

ISRAEL

Israel (population 6.2 million)¹ is a country in the Middle East that covers an area of 20,770 sq. km. It borders the Mediterranean Sea between Egypt and Lebanon and with land bordering Egypt, Jordan, Lebanon, and the Palestinian Authority in the Gaza Strip and West Bank.

The population includes about 187,000 Israeli settlers in the West Bank, about 20,000 in the Israeli-occupied Golan Heights, and fewer than 177,000 in East Jerusalem.²

According to the United Nations Human Development Index (HDI), Israel is ranked 22/177 countries worldwide (value 0.908)³. This places Israel in the group of countries with high human development.



PALLIATIVE CARE SERVICE PROVISION

Current services

Eleven organisations offer palliative care for adults in Israel delivering a total of 27 services mainly for adults via 7 home hospices (includes 1 mobile unit), 4 inpatient hospice units (3 are freestanding units, 1 is hospital based) and 2 hospitals offering inpatient palliative care. Around 6 of these services offer paediatric palliative support (Table 1).

Table 1 Palliative care provision in Israel, 2005

	Freestanding unit	Hospital unit	Hospital consultation	Paediatric support	Home care	Day care	OPD clinic	Drop-in centre	Grand Total
Tel-Hashomer Hospice, Sheba Medical Centre	1				1		1		3
Ina and Jack Kay Hospice, Hadassah, Mount Scopus	1				1				2
Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Center		1	1			1	1		4
Hannah Eshed Hospice, Nof Hadar Hospital, Haifa	1								1
Negev Palliative Care Services ~ home hospice ~desert mobile unit ~ hospital consultation service ~ Ma'agan House			1	1	1			1	5
Milton and Lois Shiffman Home Hospice in the Valleys					1				1
Home Care Hospice of Kiryat Tivon					1				1
Jerusalem Home Hospital				1	1				2
Nancy Caroline Hospice of the Upper Galilee					1				1
St Louis Mission, Jerusalem		1							1
Italian Hospital, Haifa		1							1
Edmond and Lily Safra Children's Hospital				1					1
Meyer Children's Hospital				1					1
The Marion and Elie Wiesel Children's Pavilion		1		1					2
Schneider Children's Medical Centre				1					1
Total	3	4	2	6	8	1	2	1	27

In addition to these specialist services around 80 community health centres will provide pain and symptom relief for patients at the end of life at home. Some oncology clinics also provide psychosocial palliative support. There are over 500 oncology nurses in Israel, most of whom have completed a formal postgraduate oncology nursing qualification which includes symptom management and palliative care. Around 30 oncology nurses have completed further palliative care training. These nurses work in hospital oncology units or in community health settings; some of those with further training are based in the specialist palliative care organisations.

A National Cancer Control Program (NCCP) for Israel was established during the early 2000s.^{4 5} A National HIV/AIDS Policy was established in the late 1990s.⁶ These policies include an acknowledgment of palliative care as a component of the management in HIV/AIDS and cancer control. The NCCP has an advisory committee set up to examine palliative care needs.⁷

Tel-Hashomer Hospice, (Miriam and Max Freedman House), Sheba Medical Centre, Tel Aviv

Tel Hashomer provides end of life care and support to cancer patients and their families.⁸ The hospice is situated at the Chaim Sheba Medical Centre, a large regional 1,563 bed hospital. The hospice founded in 1983 by Dr Marian Rabinowitz,⁹ was the first specialist palliative care service to be established in Israel. The service has developed a multi-professional team (physicians, nurses, physiotherapist, social workers, and clinical psychologist) who are particularly experienced in offering specialist pain and symptom relief, together with psychosocial care and physiotherapy. The service includes:

- a purpose-built, 22 bed inpatient unit (staff and patients moved into the new building from the original, older facility in 2003),
- a homecare team providing 24 hour care for up to 20 patients from within a 25 mile radius from the hospice
- a palliative care outpatient clinic at the oncology department of the Sheba Medical Centre.

The service is based on an ethos of providing the best quality care at the end of life in a tranquil environment with adequate symptom management and support but with as little intervention as possible.¹⁰ The service does not encourage unnecessary tests, routine use of oxygen or antibiotics.¹¹ The average duration of care is 16-18 days. Patients are referred by their physician or oncologist – dependent on approval from the Medical Centre's health insurance provider.¹²

Ina and Jack Kay Hospice, Hadassah Mount Scopus, Jerusalem

The hospice, founded in 1986 by Dr Theodor Fink and Ruth Gassner RN MA and situated in the grounds of the 300 bed Hadassah Mount Scopus Hospital, provides end of life care and support to adults with cancer and their families. Working as a multi-professional team (physician, nurses, social workers, physiotherapist and occupational therapist) under the directorship of Ruth Gassner, the service offers specialist pain and symptom control, physiotherapy, occupational therapy and psychosocial support. A part time art therapist also attends the hospice at various times.¹³

The hospice service includes:

- a 14 bed inpatient unit (renovated in 2004)
- a homecare service providing 24 hour care for up to 20-25 patients
- links with the charitable organisation Yad Sarah that lends nursing and home care equipment (hire is free or in exchange for a donation)

In 2003, the inpatient unit cared for 170 patients. Fifty patients were cared for by the homecare service which provides 24 hour nursing care from a team of nurses working from the hospice.¹⁴ The hospice has developed a highly individualised service with dedicated and skilled psychosocial support led by social worker Malka Yehezkel. The team also works with trained volunteers who are able to offer general support to patients and their families. The social worker and other team members provide opportunities from the first assessment for patients and families to share anxieties and discuss concerns with hospice staff. Families are encouraged and supported to be involved in their relatives care equally at home or in the hospice unit. Members of the hospice team (the senior physician and home care nurses) run a counselling support service for patients in the hospital who transfer to the hospice.. The hospice also offers bereavement support.

Part of the palliative care in this service includes maintaining varying degrees of medical intervention. For instance, senior physician and researcher Dr Daniel Azoulay may, in addition to pain relief and symptom management, also prescribe antibiotics, oxygen and subcutaneous fluids to be used if appropriate.¹⁵

Patients, or their families, can self-refer or they are referred by staff in a hospital unit, or their family physician or oncologist.¹⁶

Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem

The Cancer Pain and Palliative Medicine Service, established in 1994, is part of the oncology unit at Sha'are Zedek, a large 500 bed medical centre in Jerusalem. The diverse, multi-professional, multi-lingual team includes physicians, general and oncology nurses, a research co-ordinator (who is also a clinical pharmacologist), social workers, a spiritual counsellor and a consultant psychiatrist. The team offers integrated oncology and palliative care including spiritual counselling to adult patients with cancer. The service has:

- an out patient unit
- a day care service
- a 22 bed inpatient unit (opened in 2003)
- inpatient consultation service

The inpatient unit was opened for the acute management of haematology and oncology patients and for those in need of palliative care. Dr Nathan Cherny explains:

‘The average census is that there will probably be about 12 palliative care inpatients at any one time. The sorts of problems that are dealt with are acute symptom control problems, patients who are imminently dying, patients who are not coping at home but are not imminently dying. We will generally stabilise them and in most cases pass them on to the hospice or the French Hospital. Occasionally they will stay with us until they die.’¹⁷

In 2004 a full time spiritual counsellor, Jonathan Rudnick, joined the Service and his role in the team has proved successful for many patients whether they are religious or secular,

and is felt by staff to have provided a very positive contribution to the Service's overall ethos of supporting the whole person.¹⁸ The Service provides palliative care for around 500 new patients per year, seeing around 1000 patients per month of which a third require palliative care. Patients are referred to the palliative care services by oncologists within the unit and from other departments.

Negev Palliative Care Services, Beersheva

The service works as a multi-disciplinary team (physicians, nurses, social workers) offering specialist pain and symptom relief and a range of psychosocial support for adults and children with cancer.¹⁹ The service was established in 1991 as a home care service for adults in the city of Beersheva. In 1994 a more extensive home based service was initiated and a hospital consultation service developed for adults.²⁰ Since the establishment of the children's oncology unit at Soroka Medical Centre in 1999, the service also offers inpatient palliative care consultation for children.

Based in Beersheba, the only major city in the south of the Israel in the Negev desert, the service has to serve a large multi-cultural population dispersed over hundreds of miles.²¹ The organisation has responded to this challenge by developing several different multi-professional services including:

- three homecare teams working over a wide area from different urban locations
 - Beersheva: up to 24 patients
 - Qiryat Gat : up to 46 patients per year
 - Rahat: between 4-6 patients (up to 14 per year)
- a mobile desert unit (set up in May 2004) up to 26 patients
- a bereavement service based in Beersheva and run by trained volunteers
- Ma'agan House, a charitable drop-in day centre, situated in Beersheba; this centre offers psychosocial support including therapy support groups, art and music therapy
- hospital based adult and paediatric palliative care consultation and support offered at the only regional hospital, the 1,000 bed Soroka Medical Centre in Beersheva.²²

The homecare teams offer 24 hour support. Each year, the teams care for around 140 patients at the end of life. Roughly 78% of these patients are able to be supported to die in their own home. Seventy percent of those who die in hospital are only admitted in the last 24 hours of life. Admission to the homecare service is based on three criteria, as medical director Dr Yoram Singer explains:

‘There must be a main caregiver, so the patient is never alone and he must be in such a situation that he can't get his medical care in the local clinic. He has to be more or less housebound. Average duration of treatment is 47 days, so we're really talking about the very end. ... ‘

The hospital consultation service is accessible all patients in Soroka Medical Centre, Beersheva: they have either to be referred by their physician or oncologist, or they or their family may request referral. Dr Singer reports:

‘This year [2004-2005] I've seen about 450 patients. I see patients at the oncology day care and I get called to the various wards to give consultations ... Many services are supported by volunteers; for example, the bereavement service -

currently being developed – is organised by social workers with a large group of trained volunteers.²³

Patients may self-refer to one of the three homecare service teams or be referred by one of the hospice service oncologists following a hospital consultation, or be referred by their own physician or oncologist from another department.

The homecare service has strong team support for permanent and student placement staff (family medicine trainee physicians). The team convenes once weekly report and supervision meetings and senior team members provide 24 hour on-call advice.

Milton and Lois Shiffman Home Hospice in the Valleys

The hospice, founded in 1999, provides home based specialist palliative care including pain relief, symptom management and psychosocial support for adults at the end of life regardless of their illness, although the majority have cancer. The hospice has focused on developing a service sensitive to a culturally diverse, multi-religious population.²⁴ For example in Arab Nazareth the team may include a Jewish physician, Muslim nurse and social worker and Arab speaking Jewish nurses with additional support from Christian and Muslim volunteers and clergy.²⁵ The hospice service includes:

- 7 multi-professional, culturally diverse, multi-lingual teams (each with supporting physician, nurses and social workers): providing care for up to 45 patients at any one time
- good links with local community health centres
- strong support of trained volunteers
- palliative care training programmes for primary health care providers
- on call consultation services for community health care clinics in the area

A total of 162 patients were cared for in 2004, for an average duration of 60 days. Since 1999, the hospice has cared for around 600 patients. The emphasis is on supporting patients and families to cope with the end of life process; hospice staff will educate caregivers and also undertake to stay with patient and their families as long as they are needed.²⁶ Around 74% of patients are supported to die at home. Hospice director, Mali Szlaifer explains:

‘When you give [the family] good education - and also if you give them some tips what to do to feel better, so they can manage with [the patient] they are not afraid and they feel comfortable, confident in being there and they know that now it’s not an emergency.’²⁷

Patients can self refer but more usually they are referred by their physician or oncologist.

The hospice has also developed strong support for its staff. There are regular team meetings, group supervision (plus individual if needed) and 24 hour on call advice from senior team members.

Jerusalem Home Hospital

This large organisation, established in 1991 and run by health maintenance organisation (HMO) Clalit Health Services (Kupat Holim Clalit),²⁸ offers community based ‘home hospitalization’ for patients, the majority over 65 years old, suffering a range of sub acute

and chronic illnesses, including cancer, renal and heart failure, and ALS. The service provides treatment, rehabilitation, and for patients at the end of life, specialist palliative care.²⁹ The service will also support young people and children at the end of life. The multi-professional team (physicians, specialist oncology nurses, nurses, physiotherapists, social workers, nutritionist, occupational and speech therapists) is led by geriatrician Dr Jeremy Jacobs and palliative care consultant Dr Ora Rosengarten. The service offers pain relief, symptom management, physiotherapy, psychosocial support, occupational therapy, speech therapy, nutritional advice, and home help. The service currently cares for around 300 patients at any one time. Roughly half of all patients admitted to the service are palliative care patients and on average 30% of these have cancer. The criteria for admission to the service include:

- Diagnosis is clear, but the patient no longer needs continuous monitoring
- The patient is in need of hospital level care
- The patient and family must both agree to home based care
- There must be a supportive caregiver for the patient at home (not necessarily a family member)
- The patient's home is a suitable environment in which to nurse the patient
- The patient is insured with the Kupat Holim Clalit

The aim is to reduce hospital admission and maintain a high quality of total care for patients at home. Around 50% of palliative care patients are supported to die at home or within 24 hours if admitted to hospital in the last hours. Since the service was established it has cared for over 13,000 patients.³⁰

Nancy Caroline Hospice of the Upper Galilee Hospice of the Valleys

This hospice is a specialist, not for profit, home care service primarily for adults with cancer. The hospice was founded by Professor Nancy Caroline in 1994. She herself became ill and died in 2002. Since 2001 the multi-professional team has been led by medical director Dr Jim Shalom. The hospice provides pain relief, symptom management, physiotherapy, nutritional advice and dedicated psychosocial support.

The hospice is committed to highly individualised care with the focus on a holistic approach. The multi professional team (physicians, specialist oncology nurse, nurses, social worker who is also a family therapist, clinical psychologist, art therapist, music thanatologist - a harpist) are attentive to skilled symptom management but also in supporting a patient's emotional and spiritual needs, drawing particularly on the use of creative therapies. House calls are typically made by a physician and nurse together. Rather than replace existing services, the HUG team coordinates care with both the primary care team and the regional Oncology Department.

Trained volunteers are an important part of the team, offering personal support and assistance to the patient and families when requested. The hospice staff is equally involved in training volunteers.

As of 2005 the service can care for up to 35 patients at any one time, and the service is being expanded to increase care capacity. Patients are self referred or referred by their physician or oncologist. Around 70% - 80% of patients are supported to die in their own home.

Home Care Hospice of Kiryat Tivon, Northern Israel

The hospice is a small, not for profit, home care service run by volunteers for adults living in Kiryat Tivon with cancer at the end of life. The hospice was co-founded in 1983 by sociologist Dr Ilene Ora Cibulski and other multi-professional colleagues. Dr Cibulski is also a founder member and first chair of the Israeli Association of Palliative Care). Under her direction the hospice developed an emphasis on providing practical support for the patient and their family that includes:

- co-ordinating volunteer professional medical, nursing, therapeutic, and psychosocial support (the patient continues to receive care from their hospital physician and oncologist)
- arranging support from trained volunteers who as ‘friendly visitors’ offer:
 - home help
 - social support
 - help with child care
 - collection of prescriptions
 - cooking, shopping or other special needs
- hospice volunteers provide a telephone information helpline for families living outside Kiryat Tivon
- support to other organisations around Israel to develop volunteer groups
- links with the other charitable organisations:
 - the Association of Services for the Elderly
 - Yad Sarah; that lends nursing and home care equipment (free or in exchange for a donation)

The hospice head nurse and social worker evaluate the needs of the patient and family caregiver, and they coordinate the visits of the volunteer multi professional team members (physician, nurse, psychiatrist, social worker, physiotherapist, occupational therapist and yoga teacher) who are supported by a dedicated group of non-professional volunteers. All volunteers do a basic course together and continue to meet on a regular basis. The service is able to care for between 10 – 18 patients at any one time, for an average of 3 months.

Hannah Eshed Hospice, Nof Hadar Hospital, Haifa

The hospice was founded in 1992 as a unit within the private Nof Hadar Hospital. A multi-professional team provides palliative care in the 17 bed inpatient unit. The hospice has always worked closely with trained volunteers who provide support for patients and families.³¹ The unit is one of the 4 inpatient palliative care units formally recognized by the Israeli government.

French Hospital, St. Louis Mission, Jerusalem

This ‘free’ hospital is run by a French religious order, the Sisters of St Joseph. The 44 bed hospital is dedicated to the care of all patients with ‘advanced disease’, regardless of their faith or belief.³² They have an 18 bed inpatient palliative care facility. Patients may be referred by physicians or oncologists from other hospitals.³³

Al-Taj for Health and Heritage Association

This charitable association is being established as a volunteer run home hospice service in north Israel. The service is operating with the founder, Kassim Baddarni, who is

registered nurse, able to undertake home visits to around 20 cancer patients. A needs assessment for the organisation is completed. A multi-disciplinary team of 2 full time and 10 part time volunteer health professionals and lay support staff are enrolled for an official start in January 2006.³⁴

Additional hospital based services

The *Italian Hospital, Haifa* provides palliative care for patients at the end of life.³⁵ The 95 bed hospital, founded in 1905 by Italian doctors and staffed by a religious order of nursing sisters, developed an oncology unit in the 1950s; this is now supervised by the Rambam Hospital, a large regional medical centre in Haifa.³⁶ The unit offers palliative care (including palliative radiotherapy with a treatment capacity of up to 500 patients a week) and psychosocial support.³⁷

A Reiki healer is currently working as a volunteer in the *Rambam Hospital* oncology unit, offering Reiki healing to all cancer patients at the unit who request it, at whatever stage in their illness.³⁸

Paediatric Support

At the time of this report (2005) there are no government recognised or formal specialist palliative care services available for children in Israel.³⁹

There are, however, a number of informal and general services offering consultation, advice and psychosocial support for children at the end of life. Palliative consultation and support is offered by paediatric oncologists at:

- Chaim Sheba Medical Centre, Tel Aviv
 - *Edmond and Lily Safra Children's Hospital*
 - *The Marion and Elie Wiesel Children's Pavilion* (although specialist palliative care is no longer the emphasis in this unit, support is provided for children at the end of life)
- Rambam Medical Centre, Haifa
 - *Meyer Children's Hospital* (This hospital (based at *Rambam Medical Centre*) has no formal palliative care service, however medical oncologists Dr Sergey Postovsky and Professor Miriam Ben Haroush, are dedicated to providing paediatric palliative care whenever needed.
- *Negev Palliative Care Services* (Ben-Gurion University of the Negev – Faculty of Health Sciences) offer paediatric palliative care consultation at the
 - Children's Hospital, Soroka Medical Centre, Beersheva

The homecare multi-professional team at:

- *Jerusalem Home Hospital* will care for children and young people at the end of life

Members of the Psycho-Oncology Society working at:

- *Schneider Children's Medical Centre, Rabin Medical Centre, Petah Tikva, Tel Aviv* offers palliative support for children and also provides bereavement support for parents.⁴⁰

Community Health Centres

There is a network of around 80 community centres that offer a home medical and nursing care service for patients with a range of sub-acute and chronic conditions, including those

at the end of life.⁴¹ These community based services vary in different locations; the extent and expertise of the palliative care offered depends on whether medical and or nursing staff have had specialist training.⁴² Within the available cancer services throughout Israel, there are around 500 oncology nurses with specialist oncology postgraduate training, which includes training in palliative care and symptom management. These nurses are working in hospital oncology units or community settings. Currently, around 30 oncology nurses have completed further training in palliative care and some are now working within hospices (hospital or home based).⁴³

Oncology Units

Several oncology units provide psychosocial support for patients. A particularly comprehensive service has been developed by psycho-oncologists at the *Beilinson Unit*, part of the *Davidoff Centre*, opened in 2005, at the *Rabin Medical Centre*, Petah Tikva near Tel Aviv. This support is offered not only for inpatients at the end of life but also for patients attending the unit throughout treatment – regardless of outcome.⁴⁴

Reimbursement and funding for services

Specialist palliative care services are provided in a number of different health care settings most of which rely on complex sources of funding (Table 2). Patients with cancer are entitled to free medication. Patients with other illnesses are entitled to medication, including opioids, at a discounted rate depending on their health plan insurer; usually this is a flat rate per prescription.

Table 2: Funding sources for hospice and palliative care services in Israel

Organisation or service	Institution (if applicable)
HMO Health plan funded – all with Kupat Holim Clalit (includes annual per capita proportion of MoH funds)	
Tel-Hashomer Hospice * Edmond and Lily Safra Children's Hospital The Marion and Elie Wiesel Children's Pavilion	Chaim Sheba Medical Centre
Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Center	Sha'are Zedek Medical Centre
Negev Palliative Care Services ~ home hospice ~ hospital consultation service	Ben Gurion University of the Negev / Soroka Medical Centre
Jerusalem Home Hospital	
Schneider Children's Medical Centre	Rabin Medical Centre,
Meyer Children's Hospital	Rambam Hospital, Haifa
Combined HMO (all with Kupat Holim Clalit) + charitable – (international /national and or local donations)	
Negev Palliative Care Services ~ desert mobile unit ~ Ma'agan House	Ben Gurion University of the Negev
Nancy Caroline Hospice of the Upper Galilee	
Milton and Lois Shiffman Home Hospice in the Valleys	
Ina and Jack Kay Hospice	Hadassah Mount Scopus Hospital
Charitable – (international /national and or local donations)	
Home Care Hospice of Kiryat Tivon	
St Louis Mission, Jerusalem	Sisters of St Joseph
Italian Hospital, Haifa	
Private fee paying	
Hannah Eshed Hospice	Nof Hadar Hospital, Haifa

**Tel Hashomer Hospice has made a transition from combined charitable/HMO to sole HMO/MoH funding*

Palliative care services which are entirely charitable and relying on donations are able to offer all patients free care and consultation. There is one private service available to any patients able and willing to pay fees. Health plan insurers are also referred to as health maintenance organisations (HMO).⁴⁵ Three services receive a combination of charitable funding and HMO funds. One service has made the transition from combined funding to HMO/MoH funding only. (HMO funds all include an annual per capita proportion of government Ministry of Health (MoH) funds). Some palliative care services operate within one of the institutions owned and run by Clalit Health Services; the oldest and largest of the four non governmental health plans providing insurance and services to 55% of the population. Where an HMO, such as Clalit Health Services (Kupat Holim Clalit) runs all or part of the service the patient can only receive free care for a certain number of services if they are signed up to that HMO insurance.

Charitable funding may include monies from national and international donors from institutional or private sources. Currently the largest and most generous national, institutional donor funding palliative care services is the Israeli Cancer Association. The Jewish Federation in the USA (specific donor branches include New York and Detroit) is a major international donor. Charitable funds support a range of activities in a service; funding a health professional post; providing financial support to run a service; funds for individual projects as part of establishing a service; new facilities within a service; research and development.

Although an institution within which the palliative care service is based also receives a percentage of Ministry of Health (MoH) funds, the palliative care service does not itself receive any direct government funds. The competitive nature of government versus HMO allocation can result in loss of funds for the service.⁴⁶ Some elements of community based services and half of all acute or rehabilitation hospitals are government funded, and patients can access free care if they have Israeli ID with paid up National Health Insurance (NHI) benefits. However, no government funded NHI cover directly funds any specialist palliative care service. Hence, access to any degree of specialist palliative support within government funded settings is entirely dependent on whether physicians or nurses in that unit or institution have received specialist training elsewhere.⁴⁷

Palliative care is not in (what is known as) the 'basket of services' of the four national HMOs - who consequently are under no obligation to fund end of life care.⁴⁸ HMO funding is subject to continual negotiation i.e. year on year (or in some cases month on month)⁴⁹ and accordingly the palliative care services funded through a HMO have been found to be financially precarious and subject to sudden loss of funds.⁵⁰ In fact, some (though not all) services funded either entirely or in part through charitable, non government organisations (NGOs) may have greater financial security if they are fortunate to have highly committed benefactors and regular donations.⁵¹

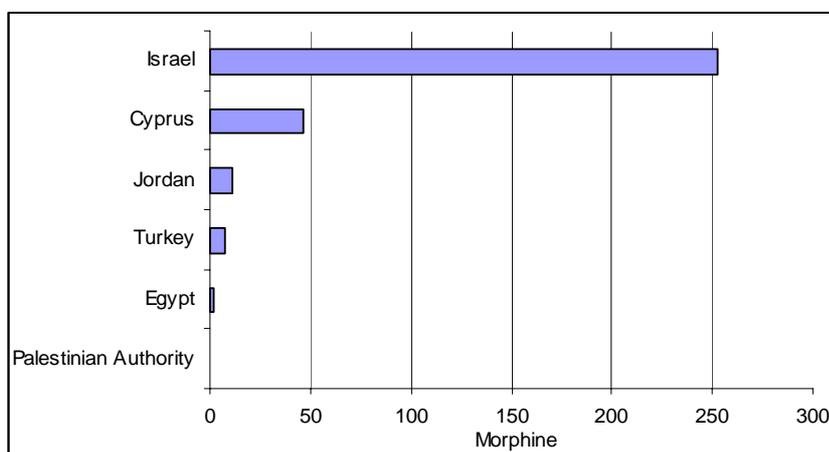
Opioid availability and consumption

The International Narcotics Control Board^{52 53} has published the following figures for the consumption of narcotic drugs in Israel (2002): codeine 453 kg (down from 550 kg in 2000); morphine 42 kg (down from 89 kg in 1999); pethidine 36 kg (down from 128 kg in 1999).

For the years 2000-2002, the average defined daily dose consumption of morphine for statistical purposes (S-DDD)⁵⁴ in Israel was 253. This compares with other countries in the Middle East region as follows: Cyprus 46; Egypt 2; Jordan 11; Turkey 7. The Palestinian Authority reported no morphine consumption during 2000-2002 (Table 3).

A comprehensive range of opioids is available and accessible for prescription throughout Israel. This situation is reported as having radically and steadily improved from the early 1990s, largely as a result of concerted campaigning by pioneers of palliative care to change government policy and legislation around opioid availability.⁵⁵

Table 3 Average daily consumption of defined daily doses (for statistical purposes) of morphine per million inhabitants, 2000-2002: the six MECC⁵⁶ member countries in the Middle East region.



Source: International Narcotics Control Board *Narcotic Drugs: Estimated World Requirements for 2004. Statistics for 2002.* New York: United Nations, 2004.

The commonest generic opioid in use is morphine sulphate used as oral tablets, as injectable solution, or in IV infusions and subcutaneous ‘pumps’ (syringe drivers). There is widespread and increasing use of proprietary opioids such as Fentanyl (Durogesic), Oxycodone and Hydromorphone. Pethidine is used for palliation in some hospitals and nursing homes, but more physicians are now prescribing either generic or proprietary morphine salts.⁵⁷ Some physicians find that patients and pharmacists are happier to be prescribed proprietary opioids as the names do not suggest an obvious association with morphine.⁵⁸

Other synthetic drugs with opioid properties such as Tramadol are used extensively by some physicians in cases of moderate to severe pain, particularly as these analgesics are subject to fewer restrictions and can be used for people who are morphine intolerant. Non opioid sedatives such as Midazolam are widely used by specialist palliative care physicians.⁵⁹

The current law permits physicians to prescribe up to 10 days supply of opioids per prescription which can be increased up to 30 days supply if there is good justification. There is no upper limit set on opioid dosage per prescription. Dr Nathan Cherny, Director, Cancer Pain and Palliative Medicine, Sha’are Zedek describes the current legislative and access situation:

‘We have excellent access to all analgesics and for patients with advanced cancer the analgesics are all free of charge and we don’t have dosing limitations. The prescribing limitations; you can prescribe only one month at a time but that’s not insurmountable and so there is excellent availability of drugs.’⁶⁰

In spite of legislation permitting 30 days supply, the preference is a maximum 10 day prescription; as Dr Amitai Oberman, medical director, Home Hospice of the Valleys explains:

There is a possibility that if you write on the prescription that the patient is bed bound, you can get it for 30 days. That's more tricky and the pharmacies sometimes don't like it, but if you give them a call it's fine, but otherwise you would have to fill it for 10 days.⁶¹

Unless, however, prescribing physicians are specifically trained in palliative care or pain management, it is still the case that not all physicians have the necessary confidence or training when prescribing opioids, Amitai Oberman continues:

'You know, you have to learn how to write a prescription for opioids and people don't know how to write such a prescription, they make mistakes and some of the pharmacies are a bit hesitant when they see, like, colossal doses of Fentanyl, but on the whole I think we're doing OK.'

There continues to be a need for improvements in prescribing practices for palliative pain relief and symptom control.⁶² Most commentators emphasise the importance of ensuring adequate and sustained education and training for physicians (and pharmacists) at all levels. Dr Jim Shalom, medical director of the Nancy Caroline Hospice of the Upper Galilee (HUG) describes some issues in the current situation:

'One of the [notes] that [hospice founder] Nancy [Caroline] had on her refrigerator was that 'Pain is a medical emergency.' In other words we encounter problems with two types of physicians. We encounter problems with what I would - and I'm generalising - with physicians who just back away from any involvement with cancer patients, including referring them to us. For a long time, and probably still in areas that are under-serviced, people just don't get treated properly: they don't get treated by the hospital and they don't get treated by the family physicians properly - although hopefully there are less and less of them. So that's one category. The other category is the sort of proud family physician; he knows his stuff and thinks that he can handle it, when today really palliative care is different than it was 15 years ago. It's far more complex, you know, the drug regimens are more complex and the orientation is far more sophisticated than it was before.'⁶³

Aliza Yaffe, Head Nurse at the Israeli Cancer Association, echoes these concerns, particularly the ongoing need to teach the principles of pain management:

'The other day, one of the nurses came and said she went to see a patient in our regular surgical department, 'The doctor said that the patient that I was visiting, he's not in pain but he is very restless.'
So we have to decide, do you treat that restlessness or not? Everybody must treat restlessness. But [the doctor] said, 'No, that's not pain so I'm not giving anything, bring the oxygen.'
You know, you have to teach all the time, all the time, all the time.'⁶⁴

National and professional organisations

There are three national and professional organisations concerned either totally or in part with palliative care: for example, promoting awareness, organising or advising on training

programmes, raising or providing funds for services; the *Israeli Association of Palliative Care (Tmicha)*; the *Israeli Cancer Association*; and the *Israel Palliative Medical Society*, which is affiliated to the Israel Medical Society.

Israeli Association of Palliative Care (Tmicha)

Established as a voluntary (not for profit) association in 1993, the *Israeli Association of Palliative Care (Tmicha) (IAPC)* is an organisation for all health professionals and trained volunteers actively involved in palliative care in Israel. IAPC membership includes leading figures in palliative care, who encourage professional and public education about the concepts of palliative care and promote the development of services. Membership, which is currently around 800, is open to all health professionals, volunteers and interested lay people that identify with its philosophy.

Initially chaired by Dr Ilene Ora Cibulski the IAPC produced a bi annual Hebrew/English newsletter '*Support*' until her retirement in 2000.⁶⁵ Since 2001, the IAPC has been chaired by Mali Szlaifer, who is dedicated to continuing to develop training and networking for its members and for palliative care services around the country. IAPC has an elected Board of Directors that aims to represent all the professions involved in palliative care and from a range of different services. The work of IAPC includes:

- Convening annual conferences, regular meetings and study days, seminars, and training programmes for health professionals; including physicians, nurses, social workers and also for trained volunteers, all of whom are actively working in the palliative care services.⁶⁶
- Involving members in teaching on the professional palliative care programmes in Israel. Promoting clinical and academic research by its members and the dissemination of findings within the association.
- Campaigning via conferences, publications and the media to have palliative care included in the NHI legislation; and to advocate for the rights of terminally ill patients with palliative care included in the NHI.
- Supporting local projects that are developing and expanding services throughout the public sector.
- To seek to define palliative care and develop standards of quality and adequate service provision.
- Collating data on existing services, with the aim of publishing a guide to services for use by health professionals and the public.⁶⁷

The association puts an emphasis on the importance of collaboration between health professionals from different disciplines with the aim of encouraging maximum support for patients and families. IAPC is a collective member of the European Association for Palliative Care (EAPC).

Israel Cancer Association (ICA)

Established in 1952, as a not for profit non government organisation, the *Israel Cancer Association* is dedicated to the education and development of services for professionals working in the field of oncology and to promote treatment, support and services for cancer patients and their families. The ICA has a long term aim to 'reduce the mortality and morbidity rates of cancer.'⁶⁸ Since 1983, with the opening of the first hospice (Tel Hashomer) which was funded collaboratively by the ICA, MoH and HMO Kupat Holim Clalit, the association has also addressed the need to support and fund the development of palliative care in Israel. The association is now the largest national source of non government funding of palliative care services.

The ICA works both independently and in collaboration with HMOs and the MoH, to fund service provision, work placements and posts (physicians and nurses) education, training and research. Since the early 1980s Aliza Yaffe, ICA Head Nurse has, with other professional colleagues, promoted the concept and development of specialist oncology nurses, which now includes offering additional palliative care training, by providing grants for training and posts. The concept of the specialist oncology nurse was initiated in part by recognising and responding to the needs of health services and in part by those health services realising the benefits of having specialist nurses, as Aliza Yaffe explains:

‘The manager of the health service in that specific section, came each year to Israel Cancer Society and said we would like to have an oncology community nurse. I did lots of lobbying for a while, and that nurse, her job would be this and that as needed, [for example] specifically in Arab communities she will take care of, let’s say, more elderly people. The Cancer Society (ICA) gives a grant of half-time for a registered oncology nurse for three to five years. Afterwards, they [the community health service] will absorb that job.’⁶⁹

Those oncology nurses working in community health centres who have completed palliative care training can now offer nursing care at the end of life, alongside their work with cancer patients during and after treatment. The ICA manages a website which provides information about promotion of cancer prevention, raising public awareness for example, about smoking. ICA also runs media campaigns, produces multi-lingual leaflets and publications about cancer prevention, early detection and available cancer related services. The association has a telephone helpline providing public information.⁷⁰

Israel Palliative Medical Society (IPMS)

This organisation, established in 1996, is a branch of the *Israel Medical Association*. Chaired by hospice physician Michaela Berkowitz, membership is restricted to physicians. The aim of the IPMS is to represent physicians practising palliative medicine and to promote palliative medical services, education and research: there are plans to develop a training fellowship.⁷¹ The society encourages meetings, seminars and participation in national and international conferences, and links with national and international palliative medicine organisations. The IPMS is a collective member of the European Association for Palliative Care (EAPC).⁷²

There are two international organisations: *European Association for Palliative Care (EAPC)* and the *European Medical Oncology Society (ESMO)* both of whom support and provide educational links for palliative care professionals in Israel, involving professionals in conferences, networking, and dissemination of publications.⁷³

Palliative care coverage

There is relatively wide palliative care coverage in some major cities and well populated regions of central and northern Israel. In spite of the existing range of services, however, there is considerable concern about the shortfall in palliative care provision, particularly in remote, rural areas of the country, but also in large population centres, such as around the Tel Aviv region. Although many people at the end of life may have access to supportive care from one of the 80 community health services throughout the country, only a small proportion (relative to needs of the population) have access to one of the 27 specialist home hospital-based or inpatient hospice services.

Central Israel

In central Israel there are 5 specialist palliative care services for adults and four centres supporting children. Four of the 5 available services can only care for cancer patients:

- four of these services are based in Jerusalem (with a combined city and district catchment population 829,800);⁷⁴
- Tel Aviv (with a combined city and district catchment population 1,177,300) has one specialist service for adults with cancer; three centres support children. Only an estimated 15 – 20% of the population has access to specialist services. Supportive care for adults is offered via hospital and community services.

Southern Israel

There is one specialist service in the south that provides coverage in 3 cities and some of the surrounding desert region including:

- Beersheva, the capital city of the Negev Desert, with a catchment population of about 180,000 people.
- Rahat, a Bedouin city, providing for a population of around 32,000. A palliative care team cares for patients in the city and in the neighbouring Jewish kibbutzim outside the city.
- Qiryat Gat, a city 50kms to the north of Beersheva with a population estimated at 50,000. A team cares for patients in the city and those living within a radius of around 20-30 minutes drive from the city.
- The mobile palliative care unit provides coverage for the Bedouin people living in remote settlements up to 40 – 50kms south of Beersheva in the desert region.⁷⁵

Northern Israel

There are 3 home care hospices in the north; one service provides coverage in Nazareth with a catchment population of 350,000.⁷⁶ In the Upper Galilee and northern Golan Heights areas another service based in the small town of Rosh Pina covers a catchment population in the region of 150,000;⁷⁷ in Kiryat Tivon one service provides coverage for the population of 14,000.⁷⁸ There are two hospital based services in Haifa, the largest northern city (with a combined city and district catchment population 852,600).⁷⁹

Palliative care in Israel is focused on patients with cancer. In 2004 a study of palliative care services in Israel conducted by Dr Netta Bentur at the Myers-JDC Brookdale Institute, Jerusalem, estimated around 95% of all palliative care patients have cancer. Only 5% of patients with other illnesses have access to one of the 4 specialist palliative care services able to care for them. In 2004, only an estimated 2,000 cancer patients received specialist hospice care of the total new cases of 15,000 cancer patients that year, many of whom would benefit from these services.⁸⁰

Education and training

Education and training for all health professionals is regarded as key in the development of palliative care services in Israel, and has been an important aspect of service development from the early 1980s, with the opening of the first hospice. Since the late 1990s there has been an increase in organising and developing training with more courses available.⁸¹ Although palliative medicine is still not recognised as a specialty in the health care service, it is part of all general nurse training and also part of postgraduate oncology nurse training. Some medical schools include short units for fifth year medical students.

There are currently also training opportunities in Israel for physicians at postgraduate level with a two year diploma course at *Tel Aviv University* for physicians co-ordinated by Alexander Waller, Medical Director of *Tel Hashomer Hospice* (Table 4).

Table 4: Palliative care education and training available in Israel - 2005

Core education		National specialist education and training		International education/links
Physicians	Nurses	Diploma/MSc/ CME/ Specialist courses	Short units/ seminars	Fellowships/ diplomas/ Masters/ short courses etc
Short units of palliative medicine accessible in some medical schools for 5 th yr medical students (full inclusion as part of core curricula in all medical schools is under development)	All general nursing courses include a unit of palliative care nursing. Several inpatient hospice units offer placements for student nurses for training in palliative care.	Physicians: postgraduate diploma - 2 yr / 400 hours). Nurses – post graduate Oncology Nursing qualification includes training in palliative care and symptom management. Further training available, as below. Physicians and nurses working in palliative care services can take available short courses for CME credits ‘Train the trainers’ short courses (40 hours) run in different venues around the country – these are mostly for physicians and nurses. Specialist courses (which include placements for students within existing specialist services) are available for healthcare professionals/trainees including psycho-oncologists, psychologists, social workers (e.g. the Masters course, with placements at Ina and Jack Kaye Hadassah), spiritual counsellors. Many hospice teams train their own hospice volunteers.	Regular short courses run from the IAPC, ICA and from hospice services. These courses are designed for physicians, nurses, social workers, allied healthcare professionals and trained volunteers.	Physicians and nurses can apply for Masters level degree courses, diplomas and fellowships in other countries, e.g. USA and UK. Short seminars and courses are accessible for healthcare professionals working in palliative care via international organisations, such as ESMO, ASCO, EAPC, MECC etc. Specialist training for creative therapies in palliative care e.g. art therapy and music thanatology, are accessible in the USA and UK.

Nathan Cherny, Director of the *Cancer Pain and Palliative Medicine Service, Sha’are Zedek Medical Centre, Jerusalem* explains the current situation:

‘Palliative care is part of core training for nurses and it is an integral part of the training for oncology nurses. Palliative care training for oncologists is weak and relatively ad hoc, despite the fact that at least on paper they have adopted the curricular guidelines of the European Society of Medical Oncology (ESMO) which are fairly stringent guidelines as to what has to be incorporated in training, it’s between the policy and practice that there continues to be a gulf. Outside of the oncology framework palliative care is very under developed; when the AIDS crisis was at its peak there was an in patient hospice but the whole picture has changed. But for people with degenerative neurological diseases or whatever they fall into the rubric of whatever of the home care services but in a very ad hoc manner and not necessarily with a lot of skilled care.

In terms of physician training there is a diploma programme in palliative care that has been running for a number of years and I think has put through probably close to about 90 or 100 graduates. It’s a 2 year part time programme through *Tel Aviv*

University, which has been primarily co-ordinated by Alex [Alexander Waller, Medical Director, *Tel Hashomer Hospice*] and has been a very successful programme, and people come to do that from a broad variety of disciplines and from very diverse parts of the country. The specialty accreditation is all co-ordinated through the *Israel Medical Association*. At present they are resistant to the development of palliative medicine as a sub specialty but there are moves afoot to have a fellowship recognised. In the presentation that was made the recommendations have gone to the Ministry of Health, this issue is being addressed but these decisions are not in the hands of the ministry alone.⁸²

In addition to formal education courses there are a variety of training programmes for health professionals (physicians, nurses, social workers, psycho-oncologists, spiritual counsellors and creative therapists) that are organised by individual palliative care services and also as part of the work of national associations (see IAPC, ICA, IPMS). These programmes include study days, seminars, conferences, Continuing Medical Education (CME) courses and specialist training units.

Israel Cancer Association (ICA) has a strong commitment to professional and public education. Since 1978, Head Nurse Aliza Yaffe and her colleagues at ICA have pioneered a specialist community oncology nurse training, which includes stoma care, breast care and palliative care. One of the current goals is to create a palliative care nursing specialty. ICA funds short specialist programmes, for example training radiographers in mammography. Regular public education programmes are organised to raise awareness about cancer, early detection treatment, and support.⁸³ ICA also funds research into cancer, including initiating and evaluating new developments in medical and nursing services.

Israel Association for Palliative Care (IAPC) in collaboration with the *Israel Cancer Association* and *Ben Gurion University of the Negev* is currently organising short 'train the trainer' courses in different centres around Israel. Three courses ran in 2004, and 5 in 2005. These are run as a 40-hour course with the hours divided equally between psychosocial issues, physiology, symptom control and pharmacology. Nurses can get CME (Continuing Medical Education) points for attending. IAPC board member Dr Amitai Oberman describes the future direction for palliative care education:

'I believe that geriatric and oncology postgraduate nurses should know something about [palliative care]. On the whole the feeling is that positive things are happening, and the last two years have been very fulfilling and we see change, and there's money and there's more people, and people are coming to the conferences, which have been very, very successful. We are able to attract more professionals and more public figures and health professionals, key leaders in medicine. Tons of work to do, especially within the hospital system, but the fact is that we have this committee which also Pesach headed, from the Health Ministry, is a major, is a major change. It will take time 'til it will be implemented and there will be money and funding for palliative care, but it's a change, it's a move.'

Many services also train volunteers as part of their ongoing work. There are other specialist programmes including spiritual counselling, and international opportunities: such as fellowships and Masters courses.

At *Ben-Gurion University of the Negev* there is a programme of palliative care residencies for trainee family medicine doctors run through the *Negev Palliative Care Service*. Through the university's Faculty of Health Sciences the palliative care service runs a

variety of post graduate and undergraduate courses. These include short training units for medical and nursing students as part of their professional development; postgraduate courses; seminars; and specialist training for oncology nurses. Medical Director, Dr Yoram Singer explains current developments in palliative medicine education and research, including more details about the collaborative 'train the trainer' courses:

'We are more and more involved in education, to get [palliative medicine] into [the] undergraduate curricula. At the moment we are more involved in Continuing Medical Education (CME) courses for medical professionals - nurses and doctors mostly - and, because of the success of the mobile unit, we got an extra funding for this from the New York Federation. [NYF funded the Negev desert mobile unit]. They are enthusiastic at how things work. We had a six-day get-together for a 'train the trainer' course, and there we [developed] the curriculum. Now we're in the middle of running [courses], 'til the end of June we will run three national courses on palliative care (40 hours each). It's very interesting; the enrolment is from social workers, nurses and doctors: multi/interdisciplinary experience. Now we have requests from many other places and we're slowly building it up. And, of course, [we have] the family medicine medical students. We do a little bit of research, more kind of audit kind of research at this stage.'^{84 85}

Middle East Cancer Consortium (MECC) as part of its ongoing educational and research work organises regular seminars in cancer registry and in oncology.⁸⁶ Since 2004 MECC has also started to address the need for information and education in palliative care for all health professionals working in the field. The consortium has funded members to attend courses with the American Society of Clinical Oncology (ASCO) and has set up a collaborative 'training the trainers' palliative care course between Calvary Hospital, VA, USA and the oncology unit in the Italian Hospital, Haifa. In February 2004 and November 2005 palliative care seminars were run for health professionals from MECC member countries.⁸⁷

With the growth in education and training in Israel there have also been more opportunities for research in the field. There is currently a well established clinical and academic research base in palliative care, with a strong record of extensive national and international publications and dissemination at international conferences. Key research in palliative care is undertaken by clinical and academic researchers from all disciplines involved in palliative care provision, many in collaboration with major universities in the country.⁸⁸ Major areas of research include pain and symptom management;^{89 90 91 92} pain assessment and needs;^{93 94} cultural aspects of palliative care.^{95 96} Palliative care research publications are also internationally disseminated from nursing and related clinical health professionals including social work, psychologists,⁹⁷ therapists, and academic health researchers.

Palliative care workforce capacity (as of 2005)

Tel Hashomer Hospice

The hospice employs around 30 full and part time staff: medical director, inpatient hospice physician (also co-ordinates research), for the inpatient unit, 10 full time nurses including head nurse and 10 part time nurses, administrative director, secretary, part time staff including social worker, physiotherapist, clinical psychologist. Other professionals are called in as needed including occupational therapists. The home care staff includes one physician, 3 home care nurses, a part time social worker.⁹⁸ The home care team can request a physiotherapist from the HMO for a patient if needed. The hospice also has support from around 22 volunteers.^{99 100}

Ina and Jack Kaye

The hospice employs around 29 full time and part time staff: hospice director, physician, 25 nurses (3 nurses rotate duties between home care and inpatient unit), 2 social workers. They can also call on external services for a psychologist and physiotherapist when needed.¹⁰¹

Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem

The service employs around 32 full time staff: 5 full time physicians, including 2 oncologists, a physician fellow, a consultation psychiatrist, a clinical psychologist, a specialist palliative care nurse, a research and education co-ordinator (who is also a clinical pharmacologist), 3 multi-lingual social workers, a spiritual counsellor, a palliative care nurse for the day care unit, 7 oncology nurses, inpatient ward staffing is allocated an additional 6 nurses according to patient numbers and 4 nursing aides. There are also regular placements for up to 4 medical internees, and for medical, nursing and spiritual counselling students.

Negev Palliative Care Services

The service employs a total of around 22 full and part time staff. The service also has placements for 3 or 4 physicians at any one time who are completing residencies in palliative medicine as part of their family medicine training. Around 12 full time and part time staff are based in Beersheva: head of division, medical director, 4 part time physicians, 1 full-time and 3 part time nurses, a full-time social worker and a part time social worker who can be called upon from another facility. Two part time physicians and 2 part time nurses are based in Qiryat Gat. One part time physician, one part time nurse and a part time driver are based in Rahat. The mobile desert unit is allocated 3 part time staff: a physician, a nurse and a driver. A social worker and a group of volunteers are based at Ma'agan House.¹⁰²

Milton and Lois Shiffman Home Hospice in the Valleys

The hospice employs 31 part time staff: Hospice Manager, 6 physicians including the Medical Director, 16 nurses, 6 social workers, and a team secretary. One of the social workers is also the volunteer co-ordinator managing around 20 volunteers at any one time.¹⁰³

Jerusalem Home Hospital

The service employs around 50 staff including 2 consultant geriatricians, a consultant medical oncologist, 30 part time physicians (paid on a fee per patient basis), 7 full time and 5 part time senior nurses (including a specialist oncology nurse), 35 part time nurses, speech therapist, occupational therapist, physiotherapist, social worker, dietician. Volunteers offer additional support for patients and families.¹⁰⁴

Nancy Caroline Hospice of the Upper Galilee (HUG)

The hospice employs 13 staff: medical director, 3 physicians, 4 nurses (one is a specialist palliative care nurse) a social worker, part time music thanatologist, art therapist, secretary, clinical psychologist. The hospice has support from a group of trained volunteers.¹⁰⁵

Home Care Hospice of Kiryat Tivon, Northern Israel

The hospice is run by 12 paid and volunteer professionals and 20 trained lay volunteers. Professional staff includes 4 on-call physicians plus an internist physician, head nurse, 2 oncology nurses, social worker, physiotherapist, occupational therapist and a yoga teacher.¹⁰⁶

Exact numbers of workforce are not available for other adult and paediatric hospital based services, community or other non-specialist services. There are ICA funded individual specialist nurses in some adult and paediatric oncology units.

HISTORY AND DEVELOPMENT OF PALLIATIVE CARE

Narrative history of palliative care

There has been a long history of hospice care in this region dating back to the Middle Ages with the Christian and Jewish tradition of hospices along the crusader and pilgrims' paths providing care for the needy, sick and dying. One or two of these ancient institutions are still remembered in old names and buildings in Jerusalem.¹⁰⁷ In the late 1970s a group of concerned nurses, led by Aliza Yaffe and her other colleagues based at the Israel Cancer Association (ICA), started to develop postgraduate specialist oncology nurse training which was established in 1978, and included a component of palliative care and symptom management. As more nurses took up specialist nurse training there were greater opportunities for patients at the end of life to be cared for at home by specialist nurses; first as part of the family physician system and later as part of community health teams, where currently over 500 trained oncology nurses with palliative care skills continue to play a vital role in providing care at the end of life. Aliza Yaffe, head nurse at ICA, describes the first ICA initiative to develop the community based palliative care nursing service:

'It started in 1978, more or less at that time a few nurses of the American Oncology Nursing Society came here and presented a seminar on pain management. It was a good place to start thinking about some other things, not only the care of the patients in the hospital, but also to see what you can do to take care of persons in the community. And after we were finished that course - it was not a very long one, 80 hours that first postgraduate education - I came to the Manager and I said, 'I think that we need to develop oncology nursing services in the community. The patient is staying in the hospital for a short time, and when he goes home then somebody has to go on taking care of him. The hospital experience is very short, and most of the time he will be spending at his own home.' It started with two nurses in Tel Aviv and Ramat Gan; their job was to get information from the hospital about who was going to be discharged and go and visit him at home and make an assessment of his needs, and try to take care of those needs. The theoretical model said that we are going to do that from prevention, early detection 'til bereavement, but it very soon became obvious that that couldn't be done, because the patient was suffering a lot of symptoms, mostly pain. The nurses were working half-time, [they] had to go and see what the patients needed and to learn the needs of the nurses that are taking care of him. So it was a lot and then we said, well we will postpone the prevention, early detection for a little later, and we will try and do as good as possible symptom management. Very few [nurses] had access to a physician that would come with her to see the patient and help him. There were community nurses but they had no specific cancer nursing education: no palliative care, no cancer nursing. They came and they were very nice and they were very good at the heart but not so good at the other things.'¹⁰⁸

By the early 1980s, this concern by the Israel Cancer Association to develop the skills and knowledge of nurses in end of life care for patients at home, and the needs of patients to have access to skilled care, facilitated the emergence of the modern hospice movement in

Israel, which has overseen the development of freestanding hospice units and specialist home care services throughout the country (Table 5).

Table 5: Chronology of the establishment of palliative care services in Israel

Year services established	Organisation	Type of Service Provision
Pre-1970s	Charitable religious hospitals; French Hospital, St Louis Mission, Jerusalem and the Italian Hospital, Haifa	These charitable institutions have a history, throughout the 20 th century, of care for the dying. The Italian Hospital had specifically cared for dying cancer patients since the 1950s. Since the 1980s specialist palliative care units were developed within both these hospitals as the modern hospice movement evolved in Israel.
1970 - 1980	Israel Cancer Association (ICA)	Recognition and awareness of palliative care needs led to the start of opportunities for initiating palliative care training within a new specialist branch of oncology nursing that was developed from 1978 onwards. This led to the first community home care service run by nurses trained and funded by ICA in Tel Aviv.
1983	Israel Cancer Association at the Tel Hashomer Hospice, Chaim Sheba Medical Centre, Tel Aviv	First inpatient hospice for adult cancer patients.
1984	Home Hospice of Kiryat Tivon	First home care hospice service for adult cancer patients run by volunteers
1986	Ina and Jack Key Hospice, Hadassah Mt Scopus	Inpatient hospice unit for adult cancer patients
1989	Tel Hashomer, Chaim Sheba Medical Centre, Tel Aviv	Home care service for adult cancer patients within 25 mile radius of Tel Hashomer Hospice.
	Ina and Jack Key Hospice, Hadassah Mt Scopus, Jerusalem	Home care service for adult cancer patients
1991	Jerusalem Home Hospital	Home care service to include palliative care for adults and children with all kinds of illnesses.
	Negev Palliative Care Services, Beersheva	Home care service and hospital consultation for adult cancer patients
1992	Hannah Eshed Hospice, Nof Hadar Hospital, Haifa	Inpatient private (fee paying) hospice unit for adult cancer patients
1994	Hospice of the Upper Galilee (HUG) (now the Nancy Caroline Hospice)	Home care service primarily for adult cancer patients - children also cared for if requested.
	Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem	Hospital based day care, out patient and inpatient consultation, now includes inpatient palliative care unit for adult cancer patients.
	Negev Palliative Care Services, Beersheva	Extended home care service for adult cancer patients to cover wide geographic area managed from a single base.
1999	Milton and Lois Shiffman Home Hospice in the Valleys	Home care hospice for adult cancer patients.
	Negev Palliative Care Services, Beersheva	Paediatric inpatient hospital consultation developed.
2004	Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem	Spiritual counselling service developed.
	Negev Palliative Care Services, Beersheva	Mobile desert home care unit for adult cancer patients in remote geographic areas established.
2005	Ina and Jack Key Hospice, Hadassah Mt Scopus	Counselling service provided by hospice team for hospice patients transferred to hospital.

Since the 1990s, in spite of ongoing financial and political challenges, significant and steady development has continued in hospice and palliative care services, policy, professional education and public awareness.

The current situation from the perspective of positive and negative aspects of palliative care service development is summarised by Nathan Cherny, oncologist and director of the *Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem*:

'The things that are strong are now our very wide network of palliative care home care services, which are being provided in multiple different frameworks, many of them by the HMOs who are the payers, which go under different titles of home admission and oncology home admission or sometimes home hospice care. There are also several free standing hospice services which don't belong to any HMO but which the various HMOs can buy services from. And there are different patterns of service delivery in different parts of the country. Most of the country, and this is talking about Israel as distinct from Palestinian territory has an increasing availability of some sort of home care. The quality of care is various and the training of manpower is very variable, and if one can make a generalisation, the nursing element of the teams generally has some modicum of training in palliative care. The physician part of the team is very variable; from people who have got diplomas in advanced training in palliative care to people who really have no training, but who hopefully have some degree of supervision.

I think that the last 10 years has seen a dramatic change in terms of the awareness of analgesics and the number of people involved in this endeavour is very large. Just at a local meeting of palliative care they get somewhere between 400 and 600 people. For a little country that's a very impressive number, it would be an impressive number in a big country. That's the positive side.

The negatives; the downside is that the level of funding is very small and thus the amount of service you can obviously bring into peoples houses is very limited. With very sick people, where you're going to be dependent largely upon family care givers with really a relatively small amount of professional support, there are limitations as to how successful home care can be and how far it can go. The number of services available outside of the home: there is a small number of free standing hospices, and to date there is only one inpatient palliative care unit in a general hospital which is the unit here. Overwhelmingly the rest of the hospitals in the country not only don't have dedicated palliative care beds but the palliative care services within the hospitals are generally limited to maybe a part time nurse. There is no widespread recognition that this is an important service to bring in to hospitals.

A commission was called by the Ministry of Health to get advice about improving palliative care services and a palliative working paper has been presented to them, and one of the things that's been emphasised in that is the importance of developing palliative care inside general hospitals. Certainly given that most of the cancer services are in general hospitals we need to make sure that these are amply supported with adequate manpower.'¹⁰⁹

Aliza Yaffe details more of the current challenges:

‘When we look at the little map of Israel, if you will look at the whole area, we have so many different services and our problem is how people communicate with each other. If we do not have an inpatient hospice in Beersheba then we *need* one because not everybody can take care of a person in his own home all the time. You need a possibility, even for respite, even for a few days; let the family rest a little bit, to have a place where the patient knows the people that will be taking care of him and ... and even if they want to open one more door and they’re going to build something in his home to make it more comfortable. That’s one of the things that I am sorry that happening, that we are not really linked. The problem of inpatient hospices is that patients are not referred, not because they don’t need to be, but because the health care system is reluctant to pay the price that the hospital management is taking for the service. That’s very complicated and we should do more.

The new service that we have developed is in the hospital palliative care, it should be a team but it’s really [often just] a hospital palliative care nurse not a team. Some places it is a team and some places it’s only one nurse. This is something that we started about five years ago. One of the nurses, the head nurse of the hospice, developed it in Haifa in Meyer Hospital. The nurse is giving the service to the oncology department and patients that are suffering the symptoms who are getting the treatment. She makes a whole assessment, and refers to the specific physician. Dr Waller is doing that in Tel Hashomer; he goes to the oncology department once a week and has a clinic there. The nurse [refers] the patients that need his expertise, especially if they have a number of symptoms that one medicine for makes it worse and things like that. Usually they are referred to their oncology nurse in the community if they are not [already an] inpatient. But if they are in the hospital then the staff are given [information] about what to continue, what to stop, and how to change treatment.’¹¹⁰

Individual service development since the opening of the first freestanding hospice is described below:

Tel Hashomer Hospice

In 1982 Dr Marian Rabinovitch, who was chair of geriatrics at Chaim Sheba Medical Centre in Tel Aviv, and other colleagues in the Israel Cancer Association, decided to address the end of life needs of their patients. Dr Rabinovitch explored hospice care in other countries, first in Germany and then England, where he visited St Christopher’s Hospice and was inspired by the work and teaching of Dr Cicely Saunders. Returning to Israel he set up a multi-professional team with the support of head nurse Dvora Goren, and in 1983 they opened the first freestanding inpatient 25 bed hospice, ‘Tel Hashomer’, in the grounds of Chaim Sheba Medical Centre. The care provided was based on the British hospice model pioneered by Dr Saunders.

At Tel Hashomer, Dr Rabinovitch was joined by other physicians, most of who worked on placements from the geriatric department at Chaim Sheba. Physicians Alexander Waller, who became Medical Director in 1989, and Professor Nancy Caroline took on Dr Rabinowitch’s work developing the multi-professional team (physicians, nurses, physiotherapist, social workers, and clinical psychologist). The team was joined in 1988 by hospice physician Michaela Bercovitch, who also co-ordinates research.¹¹¹ Tel

Hashomer pioneered the hospice movement and was influential in supporting the development of other services, co-ordinating the establishment of professional training and education, and encouraging research. In 1989 the hospice set up a home care service for patients living within a 25 mile radius of Tel Hashomer. This service is now well-established and the nursing team can care for up to 20 patients at any one time.¹¹²

Home Hospice of Kiryat Tivon

In 1984, the following year after Tel Hashomer opened, a small home hospice was established in the small town of Kiryat Tivon in northern Israel. As the founder, sociologist and gerontologist Dr Ilene Ora Cibulski explains:

‘I had the privilege of joining a wonderful group of people who were the first group who tried to create palliative home care, at the same time in Tel Hashomer, I heard Dr Rabinovitz who was a geriatrician, he was actually the first [doctor in palliative care], talking about doing [palliative care] in a hospital setting. I said 90 per cent of the people, are 90 per cent of the time at home, the future solutions have to be in the community, and I had the privilege of having a physician, Dr Miriam Boaz, who was the head of the outpatient clinic at Afula Hospital, and Professor Schaeffer Scharf who was the head of the rheumatology clinic in Haifa, Ramban Hospital, and Ruth Givon who became our head nurse, she was a public health nurse and she had developed community programmes for infants who came out of the Holocaust. All of us together felt that we had to do something about what was happening ... and we began immediately as an interdisciplinary team.’ For example, Professor Scharf, he would go to visit a patient, he would let the local physician know, this was a physician who never visited a patient, especially when [the patient] became homebound, [physicians] never went to visit. The only people who did home visits at the time were nurses, physicians just didn’t do it. ... We started a training course, and within a year we had about 12 volunteers, plus another 12 who were professionals and they were wonderful.’¹¹³

Ina and Jack Kaye Hospice, Hadassah, Mt Scopus, Jerusalem

In 1986, the second inpatient hospice in Israel based at Hadassah, Mt Scopus, supported by a combination of funds from independent benefactors and the HMO, was opened by physician Dr Reuvan Fink, social worker Roni Gertel; and paediatric oncology nurse Ruth Gassner, who describes the early years:

‘The hospice was opened in ’86. I came one year before to think what we need, what we want, how to develop, how to start ... the only place that we knew in Israel was Tel Hashomer, they opened in ’83, so we went to Tel Hashomer, we visited to get some ideas. And in ’86 we started the hospice with only one patient at the beginning. Before that I was in paediatrics; a head nurse in a paediatric department.

In ’85 they decided to open, there was a big donation from the States coming from a Jewish family that donated a lot of funds and this went to re-open the renovation because the house was deserted [since the previous occupant, the Hadassah hospital director, had been killed during military action in 1967]. I started to recruit some staff, and I did it on my own intuition. I didn’t know what I want; I just knew that I wanted good people. Most of the staff working here in the hospice [now] are people that started with me in ’86.’

In 1989, supported by donations from independent benefactors (the Crown Fund) the hospice opened a home care service, as Ruth Gassner explains:

‘Dr Fink saw the need, he was very aware of the need of some of the patients that came here, who said that they want to go back home, and if they had support at home they wouldn’t come to the hospice. It came from the patients. And he had a dream and he talked about that, I must say home care is not my part, but he insisted and he raised the money for home care with Professor Penchas who was the General Director of Hadassah.’¹¹⁴

Helen Englesberg, one of the first nurses in the hospice who later joined the home care service and Judy Yoran, the home care social worker note that the home care was set up to offer a 24 hour on-call service for patients and their families. Helen Englesberg explains:

‘They can call ... each family has a specific nurse that’s their nurse, but the other nurses will come to them, be there on a day when the nurse is not there, and then they’re also on-call at night and on the weekend. So any time of the day and night they can call to get an answer [like] you know, should we give more pain medication?’

The hospice worked to create a place of empathy and trust, with staff keen to explore different therapeutic approaches to improve support for patients and their families. Social worker Malka Yehezkel describes some of the very successful initiatives tried over the years for adults and for bereaved children, some of whom later as adults, report great benefits:

‘We try all kind of things during the years, like group work here: we had an art therapist working with us and we tried to do groups with the families here, and it didn’t succeed very much. It was an open group, you know, a group every week it was different persons come, the family that were here, but I felt that families prefer the one-to-one. Sometimes we do it, not formally, but... the family sit there so I join them and we sit together, so it’s like a group. ... But group work after the death of the patient, maybe I would like to do more groups, support groups?’ Before a few years we did a course of group work in Tel Aviv, Ruthie [Gassner] and me, a nurse and a social worker, and the group was of one nurse and one social worker from hospices and this kind of unit at home care, and we opened a group here for small children, not so small, 9 to 12, of patients, children of patients, a support group *after* the death of the parent. And it was a small group but a very good, very good experience for us.’¹¹⁵

Nancy Caroline Hospice of the Upper Galilee (HUG), Rosh Pina

Founder of HUG, physician Professor Nancy Caroline became interested in palliative care in the course of her pioneering work training emergency paramedics. She joined Tel Hashomer Hospice for a time in the late 1980s to train in palliative medicine with Alexander Waller, and to gain practical experience. She left Tel Hashomer in the early 1990s to establish her own home hospice which opened as the Hospice of the Upper Galilee (HUG) in 1994. She died in 2002. The multi-professional team has been led by medical director Dr Jim Shalom since 2001, with the emphasis on offering a range of therapeutic skills to cancer patients and their families. The team includes physician and homeopath Dr Eyal Goldberger, Dr Marianna Zrobliov, Dr Ehud Barav, specialist

oncology and palliative care nurse Yael Bleich, nurses Mazal Nitoker, Liora Aloni and Meira Gerlick, and social worker and family therapist Yaniv Ben-Shoshan. The team also calls on volunteer psychologist Niva, art therapist, Leila and music thanatologist Adira. Some key aspects of the ethos that have, and continue to be, developed in this hospice are explained by Jim Shalom:

‘As a policy, almost always house calls are made by two staff members. Usually it’s a doctor and a nurse, but it can be the nurse and the social worker, occasionally there’ll be even three. This was something that Nancy set up from the beginning. It’s logistically complicated because we’re often coming from different geographic directions. There are two separate reasons for this policy, one in order to improve patient care, and the second to provide support for the staff itself. When you have a very complex case that has different technical and emotional components and you’re alone you tend deal with the technical aspects. You will be better equipped to go into the more painful, less quickly available solutions if there’s another person there. In that respect a visit of two facilitates comprehensive and intimate care. A visit by two staff members, especially if it is a difficult visit is easier on the staff and helps prevent burn out, rather than a single staff member going to the visit alone. So this policy both works to the benefit of the family, and I think it also works to the benefit of the staff. It also usually necessitates less frequent visits. Furthermore, I suspect often when it’s a physician and a nurse there’s an element of psychological balance, a parenting model, where one person can deal with the more, the drier, technical, fatherly-type stuff, and somebody can sort of be more of the hugger. I think another thing that has become important, something that was very important for Nancy, and I think we’ve tried to maintain to maintain right from the beginning, is aggressive symptom control. We’re striving - we’re not quite there - to be able to evaluate in our charts too so that one can take a symptom, score it and then see what happens over time.’

The hospice also aims to provide reliable and varied sources of information by which to support patients through treatment and at the end of life, and in 2005 started creating a small library, as part of this process, explained in more detail by Jim Shalom:

‘What happens all over the world, and also here in Israel, is that when people are dying with cancer, they try, they are looking everywhere for hope. So besides taking the orthodox treatment of chemotherapy or radiation, they go to all kind of healers, serious and charlatans and they spend a lot of money for these things and travelling very big distances for this. So Nancy’s dream, which we share, is that we should be also a centre for information of this, not just treating the dying patient, which is the main field of the hospice, but also supporting, giving advice in all the fields related to palliative care. So we have many dreams also of having a place, a centre, not just going to out there in the field but having a place that will be a centre for these kind of services. We are far away from that possibility but that’s the general direction. At present in order to help patients who are looking for support, we are in the process of setting up a small library to give books on the field that could help someone deal with this stage of life.’¹¹⁶

Negev Palliative Care Services

The service was established in 1991 by Professor Pesach Shvartzman, a family medicine specialist, originally as a home care service for adults in the city of Beersheba. In 1994,

Dr Yoram Singer, also a family medicine specialist, joined the service and developed an extensive home based service and a hospital consultation service for adults. He describes the development of the service:

‘The home hospice team was started by two physicians and a nurse - and they built it according to the British model and one of the things about the British model is that, in order to get home palliative care, you have to sign a consent form by which you really do sign the fact (a) that you realise the fact that you have a life-limited disease and (b) that you are not going to get any kind of active treatment. Now nobody in this culture in the Middle East anywhere was willing to sign that kind of consent form, so there were about three patients, all of whom were American or British people, and that’s how the thing worked. And after a year and a half the staff resigned and Pesach [Shvartzman], who was just come to Beer Sheba, asked me to take over this and I said to him, ‘No way,’ you know, I was just setting up this very difficult initiative, trying to set up a teaching clinic against all odds and it was enough for me to do that, and I said to him, ‘I’m sorry, there’s a limit,’ and he said, ‘No, it’s good for you and it’ll be nice and interesting and we’ll do it together,’ really tried to convince me but I said no, no, no way. And so they took somebody else and it was a complete failure, it really almost disintegrated then. Pesach came to me again, he said, ‘Listen, we’ve tried it and it doesn’t work. Why don’t you give it a try? Try it for three months, if you don’t like it we’ll find somebody,’ and after two weeks I was completely sucked in and that was that, and since then we’ve been really doing it together.

The service has really grown quite a bit now. It began against all odds because it’s not part of the basket of services and there’s no initiative, no reason why to develop this kind of service because it doesn’t even save money because of the way the health system works. It means finding posts which is something that’s very difficult to get. So we were really having a very, very difficult struggle. We started off and now we have is a service consisting of three home care units and one mobile unit. The home care unit, one is in Beersheba, which is the main one and it’s the biggest one, and we have 24 patients ongoing at all times.

We have the meetings at the [community health] centre where Pesach works. [The service] is a joint initiative of the University, the Division of Health in the Community in the Faculty of Health Sciences, and the HMO and actually we get a little bit of funding from the Israel Cancer Association as well. Part of our post, well one half of our nursing posts and a half of our doctor posts are financed through this.’

The hospice has developed working criteria, and has an ethos of maintaining personal contact with the patient as Yoram Singer explains:

‘One criteria for working in our service is either you must have a position in the service or you must be a resident - we don’t have any doctors who are not part of the service doing calls, because the physician or anybody who does any kind of call duty must be at that Thursday afternoon meeting to get input, and we don’t want somebody to sort of go to the patient and start saying, ‘Well, there’s nothing for me to do, go to the hospital.’ That’s not what we’re about. We have our patients, we have this personal contact which is absolutely essential; otherwise it won’t work.’¹¹⁷

Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem
In 1994, the Sha'are Zedek Medical Centre called on oncologists Dr Nathan Cherny and Professor Rafael Catane to set up a service for cancer patients, to include a programme of integrated oncology and palliative care. Nathan Cherny takes up the history:

'Professor [Rafael] Catane was the first Chair of Palliative Care and he is now Chair of Oncology at the Sheba Medical Centre [in Tel Aviv]. Initially the service was an out patient consultative service and over the years the programme has grown. Two of us are both oncologists and palliative care physicians, one of them is Dr Ora Rosengarten, who also co-ordinates the Jerusalem Home Hospital (the home care programme for the largest of the HMOs in Jerusalem). In terms of the palliative care team since 1995 we've had a palliative care nurse, she was initially funded by a philanthropic grant, and since 1997 she's been on staff and we've had funding. We also have a research and education co-ordinator whose name is Rama Sapir, her background is that she's a clinical pharmacologist and together she's been a key player in research and in terms of developing educational publications in Hebrew but also translated into Russian and now Arabic; the management of pain, the management of symptoms, the management of post operative pain which have been very widely disseminated.'

An important aspect of the service has been the dedication of the team to address the need for the relief of suffering in patients at the end of life. The team works to improve pain relief and symptom control; conducting ongoing research and thereby constantly refining good practice, and also by developing psychosocial support. The initiation of spiritual counselling is part of the overall ethos of the service. Nathan Cherny explains:

'When I started in Israel, although there was a rabbi in the hospital, there was no tradition of chaplaincy organised spiritual care and this was clearly missing from the programme. We had a limited, a couple of volunteer chaplains who'd come and gone but not very successfully. Partly because of cultural issues, and there was some degree of scepticism as to whether Israeli patients had a lot of spirituality. In 2002 Jonathon Rudnick approached me, he was a young rabbinic student who was interested in chaplaincy, and I said we were interested in taking him on but only after he got formal training. And he went to the States and did the thing called Pastoral Care Programme and came back and started working on a voluntary basis; initially once a week. We introduced the service with a degree of scepticism on the part of some of my colleagues but from the outset it's been an enormous success. Partly because of his specific skills, not only interpersonal skills and religious skills but he is also multi lingual speaking Hebrew, English and Russian, remembering that there are a million Russian immigrants in Israel. What we saw through that experience was that there was a huge need a huge yearning for it and that we found we were able to spiritually engage patients across the entire sociological spectrum, from the ultra orthodox to modern orthodox, through secular, Christian, Moslem in a very productive and rich way, and it's really been one of the turning points in the development of the programme. There is good co-operation between his work, the social worker and the psychologist without competition over patients. There are different issues being addressed and good communication between the services. Based on that initial experience on a volunteer basis we applied for funding from the New York Jewish Federation, and they gave us a grant to make Jonathon's position a full time position and to start an internship programme and this is what Jonathon

has described to you. And besides the clinical programme here he's put in a lot of his energies teaching about the concept across the country, and in the next stage of our programme is to get funding to take on interns who will see it into other institutions. Not only to train interns but you need to train staff and to socialise them into the concept of this aspect of care, which we strongly believe is an important part of care.'¹¹⁸

Rabbi Jonathan Rudnick describes the ways in which the spiritual counselling supports, not just the patient but also supports the staff:

'We're trying to learn about how [this kind of approach] happens here, in order to try to help that happen in other hospitals, and part of it is clearly how the staff related to it. The whole other issue, in terms of the staff benefiting from this for themselves, for the spiritual care that the staff need, is a bit more difficult conceptually but I think that in general not just in spiritual care many people kind of feel like the whole issue of self care, like everyone says, "yeah, we need to take care of ourselves but lots of us don't do it so well." But seeing this as something that is an important resource and something they can help in terms of the care for patients and families; the whole staff went along with this. And slowly and slowly [staff] started referring patients, in a sense of it being very slow and organic which is one of the important issues that Nathan emphasises in terms of changing and developing the culture in the hospital setting in Israel where this is seen as OK, positive and something that the staff will want to support because it helps them as well.'¹¹⁹

Milton and Lois Shiffman Home Hospice in the Valleys

The hospice is one of the few services owned by HMO Kupat Holim Clalit. Founded in 1999 by nurse Mali Szlaifer, the hospice took over the work of the (now closed) Afula Hospital Home Care, on the retirement of the medical director Isaac Kersz. Mali Szlaifer explains the aims and ways the service has developed since 1999:

'For terminal patients I really felt that we can not do too much, and the needs were very large. The problem was that nobody was really in charge of that and the community send them to the hospital because they already paid for it, and they don't know how to manage their symptoms and things like this. The hospital sent them back home and the people were very miserable - really. ... Sometimes they give them something, or here or there, but didn't help a lot, and then they sent them back to the hospital and the hospital sent them back home. The vision of our hospice when we were establishing, is to provide excellence - not good but excellent palliative care for patients and family, and also to be one of the leaders in palliative care in Israel, and to ensure that high-quality standard of palliative care services will be accessible to all patients suffering from progressive diseases - see that I'm not using the word 'cancer' ...in our hospice we will see other diseases, ... but we see very few referrals [for other illnesses]. In the beginning, the American partners (the Jewish Federation of Detroit) agreed to pay for three years. We are in the sixth year, so they decided that they will give for another three years but smaller amounts of money, and maybe I'll have to close some of those regions.

Staff satisfaction [is important], because one of my concerns at the beginning was that nobody works for the hospice a full-time job, everybody works very part-time, so I was afraid that, OK, this is not important and so on. But what

happened over time [although they said] ‘it’s very bad time’ but they ‘see this as the quality work’, as the nurses say: this is where they can magnify their profession. Because the district is very spread, one of the options was that I would take a nurse, for example, and she would be travelling most of the time because she must go from here to there to there to there - so I decided to take nurses or physicians who live in the region, a very small region, but that they can cover this region in 10/15 minutes of driving, and for example a nurse can have between one and four patients. [She is on call] 24 hours a day, all year. If she is not able to go to the patient, in every region there are two nurses, and then she will refer the patients for the other nurse, and sometimes today what happens is, if the nurse goes on vacation the doctor is on call for the patient because they build a very strong relationship in their team.

In Israel, as I told you, in the beginning the Jewish Federation of Detroit gave us money to make a partnership, but in the Arab city they have no partnership, and I felt very bad because I felt like it’s some kind of discrimination, and I ask them that it doesn’t look good that we only give treatment for Jewish people. And they think about it and in Detroit they also have a very large Arab community and they want to improve the relationship between the Arabs and Jews so this also met some agenda of theirs. They give me the money to open the hospice in the Arab city of Nazareth, and then I was in United States with an Arab social worker but she was working for the hospice of us here, and we made some projects together with the community of Israel and United States. OK? So this is what I was writing about, you see, that sometimes when you are talking about mutual issues that are important for both communities and you are not talking about *peace* but those things that improve peace and understanding because, you see, we are people the same.

So the goals were to provide high-quality culturally and religiously tolerant palliative care and train professionals from the various religious groups emphasising the ethnic diversity of patients. And patients and families stated in this satisfaction questionnaire that the spiritual and cultural differences were appreciated and respected, you see that and this unique project demonstrated the feasibility of multi-religious collaboration in palliative care is a potential to promote understanding and peace.’¹²⁰

Jerusalem Home Hospital

Founded in 1991 as an HMO run service, the Home Hospital was established to provide ‘hospital’ type care at home for patients with a range of acute and chronic illnesses, including palliative care at the end of life. The service is unusual because from the start palliative care has been offered to patients with a range of illness, not just cancer, and also the service provides palliative care for children at home. The medical director Dr Jeremy Jacobs explains:

‘We’ve got, we have about 25 – 30 patients, full-time ventilated patients at home ... with tracheostomies, and home ventilators the size of a shoe box. They’re at home, most of them are in home hospital; the minority manage to do without us.’

The service was also encouraged by work with heart failure patients at the end of life to ensure an effective home care service that would benefit both the health service and patients by preventing recurring hospital admission, Jeremy Jacobs continues:

‘We discharged a lot of patients at one stage and we found that the heart failure patients went back to the hospital very significantly, so that we persuaded our bosses to reallocate funding in order to open up the service again. We have started a pilot service that’s focused on heart failure patients. Whereas in the past we have always waited for patients to be referred to home hospital, with the heart failure patients who are home bound/bed bound with recurrent readmissions to hospital we are actively seeking out patients to admit to home hospital. We’re going to take them in and give them the service for as long they, as long as they remain at the level of heart failure. We’ll keep them for a long period of time, with a nurse practitioner going in and a doctor going in, and see if that really keeps them out of hospital or not.’

The service continues to emphasise the importance of palliative care provision and employs a part time palliative care consultant Dr Ora Rosengarten and a specialist palliative care oncology nurse Yonat Lamed. The Home Hospital, as a concept and in practice, has proved both efficient and well-regarded and the nature of the team and the way they work have changed since the hospice was established as Ora Rosengarten explains:

‘Some 20 physicians work today in the Home Hospitalization service and provide the best possible care to the patients. Most of the physicians have been working with us for a long period, they have acquired good experience in palliative care, and they do their best to respond to patients’ needs 24 hours a day. Along with the nurses, we provide all services for end of life care – as much as can be done in the Hospital setting, allowing the patient to enjoy the home without compromising the quality of care. The work done by the team of the home hospitalisation is very difficult and only those really devoted persist in this work.’

An important part of the service has been to develop the supportive role of nurses for families in the home care setting. As Yonat Lamed, specialist nurse explains:

‘A big part of the nursing work actually is supervising nurses, and the nurses themselves, to guide the family, it’s a big part of our role. If they get infusions they are taught how to change the bags, sometimes even with the sores the families are taught how to treat and change the bandages and everything; pain medication, of course. And we have to prepare the family what’s going to be, I mean, if we know already what is the deterioration of the patient, we have to start to prepare the woman, the wife, what she can expect to see, and what are convulsions and what are etc, and not just using those high words. Then it’s like we prepare her for what she will meet, will see, and then what to do if there’s something else, what will happen. This is really a big part of our role to do, the nurses.’¹²¹

By 2002 the *Jerusalem Home Hospital* had built its capacity to provide care for 450 patients at any one time. However, funding is always precarious, and the service was severely tested in 2002 when over two months, due to unexpected funding cuts by the health insurer, the service was forced to reduce the number of patients to 150, prioritising cancer patients needing palliative care. A consequent sharp increase in hospital admissions prompted the insurer to acknowledge the cost effectiveness of home care and to restore some of their funding. By 2005 the service had managed to increase capacity back up to 300 patients.

Bereavement services

Formal bereavement counselling is being developed in some services: the *Ina and Jack Kay Hospice*; and from 2005 at *Tel Hashomer*.¹²² In 2005 *Negev Palliative Care Services* started to develop bereavement counselling through Ma'agan House, Beersheva.

However, most services offer some element of bereavement counselling that builds on well-established informal support already provided by the service prior to a patient's death. Bereavement support may, as for instance at HUG, include one or more members of the whole team, or in other services tend to be taken up mainly by social workers or psycho-oncologists. Malka Yehezkel, the inpatient social worker at the Ina and Jack Kay Hospice, Hadassah describes how she supports the family in the first stages of bereavement:

'After the death of the patient I sometimes go: first I go to the visit of the 'shiva'; the Jewish have the 'shiva' [7 day mourning period immediately following the burial]¹²³, the Moslem have 3 days, so I go to visit at this stage ...I open the door to continue this follow-up if they want. Sometimes they are ready to come back here [at the hospice] and meet me regularly. At the beginning when the patient is here it's not a regular meeting, every day I go up, I see them here or we meet. Afterwards, with the follow-up, it's regular meetings, like in a clinic, it's very different, that part. And I'm ready to go to their home if they feel it's too difficult to come to the hospice again.'¹²⁴

Other services will usually try to offer some bereavement support but may depend on volunteers being available. For example in Kiryat Tivon as Ora Cibulski explains immediately following the patient's death:

We do very little. [But] we always go to the 7-day mourning period [Shiva]. We're always there immediately after the patient dies. We call up or make contact [for] 30 days - 30 days is usually, it's a sort of type of mourning period ['Sheloshim'] - and then whoever was in direct contact with the particular family calls about once a month until six months. Sometimes there are visits - it very much depends upon the particular volunteer.¹²⁵

Paediatric services

Palliative care services for children have developed slowly since the 1990s. For a few years there was one dedicated, though small, inpatient unit at Chaim Sheba – The Marion and Elie Wiesel Children's Pavilion, but a change in staff in the 2000s has meant that this unit has a greater emphasis on curative care. There are two home care hospice services able to care for children (Jerusalem Home Hospital and HUG). However, as paediatric oncology nurse Ruth Gassner notes:

'In oncology paediatrics, mainly when children die they stay in the hospital. From my experience I don't believe that you can open an inpatient hospice for children, I don't think that. Not even one parent would give up treating here, I mean treating, giving chemotherapy, etc to the children, I don't think so. Usually they give it until the end. Very rare that they take the child home and he dies at home. It's not so often.'¹²⁶

Professor Pesach Shvartzman, who has helped to develop the paediatric palliative care consultation service at the *Soroka Medical Centre, Beersheva* agrees and continues:

'Children are another issue, you know. [For] children, what we lack, what we don't have is inpatient care, and we are doing our best to get a contribution to

have an inpatient department. Now our children, you know, we have some children at our palliative care unit, usually children culturally - and it might be a Jewish culture - although we have many of the children who are Bedouins, usually children die in the hospital. It's very difficult for parents to go home and let the child die because it might be obvious that the old people die, it's not obvious that children have to die, so I can tell you that there are not many families in whom we could take the child out and take care of him at home. ... We have about 4 or 5 children dying each year and of course, just having ... I usually work with the social workers of the paediatric oncology department, so there is not ... what I did I just first of all trained the department themselves to do something by themselves and just give them the support and usually I used the resources of the paediatric oncology department because, you know, just to have a few people - five children a year - it's problematic when you talk about cost-effectiveness.'¹²⁷

Because families rarely request home hospice care for children, since the late 1990s in response to these very different needs of dying children and their families, paediatric services have tended to develop hospital based services rather than home or specific hospice services. For instance, there are currently hospital consultation teams and hospital based support groups for families within paediatric oncology units at several large medical centres.

Drop-in centre

The only drop-in centre in Israel was established in the early 2000s, Ma'agan House, in Beersheba, run by *Negev Palliative Care Services* as a charitable venture funded by an independent, overseas, benefactor. Dr Yoram Singer explains:

'Ma'agan House is a community house whose function is to support cancer patients and their families. It's like a club, where they have all kinds of activities for cancer patients and their families. There are, there are also group therapy sessions, and there's an art therapist and a music therapist who come. They have lectures on all kinds of, not medical issues but sort of bringing together cancer patients - not only terminal cancer but cancer patients and their families under one roof.'¹²⁸

The centre is organised by a social worker with a group of trained volunteers able to offer a range of supportive and creative therapies.

Changes in service provision

Since the late 1990s, financial and staffing difficulties have resulted in closure of some home hospice services such as the Haifa Home Care Hospice in 2003, the reduction in provision of services as at the *Jerusalem Home Hospital* in 2002, and the shift of emphasis from palliative care to more curative based paediatric care at the *Marion and Elie Wiesel Childrens' Pavilion* when dedicated palliative care staff moved to other locations.¹²⁹

There are, however, new services are under development, for example, a home hospice will open in January 2006, *Al-Taj for Health and Heritage Association* near Nazareth.¹³⁰ Likewise various new services have been set up in the last 2 to 3 years within existing organisations, for example, the mobile desert unit started in May 2004 at the *Negev Palliative Care Services*; the inpatient unit and the spiritual counselling service at the *Cancer Pain and Palliative Care Unit at Sha'are Zedek*, the development of palliative care services at the new *Davidoff Oncology Unit* which now incorporates the *Beilinson*

Unit at the Rabin Medical Centre and the current expansion of services at the Hospice of Upper Galilee.

Since the 1980s, with the support of the *Israel Cancer Association (ICA)* and the *Israel Association for Palliative Care (IAPC)*, dedicated services have been developed in many areas of the country; including an extensive community nursing service and regular training programmes.

Hospice success stories

Tel Hashomer Hospice: Alexander Waller, medical director writes:

‘Tel Hashomer Hospice has not only provided good and appropriate treatment to patients in the terminal stages of cancer, but has also strengthened the awareness of their particular needs – among the Israeli medical community and Israeli society at large. By its successful example the Tel Hashomer Hospice has stimulated the establishment of additional hospices throughout Israel. Ours was a truly international effort, for since our very first days we enjoyed the friendship, advice, and support of colleagues abroad, most notably our English friends and especially those from St Christopher’s Hospice.’¹³¹

Ina and Jack Kaye: Ruth Gassner, director highlights one important aspect of the success at the hospice at Hadassah:

‘Avoiding burn out and keeping your good staff. I read in the literature that in hospices every two or three years nurses are rotating, that’s exactly what I wanted to avoid, so how do I avoid it? [Harriet Copperfield] said that burn out comes only from hard conditions, not from hard work, and, you know, during the years, now I can say because now I’m almost 20 years here, that she was so right. Look at the nurses, they are still with me, most of them - some left because they left Israel, some left for the north - but most of the nurses are with me.’

Malka Yehezheh, inpatient social worker agrees and also notes that:

‘This multidisciplinary work is, I think, one of the keys of doing the best job here, and I know it’s not everywhere, we appreciate it very much.’

Judy Yoran, home care social worker describes success at the patient level:

‘When you help them when you see a patient that suffers, the day after he has a very tiny smile, small, a smile; that is a huge success. I think we have to, we have to see our little steps as our successes because there are a lot of battles to fight, I think, around the, what society sees as a hospice, you know, we still, people see us as a place where you come to die and you don’t leave, and so we are all fighting that when you try to explain to someone, you’re trying to give them quality of life, not only end of life, that’s a very big change of mind. But I think also you can add to your successes starting to educate the rest of the hospital about what palliative care is. They’re called in by nurses in the internal medicine department, the nurses are sometimes in the middle of the night consulted about how to help someone with pain; and the doctors are educating other doctors.’¹³²

Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem
Nathan Cherny, oncologist and director identifies some key developments as markedly successful, and includes research (amongst many other strengths in the service) and the dissemination of this work through ESMO to the wider community as a particular important part of the service:

‘Since 1994 the key things have been, the four biggest things have been getting the position for a dedicated palliative care nurse, the second was getting the nurse and research assistant, secondly getting more staff, having more help, then the development of the in patient service and finally the development of the chaplaincy service. In terms of research and education we’ve had a long history of involvement, looking back at issues looking at attitudes and practices and also issues of specific interventions. When Professor Catane was head of the department here, at the time he was the national representative for Israel on the board of the European Society for Medical Oncology, and he suggested to them that they form a task force to approve the integration of oncology and palliative medicine all across Europe and this was approved by the Board. Since that time I have run this task force which has had a very strong ripple effect in the organisation. ESMO have adopted a series of policy statements on the role of the oncologist, and minimal standards for cancer centres in the delivery of palliative care. It surveyed its entire membership on their practices and that’s been published and it has set up an incentive programme to award centres of excellence in the integration of oncology and palliative care and this is to try to encourage centres across Europe to really look at this issue and it’s been a very successful programme in ESMO and is widely publicised the organisation on the front page of their website and it’s early to say but there’s definitely a ripple effect and an awareness that’s been generated through this intervention and this whole programme has come out of this department.’¹³³

Negev Palliative Care Services

Dr Yoram Singer describes the successful developments as providing a vital service for patients as well as providing opportunities to train physicians:

‘Many of the people, by the time we come on, they’ve been *so* disillusioned and they’re *so* angry at the health system that it may take a week or two for us to regain their confidence in any kind of health, any kind of system which has to do with health, because they’ve, you know, had a recurrence and *another* recurrence, and finally the oncologist has called them together and said, ‘Listen, there’s nothing more we can do.’ Now then they send them home, and there’s nothing more horrendous for a family than to sit at home and feel that there’s nothing more can be done. And then we come and we say, ‘Well, we have, there’s lots we can do.’ ‘How’s that possible? I mean, in the hospital the Professor said there’s nothing, how is it possible that *you* think you have [something]?’ And then we say, and we start doing, and suddenly the patient feels better. Wow, it works, and it makes a whole difference because then the patient suddenly has enough energy to be able to do all these things that he has to do, you know, closing, forgiving, asking for forgiveness, the whole thing.

The important point in all this is how to teach? We have to convert the non-converted. I can tell you that 90 per cent of the [family medicine trainee] residents when they start are *absolutely* petrified ‘What is ... how are we

going to get ...?' I mean, you know, residency is not a very easy thing anyway, but 'How are we going to deal with this issue? I don't know; this is too much.' And very often they come up with most amazing excuses why they just can't possibly do this kind of thing, but by the end of the nine months [training] they're pretty good at it, I must say. So I think it's absolutely important and you can see if somebody's been through this programme, they will call up and ask for advice because they know that there's something - they can't always remember or whatever, but they call up and they know where to look for advice, they know that it's possible to, and you can tell the difference, I mean, there's no doubt whatever.'¹³⁴

Milton and Lois Shiffman Home Hospice in the Valleys

Mali Szlaifer, director explains some of the success is due to the ways the team is trained and works together:

I think what is the special thing in our hospice here is that all the education we are doing is on a multidisciplinary basis. It means that even the social worker learns about medication, and the Edmonton [pain assessment scale] and everything. So she supports also if she goes there and the patient is in pain. She's not supposed to treat the pain but to call the doctor, she doesn't have to treat, but assess, yes.¹³⁵

As Mali Szlaifer notes this has resulted in everybody in the team being involved in assessments and then responding according to what is required. Dr Amitai Oberman, medical director highlights the staff commitment:

'They don't do it just for the salary; I mean you have to like what you do. So there've been rotations and some people came and some people left, and we basically ask people 'Are you interested, there's money, but are you interested in coming to work with us?' Because there have been rotations, although we didn't plan it this way, many of the nurses within the Nazareth region have been exposed to palliative care. So we all know one another and I feel at home here. It's less ... it's more complicated with the physicians because I don't really see them too often - I talk to them in conferences, I talk to them over the phone - but with the nurses and the social workers there is wonderful liaison; I can tell [the social worker] Shauki, 'Tell the physician to do this,' and it's done.'¹³⁶

Jerusalem Home Hospital: Medical director Dr Jeremy Jacobs reports two important elements in the success of the service:

'Everyone's very pleased with our service here, which is not a surprise. As regards the quality, what's important is the communication, that's what makes or breaks the service: in addition to the medical or nursing or the professional side of it, probably what makes it successful and ensures the patients to stay at home is the level of communication. And the more communication the better the service is. And it's good for our bosses because supposedly it costs much less than being in hospital and we consistently show that it reduces hospitalisation rates. So it is financially viable.'¹³⁷

Nancy Caroline Hospice of the Upper Galilee Hospice of the Valleys

Medical director Dr Jim Shalom describes some aspects of the hospice's success:

‘We have quite a good connection with the pain clinics in all the main, big hospitals in Israel, and we have one patient which we are going to present next week, in a seminar, that he is with us for more than three years, he has a spinal pump, and we do all the ... all the refilling of the pump, we do it by servicing at home, so we try to do, that’s one of the things that hospice is doing extraordinary things, many different examples, so I think we are quite good at it, at trying to treat each case as, each case individually, seeing the needs and trying to improvise sometimes.’

Yaniv Ben-Shoshan, social worker, explains the success of the patient/staff approaches:

‘I think that, I think all of us receive a lot of, from our work. For me it’s a lot of life, of a sense of life, and a love of life, I find in the family and the person, not in all the person, not all the patients and their families, but the process that I go with a person and with them to find some [meaning] in their time of life, in *this* time of life, and I with them, it’s a lot.’¹³⁸

Home Care Hospice of Kiryat Tivon, Northern Israel

Dr Ilene Ora Cibulski describes the greatest success from her perspective in Tivon:

‘In Tivon, we always had our training of professionals and non-professionals together, and we always used the professionals to teach their particular thing. I met the most wonderful people in the world. Not one, not two, I’m talking about *dozens* of very, very special people, dedicated people, knowledgeable people, responsible people, people who would crawl on their knees in order to get to a patient. It wouldn’t make any difference if it was two o’clock in the morning or on Yom Kippur, it wouldn’t make difference: if the patient needed them they would be there. And that’s a privilege, you know, how many of us have chance to meet people like that?’¹³⁹

Life/oral histories

Aliza Yaffe – *Head nurse: Israel Cancer Association*: interviewed by Amanda Bingley, 13 May 2005. Length of interview: 1 hour 20 minutes

In this interview Aliza Yaffe describes her work with the Israel Cancer Association, developing specialist nurse training and community home care:

‘When I came to the Israel Cancer Association I was working in a general hospital in Tel Aviv and I was teaching at nursing school and I already had experience of treating the patient with stoma but I didn’t have the formal education in stoma care. And later on I went to the United States to, in order to have specific education. And that was my job description. But stoma care is not the only thing that they should need, and not everybody has a stoma, so gradually we developed in the Israel Cancer Association some nursing services and some nursing education. I think it was kind of bolting things together. I went to the first Cancer Nursing Conference in London in 1978 when Mr Bob Tiffany from the Royal Marsden, he said, ‘We need an international conference.’ When I returned from there, I went to the General Director of the Israel Cancer Association, Miriam Boaz. She said, ‘OK, what do you think we need here?’ Then I said, “we need some education for nurses in cancer, nursing not only the general, the general nursing education that we get.” There were specific courses on midwifery - not like in England, the

nurse study differently, but postgraduate courses, midwife courses. Then we said we need also something like that in cancer nursing, and that was the first step doing something different from stoma care, starting a course in cancer nursing.’¹⁴⁰

Dr Nathan Cherny – *Co-founder and director, Cancer Pain and Palliative Medicine Service, Sha’are Zedek Medical Centre, Jerusalem*: interviewed by Amanda Bingley, 4 May 2005. Length of interview: 1 hour 19 minutes

Nathan Cherny describes his early interest in medicine and his eventual training as a physician. He explains that he was made powerfully aware of the needs of cancer patients and palliative care partly through his own experience of illness and partly through the impact of seeing two documentaries on St Christopher’s Hospice and another on the work of Elizabeth Kubler Ross, who he later met, and then caring for a young patient who was dying. These influences led to his training in medical oncology where he was struck by the lack of awareness in other oncologists of palliative care:

‘When I started my training in medical oncology one of the things that struck me was that the residents around the hospital really knew nothing about palliative care and this was a problem in terms of care round the wards and I approached the medical school to see if they would allow me to teach palliative care to the students on the internal medicine rotation and this is now 1988/89, and that was supported and I wrote part of the palliative care training programme for Monash University and I taught that through the rest of my fellowship in oncology and you know the preparatory work that went into preparing that material gave me a lot of background into palliative care and the clinical skills of palliative care and led me to the next decision point which was in seeking a fellowship, to seek out a fellowship in palliative care. I went to talk with Kathy Foley. So you can see there have been multiple steps along this way, and when people ask me who inspired me, no single person inspired me, there was the very brief exposure to the work of Elizabeth Kubler Ross and then these trigger experiences with patients as a young medical student. As I have gone along the path there are people who I’ve found wonderful inspirational people along the way, certainly Kathy Foley and Russell Portenoy were wonderful mentors to me when I was at the Memorial Sloan-Kettering Cancer Centre. While I was there I was exposed to a couple of other people who had a disproportionate impression on me to the amount of contact, one was Derek Doyle and the other one is Ned Casson. Kathy and Russell in particular created opportunities for me to develop professionally to develop an interest in policy beyond just service delivery.’

In 1993 he arrived in Israel at the invitation of the director of Sha’are Zedek to establish, with Professor Rafael Catane, the service at the centre, which has proved to be a highly successful unit. He notes that in the course of his work in palliative medicine he has instigated research into pain and symptom control and the relief of suffering at the end of life.

Jonathan Rudnick – *Rabbi, spiritual counsellor, Cancer Pain and Palliative Medicine Service, Sha’are Zedek Medical Centre, Jerusalem*: interviewed by Amanda Bingley, 4 May 2005. Length of interview: 35 minutes

Jonathan Rudnick talks about how spiritual counselling was initiated into the service and is currently being developed. He explains that his interest in bringing spiritual counselling into palliative care was supported by Nathan Cherny and other colleagues in the service.

He speaks about his specialist training in the USA, and how the service is now supporting the course he is teaching for others to train in this work. He describes how successful the counselling is proving to be for patients, families and staff.

Dr Amitai Oberman – *medical director Milton and Lois Shiffman Home Hospice in the Valleys*: interviewed by Amanda Bingley, 10 May 2005. Length of interview: 58 minutes



Amitai Oberman describes how his interest in palliative medicine developed out of his work in geriatrics. He explains how after his training in internal medicine in 1996 he went to the United States to do a Fellowship in Geriatric Medicine at Harvard. After two years of clinical training and a year of research, he was increasingly fascinated by the USA approach to end of life issues and treatment, such as the advanced directives and patient autonomy. This led to a two months palliative care training in an inpatient hospital based hospice unit. On his return to

Israel he continued, as a geriatrician, to be involved in palliative care, both in the nursing home system and in his work in internal medicine in one of the hospitals:

‘Mali [Szlaifer] approached me and said, “Would I like to come and help out, because she knew of my interest in setting up the home hospice unit?” Then I joined the Israeli Palliative Care Association and from there things began rolling very quickly and I became very involved, both on a local level setting up the services here, a lot of education, and on a national level meeting people, getting to know the system. Over the last few years we’ve been working in parallel lanes: one is the local hospice here and the other on a national level. I have to devote much of my time to the national level, setting up, getting to know people, bringing people together, setting up these big annual conferences, and also working on a regional level. When I went to work in Poria at the Geriatrics Department, originally there was an inpatient unit there which was a more skilled nursing facility, but I managed to get education for the nurses there, so until it was closed down a year ago all the terminally ill patients at Poria were moved over to my department; and we’ve got good staff over there. I’ve been involved with the EAPC from 2001 or so, we’ve had the poster, then I had some more posters, in The Hague I gave a lecture on palliative care and dementia. A lot of the work is devoted to the national level kind of stuff in order to promote palliative care on a national level. I’m very active in the Education Committee and the Health Services Committee, teach a lot, but also try to get involved as much as I can in doing true clinical care. In the kibbutz which I live in we had a couple of patients die at home. I wish I could have more time and devote more of my time to palliative care, which I don’t do enough. I could do more but these are the limits which I have.’¹⁴¹



Mali Szlaifer – *Chair of IAPC and hospice director Milton and Lois Shiffman Home Hospice in the Valleys*: interviewed by Amanda Bingley, 9 May 2005. Length of interview: 2 hrs 20 minutes

Mali Szlaifer talks about the history of her involvement in the Israel Association for Palliative Care (IAPC) and her election as chair of the association. She describes her work in the largest of Israel’s health insurers Clalit Health Services, where as a trained nurse and regional nurse manager she organises the provision of nursing services for patients at home with chronic illness. She relates how in the course of this work she became acutely aware of the needs of patients at the end of life and decided

in 1999 to set up a palliative home care service. Drawing on her considerable management experience she negotiated with Clalit to fund the service and called on another IAPC board member and local geriatrician Dr Amitai Oberman to join her in establishing the home hospice. She talks about her determination to create opportunities in developing her own and her colleagues' knowledge and skills in palliative care through links with healthcare professionals in organisations in Israel and overseas. She describes her research and evaluation work in home care and her enthusiasm in developing the IAPC educational programmes.

Hospice team interviews:

Team interview: Ina and Jack Kay, Hadassah, Mt Scopus:
team interviewed by Amanda Bingley, 4 May 2005. Length
of interview: 2 hours 7 minutes
(Photograph: Ina and Jack Kay Hospice, Hadassah, Mt Scopus)



Ruth Gassner – co-founder and director.

Ruth talks about her long history with the hospice, as co-founder and director since the start in 1986. She trained in paediatric nursing specialising in paediatric oncology before she became involved in establishing the hospice. She describes how the renovation of the building and the setting up of the hospice was funded by American benefactors; the Kay family and then she had to find staff:

‘I started to recruit some staff, and I did it on my own intuition. I didn’t know what I want; I just knew that I wanted good people. What is good I don’t know - now I know, then I didn’t know. I made a few mistakes: I don’t think too many, but a few mistakes I made. Those that weren’t so good left, but very small number of people. Most of the staff which is working here in the hospice are people that started with me in ’86.’

She talks about how the team has developed ways to best support patients and families and relates some of the challenges they have faced in their work within the inpatient hospice and in the community.

Dr Daniel Azoulay - physician.

Daniel Azoulay describes his work at the hospice, the ethos of the care, and how he came to work there. He explains that he was practising general medicine in France and came to Israel to train in internal medicine. He began to work in geriatric medicine which started his interest in palliative care. Around 10 years ago he was asked to take the position as hospice physician in addition to his geriatric work at Mt Scopus hospital. He discusses his dedication to working in palliative care, his enthusiasm for teaching and training other health professionals and his involvement in seminars and conferences nationally and internationally.

Malka Yehezkel - social worker.

Malka explains that she has worked at the hospice for around 16 years, following community social work. She relates the story of her introduction to the hospice:

‘I was working in the community, I had a patient that I felt maybe should be in hospice and I asked the family and they were interested; her son was a doctor, and her daughter was a social worker. We got in touch. It was a good relationship with the patient ... it was the first time I talked to someone about death and hospice - and I asked her what she thinks about it, and she said, ‘I

feel I need it'. And then I talked to the family and I called Ruthie [Ruth Gassner] and the patient was hospitalised here. I came to visit once ...she was only here a few days; I came to visit only once. It was a time that I thought I need a change, a different kind of work in my profession, and it was the first convention of the hospice, three years after the hospice was opened, and you invited me to come. The first social worker, she said in front of everyone that the hospice is looking for a social worker to the home care, and I came to talk to her and I said I feel I want to be in the inpatient unit at the beginning, and that's how it started.'

She talks about the importance of how the team support each other and how much she loves her work.

Judy Yoran - *home care social worker*.

Judy talks about her work in the home care and the family support offered by the service. She explains how the work changes and presents different challenges, which reflect the ways communities and cultural groups have had to change in the face of the conflict.

Helen Englesberg - *home care nurse*.

Helen talks about how she came to be one of the first nurses recruited to the hospice when it opened. She started nursing in London and was working in oncology before she was unexpectedly introduced to palliative care:

'I'd met Cicely Saunders many years ago when I was in London. I went to the Royal Free Hospital to visit a friend, and I'm looking at the noticeboard, I was working in oncology, and I see [there was a] Cicely Saunders' lecture; [I thought] that sounds interesting. I went to the lecture and I just fell in love with this whole idea. I said this is wonderful, this is what we need, this was in 1975, something like that. And then [Cicely Saunders] came to Israel and she came to Hadassah, she gave a lecture and I went to the lecture, and again I said this is wonderful and I was full of it all. And the years went by and I'm not in oncology any more, and I'm reading the Jerusalem Post one day and I suddenly see 'Hadassah Medical Organisation ... opening a hospice ... contact Ruth Gassner' so immediately I called Ruth Gassner. We arranged a meeting, she said 'I'll meet you, come to the hospice,' and she told me how to get to here, and she met me at the door. The place was empty, there was no furniture, I think there were a few chairs in here, and we sat. I remember exactly, we sat over here on those brown chairs, just a few chairs. We sat together and we talked and I told Ruthie about my history, she told me her history and I think I was one of the first nurses probably to be employed here actually.'

Jerusalem Home Hospital - team interviewed by Amanda Bingley, 3 May 2005.

Length of interview: 1 hour 9 minutes

Dr Jeremy Jacobs, *geriatrician and medical director*, Dr Ora Rosengarten, *consultant in palliative medicine*, Yonat Lamed, *specialist oncology palliative nurse supervisor*, Timna Zistling, *head nurse*.

Jeremy Jacobs leads the team discussion about the work of the Home Hospital and how the service is managed and organised. He describes the flexible approach they have developed in order to be able to care for patients with a range of complex illnesses. He explains some of the history of the service and how, because the service is run by the HMO Clalit, they have had pay particular attention to balancing economics with

providing good care for a large number of patients. Ora Rosengarten, Yonat Lamed and Timna Zistling describe some of the situations and challenges of bringing hospital type care into the home with a wide range of patients. They talk about the importance of helping to reduce the physical, mental and emotional suffering for people at the end of life and how they try to do everything needed for the patient; offering such a wide ranging home care service enables them to support many people to stay at home who would otherwise die in hospital. They sometimes have to deal with difficult ethical dilemmas but have proved the service to be both efficient and welcomed by patients and families. Yonat Lamed explains:

‘I started to work here something like nine years ago and today it seems so different from since I started. You know, at the beginning when I called a doctor and I said, ‘Well maybe we do that,’ and he was shocked, I mean, ‘Who you are? A nurse?’ and today we just work together, it’s really a team and we advise each other and the doctors know that I know palliative care maybe more than many of them and they are willing to hear advice etc and we just work as a team. You do need an oncology nurse who is palliative care oriented, you know, to be able to do it.’

Dr Ora Rosengarten confirms the importance of the commitment of those dedicated to palliative care:

‘If you look at the doctors, really it’s something that’s very special, I think; like we have a surgeon in the service that’s giving palliative care today: I think you can take a lot of oncologists who could learn from him how to deal with patients with their last days of life, really. They’re really dedicated and devoted, they’re devoted, it’s more than dedicated, they’re *devoted*.’

Team interview: Nancy Caroline Hospice of the Upper Galilee (HUG): team interviewed by Amanda Bingley, 9 May 2005. Length: 2 hrs 3 minutes (Photograph of music thanatologist Adira with Shosha – kind permission of the team at HUG)



Dr Jim Shalom - *medical director*.

Jim Shalom talks about his involvement in palliative care and he also relates the story of Nancy Caroline, in whose memory the hospice is named; she was an influential physician in palliative care before her untimely death in December 2002:

‘Nancy grew up in Boston, USA and from a very young age she knew that she wanted to be a physician, studying at Harvard. She got involved early on in her career in emergency medicine, and set up an educational programme for paramedics and wrote a handbook called *Emergency care in the streets*. The paramedic programme became nationwide and then was basically exported, certainly Israel uses paramedics and Canada uses [them] and other places. She came to Israel and started working with the Israeli Red Cross, which is called Magen David Adom, as the medical director, and found out that they were corrupt. Eventually some of the people were exposed and had to resign and she left and settled in Metula, Upper Galilee, and she continued to do emergency care. At some point a physician friend of hers had terminal cancer, she was working during the last month and she found herself helpless not being able to help him. And that sort of caused her to change: she declared that she would never let that happen again, and she started going down to Tel

Hashomer which is one of Israel's big hospitals and studied oncology for 4 years. Then she met Alex Waller, (head of the Tel Hashomer Hospice) and started studying; going down to the hospice there. She got very interested and learnt the subject well and she co-wrote a textbook of palliative of care with Alex Waller, based on their experience.

Then she decided to set up a hospice and that's where I met her. She tried to persuade me that the Upper Galilee needed a hospice. I said, 'Nancy, you know, I've worked in palliative care in semi-rural Canada, and when I came here I was surprised at how antiquated things were; their hesitation about using opiates, the idea of not treating people at home or, if they're treated in hospital all the very basic stuff, but that's just the way it is here. Because when I was working that's not only how the *hospital* practised but the families, that's what *they* expected: 'They're gonna give my father *narcotics!* I mean, he'll become addicted to it.' He's gonna die in three days. So I said [to Nancy], 'You don't have to persuade me, I just don't think that you'll be able to get through the red tape.' Well she did and she set things up and she had this way of getting people to agree with her. You could argue with her but it didn't help because she always had the arguments to justify. But when I took over as the administrator it was a little bit intimidating and she didn't interfere at all, nothing, absolutely nothing. There was a period of about, I took over in October 2001 and she died December 2002 - never once did she have a word of criticism. She was just helpful and supportive in any way that she could be. And then we took care of her.'

Yael Bleich – *specialist oncology nurse*.

Yael Bleich describes how she became involved in this work at HUG 9 years ago:

I met Nancy Caroline at 1996. I first went on the oncology nursing course, a postgraduate course for one year. Then Nancy invited me to meet her and to see if I would work with her. She *was* the hospice [at that time], she did everything there; doctor, nursing, secretary, driver. She treated about, say, five, six patients at a time. I started to work with her and it was only two days a week, but more and more I left everything else and I did this work. Between all this more and more families and physicians and nurses, started to ask us come to see the patient: and it grew and grew, and one more doctor came, Dr Marianne, and then one more nurse, another American doctor, and then Nanny got sick and Dr Shalom started work. Now we are about 10 or 11 people.

Yael discusses the way the team works to resolve pain relief and symptom control in collaboration with the oncology department, always with the aim to connect sensitively to a patient's individual needs. Where appropriate, Yael will bring in the expertise of the team art and music therapists (Leila and Adira) to support a person's journey at the end of life.

Dr Eyal Goldberger – *physician and homeopath*.

Eyal Goldberger describes how his interest developed in homeopathy and palliative care: After I finished my internship, I was interested in oncology and especially as a student I was always seeing the old patients, if nobody wanted to see them myself, I was not afraid of the real people. So when we had the opportunity to do the one year course included two or three months in the department that you are interested in, so I went to the hospice in Tel Hashomer for one month and then after the course for a one year I was mainly in

charge of the home hospice, but also working in the department. They asked what was a young doctor at the beginning of his career doing with people at the end of their career? But it was a very, very important experience for me. Then I did an officer course as a medical doctor with the army, and then the Gulf War began. Afterwards I went to England to study homeopathy at the Royal Homeopathic Hospital. Even in the army I was interested in complementary medicine. For almost ten years I left the palliative field and was doing mainly homeopathy, teaching and working here [in a hospital]. Then my father-in-law had cancer: at the end of his life I arranged for him to go to Tel Hashomer, and I spent the last two weeks of his life with him there. I met people that I knew ten years ago. I said, 'When I go back I must check what's happening in palliative medicine in the north.' A week later I had a message on my answering machine from Niva - she's the psychologist - that I should call her urgently connected to Hospice of the Upper Galilee, which I never heard before. I said what a coincidence. So since then ... and then I was in a kind of a turning point, I had to decide to start a new job in somewhere else or I was ... and I was ready to go into it. I heard of Nancy just through the emergency part, I read her book in the Army, I was teaching paramedics in the Army. I began to work, it didn't take me long to get, to go back to things, even though ten years away, and I started to work. Very quickly it became the main thing that I am doing so basically I am, I got, cut down my homeopathy but in this last two years I had to see how homeopathy is going in the world, I attend lot of seminars here in Israel, so it was a good time to do some kind of change. I enjoy the work. At first I was not religious and going to homeopathy from orthodox medicine, I also, through a long process of spiritual searching which were all over many other fields so I became religious here. And here, when I work, everything that I did in the past, it was as if it is connected, it's all going to the same - the orthodox medicine, homeopathy, the spiritual part, a new age movement that I was in - all the things that I am doing, there's a lot of field to develop. So, basically, there's not enough time, but I have a few plans for research I think with the oncology, things to combine homeopathy with. I have many ideas but not the time to check it right now. I enjoy very much seeing the patient in their home, not in a clinic, see where they live and how they thought, and the team is a very, very excellent... I think the potential is very big for things in the future in many fields.'

Yaniv Ben-Shoshan – *social worker and family therapist.*

Yaniv Ben-Shoshan talks about how he became involved in palliative care and how this experience enriches his work at HUG:

'When my daughter was six years old she was sick of cancer for one year, and received chemotherapy in Haifa Hospital. Ten years after, when I work with our hospice patients, I bring with me not only my experience of my work, but also the family, own family experience.'

He explains the importance of the way the team works, where each member is an integral part and can refer to the other in any way that best supports the patient and the family.

Negev Palliative Care Services, Beersheva

Professor Pesach Shvartzman: *paediatric oncologist and head of division:* interviewed with Dr Yoram Singer by Amanda Bingley, 5 May 2005. Length of interview: 45 minutes
Professor Pesach talks about his palliative medicine research work, specialising in paediatrics and his role in setting up the first hospice services in Beersheba. He is trained in family medicine and this led into his interest in palliative care:

‘When you look at palliative care and it’s actually very close to the way that family medicine works and actually I think if you look at the UK, a lot of GPs are involved in palliative care. It’s not just by chance, I think that the way of thinking, the way of looking at patients and not at diseases, the way of looking at the context of families, the way of not seeing the fact that you cannot cure everything as our own failure, but just as a fact that medicine cannot cure everything and just to recognise the fact that people die, and they will die. So I think that the way of thinking is not far off and actually I felt that probably it is actually pretty neglected in - not in the UK, but the UK is an exception I think - UK, Australia, Canada, the States, and probably that’s it, New Zealand maybe - but if you look at our country we have still a far way to go.’

He explains that he did some training in Canada with Balfour Mount at McGill University and conducts a research programme as part of his own work as a Professor in the Faculty of Medical Science at Ben-Gurion University of the Negev. He is also involved in training in paediatric palliative care.

Dr Yoram Singer, *medical director*: interviewed with Professor Pesach Shvartzman by Amanda Bingley, 5 May 2005. Length of interview: 45 minutes. Interviewed individually: 1 hour 10 minutes



Yoram Singer describes his commitment to palliative medicine and his diverse experience in Africa, where he was involved in setting up effective community medicine projects; and in Israel as a community and family practitioner before he became involved in developing the service at Negev. He talks about how the service is organised and some of the extraordinary generosity of benefactors and the ways in which he has managed to raise the profile of palliative care by working sensitively with multi-cultural communities in remote parts of the country. He

explains how his previous work has both enriched and inspired the ways he and his colleagues are developing the service:

Tel Hashomer Hospice, Chaim Sheba Medical Centre, Tel Aviv (team interviewed individually) (Photograph: Tel Hashomer Hospice, 2005)



Dr Alexander Waller - *medical director*: interviewed by Amanda Bingley, 8 May 2005

Alex Waller discusses the ways in which Israel has developed a hospice and palliative care service that is on a par with Europe. He talks about the early history of Tel Hashomer and the importance of the hospice in starting to raise awareness of palliative care and in

encouraging the education of health professionals.

He describes how Tel Hashomer influenced others, stimulating the opening of new hospices around the country. He explains his interest in education and the importance of exploring ways to improve the practice of palliative care, for example, the development of a multi-disciplinary hospice team that aims to address needs of the patient.

Dr Michaela Bercovitch - *physician and researcher*: interviewed by Amanda Bingley, 1 May 2005.



Michaela Bercovitch describes how she joined the hospice in 1988 when she arrived from Romania. She talks about how the hospice is organised and her role as researcher and physician. She has seen the hospice through many changes, most recently the move to the new purpose built unit, and she talks about some the challenges they face as a unit and in the hospice movement.

Tamie Goan, *nurse, home care service*: interviewed by Amanda Bingley, 1 May 2005
Tamie Goan explains how she became interested in palliative care when she was a dietician in a dialysis unit and went on to train in nursing, specialising in oncology nursing. She now organises the nursing in the home care service.

Sarah Rimer, *social worker*: interviewed by Amanda Bingley, 1 May 2005
Sarah Rimer joined the hospice as a part time social worker for the inpatient unit. She talks about her interest in palliative care and her commitment to work with patients and families.

Shlomet Winer - *physiotherapist*: interviewed by Amanda Bingley, 1 May 2005
Shlomet Winer is a retired university tutor in physiotherapy. She talks about her lifetime of experience as a physiotherapist and how she enjoys her part time work at the inpatient hospice. She describes her dedication in supporting patients at the end of life and the ways she can help to improve their quality of life.

Kiryat Tivon Home Hospice

Dr Ora Cibulski, *sociologist and gerontologist, co-founder of the hospice and co-founder and retired chair of the Israel Association of Palliative Care*: interviewed by Amanda Bingley, 12 May 2005. Length of interview: 1 hour 13 minutes

Ora Cibulski describes her involvement and motivation in setting up the home hospice at Tivon. She was born in the USA and had trained as a sociologist and became increasingly interested in gerontology. She was inspired to work in some way in palliative care following the experience of watching a close friend and also family members die from cancer and realising that there was no real support for them. Gathering other interested people; physicians, nurses, social workers she set out to establish the home care service in 1984 and also in 1993 to set up the Israel Association of Palliative Care, of which she was the first chair, retiring in 2002:

‘In order to build the organisation I went to the library, I looked for all the research on palliative care. By training I am a sociologist/anthropologist and then I went into gerontology and so today I call myself a gerontologist. OK? And I’m used to doing research because that’s what we do. There were four or five books altogether on hospice at the time, or anything to do with hospice: and there were journal articles. An important book for me described how these people wanted to introduce palliative care into their hospital in the United States. They made this wonderful plan to change the whole hospital and put palliative care in every department. They worked for a year but in the planning they had not included the people who were supposed to use the service, and they were completely ignored and thrown out of the departments. Well that told me something. It meant that everything we did, every step of the way, we had to explain to the people who would have to provide services and include in the planned provision. The initial reaction of local physicians, the Ministry of Health and the Ministry of Social Services was that we were

slightly mad: palliative care was neither medicine nor social services. However we were very persuasive.

I'm always talking in the plural for the very simple reason that we were four or five people who did this work consistently. We added a young psychiatrist; we thought the psychiatrist would be for the patients, in the end he was actually for the team. Because for all of us this was something new, dealing with death, immediate death, how do we handle it? ... I'm not a physician, I'm not a social worker, I'm not a nurse, and I'm not any of the direct disciplines of palliative care. I always was in the position of learning the material. What I would do is I'd learn it, and I'd and I'd ask the nurse or physician, 'Would you say this was this way?' and they would correct me, 'Would you say this was that way?' So it turned out that I could develop a general plan for developing training programs and palliative care services in Israel. I wasn't being paid by anyone. OK? So that was my great advantage, that I could say exactly what I think and without anyone feeling attacked or competing or anything of that sort, and very long time ago I learned anything that had to do with a patient, I just put aside my ego.'

Dr Netta Bentur, *sociologist, academic health research, Myers – JDC, Brookdale Institute, Jerusalem*: interview by Amanda Bingley, 3 May 2005. Length of interview: 1 hour 4 minutes

Netta Bentur talks about her work in academic health research and how she has specialised in research in palliative care; mapping services and exploring patient and caregiver experiences of care, pain relief and symptom control. She co-authored a report on service provision in Israel in 2004, which included looking at different models and systems by which palliative care is provided.¹⁴²

Miryam Morganstern, *homeopath and trainee spiritual counsellor, Cancer Pain and Palliative Medicine Service, Sha'are Zedek Medical Centre, Jerusalem*: interviewed by Amanda Bingley, 7 May 2005. Length of interview: 1 hour 10 minutes

Miryam Morganstern is currently training in spiritual counselling. She talks about her background in education and psychology, going on to train and for the last 13 years to practice as a professional homeopath. She discusses how important palliative care work is for her, and the extraordinary lessons in compassion she has learned in the course of her professional work as a homeopath emphasised in her current work as a trainee spiritual counsellor at Sha'are Zedek.

Dr Shlomit Perry, social worker, Beilinson Oncology Unit, Rabin Medical Centre, Tel Aviv, Head of the Psycho-Oncology Society, Israel: interviewed by Amanda Bingley, 1 May 2005. Length of interview: 55 minutes

Shlomit Perry talks about her supportive and palliative care work as a social worker with patients in the oncology unit. She completed her doctorate in genetic counselling for women with breast cancer and has a particular interest in work which addresses these kinds of ethical dilemmas for cancer patients, especially those patients who have a poor prognosis:

'At the beginning, I thought that we should stop all the DNA testing. At the end, I've realized that people can manage it, and we have to be with them all the way and they can decide very good decisions, but the medical system has to be with them, not to make the tests and go back, but to be involved in the decision. So after I finished the Ph.D. we opened clinics for high-risk women, this was the fruit of my Ph.D. We opened [clinics] here in the

hospital for follow-up.’

She explains that her work in palliative care is due to increase as the new Davidoff Centre opens and they plan to have a dedicated palliative care consultant and team. She is head of the psycho-oncology society in Israel and actively involved in developing support for children at the end of life and their bereaved parents, and also in encouraging psycho-social support and education for patients.

Professor Michael Silbermann, director of the Middle East Cancer Consortium (MECC): interviewed by Amanda Bingley at Haifa, Israel, 10 May 2005. Length of interview: 1 hour 3 minutes

Professor Silbermann talks about his role in developing the work of MECC and the original aims and objectives of the organisation to promote a standardised cancer registry in member countries in order to develop effective cancer control programmes. He describes how, since 2004, MECC has started to address the palliative care needs in member countries, funding health professionals to attend training seminars and setting up ‘train the trainer’ courses nationally and internationally. Professor Silbermann explains that he is a surgeon and served as the Chief Scientist for the Ministry of Health in Israel. He talks about his own increasing interest in palliative care, and his involvement at the Italian Hospital, Haifa who now have developed their palliative care services and run a hospital-based unit, where the patient is cared for physically and emotionally:

‘What impresses me most there is really the attitude of the staff - most of them are nursing sisters, nuns - to the patient; that is just amazing. I’m so impressed, you know, they sit with the patients on their own initiative, the patient doesn’t have to ring and ring and ‘please come and do ...’ - they come and they say ‘How are you doing? Can we do something for you?’ I mean, many of the cancer patients, many are lonely, so being alone and being a patient that is close to die, that’s a very, very unpleasant situation. So if somebody bothers to come and sit with you and puts his hand on you and asks ‘How are you feeling today? Can I do something for you?’ and this ... this is I think a big, big thing. And I was there and I visit there quite often, just to see what’s going on. And I think this will be one of the topics that we are going to really emphasise ... and palliative care would eventually become one of the very most important issues that MECC will be involved in.’

Professor Abraham Steinberg, Centre for Medical Ethics, The Hebrew University-Hadassah Medical School, Jerusalem: interviewed by Amanda Bingley, 4 May 2005. Length of interview: 47 minutes

Rabbi Steinberg discusses his work in medical ethics as chair of the Steinberg Committee which is currently debating the formulation of a law for the dying patient, which will address end of life issues, including instituting statutory provision of palliative care, and legislation on euthanasia and assisted suicide. He describes the political, religious, medical and humanitarian aspects of the debate and concludes that the law must adhere to moral principles, and although this may not be perfect for everyone, for example those in extreme, intractable situations, the important point is that the law proves workable and acceptable for the greatest number of people.

PUBLIC HEALTH CONTEXT

Population

Israel’s population of around 6,199,008 million is made up of the following ethnic groups: Jewish 80.1% (Europe/America-born 32.1%, Israel-born 20.8%, Africa-born 14.6%, Asia-born 12.6%), non-Jewish 19.9% (mostly Arab) (1996 est.)

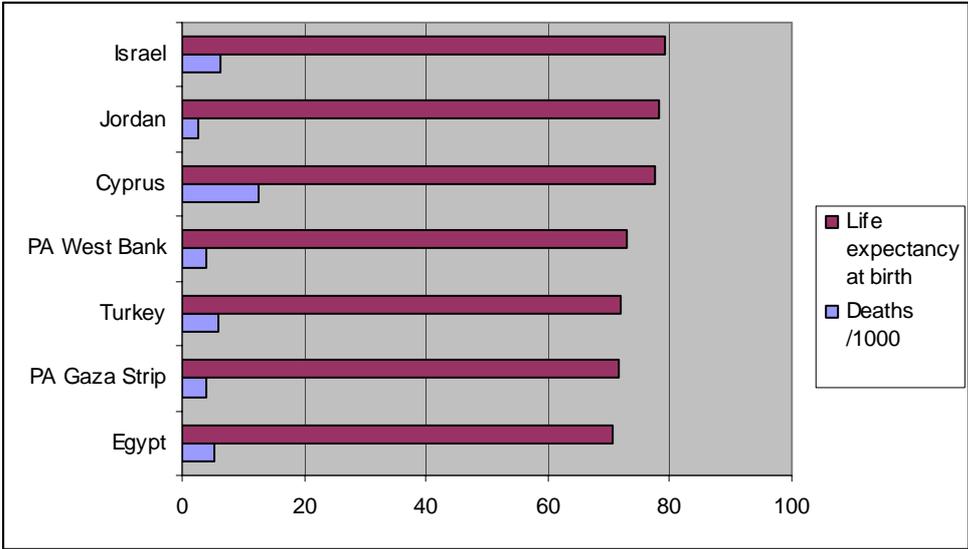
Religious groups include: Jewish 80.1%, Muslim 14.6% (mostly Sunni Muslim), Christian 2.1%, other 3.2% (1996 est.)¹⁴³

Epidemiology

In Israel, the WHO World Health Report (2003) indicates an adult mortality¹⁴⁴ rate per 1000 population of 98 for males and 53 for females (crude death rate 6.18 deaths/1,000 population and life expectancy at birth (total population) 79.17 years (2004 estimate)¹⁴⁵ (see Table 6).

Life expectancy for males is 78 years; for females 82 years. Healthy life expectancy is 70.5 for males; 72.3 for females.¹⁴⁶

Table 6: MECC member country death rates and life expectancy at birth (total population)*



*World Factbook estimate 2004¹⁴⁷

The primary cause of death in Israel is cardio-vascular and heart disease (31 % of total deaths). Cancer is the second commonest cause of death. In 2000 there were a total 8878 deaths reported from cancer (23 % of total deaths).

In 2002 around 21,000 new cases of cancer were reported; 54% new cases diagnosed in men and women over 65 years old. The commonest cancer in men is lung cancer (4.5 % of all new cases). Lung cancer accounts for 9.7 % of all cancer deaths. The commonest cancer in women is breast cancer (15 % of all new cases). Breast cancer accounts for 10.3 % of all cancer deaths.¹⁴⁸

Israel has a relatively low prevalence of HIV/AIDS. Updated UNAIDS estimates at the end of 2004, suggest that around 5000 people with HIV/AIDS were living in Israel, with an adult (15 – 49 years old) prevalence of between 0.1% - 0.2%.¹⁴⁹ There were no estimates given of HIV infection rates in women or children (0-14 years) or for that year’s number of deaths from the disease. The UNAIDS ‘Assessment of the epidemiological situation 2004’ reports that:

'During the period between 1980 and the end of June, 2003, 3,802 new cases of HIV/AIDS were registered among them: 915 have developed AIDS and 539 have died. It is estimated that approximately 5,000 people are currently living with HIV/AIDS in Israel. An HIV/AIDS registry has existed since the beginning of the epidemic. HIV testing is systematic among blood donors and prisoners and among select groups of immigrants from HIV-hyper-endemic countries. Testing is confidential and free of charge for any person requesting the service. Testing is done at all community clinics, all across the country. Since the mid-90's there has been a slight but steady increase in new HIV cases detected annually in Israel.'¹⁵⁰

An epidemiological study on the change in rates and pattern of infection in Israel from 1991- 2000 reports a rise in HIV incidence, thought to be mainly influenced by immigration of people from countries with a high incidence of the disease.¹⁵¹

Since the mid 1990s, an Israeli NGO *The Jerusalem AIDS Project* has run regular training workshops for health professionals and 'supports an ongoing network of concerned health professionals, devoted to AIDS prevention.'¹⁵²

Health care system

In 2003, Israel's total per capita expenditure on health care was Intl \$1839 (8.7 % of GDP).¹⁵³ Among the six MECC countries of the Middle East, this figure falls within a spending range of Intl \$1839 in Israel (8.7 % of GDP) and Intl \$153 in Egypt (3.9 % of GDP). At 3.9 % the smallest spending as a percentage of GDP is in Egypt (Tables 7 and 8).

The WHO overall health system performance score places Israel 28/191 countries. This composite measure of overall health system attainment¹⁵⁴ is based on a country's goals relating to health, responsiveness, and fairness in financing. The measure varies widely across countries and is highly correlated with general levels of human development as captured in the human development index.

Tables 7 and 8 Total health expenditure (Intl \$) per capita and as a percentage of GDP: Six MECC countries of the Middle East, 2003

Table 7 Health expenditure (Intl \$) per capita: MECC countries		Table 8 Health expenditure (Intl \$) as a percentage of GDP: MECC countries	
Country	Per capita	Country	% GDP
Israel	1839	Israel	8.7
Cyprus	941	Cyprus	8.1
Jordan	412	Jordan	9.5
Turkey	294	Turkey	5
Egypt	153	Egypt	3.9
Palestinian Authority	No figures*	Palestinian Authority	2.4*

Source WHO World Health Report 2003 **Source Palestinian Central Bureau Statistics*

Israel has a health care system based on health plans provided by four not for profit institutions; these were originally known as 'sick funds', and were established, from 1948, by workers' associations (by which they were politicised by affiliation with different party factions). Until 1995, when the government National Health Insurance (NHI) law

was introduced, people paid voluntary contributions into the health plan of their choice. Since 1995, contributions to the health plan of choice have been collected compulsorily as health tax: in exchange all Israeli citizens, irrespective of their income or age, are entitled to full medical insurance with a health benefits package from the health plans, stipulated by the NHI. Individuals can also pay additional Voluntary Health Insurance (VHI) for supplements to their basic benefits, which cover private medical provision and complementary therapies.

There are four health plans, known as Health Maintenance Organisations (HMOs); Clalit (the largest and oldest HMO, still insuring around 55% of the public), Maccabi (24%), Meuhedet (11%), and Leumit (10%).

The government role, from the Ministry of Health (MoH), is to provide services not covered by HMOs; most importantly this covers public health, including communicable disease control, mother and baby care, psychiatric care and long-term hospitalization. The MoH also subsidises some HMO activities, by a NHI per capita reimbursement system, as well as planning, supervising, regulating and licensing different aspects of health services. The MoH has developed, owns and operates government funded hospitals, which account for around half all the acute beds in Israel.¹⁵⁵

Currently, palliative care services are not a stipulated NHI benefit or an essential component of the health plans' 'basket of services'. Health funding for palliative care is discretionary from HMOs prepared to fund services either completely or, depending on whether the service is based within a health plan institution, in part alongside MoH funds or charitable monies.

Political economy

GDP per capita in Israel ¹⁵⁶ is Intl \$21,223. This falls within the range of \$21,223 (Israel) and \$600 (Palestinian Authority Gaza Strip) in the 6 MECC countries of the Middle East (Table 9).

Table 9 GDP per capita (Intl \$): 6 MECC countries of the Middle East, 2001

Country	GDP per capita (Int \$)
Israel	21,223
Cyprus	11,588
Turkey	5,830
Jordan	4,348
Egypt	3,901
Palestinian Authority West Bank*	**800
Palestinian Authority Gaza Strip*	600

*Source WHO (2001) *CIA World Factbook (2003est.)**(2002est.)*

Following World War II, the British withdrew from their mandate of Palestine, and the UN partitioned the area into Arab and Jewish states, an arrangement rejected by the Arabs. Subsequently, the Israelis defeated the Arabs in a series of wars without ending the deep tensions between the two sides. The territories occupied by Israel since the 1967 war are not included in the Israel country profile, unless otherwise noted. In April 1982, Israel withdrew from the Sinai pursuant to the 1979 Israel-Egypt Peace Treaty. Israel and Palestinian officials signed on 13 September 1993 a Declaration of Principles (also known as the "Oslo accords") guiding an interim period of Palestinian self-rule. Outstanding

territorial and other disputes with Jordan were resolved in the 26 October 1994 Israel-Jordan Treaty of Peace. In addition, in May 2000, Israel withdrew unilaterally from southern Lebanon, which it had occupied since 1982. In keeping with the framework established at the Madrid Conference in October 1991, bilateral negotiations were conducted between Israel and Palestinian representatives and Syria to achieve a permanent settlement. US and other international attempts, since September 2000, to encourage a permanent status agreement have failed in the face of ongoing violent conflicts between Israelis and Palestinians. A change of Palestinian leadership took place following the death of long time Palestinian leader Yasser Arafat on 10 November 2004. A new president, Mahmoud Abbas was elected on 9 January 2005, since when there have been renewed negotiations towards a peaceful settlement.

ETHICAL ISSUES

There are several issues identified as ethical dilemmas in palliative care in Israel; issues around disclosure of prognosis, the impact of genetic testing on discussions of prognosis with patients, decisions around stopping treatment when a patient is at the end of life, children and bereavement, the new law of the dying patient, and inequalities and difficulties around shared responsibilities when managing of service provision. There is also a continuing problem of opioid phobia, which affects access to pain relief and symptom control.

In Israel the patient has a right to full disclosure of prognosis from their physician. However, there are many problems that continue to arise with families requesting that the doctor does not tell the patient, as Professor Shvartzman explains:

‘The main issue that arises all the time is getting into the house and people telling you, family members telling you, ‘Psst, don’t tell anything to the patient.’ I think that’s the most problem, ‘Don’t tell him anything at all, if he finds out he’ll commit suicide.’ And it’s a very complicated issue because, first of all, we are visitors, so you go to their house; you have to be polite, you cannot say, ‘Hey, I’ll tell you what I’ll tell you.’ But still you have to do what you have to do, so I think that’s the most common issue....What happens is the son says ‘Don’t tell Dad that he has cancer, or he’ll be upset.’ Dad says to his son, ‘Joseph, go in the kitchen, make a cup of tea for me, a cup of coffee for the doctor, get the cake from the larder and do something else ...’ and as the son’s going out, ‘Don’t tell Joseph that I have cancer, he’ll be devastated if he finds out.’ That’s what usually happens.’¹⁵⁷

This situation is changing as there is more awareness through the media. Although as Amitai Oberman explains, physicians still withhold information:

‘They tend not to tell, on the whole. Nathan always says the physician is the first liar, and, which is true. Usually, in many cases it is up to us, or the oncologist will say, ‘You don’t have to come any more. If you want you can come again.’ In many situations we don’t directly speak to the patients, but it varies from culture to culture and sometimes theoretically you would think that you would [discuss this less] with more orthodox people, but we’ve found that we will discuss death with the rabbis and imams and sheikhs. It varies: it’s not based on a socio-economic or education level or anything like that, it’s very personal, I think. But compared to America where I trained,

we're still more paternalistic in Israel but the system is changing *fairly* rapidly and people are getting orders to tell patients and getting, 'if you don't tell patients, you may be liable, they can sue you.' But still, there are problems, there are problems.'¹⁵⁸

Shlomet Perry, who has specialized in research on the impact of genetic testing for women with breast cancer, is very aware of the ethical dilemma this poses for families of people who may have the test and then have to be told about a poor prognosis:

'[I feel that] people should learn how to deal with this issue, all the genetic issues, all the medical genetics which become very important, to change the attitude to what is ill, to who is ill and who is not ill. Is a carrier ill or not ill, because few of them have preventive mastectomies? How do you divide the division from illness and health? So I think that the issue of the family is very important in this, in the genetics because DNA is a family affair, and also at the end. So I think that in the medical continuum, there are a few areas where the family becomes very important: palliative care, genetics, donating [organs].

Shlomet Perry notes other ethical issues she has identified, around decisions by physicians and patients whether to continue (or begin treatment) or when to stop treatment:

'It starts from the beginning, and here it will be more important. Palliative care will be well established here; and part of the thinking in palliative care will be the influence on all the care of the patient. In Israel we don't know when to stop [treatment], the patient wants more and more drugs and doesn't know when to stop. I think it's a problem in Israel, a society's not well educated to decide when to stop; they need all the time to continue. They all need education, how to be more conscious, more aware of the decision, not to take more chemotherapy and more chemotherapy because you can stop chemotherapy. I think we don't know it. I think that in Israel we take the most and expensive drugs, because then people want more and more and more. This environment is that you must treat, you know, I think this is a Jewish cultural [thing] that you have to save people.'¹⁵⁹

Ruth Gassner at Hadassah agrees that this is a problem at the very last stages of life and describes how they deal with the issue in the hospice:

'The way forward is to talk with patient and family. I think they look at every case from a start at the zero point all over again. We haven't made decisions like: we don't give blood, or we don't give feeding tubes, or we don't do this. Every case is an individual case and we start depending on who the patient is, what the family wants. We are very open, talking to them.'¹⁶⁰

There are many ethical concerns about how to support children in bereavement prior to their relative's death. Social worker Malka Yehezkel explains:

Sometimes I feel when there are small children, that we won't let them come and visit parents or grandfather or grandmother; the patient doesn't want the visit, so what do we do? Usually, of course, first I try to explain and to work with the patient and to explain how important it is and that we can find a situation that will be OK for him, also not too difficult, not to let him feel he has to be nice and ... even if he is sleeping just to let this child come and do

his separation. This is one of the things when it's children that I know for everyone, and for me too, is more difficult with the years, but I am so sure how important it is to help these children because I know how families try to protect them and try to avoid from them pain, so before death comes they try not to talk about, and I really do a lot of work with the family to help them understand how important it is to remember the children; to help them understand what's happening, see what's happening and feel what's happening, so they need support, they need to feel they can talk about what is happening. If the family thinks he is too small, he doesn't understand; it's a mistake. Of course it's a lot of work because I have to show them how they don't protect them and they don't help them, and it's very, very vulnerable really work, but I do it even if it's difficult. And all the staff is very happy that I'm doing, but they help me when I need, Dr Azoulay comes and sit with the children, they have questions, they want to ask questions and he is wonderful, really wonderful, and the nurses also. The children become very frightened to see the parent, to see this place, and they get this beautiful hug, yes, it helps a lot: it helps me of course to continue to work with them. They are happy to come to here, even if it's difficult, but it's a nice place, it's ... they feel the parents is taken care very nicely, they feel they are wanted here, and it's so important.'¹⁶¹

There is an active debate in Israel about palliative care, euthanasia and assisted suicide, which is culminating in a new law of the dying patient.^{162 163} Professor Abraham Steinberg who is chairing the committee on this debate explains the kinds of ethical dilemmas they are attempting to address by passing a law that will attend to the needs of the majority of patients:

'I feel that it won't be fair not to provide the best palliative care to those who are suffering, who want to die, but if we provide them with palliative care they may still want to live, or at least have some reason to continue to live. And therefore we included as part of the law, which I understand there are very few countries, if any, that the law provides for the government to be responsible to give palliative care. Which means that the law says that every dying patient, obviously we can extend it to the non-dying, but the law talks about the dying, so we talk about the dying, every dying patient should get the best palliative care according to the standard at that time/...

It should include finding for the accessories, for medications, for anything that palliative care demands, which nowadays is not available on a governmental level. And also we suggest that, not in the law but it comes out from this paragraph, that palliative care should be recognised as a field of medicine in the way that it should be studied, it should be recognised as a sub-specialty, there should be experts in the field - in other words it should be part of medicine like any other part of medicine, which I think is something new from a legal point of view, certainly in Israel but I think worldwide as well./

On a philosophical level there might be differences on how we interpret palliative care: does it include always food and fluid and only no resuscitation, or does it include medication, routine medic-, I mean they are debates there are debates that are ongoing. So the standards of palliative care obviously will be presented by the experts and then there may be some variations on what is acceptable or not. Now whether it should be an acute care facility or in a hospice or in a home hospice or whatever, I mean, these

are things that have to be worked out, I assume on individual levels, I mean, that has not to be decided on the *legal*, on a *law* level. Because I think that certainly the hospices know how to work with such patients, that's their job, but the problem I think is in acute care facilities where patients of this kind are admitted, they're being treated like anyone else, no-one knows how to take care of the aspect of suffering of pain, and that's where she should put more emphasis. Now whether to move them out or not is a very individual decision, but as long as they are here or in an old age home or even at home, they should get the best palliative care - that's the concept. ... I know some people say that part of palliation is hastening death because he is suffering and, let's say the Dutch, their view of palliative care is active euthanasia, it's a way of palliative care - that obviously is unacceptable from a Jewish point of view, I think from a true palliative care perspective as well. But if it involves medication and support and family and the social and psychological, that is *very* positively viewed even if medication occasionally may hasten death; that is taken into account. In fact from a Jewish point of view pain and suffering is viewed as any other illness - let's say someone has a brain tumour, what do you do for him? You take him to the operating room, you operate him, and a few die on the table, so it doesn't mean that you don't operate because somebody died. So the same here, if you, if you equate pain to a brain tumour, the same way that there you give a treatment which is called operation and some die, you give a treatment which is called morphine or whatever and some die, so that really does not take away from the legitimacy, unless you purposely give such amounts that will kill because you think that this is the way to help the patient, that is not a help from the Jewish point of view. ... If the patient *wants* to live, to continue living, even though from a medical point of view it doesn't make sense, it's futile - whatever futile means - you must provide him whatever needed for him to continue living, including palliative care. Now if the patient *doesn't* want to continue to live, then it depends what he wants. If he just wants to withhold treatment that is fine: if he wants to withdraw treatment it's also fine as long as the withdrawal is not causing instant death. So for instance if he's on dialysis treatment and he got ten rounds and now he doesn't want any more, so you don't give the next one because it'll take days before he'll die because of his decision, so that's a withholding process from the law.'¹⁶⁴

The ethics the Professor Steinberg is working to resolve are closely allied to the inequalities of access to adequate and appropriate service provision. Palliative care consultant Dr Ora Rosengarten discusses some aspects of this dilemma she and other colleagues face in home hospice care:

'First there's always the problem of keeping the patient at home or not. One of the problems encountered is the question of whether to go on with the home hospitalisation or not because, if the family and the patient is able to manage with all this, sometimes we do have the feeling that - this is not a majority - but sometimes we have patients who call other doctors who are involved in the treatment. In that case we have a real medical problem in managing and taking the responsibility for the treatment.

We do have a problem sometimes when a patient is alone, he doesn't have a family to support him, and the dilemma is whether to get in there and give him what we can, but we know that it's not optimal because there's nobody there to take the responsibility. Or [can we] leave him like this, because if

you're not there then nothing will be done? But if you are there you know you cannot do your job properly.'¹⁶⁵

In spite of the increase in education and training, several palliative care specialists noted that opioid phobia and fear of sedation continues to be a problem, both among health professionals and the public.¹⁶⁶ Amitai Oberman and Jim Shalom in the north of Israel note, they still encounter physicians who are afraid to prescribe opioids. Amitai Oberman describes the practice of pharmacists who still put 'poison' on an opioid prescription:

'I give a couple of lectures to pharmacists. It's fascinating to talk to them because they have their own perspective, and stories. I can give them a call and say, 'Look ... please help us with this,' and it's usually fine. They've got their own laws and rules; they're not allowed to be flexible - you can't give this, and this has to be written down - and still when a patient gets a script of MCR, they put on the back sometimes a notice saying 'poison' on it. We're working on them to try and convince them it's not really clever to put 'poison'. But there's still this thing about narcotics in Israel. But it is changing. Some of the old pharmacists keep putting, just out of habit, I think, 'poison' and during my talks about, I have these slides showing them what are the obstacles to perception of opioid and then I show them, and I say to them, 'Who wants to take a drug which is poisonous?'¹⁶⁷

At Hadassah, director Ruth Gassner and social worker Malka Yehezkel discuss the difficulties they find where patients ask for sedation, although the family maybe afraid to see their relative sedated:

'That's a dilemma that we have; the whole issue of sedating, when the patient is awake and asks us to sedate him and it comes from the patient. When we deal with the dilemma, first we have to feel we know what we feel and what we think we are ready to start to do, and then we come to the family, because we don't want to let them feel the responsibility is [just theirs] or the patients - we want to help, we want to be there really as helpers.'¹⁶⁸

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¹³⁶ IOELC interview: Dr Amitai Oberman, Home Hospice of the Valleys, Nazareth - 10 May 2005

¹³⁷ IOELC interview: Dr Jeremy Jacobs, Dr Ora Rosengarten, Yonat Lamed, Timna Zistling, Jerusalem Home Hospital – 3 May 2005

¹³⁸ IOELC interview: Dr Jim Shalom, Dr Eyal Goldberger, Yael Bleich and Yaniv Ben-Shoshan, HUG – 9 May 2005

¹³⁹ IOELC interview: Dr Ilene Ora Cibulski, Home Care Hospice of Kiryat Tivon – 13 May 2005

¹⁴⁰ IOELC interview: Aliza Yaffe, Head Nurse, Israeli Cancer Association – 13 May 2005

¹⁴¹ IOELC interview: Dr Amitai Oberman, Home Hospice of the Valleys, Nazareth - 10 May 2005

¹⁴² Bentur, N. & Resnitsky, S. (2004) *An Overview of Palliative Care Services in Israel*, presentation from Myers-JDC, Brookdale Institute, Jerusalem

¹⁴³ World Factbook: <http://www.cia.gov/cia/publications/factbook/geos/ug.html>

¹⁴⁴ This refers to adult mortality risk, which is defined as the probability of dying between 15 and 59 years.

¹⁴⁵ World Factbook <http://www.cia.gov/cia/publications/factbook/geos/ug.html>

¹⁴⁶ See: WHO statistics for Israel at: <http://www.who.int/countries/en/>

¹⁴⁷ This entry gives the average annual number of deaths during a year per 1,000 population at midyear; also known as crude death rate. The death rate, while only a rough indicator of the mortality situation in a country, accurately indicates the current mortality impact on population growth. This indicator is significantly affected by age distribution, and most countries will eventually show a rise in the overall death rate, in spite of continued decline in mortality at all ages, as declining fertility results in an aging population. <http://www.cia.gov/cia/publications/factbook/geos/ug.html>

¹⁴⁸ All figures in this section have been calculated from returns by Israel Ministry of Health Statistics 2002 <http://www.health.gov.il/english/>

¹⁴⁹ ‘In 2003 and during the first quarter of 2004, UNAIDS and WHO worked closely with national governments and research institutions to recalculate current estimates on people living with HIV/AIDS. These calculations are based on the previously published estimates for 1999 and 2001 and recent trends in HIV/AIDS surveillance in various populations.’ <http://www.unaids.org>

¹⁵⁰ UNAIDS Epidemiological Fact Sheet on HIV/AIDS and sexually transmitted diseases - Update 2004: Israel <http://www.unaids.org>

¹⁵¹ Chemtob, D. and Grossman, Z. (2004) Epidemiology of adult and adolescent HIV infection in Israel: a country of immigration, *International Journal of STD & AIDS*, 15, 691-696

¹⁵² Schenker, I. (1997) HIV/AIDS in the Middle East and Israel: The Jerusalem AIDS Project, *Shalom Magazine* 2 <http://www.jewishvirtuallibrary.org/jsource/Health/HIV.html>

¹⁵³ Total health expenditure per capita is the per capita amount of the sum of Public Health Expenditure (PHE) and Private Expenditure on Health (PvtHE). The international dollar is a common currency unit that takes into account differences in the relative purchasing power of various currencies. Figures expressed in international dollars are calculated using purchasing power parities (PPP), which are rates of currency conversion constructed to account for differences in price level between countries. <http://www3.who.int/whosis/country/compare.cfm?country=s&indicator=strPcTotEOHIntD2000&language=english>

¹⁵⁴ Tandon A, Murray C.L.J, Lauer J.A, Evans D.B. Measuring overall health system performance for 191 Countries, *GPE Discussion Paper Series: No 30*; WHO

¹⁵⁵ For full details of the health care history and structure in Israel see Rosen, B. (2003), In S.Thomson and E. Mossialos (eds.) *Health care systems in transition: Israel*, Copenhagen: European Observatory on Health Care Systems 5 (1)

¹⁵⁶ <http://www.cia.gov/cia/publications/factbook/geos/ug.html>

¹⁵⁷ IOELC interview: Professor Pesach Shvartzman, Negev Palliative Care Services – 5 May 2005

¹⁵⁸ IOELC interview: Dr Amitai Oberman, Home Hospice of the Valleys, Nazareth - 10 May 2005

¹⁵⁹ IOELC interview: Dr Shlomet Perry, Beilinson Unit, Rabin Medical Centre – 1 May 2005

¹⁶⁰ IOELC interview: Ruth Gassner, Dr Azoulay Daniel, Malka Yehezkel, Helen Englesberg and Judy Yoran, Hadassah, Mt Scopus – 4 May 2005

¹⁶¹ IOELC interview: Ruth Gassner, Dr Azoulay Daniel, Malka Yehezkel, Helen Englesberg and Judy Yoran, Hadassah, Mt Scopus – 4 May 2005

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¹⁶⁴ IOELC interview: Professor Abraham Steinberg, Sha'are Zedek Medical Centre, Jerusalem – 4 May 2005

¹⁶⁵ IOELC interview: Dr Jeremy Jacobs, Dr Ora Rosengarten, Yonat Lamed, Timna Zistling, Jerusalem Home Hospital – 3 May 2005

¹⁶⁶ Azoulay, D., Brajtman, S., Yehezkel, M., Shahal-Gassner, R., Cohen, A. (2000) When the family demands the discontinuation of morphine, *European Journal of Palliative Care*, 7:4, 138-140

¹⁶⁷ IOELC interview: Dr Amitai Oberman, Home Hospice of the Valleys, Nazareth - 10 May 2005

¹⁶⁸ IOELC interview: Ruth Gassner, Dr Azoulay Daniel, Malka Yehezkel, Helen Englesberg and Judy Yoran, Hadassah, Mt Scopus – 4 May 2005