin EM. Brain death and Islam: The interface of religion, culture, history, law, and modern medicine. *Chest* 2014;146:1092-101.
16. Boucher NA, Siddiqui EA, Koenig HG. Supporting Muslim patients during advanced illness. *Perm J* 2017;21:16-190.
17. Correa-de-Araujo R. Evidence-based practice in the United States: Challenges, progress, and future directions. *Health Care Women Int* 2016;37:2-22.
18. Huang HL, Cheng SY, Yao CA, Hu WY, Chen CY, Chiu TY. Truth telling and treatment strategies in end-of-life care in physician-led accountable care organizations: Discrepancies between patients' preferences and physicians' perceptions. *Medicine (Baltimore)* 2015;94:e657.
19. Abolfotouh MA, Al-Assiri MH, Alshahrani RT, Almutairi ZM, Hijazi RA, Alaskar AS. Predictors of patient satisfaction in an emergency care centre in central Saudi Arabia: A prospective study. *Emerg Med J* 2017;34:27-33.
20. Baynouna LM, Shamsan AI, Ali TA, Al Mukini LA, Al Kuwiti MH, Al Ameri TA, *et al.* A successful chronic care program in Al Ain-United Arab Emirates. *BMC Health Serv Res* 2010;10:47.
21. Mierendorf SM, Gidvani V. Palliative care in the emergency department. *Perm J* 2014;18:77-85.
22. de Pentheny O'Kelly C, Urch C, Brown EA. The impact of culture and religion on truth telling at the end of life. *Nephrol Dial Transplant* 2011;26:3838-42.
23. Hussein S, Ismail M. Ageing and elderly care in the Arab region: Policy challenges and opportunities. *Ageing Int* 2017;42:274-89.
24. Puchalski CM, Kilpatrick SD, McCullough ME, Larson DB. A systematic review of spiritual and religious variables in Palliative Medicine, American Journal of Hospice and Palliative Care, Hospice Journal, Journal of Palliative Care, and Journal of Pain and Symptom Management. *Palliat Support Care* 2003;1:7-13.
25. da Costa DE, Ghazal H, Al Khusaiby S. Do Not Resuscitate orders and ethical decisions in a neonatal intensive care unit in a Muslim community. *Arch Dis Child Fetal Neonatal Ed* 2002;86:F115-9.
26. Wiener L, McConnell DG, Latella L, Ludi E. Cultural and religious considerations in pediatric palliative care. *Palliat Support Care* 2013;11:47-67.
27. Pegg AM, Palma M, Roberson C, Okonta C, Nkokolo Massamba / Koudika MH, Roberts N. Providing end-of-life care in the emergency department: Early experience from Médecins Sans Frontières during the COVID-19 pandemic. *Afr J Emerg Med* 2020;10:103-4.
28. Madadin M, Alsaffar GM, AlEsa SM, Khan A, Badghaish DA, Algarni SM, *et al.* Clinicians' attitudes towards do-not-resuscitate directives in a teaching hospital in Saudi Arabia. *Cureus* 2019;11:e6510.
29. Bodas M, Velan B, Kaplan G, Ziv A, Rubin C, Peleg K. Assisted life termination and truth telling to terminally ill patients – A cross-sectional study of public opinions in Israel. *Isr J Health Policy Res* 2020;9:57.
30. Economos G, Cavalli P, Guérin T, Filbet M, Perceau-Chambard E. Quality of end-of-life care in the emergency department. *Turk J Emerg Med* 2019;19:141-5.
31. Mobeireek AF, Al-Kassimi F, Al-Zahrani K, Al-Shimemeri A, Al-Damegh S, Al-Amoudi O, *et al.* Information disclosure and decision-making: The middle east versus the far east and the west. *J Med Ethics* 2008;34:225-9.
32. Kagawa-Singer M, Blackhall LJ. Negotiating cross-cultural issues at the end of life: "You got to go where he lives". *JAMA* 2001;286:2993-3001.
33. Montazeri A, Tavoli A, Mohagheghi MA, Roshan R, Tavoli Z. Disclosure of cancer diagnosis and quality of life in cancer patients: Should it be the same everywhere? *BMC Cancer* 2009;9:39.
34. Sachedina A. End-of-life: The Islamic view. *Lancet* 2005;366:774-9.
35. Chattopadhyay S, Simon A. East meets west: Cross-cultural perspective in end-of-life decision making from Indian and German viewpoints. *Med Health Care Philos* 2008;11:165-74.
36. Hanssen I. From human ability to ethical principle: An intercultural perspective on autonomy. *Med Health Care Philos* 2004;7:269-79.
37. Searight HR, Gafford J. Cultural diversity at the end of life: Issues and guidelines for family physicians. *Am Fam Physician* 2005;71:515-22.
38. Zahedi F, Larijani B, Bazzaz JT. End of life ethical issues and Islamic views. *Iran J Allergy Asthma Immunol* 2007;6:5-15.
39. Younge D, Moreau P, Ezzat A, Gray A. Communicating with cancer patients in Saudi Arabia. *Ann NY Acad Sci* 1997;809:309-16.
40. Yazigi A, Riachi M, Dabbar G. Withholding and withdrawal of life-sustaining treatment in a Lebanese intensive care unit: A prospective observational study. *Intensive Care Med* 2005;31:562-7.
41. Emanuel L. Changing the norms of palliative care practice by changing the norms of education. In: Bruera E, Higginson IJ, Ripamonti C, von Gunten C, editors. *Textbook of Palliative Medicine*. 1<sup>st</sup> ed., Vol. 1. London, UK: Hodder Arnold; 2009. p. 146-52. Available from: [https://books.google.com/books?hl=tr&lr=&id=QsofyIjFCeYC&oi=fnd&pg=PA146&dq=Emmanuel+L.+Changing+the+norms+of+palliative+care+practice+by+changing+the+norms+of+education.+In:+Bruera+E,+Higginson+IJ,+Ripamonti+C,+von+Gunten+C,+editors.+Textbook+of+Palliative+Medicine.+Hodder+Arnold%3B+2006.+p.+146-52.+&ots=ANHDjy1s0f&sig=TyT0otyHYWG\\_QMfD8IY0UCstjcm](https://books.google.com/books?hl=tr&lr=&id=QsofyIjFCeYC&oi=fnd&pg=PA146&dq=Emmanuel+L.+Changing+the+norms+of+palliative+care+practice+by+changing+the+norms+of+education.+In:+Bruera+E,+Higginson+IJ,+Ripamonti+C,+von+Gunten+C,+editors.+Textbook+of+Palliative+Medicine.+Hodder+Arnold%3B+2006.+p.+146-52.+&ots=ANHDjy1s0f&sig=TyT0otyHYWG_QMfD8IY0UCstjcm). [Last accessed on 2021 Aug 12].
42. Zemishlany Z, Nahshoni E. Caring for the dying patient. *Harefuah*

Qureshi, *et al.*: The end of life care in the emergency department setting

- 2009;148:34-5.
43. Amoudi AS, Albar MH, Bokhari AM, Yahya SH, Merdad AA. Perspectives of interns and residents toward do-not-resuscitate policies in Saudi Arabia. *Adv Med Educ Pract* 2016;7:165-70.
  44. Al Sheef MA, Al Sharqi MS, Al Sharief LH, Takrouni TY, Mian AM. Awareness of do-not-resuscitate orders in the outpatient setting in Saudi Arabia. Perception and implications. *Saudi Med J* 2017;38:297-301.
  45. Gouda A, Al-Jabbary A, Fong L. Compliance with DNR policy in a tertiary care center in Saudi Arabia. *Intensive Care Med* 2010;36:2149-53.
  46. Hébert PC. Do not resuscitate orders: Considerations for family physicians. *Can Fam Physician* 1991;37:1381-5.
  47. Clark K, Phillips J. End of life care – The importance of culture and ethnicity. *Aust Fam Physician* 2010;39:210-3.
  48. Hanks GW, Conno F, Cherny N, Hanna M, Kalso E, McQuay HJ, *et al.* Morphine and alternative opioids in cancer pain: The EAPC recommendations. *Br J Cancer* 2001;84:587-93.
  49. Mercadante S, Radbruch L, Caraceni A, Cherny N, Kaasa S, Nauck F, *et al.* Episodic (breakthrough) pain: Consensus conference of an expert working group of the European Association for Palliative Care. *Cancer* 2002;94:832-9.