Journal of the British Islamic Medical Association

Ethics
Vol 22 - No. 8 | April 2026 | www.jbima.com
ISSN 2634 8071

PALLIATIVE CARE IN PAKISTAN - DEVELOPING AN INTEGRATED ISLAMIC ETHICAL FRAMEWORK

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Keywords: *Palliative care, Pakistan, Islamic bioethics, end-of-life care, pain management, truth-telling, spiritual*

Abstract

Pakistan faces a critical palliative care crisis affecting millions, while possessing rich Islamic ethical traditions that can guide compassionate end-of-life care. With fewer than 10 facilities serving over 220 million people and only 2% of terminally ill patients accessing pain relief, Pakistan exemplifies the urgent need for culturally grounded palliative care development in Muslim-majority nations. However, Islamic bioethical principles offer robust frameworks for relieving suffering, truth-telling, and spiritual care that align with modern palliative medicine's goals. This review synthesizes evidence on Pakistan's palliative care landscape, classical and contemporary Islamic perspectives on end-of-life ethics, and successful models from Muslim countries to propose an integrated path forward.

Introduction

Pakistan presents one of the world's most severe palliative care access deficits. The International Observatory on End-of-Life Care reported Pakistan has the "least favourable ratio" globally—only one service for 157,935,000 people (Ahmad & Azam, 2016). Recent data indicate that fewer than 1% of the population can access palliative care services, with less than 10 facilities nationwide serving a population of approximately 220 million (Ahmed et al., 2024). The Worldwide Hospice Palliative Care Alliance categorizes Pakistan as Level 3a— isolated provision—highlighting the fragmentary nature of services (Sallnow et al., 2024).

This scarcity occurs against mounting need. Non-communicable diseases cause over 50% of adult mortality, with projections estimating 3.9 million NCD deaths by 2025 (Ahmed et al., 2023). Pakistan diagnoses 170,000-200,000 new cancer cases annually, many presenting at advanced stages requiring palliation from diagnosis (Hannon et al., 2024). However, palliative medicine remains unrecognized as a distinct medical discipline, and until recently, no physicians received specialized training in this field (Bhatnagar et al., 2018). Five major tertiary hospitals provide limited services: Aga Khan University Hospital (AKUH) in Karachi, which served 3,747 patients from 2017-2019 (Khowaja-Punjwani et al., 2022); Shaukat Khanum Memorial Cancer Hospitals in Lahore and Peshawar; The Indus Hospital in Karachi; and Shifa International Hospital in Islamabad (Ahmed et al., 2023). Christian hospices in Karachi, Hyderabad, and Rawalpindi offer additional support. This infrastructure cannot meet the population's needs.

Healthcare system deficiencies compound the problem. Pakistan allocates only 3.2% of its GDP to health expenditure, with 90% of the expenditure being out-of-pocket payments by patients (Ahmed et al., 2024). Forty-

five percent of the population lives below the poverty line without health insurance coverage (Ahmed et al., 2024). The largely unregulated private sector delivers seventy percent of healthcare, while 63% of the population resides in rural areas with limited access to any medical services (Ahmed et al., 2024). Only two specialized pain management centres exist nationally, and the absence of electronic health systems prevents coordination across facilities (Ahmed et al., 2023).

The morphine paradox: opioid access barriers

Pakistan's opioid access crisis reveals a striking paradox: the nation ranks eighth globally in opium and morphine production yet remains one of the worst countries for palliative pain relief availability (Jabeen, 2024). Pakistan falls in the lowest quartile of opioid analgesic consumption globally at 1-10 mg morphine equivalent per 1,000 inhabitants daily (Ahmad & Azam, 2016). For comparison, Canada consumed 723 mg/capita ME, the United States 718 mg/capita, and even neighbouring India 0.11 mg/capita. The Eastern Mediterranean Regional Office reported a mean morphine consumption of 0.384 mg/capita, compared to a global mean of 6.24 mg/capita in 2014 (Ahmad & Azam, 2016).

Only 2% of terminally ill patients access opioids for pain management (Jabeen, 2024). In 2012, only 300 patients received pain relief out of 350,000 who needed it (Ahmad & Azam, 2016). Morphine remains unavailable outside major surgical hospitals, with supplies inconsistent and variable (Bhatnagar et al., 2018). Short-acting narcotics are unavailable nationally (Jabeen, 2024). For long-term pain management, only tramadol and nalbuphine remain accessible (Jabeen, 2024). Regulatory barriers create formidable obstacles—approval from multiple ministries and governmental departments is required for procurement, with limited quotas allocated even to tertiary care and military hospitals (Jabeen, 2024). Pakistan's regulatory workforce comprises as few as 1-2 drug inspectors per district (Ahmad et al., 2020). However, paradoxically, opioids remain freely available without prescription at some pharmacies, highlighting enforcement inconsistencies (Ahmad et al., 2020).

This scarcity stems partly from the drug addiction context. The UN Office on Drugs and Crime reported 6.7 million Pakistani adults used opioids in 2013, with 4.25 million using them unsafely (Ul Haq et al., 2020). Pakistan has been described as the "most heroin-addicted country per capita" globally. This creates regulatory reluctance to improve medical access despite the WHO's designation of morphine as an essential medicine (World Health Organization, 2024). The International Narcotics Control Board found that 79% of the world's population—mainly in low and middle-income countries—consumed only 13% of total morphine manufactured globally (Sallnow et al., 2024).

Cultural and systemic barriers shaping end-of-life care.

Pakistan's collectivist society fundamentally shapes end-of-life care practices. Family autonomy often overrides individual patient autonomy in most healthcare decisions, with extended family members actively consulted (Khan et al., 2020). Physicians may be "adopted" into the family unit, participating in intimate family discussions (Moazam, 2006). Family members frequently protect terminally ill patients from knowledge of their condition, requesting physicians not disclose terminal diagnoses (Moazam, 2006). Discussion of death and prognosis is considered taboo, with 40% of physicians reporting they lack skills in "breaking bad news" (Ahmed et al., 2024).
Islamic beliefs significantly influence care decisions, although scholars distinguish between cultural practices and religious requirements. Death is viewed as a natural process, making Muslims more accepting than Western medicalized approaches (Sachedina, 2005). However, families may view advance directives or DNR orders as "giving up" since suicide is forbidden in Islam (Padela & del Pozo, 2017).

Strong religious teachings support home-based family care of the sick and elderly, making inpatient palliative centers potentially less culturally acceptable (Khan et al., 2020). Caring for sick and elderly relatives is considered a duty of younger generations, as embedded in Islamic teachings about family obligations (Sachedina, 2005).

Low health literacy and poverty contribute to unsafe medication practices and hinder access to care (Ahmed et al., 2024). Ninety percent of healthcare expenditure remains out-of-pocket, creating insurmountable financial barriers for many families (Ahmed et al., 2024).

Public awareness of palliative care concepts remains minimal, with misconceptions equating palliative care exclusively with imminent death rather than holistic symptom management throughout serious illness (Khan et al., 2020).

Vol 22 - No. 8 | April 2026 | www.jbima.com
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Foundational deficits in medical education

Pakistan's medical education system has critical gaps in palliative care. The medical curriculum does not include dedicated courses or clinical rotations in palliative medicine (Raza et al., 2022). Communication skills are included in the Pakistan Medical and Dental Council curriculum, but the emphasis on teaching remains inadequate (Ahmed et al., 2024). A cross-sectional study of 246 undergraduate medical students found mean knowledge scores of 9.7 out of 13, with knowledge failing to improve as students advanced through medical school (Ahmed et al., 2023). Students demonstrated notable misconceptions about the differentiation between palliative care and hospice care. Prior awareness was correlated with attending private institutions, longer study years, and higher family income; however, none of these factors were significantly associated with actual knowledge scores (Ahmed et al., 2023).

Studies of newly graduated medical students in the Middle East revealed that 56.8% reported no formal education or training in palliative or end-of-life care during medical school (Alshammary et al., 2020). Less than 25% underwent any evaluation of palliative care knowledge or skills. Fifty percent never followed a palliative care patient for more than two weeks, and 58% never experienced a patient's death in an allow-natural-death situation (Alshammary et al., 2020).

The majority of surgical residency programs provided limited training in palliative and end-of-life care, described as "alarming" by reviewers (Alshammary et al., 2020).

Recent progress includes the introduction of nine palliative care-pain medicine fellowship programs nationally in 2021 for physicians interested in this field (Ahmed et al., 2024). The Pakistan Medical Commission Act was passed in 2020, and palliative medicine gained acceptance as a specialty for postgraduate degrees (Ahmed et al., 2024).

A 2004 survey found that Pakistani doctors expressed interest in training, with 92.5% acknowledging the need for palliative care inclusion in curricula at all levels of healthcare (Bhatnagar et al., 2018). The Royal College of Physicians' Jeelani Drabu Palliative Care Programme delivered a 1-week residential course in Lahore in 2019 to 34 participants (22 doctors, 12 nurses), with another course planned for Karachi in 2025, partnering with Aga Khan University (Royal College of Physicians, 2024).

Islamic foundations for compassionate end-of-life care

The Islamic tradition offers a rich ethical framework for palliative care, rooted in fundamental theological concepts. The Quran repeatedly emphasizes death's universality: "Every soul shall taste death, and only on the Day of Judgment will you be paid your full recompense" (Quran 3:185). Death represents not an end but a transition to resurrection and eternal life. The Quran counsels believers: "O soul that are at rest! Return to your Lord, well-pleased (with him), well pleasing (Him), So enter among My servants, and enter into My garden" (Quran 89:27-30). These verses frame death as a return to the Divine, requiring spiritual preparation (Sachedina, 2005).

Prophet Muhammad's ﷺ teachings emphasize seeking treatment and relieving suffering. The authenticated hadith states: "Treat sickness, for God has not created any disease except that He has also created its cure" (Rispler-Chaim, 2000). When the Prophet's young daughter was dying and Umm Ayman wept, he said: "Verily, I am not weeping. Rather it is compassion (rahma)," establishing that compassion for the dying is religiously appropriate (Ghaly, 2022). The Prophet advised against wishing for death due to hardship but taught: "O Allah, keep me alive as long as life is better for me, and cause me to die if death is better for me" (Sachedina, 2005).

The principle of rahma (compassion/mercy) forms the foundation of Islamic medical ethics. The root R-H-M shares origins with rahm (womb), emphasizing nurturing and protective aspects of mercy. The word appears 342 times throughout the Quran (Ghaly, 2022). Ar-Rahman (The Most Merciful) and Ar-Rahim (The Especially Merciful) are divine names, as Islamic teachings state that "Allah's mercy encompasses all things" (Quran 7:156). The Oath of Muslim Doctors states: "To protect human life in all stages and under all circumstances, doing utmost to rescue it from death, malady, pain, and anxiety. To be, all the way, an instrument of God's mercy, extending medical care to near and far, virtuous and sinner and friend and enemy" (Sachedina, 2005). The authenticated hadith teaches: "Those who show mercy to others will receive mercy from Allah" (Padela & del Pozo, 2017).

Classical Islamic scholars established frameworks still relevant today. Al-Ghazali formulated five essential objectives (maqasid) of Islam: protecting religion, life,

reason (consciousness), lineage, and property (Sachedina, 2005). These objectives guide contemporary bioethical reasoning. Ibn Sina (Avicenna) and Al-Razi emphasized physicians' duty to relieve suffering while preserving life in their classical medical ethics texts (Rispler-Chaim, 2000). Fakhr al-Din al-Razi introduced considerations of pain (alam) and pleasure (ladhdah) into ethical evaluations, providing consequentialist dimensions alongside deontological principles (Ghaly, 2022).

Pain management: Islamic jurisprudence on opioid use

Contemporary Islamic bioethics strongly supports appropriate pain relief, including opioid analgesics, based on necessity (darurah) principles. The Permanent Committee for Ifta' in Saudi Arabia issued a fatwa stating morphine and pethidine are permissible for pain relief when no other alternatives exist, "so long as no greater or equal harm will result from using them, such as addiction" (Islam Q&A, 2024). The Eighth Medical Jurisprudence Symposium in Kuwait (1995) resolved: "Intoxicating substances are prohibited and it is not permissible to take them except for unavoidable medical treatment, and in the amounts specified by doctors" (Padela & Mohiuddin, 2015).

Five major legal maxims justify pain medication use despite general prohibitions on intoxicants (Ghaly, 2022). First, "matters are determined according to intention" (al-umur bi maqasidiha)— the intent is pain relief, not intoxication. Second, "hardship begets facility" (al-mashaqqatutujlab at-taysir)—difficulty in treatment allows flexibility. Third, "harm should not be inflicted nor reciprocated" (la dararwa la dirar)—relieving pain prevents harm. These principles distinguish medical treatment from substance abuse. The Islamic Medical Association of North America supports the appropriate use of analgesics, emphasizing this distinction (IMANA, 2024).

Some concerns persist regarding consciousness preservation. Muslims may worry opioids interfere with prayer performance or maintaining consciousness for Shahadah recitation at death (Daar & Al Khitamy, 2001). WHO guidelines can achieve adequate pain relief in up to 90% of patients, yet some Muslims refuse opioid analgesics due to intoxication concerns (Sachedina, 2005). Cultural perception that suffering may atone for sins exists among some Muslims, though contemporary scholars emphasize this should not prevent appropriate pain management (Padela & Mohiuddin, 2015). The transformation principle (istihalah) holds that when impure substances undergo chemical processes, losing their original characteristics, they may be deemed pure, allowing medications containing otherwise prohibited substances if they are chemically transformed (Islam Q&A, 2018).

Islamic scholars universally prohibit euthanasia and physician-assisted suicide while permitting withdrawal of futile treatment. The Islamic World League (Jeddah, 1992) declared "strong rejection against so-called euthanasia under all circumstances. Those terminally ill patients should receive appropriate palliative medication, utilizing all measures provided by God in this universe" (Sachedina, 2005). The Islamic Medical Association of North America states it is “absolutely opposed to euthanasia and assisted suicide" (IMANA, 2024). This distinction between allowing natural death and hastening death is critical—withdrawing burdensome treatment when death is inevitable differs fundamentally from intentionally causing death (Daar & Al Khitamy, 2001).

Palliative sedation: balancing consciousness and comfort

Palliative sedation raises theological tensions. Al-Ghazali's framework identifies protecting consciousness (aql) as one of Islam's five essential objectives. Inducing unconsciousness prevents religious practices until death and eliminates the opportunity for repentance (tawbah). The authenticated hadith states: "Allah accepts the repentance of His servant so long as the death rattle has not yet reached his throat." This highlights the importance of maintaining a conscious state for spiritual preparation.

However, palliative sedation may be permissible as a last resort for imminently dying Muslim patients based on necessity principles. Contemporary jurists reference the five major legal maxims, emphasizing that the primary intention must be to ensure patient comfort, rather than hastening death. When facing intractable suffering, Islamic law allows flexibility under the “hardship begets facility" principle. Terminal sedation prevents suffering, which represents the greater harm.

Permissibility requires specific conditions: sedation must be a last resort when other pain management proves inadequate; the patient must be imminently dying (many scholars suggest less than two weeks' life expectancy); the intention must be symptom relief, not death acceleration; and proportionality must be maintained with sedation level matched to symptom severity. Intermittent sedation, allowing periods of consciousness, is more acceptable than continuous terminal sedation due

to concerns of permanent loss of consciousness. A study of ten Muslim physicians in the Netherlands with palliative sedation experience found that they emphasized professional responsibility even when contravening some Islamic scholarly views, expressing moral obligation to fight patients' pain in the final stages. Most resolved tension between religious conceptions and professional duties, emphasizing the absence of death acceleration as a prerequisite.

Institutional Islamic bioethics positions on life-sustaining treatment

Major Islamic bioethics institutions have developed consensus positions relevant to palliative care. The Islamic Fiqh Academy's 2015 resolution (22nd Session, Kuwait) accepted that Muslims have no religious duty to treat terminally ill patients when treatment is deemed futile, with confirmation by three physicians. Withdrawing or withholding medical treatment is permissible based on the la dararwa la dirar principle (no harm and no harassment). The Academy issued a total of 238 resolutions on contemporary issues, emphasizing the integration between jurists and scientists.

The International Islamic Fiqh Academy's 1986 resolution (3rd Session, Amman) addressed death determination, stating: "A person is pronounced legally dead, and consequently, all dispositions of Islamic law in case of death apply if one of the two following conditions has been established: Complete cessation of cardiac and respiratory functions with physicians confirming irreversibility, or complete cessation of all brain functions with physicians confirming irreversibility and brain entering state of decomposition. In this situation, it is permissible to turn off life support equipment."

The European Council for Fatwa and Research (11th Session, Stockholm, 2003) categorically prohibited acts or omissions leading to precipitating death yet accepted withdrawing futile treatment. Patient wishes regarding prolongation of dying must receive careful attention from medical teams. The Islamic Organization for Medical Sciences' Islamic Code of Medical Ethics (1981) states:

"If the patient is in a vegetative state with no prospect of recovery, it is futile to maintain him by heroic measures diligently...but he should not take a positive measure to terminate the patient's life."

Basic human rights, including access to food, water, nursing care, and pain relief, must be maintained.

Contemporary Shiite scholarly perspectives, documented through structured interviews with eight experts, emphasize that life preservation must be "sensible"—patients can request not to have death-prolonging procedures started or continued when treatment causes more harm than benefit. They reference jurisprudential principles, including la dararwa la dirar and al-'usrwa al-haraj (financial hardship). Concepts of stable (mustaqarr) versus unstable (ghayr mustaqarr) life prove crucial for decision-making, with physician-centered teams of experts making final decisions guided by Islamic ethical principles alongside patient input.

Truth-telling and disclosure: evolving Islamic perspectives

Truth-telling in Islamic medical ethics has undergone a significant evolution from a protective paternalistic approach toward patient-centered transparency, while maintaining an emphasis on family involvement. Classical Islamic foundations uniformly prohibit lying (kidhb). The Prophet Muhammad taught: "Truthfulness leads to righteousness and righteousness leads to Paradise" (Muslim 2607). Al-Ruhawi (9th century) in "Adab al-Tabib" (Ethics of the Physician) emphasized that doctors should "always tell the truth" (Rispler-Chaim, 2000). Al-Ghazali advocated cheering patients with kind words and hope while avoiding lies—a crucial distinction between withholding information and deception (IslamWeb, 2024).

Contemporary Islamic bioethicists increasingly advocate mandatory disclosure, particularly to imminently dying patients. Manal Z. Alfahmi's groundbreaking 2022 analysis using Maqasid al Shariah argued disclosure to imminently be dying patients is mandatory because it enables material affairs management (debts, wills), allows spiritual preparation (repentance before death), and respects the hadith: "Allah accepts repentance as long as the latter is not on his deathbed" (Alfahmi, 2022). She distinguishes between non-imminently dying patients (for whom staged disclosure may be permissible) and imminently dying patients (for whom disclosure is required), arguing that the long-term harms of non-disclosure outweigh the short-term psychological benefits (Alfahmi, 2022).

A critical disconnect exists between cultural practices and Islamic scholarly positions. Farhat Moazam, founder of Pakistan's first bioethics center, distinguished "Arabian traditions" from “Islamic values," arguing that protective paternalism is cultural, not religiously

mandated (Moazam, 2006). A Saudi Arabian study found that 83.6% of 304 cancer patients wanted disclosure of their diagnosis/prognosis, yet only 59.9% of their families agreed—demonstrating that families' protective instincts often override patients expressed wishes (Alfaifi et al., 2021). Alfahmi critiques the misuse of the darar (harm) principle by families to justify concealment, arguing that socio-cultural values should not override the autonomy of competent patients (Alfahmi, 2022).

A review of medical ethics codes from 14 Islamic countries revealed a striking inconsistency in the disclosure of terminal illness: five codes remained silent, seven allowed concealment, one mandated disclosure, and one prohibited disclosure (Chamsi-Pasha & Albar, 2011). This “favours a paternalistic/utilitarian, family-centred approach over an autonomous, patient centred approach," representing a significant gap requiring standardization. The Islamic Medical Association of North America takes a clearer position: "All patients...should be informed of their rights" and "encouraged to have a living will" (IMANA, 2024).

Contemporary consensus among leading scholars, including Mohammed Ghaly, Aasim Padela, and Farhat Moazam, supports patient-centered transparency with family input. Family involvement should be consultative, rather than controlling, for competent patients (Alfahmi, 2022). Islamic autonomy differs from Western individualistic autonomy in that it incorporates a family, community, and divine framework, yet the individual remains the primary moral agent (Padela & del Pozo, 2017). Lying remains absolutely prohibited ends do not justify means (IslamWeb, 2024). Staged disclosure may be permissible in limited cases for non-terminal patients with genuine medical reasons (cardiac/psychiatric comorbidities), but withholding differs fundamentally from deception. Physicians should maintain hope using "kind words" and “sincere wishes" without deception (Alfahmi, 2022).

Spiritual care practices: preparing for Husn al-Khatima

Islamic approaches to spiritual care emphasize achieving husn al-khatima (good ending/death)—the spiritual state at the time of death. The authenticated hadith teaches: "Actions are judged by their endings" (innama al-a'mal bi al-khawatim). This concept highlights the crucial nature of the final moments for one's eternal destiny (Haq Islam, 2024). Husn al-khatima includes dying while reciting "La ilahaillallah" (There is no god except Allah), dying in a state of repentance, dying while performing good deeds, and death coming peacefully with contentment visible on the face (HaqIslam, 2024).

Talqin (prompting the dying person) constitutes the central spiritual practice. The most beloved person to the dying patient sits close and repeatedly says "La ilaha illallah" so the patient can hear and repeat (Darulfatwa Australia, 2024). The hadith from Ibn Hibban states: "Help those among you who are dying to say – no one is God except Allah – for whoever is last word before death is – no one is God except Allah – shall enter Paradise" (Islam Q&A, 2019). Practitioners should not instruct patients to recite it, but rather recite it themselves (British Fatwa Council, 2024). Once patients say it, remain silent to preserve it as their last words. If patients discuss worldly affairs afterward, repeat talqin (Darulfatwa Australia, 2024). The fuller Shahadah may be used: "I bear witness that there is no god except Allah; One is He, no partner hath He, and I bear witness that Muhammad is His Messenger" (British Fatwa Council, 2024).

Recitation of Surah Yasin (Chapter 36) during dying represents a widespread practice. The hadith (considered weak but widely accepted) states: "Recite Yasin over your dying ones” (Surah Yasin, 2024). The majority of scholars (Hanafi, Shafi'i, Hanbali) consider it mustahabb (recommended). Surah Yasin contains themes of Tawhid (monotheism), resurrection, and glad tidings of Paradise. Verse 26 states: "It was said: 'Enter Paradise'"—providing comfort and good news (Surah Yasin, 2024). Recitation is believed to ease the soul's passage and make dying less painful. Called "the heart of the Quran," it should be recited before death during the dying process, not after death, according to most scholars (Islam Q&A, 2019).

Other Quranic verses provide comfort: Ayat al-Kursi (2:255), Surah Al-Ikhlas (Chapter 112), Surah Al-Mulk (Chapter 67), beginning of Surah Al-Baqarah (2:1-5), and last verses of Surah Al-Baqarah (2:285-286) (Nwoye et al., 2022). For grieving, Quran 2:156 states: "*Inna lillahi wa inna ilayhi raji'un*" (Indeed we belong to Allah and to Him we return) (Islamic Relief UK, 2024). Practical considerations include positioning patients facing the Qibla (direction of Mecca)—on the right side, if possible, or on the back with their feet toward Mecca (Crossroads Hospice, 2024). Recitation should be done softly and peacefully. Families may give charity in a patient’s name, and patients are encouraged to seek forgiveness and make tawbah (repentance) (Islamic Relief UK, 2024).

Family-centred care in the Islamic tradition

Family involvement in Islamic end-of-life care extends far beyond Western notions of the nuclear family. Caregiving of relatives at the end of life is voiced as a familial and religious duty in Islam (Khan et al., 2023). Extended family members, neighbours, and the local religious community share responsibility. Good care implies family presence and active participation in patient support (Khan et al., 2023). Vision of a "good death" includes family providing support at home, aligning with Pakistani cultural preferences for home-based care (Sachedina, 2005).

Family members have the right to remain at the bedside, particularly during the dying process, and an obligation to comfort and support the dying person (Crossroads Hospice, 2024). They lead patients in reciting the Shahadah before death and assume post-death responsibilities for proper washing (ghusl), shrouding (kafan), and burial arrangements within 24 hours, whenever possible (Islamic Relief UK, 2024). While grief is natural and acceptable, loud wailing or extended mourning beyond prescribed periods is discouraged, balancing emotional expression with theological submission to divine will (Islamic Relief UK, 2024).

Decision-making typically includes extended family members and elders, potentially including relatives abroad (e.g., grandparents in home countries) (Khan et al., 2023). Often, an older male family member helps with necessary decisions if patients are incapacitated (MyPCNow, 2024). This collective decision-making approach contrasts with Western individual autonomy models, which require healthcare providers to accommodate multiple family members who may want to be present during medical discussions (Khan et al., 2023)—language barriers, particularly for recent immigrants, compound communication challenges. However, contemporary scholars distinguish cultural practices from religious requirements. Family authority is appropriate only when patients lack capacity or explicitly delegate decision making (Alfahmi, 2022). For competent patients, family input should be consultative rather than controlling, although this represents an evolving understanding rather than a settled consensus across Muslim communities (Padela & del Pozo, 2017).

The essential role of Islamic chaplaincy

Muslim chaplains serve distinct roles from both community imams and non-Muslim chaplains. Imams are community/congregation leaders with expertise in Islamic law and theology, who may possess deep knowledge of patients' cultural backgrounds but often lack training in pastoral/clinical care, and may not routinely visit hospitals (Khan et al., 2023). Muslim chaplains are professionals trained in both Islamic sciences and Clinical Pastoral Education (CPE), holding board certification with specialized healthcare training, and working within institutional structures while adhering to professional ethics codes (Association of Muslim Chaplains, 2024).

Islamic chaplaincy addresses critical gaps in healthcare delivery to Muslim patients. A 2023 qualitative study of 23 chaplains revealed that a dearth of fundamental knowledge about Islam among healthcare workers, low understanding of Islamic beliefs about death among physicians and nurses, and medical schools teaching little to nothing about Islam create systematic barriers (Khan et al., 2023). Muslim patients may not assert needs due to discrimination fears, with Islamophobia leading some to list religion as "unknown" or "other" since 9/11 and subsequent political climate (Khan et al., 2023).

Chaplains provide spiritual assessment and support: assessing spiritual and religious needs, providing prayer mats and Qurans, facilitating five daily prayers and accommodating prayer times, helping patients perform ablution (wudu) or tayammum (dry ablution) when unable, positioning beds toward Qibla, and supporting fasting during Ramadan if medically appropriate (Indiana University School of Medicine, 2024). They perform or facilitate talqin with dying patients, lead Quranic recitation (especially Surah Yasin), help patients maintain religious obligations despite illness, guide families on Islamic death rituals, and coordinate with funeral homes for Islamic burial (Khan et al., 2023).

Medical ethics consultation represents a crucial aspect of chaplaincy. Chaplains interpret Islamic perspectives on DNR orders, palliative sedation, and withdrawal of life support; provide religious guidance on pain management; explain Islamic views on suffering and its redemptive value; help families understand futility determinations; navigate conflicts between medical recommendations and perceived religious obligations; and clarify misconceptions about what Islam permits at the end of life (Khan et al., 2023). Many Muslims misunderstand DNR as abandoning patients entirely, requiring reframing as "allowing natural death" using Quranic verses (Khan et al., 2023). Islamic law permits withdrawal when treatment causes more harm than benefit—a message that requires religious authority to communicate effectively.

Chaplains also educate medical staff about the needs of Muslim patients, correct negative stereotypes and Islamophobia among staff, advocate for culturally appropriate care, explain dietary restrictions (such as halal food), address modesty concerns (gender-concordant care when possible), and facilitate communication between families and medical teams (Khan et al., 2023). During bereavement, they provide counseling grounded in Islamic teachings and help families understand religious obligations while supporting grief processing (Ziyara, 2024).

Successful international models offering lessons for Pakistan

Muslim-majority countries have developed successful palliative care programs offering replicable models. Jordan's experience demonstrates comprehensive, coordinated development. The Jordan Palliative Care Initiative (WHO Demonstration Project, 2001-2006) increased the number of patients served from fewer than 250 yearly (pre-2003) to over 800 yearly by 2006 (Abu-Saad, Huijer, &Dimassi, 2007). Critical achievements included changing opioid prescribing regulations, increasing the national opioid quota, establishing generic immediate-release morphine production in Jordan, and intensive bedside training producing regional "champions" (Abu-Saad Huijer &Dimassi, 2007).

King Hussein Cancer Center provides comprehensive palliative care, including inpatients, outpatients, home care, and dedicated beds, which is critical, as over 75% of cancer patients present incurable at diagnosis (Abu-Saad Huijer &Dimassi, 2007). The National Home Healthcare Initiative (2015-present), in partnership with KHCF, KHCC, and USAID, has trained over 321 health professionals across 28 facilities, resulting in diploma certification in collaboration with Jordan University (Al-Qadire et al., 2024). Outcomes included a 66% increase in home care visits, accompanied by a decrease in emergency room visits and hospital admissions (Al-Qadire et al., 2024). Jordan's National Strategic Framework (2018) provides a government-endorsed roadmap covering policy, finance, service delivery, opioid access, capacity building, and information/research/monitoring/evaluation (Ahmed et al., 2024).

Turkey's Pallia-Turk Project (2010) established a unique population-based primary care organization model, covering over 70 million people (Özçelik et al., 2019). This community-based approach expanded from 10 centers in 2009 to more than 415 palliative care centers with 1,672 registered beds across 29 Healthcare Regions (Kabalak et al., 2022). The ENABLE-TR program adapted US models for the Turkish context, incorporating religious and cultural norms as essential components (Prigerson et al., 2018).

Malaysia's dual model combines NGO community-based care with government hospital-based services. Hospis Malaysia (established 1991) leads NGO provision, while 68 government hospitals provide services (Ch'ng et al., 2018). A 2016 survey found that 98.5% of the public supported palliative care when informed, although 17.2% remained unaware (Ch'ng et al., 2018). Islamic values integrate into nursing practice with holistic care approaches where nurses serve patients as whole persons (physical, spiritual, social) (Isa et al., 2023).

Saudi Arabia's oldest program has been in operation for 30 years, with King Faisal Specialist Hospital establishing the first regional fellowship in 1992 (Alshammary et al., 2022). Palliative care gained official specialty recognition, integrated into Vision 2030 transformation under the Last Phase Initiative (Alshammary et al., 2022). The Saudi model emphasizes intensive training with ongoing mentorship—more effective than one-time training—with 415+ centers and pilot integration with primary care (Alshammary et al., 2022).

Common success factors and implementation lessons

Analysis of successful programs reveals common elements. Government policy support and official recognition of specialties prove essential. Jordan, Lebanon, Saudi Arabia, and Turkey achieved scale through national strategic frameworks, integration into national cancer control programs, and formal recognition. Without governmental backing, programs remain fragmented and under-resourced.

Community-based and primary care integration offers the most sustainable model, particularly for resource-limited settings. Turkey's population-based primary care approach and Iran's leveraging of family physician programs in rural areas demonstrate feasibility. Jordan's home healthcare reduces hospital burden, showing cost-effectiveness.
Most patients require care at home rather than in hospitals, necessitating involvement from a primary care physician.

Training strategies combining theoretical and practical clinical training with ongoing mentorship prove most effective. Task-shifting to general practitioners becomes necessary when specialist shortages are severe. Pakistan's large general practitioner workforce represents untapped potential. Multidisciplinary team training and integration into undergraduate curricula prevent the perpetuation of knowledge gaps.

Opioid accessibility requires regulatory reform balancing access and safety. Jordan's success in changing prescribing regulations, increasing quotas, and establishing local generic morphine production provides a replicable model. Education to overcome opiophobia among providers and patients is essential. WHO is International Pain Policy Fellowship offers technical support.

Cultural adaptation proves non-negotiable. The GRADE-ADOLOPMENT approach—adopt, adapt, or exclude international guidelines—acknowledges local contexts. Family-centered decision-making models, the integration of Islamic spiritual care from inception, the use of religious scholars for community education, and addressing cultural taboos surrounding death/disclosure all enhance acceptability and effectiveness.

Public-private partnerships diversify funding and leverage the strengths of different sectors. Malaysia's NGO-government collaboration and Jordan's USAID-government partnership demonstrate this approach. Palliative care champions—specialists in major centers driving implementation, national associations/societies providing professional homes, and Ministry of Health advocates coordinating efforts—accelerate development. Phased implementation, starting with one center of excellence before scaling up, reduces risk and allows for learning. However, simultaneous coordination across policy, opioid access, training, and clinical services proves more effective than fragmented approaches. Measurement and quality improvement through outcome tracking (patient satisfaction, symptom control, reduced hospitalizations) and cost-effectiveness documentation build evidence for expansion.

Recommendations for Pakistan's palliative care development

Pakistan requires coordinated action across multiple domains simultaneously. Immediate actions should include developing local clinical practice guidelines using GRADE ADOLOPMENT methodology as successfully piloted by Aga Khan University Hospital researchers. Creating referral pathways for primary care practitioners, training general practitioners in basic palliative care skills, and engaging with the WHO EMRO Expert Network for technical support can be accomplished with limited resources.

Policy development requires advocacy for the official recognition of palliative medicine as a distinct medical discipline. Drafting a national palliative care strategic framework modelled on Jordan's six-domain approach (policy, finance, service delivery, opioid access, capacity building, information/research/monitoring/evaluation) provides a clear implementation roadmap. Reforming opioid regulations to balance access and safety—learning from Jordan's regulatory changes and local morphine production—addresses the critical morphine paradox. Integration into national cancer control programs following Turkey's Pallia-Turk model ensures sustained attention.

Training infrastructure requires establishing fellowship programs modelled on Jordan/Saudi Arabia experiences, partnering with international institutions (King Hussein Cancer Center, King Faisal Specialist Hospital, Singapore programs) for curriculum development and faculty exchange. Integrating palliative care into medical and nursing undergraduate curricula helps prevent the perpetuation of current knowledge gaps. Developing Islamic spiritual care training for healthcare providers ensures culturally appropriate service delivery.

Service delivery should start with one center of excellence in a major city, building on Aga Khan University Hospital's existing program. Developing home-based care models following Jordan's National Home Healthcare Initiative addresses Pakistani preferences for home death while reducing hospital burden. Leveraging existing primary care infrastructure through task shifting makes geographic expansion feasible despite specialist shortages. Creating multidisciplinary teams, including Islamic chaplains from the outset, ensures the integration of spiritual care.

Cultural adaptation requires ensuring family-centered care models that respect collective decision-making while protecting the autonomy of competent patients. Integrating Islamic spiritual care from inception—not as an afterthought—enhances acceptability. Partnering with religious scholars and institutions for community education helps dispel misconceptions that palliative care contradicts Islamic teachings. Developing educational

materials in Urdu and regional languages ensures accessibility.

Research and evaluation should document palliative care needs assessment, implement pilot programs with rigorous outcome measurement, build Pakistan-specific evidence base, and participate in regional research networks. Publishing findings in peer-reviewed journals builds national expertise and international visibility.

Toward an Islamic palliative care ethic for Pakistan

Pakistan's palliative care crisis occurs not from the absence of ethical frameworks but from the failure to actualize Islamic principles emphasizing compassion, relief of suffering, truthful communication, spiritual preparation for death, and family support. Islamic bioethics offers a robust foundation for modern palliative medicine, particularly when cultural practices are distinguished from religious requirements. Rahma (mercy/compassion) as the foundation of healing, the permissibility and encouragement of appropriate pain relief, acceptance of death as a natural transition, family involvement within a framework that respects patient dignity, and spiritual care that prepares for a good ending, all align with palliative care's core values.

Contemporary Islamic bioethics scholars increasingly support patient-centered transparency overprotective paternalism, mandatory disclosure to dying patients to enable spiritual and material preparation, family involvement that is consultative rather than controlling for competent patients, withdrawal of futile treatment while maintaining comfort care, and appropriate opioid use based on necessity principles. These positions, endorsed by major Islamic bioethics institutions and leading contemporary scholars, provide religious authorization for the development of comprehensive palliative care.

Successful models from Jordan, Turkey, Malaysia, Saudi Arabia, and other Muslim-majority countries demonstrate feasibility. Common success factors—government policy support, community-based primary care integration, comprehensive training with ongoing mentorship, regulatory reform to ensure opioid access, integration of Islamic spiritual care, family-centered care models, public-private partnerships, and continuous quality improvement—offer replicable strategies for success. Jordan's experience particularly resonates given similar resource constraints and cultural contexts.

Pakistan possesses the necessary elements: a population desperate for services, dedicated clinicians at institutions like Aga Khan University Hospital pioneering models, rich Islamic ethical traditions that support palliative care values, strong family structures providing care infrastructure, and recent policy momentum with the establishment of a fellowship program and specialty recognition. What remains needed is political will, coordinated action across stakeholders, regulatory reform, particularly for opioid access, and sustained investment in training and infrastructure.

The path forward requires rejecting the false dichotomy between Islamic ethics and modern palliative medicine. Islamic teachings mandate the relief of suffering, truthful communication that enables informed decisions, and spiritual preparation, as well as family involvement that respects patient dignity and spiritual care, thereby preparing souls for their return to the Divine. Palliative care, properly understood and culturally adapted, represents not a Western import but the actualization of Islamic obligations to the suffering and dying. Pakistan's 220 million people deserve no less than what Islamic ethics demands and modern medicine enables: compassionate, comprehensive care honouring both body and soul throughout serious illness, dying, and death.

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