Palliative care in Lebanon: Knowledge, attitudes and practices of nurses

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Abstract

Aim: To determine the knowledge, attitudes, and practices of palliative care nurses in Lebanon. ***Method***: Cross-sectional descriptive survey using self-administered questionnaire; 1873 nurses from 15 hospitals were included. ***Results***: Non-clinical nurses had better knowledge on the outcomes of palliative care than all other specialties. Oncology nurses had more favourable attitudes than other specialties with regard to informing patients about their diagnosis, patients having the right to 'do-not-resuscitate', involving patients in treatment choices, and respecting their wishes for alternative therapy. Surgical, acute critical care, and obstetric/gynaecology nurses had significantly more negative attitudes towards patients' and families' questions and concerns than other specialties. ***Conclusion***: Formal education in palliative care and development of palliative care services are needed in Lebanon to provide quality care to terminally ill patients.

Key words: Attitudes ● Knowledge ● Lebanon ● Palliative care

When people are faced with life-threatening illness, many technological advances are available to prolong and support their lives; however, when the chance of a cure decreases, care is shifted to focus on optimizing quality of life and on palliation (Sepúlveda et al, 2002). Unfortunately, a lack of knowledge and skills among healthcare professionals are one of the barriers to providing quality palliative care. A number of studies have addressed knowledge, attitudes, and practices (KAP) of nurses regarding palliative care. In Lebanon, palliative care is new to the healthcare field (Abu Saad Huijer and Daher, 2005), and studies in this area are still lacking, especially in the nursing profession.

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Background

Palliative care studies on nurses have shown that the KAP of nurses differ within specialties. Hospice nurses scored significantly better than hospital oncology nurses regarding overall pain management knowledge, especially with regard to opioids (Hollen et al, 2000), although pain control and management are considered important aims of palliative care in cancer patients (Goodwin et al, 2003). A study conducted in Japan on confidence, knowledge, and practice of oncology nurses in palliative care, found the majority of nurses to have good knowledge on the philosophy of palliative care, the dying phase, communication, delirium, dyspnea, and pain and low adherence to the recommended practices in delirium management and the dying phase (Morita et al, 2006). White et al (2001) reported in their study on the preparation of nurses in end-of-life care that the most important competencies that nurses wished they had learnt in schools were communication with patients and families about dying, pain control techniques, and comfort care nursing interventions. One-third of respondents reported receiving less than 2 hours of continuing education in palliative care in the last 2 years. In Lebanon, only 16.7% of nurses reported receiving education in palliative care; however, the majority was able to identify correctly the main goals of palliative care (Abu Saad Huijer and Dimassi, 2007).

Nurses working in community hospitals, long-term facilities, and cardiac units reported a lack of knowledge regarding good quality palliative care (Raudonis et al, 2002; Cramer et al, 2003; Nordgren and Olsson, 2004). Wotton et al (2005) found the level of nurses' knowledge in patients with end-stage heart failure (ESHF) to be influenced by specialty; palliative care nurses believed cardiac pharmacology should be decreased in ESHF, whereas acute care nurses considered it better to have both palliative care and cardiac therapy.

A survey of paediatric nurses reported that nurses were most competent when dealing with pain management and least competent in talking with children and their families about dying (Feudtner et al, 2007). Similar results were reported in six community hospitals where 43% of nurses found it difficult to talk about death

and dying with patients and families (Cramer et al, 2003). In China, 72% of nurses and physicians reported being very competent in addressing physical symptoms in dying patients and poor in addressing psychological symptoms (Wang et al, 2004).

With regard to decision-making practices in palliative care, 91% of intensive care unit (ICU) nurses reported that decision making should be collaborative between physicians, nurses, patient, and family, but only 27% believed it occurred in actual practice (Ferrand et al, 2003). Similarly, the study by Thibault-Prevost et al (2000) reported that 62.7% of ICU nurses considered themselves infrequently involved in do-not-resuscitate (DNR) decisions; 53.1% reported rarely discussing DNR with patients and families, and 45.2% reported initiating discussions about DNR with physicians. In Lebanon, 26% of ICU nurses and 21% of families were not involved in decisions to limit care (Yazigi et al, 2005).

Many studies reported improvement in the knowledge and attitudes of nurses towards palliative care after educational interventions on palliative care (Cramer et al, 2003; Ersek et al, 2005; Steginga et al, 2005) and another stressed the importance of integrating palliative care in undergraduate curricula (Ury et al, 2000).

In Lebanon, no studies have been conducted prior to this project evaluating nurses' KAP in palliative care. The purpose of this study was to determine the KAP of nurses working in different specialties towards palliative care in Lebanon.

The research questions addressed were:

1. Do nurses have adequate knowledge and training in palliative care, and do they differ by specialty?
2. What are the attitudes of nurses from different specialties towards palliative care?
3. Do nurses provide palliative care for terminally ill patients, and how does provision of palliative care differ by specialty?

Methods

Design, sample, and setting

A cross-sectional descriptive survey using a self-administered questionnaire was used.

The target population was registered nurses (RNs) currently working in hospitals in Lebanon. Participants were chosen from 15 hospitals geographically spread in Lebanon. A contact person was designated per hospital to distribute and collect questionnaires. This was done in close collaboration with the syndicate of private hospitals in Lebanon.

Institutional review board approval was granted by all hospitals.

Data collection

The sample size determination was based on a power of 80%, alpha of 5%, and a precision (degrees of freedom) of 3%, with a baseline proportion of 0.5 (used when the proportion is not known). The calculated sample size was 1056, but to account for non-response rates, all nurses in the selected hospitals were included. A total of 1873 questionnaires were sent to nurses with a cover letter written by the first author describing the goals of the study, name of contact person, and time frame of 2 weeks for returning the questionnaire. A reminder was sent after 2 weeks; deadline was extended to 2 months to improve response rate.

Questionnaire

Since no previously existing tools were found in the literature that measure the KAP of nurses in palliative care and that are appropriate for use in Lebanon, a questionnaire was designed especially for this study and was developed based on a review of the literature and information gained from a qualitative study conducted by the principle investigator. Content and face validity were established by a team of experts that consisted of three oncologists, one cardiologist, one family medicine physician, ten nurses, and one epidemiologist. The panel of experts provided feedback on the questions and their appropriateness for use in Lebanon based on their clinical experience with terminally ill patients. The questionnaire was pilot-tested for feasibility and clarity on ten nurses and modifications were made accordingly. No reliability tests were done prior to the study.

Since the educational background of nurses in Lebanon is either English or French, the questionnaire was developed in both languages. It includes six sections: general information on specialty area (5 questions); perceptions and knowledge (10 questions) measured by yes and no; attitudes (15 questions), practices and perceptions of practices (12 questions), and needs assessment for palliative care services (8 questions). Each section was measured using a 5-item Likert scale ranging from strongly agree (5) to strongly disagree (0).

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Statistical analysis

General characteristics of RNs were reported using means and standard deviations (SD) for numerical variables, such as age and years of experience. Categorical variables, such as specialty and gender, were reported using frequencies and percentages. Items on attitude and perception of practice were re-coded as

Table 1. General characteristics of nurses*

Nurses	Results
Total	n=956
Gender:	
Males	n=160 (16.8%)
Females	n=793 (83.2%)
Age	mean 30.7 (SD=8.4)
Years of experience	mean 9.0 (SD=7.9)
Specialties:	
Clinical services	n=221 (24%)
Non-clinical	n=53 (5.8%)
Medical	n=112 (12.2%)
Surgical	n=123 (13.4%)
Acute critical care	n=213 (23.2%)
Obstetrics/gynaecology	n=47 (5.1%)
Paediatrics	n=96 (10.4%)
Oncology	n=54 (5.9%)
Exposure to terminally ill patients	n=758 (81.4%)
Numbers seen in the past 12 months*	n=6.0 (12.0%)
Ever heard of palliative care	n=845 (91.7%)
Education received in palliative care	n=154 (16.7%)

*Missing data not included; displayed results are for people who answered. ** Median was reported instead of the mean due to the pronounced positive skewness of the data caused by few respondents reporting as many as 100–300 terminally ill patients seen in the past 12 months

follows: 'strongly agree' and 'agree' into 'agree' and the 'undecided', 'disagree' and 'strongly disagree' into 'disagree'. The nurses were then compared by the newly-coded variables according to their specialties using Pearson's chi-square test (degrees of freedom [df] = 7). Specialties were compared according to age and years of experience using the one-way ANOVA. Data were analyzed using Statistical Package for the Social Sciences (version 15), and all tests were carried out at the 0.05 significance level.

Results

The total number of completed and returned questionnaires was 956, yielding a 51% response rate. *Table 1* displays the general characteristics of respondents. Note that missing data were not included in the results; displayed results are for people who agreed with the statements.

The majority of respondents were females ($n = 793$, 83.2%); mean age 30.7 (± 8.4) and mean years of experience 9 (± 7.9). Specialty was divided into eight different specialties: medical ($n = 112$, 12.2%), surgical ($n = 123$, 13.4%), paediatrics ($n = 96$, 10.4%), acute critical care (ACC) ($n = 213$, 23.2%), oncology ($n = 54$, 5.9%), obstetrics/gynaecology ($n = 47$, 5.1%), clinical services (all other clinical specialties excluding the previously mentioned ones) ($n = 221$, 24%), and non-clinical (mainly administration and management) ($n = 53$, 5.8%).

Gender, age, and years of experience were significantly different among specialties, with male nurses mostly specializing in ACC (31.9%; $n = 68$) and none in paediatrics and obstetrics/gynaecology ($P < 0.001$). Oncology nurses were the youngest (27.36, ± 6.1) and non-clinical nurses the oldest (38.88, ± 9.0) ($P < 0.001$). Similar results were found in years of experience ($P < 0.001$). Majority of nurses (81.4%; $n = 758$) were exposed to terminally ill patients, with the highest rates among oncology nurses (98.1%) ($P < 0.001$). Only 16.7% ($n = 154$) of all sampled nurses received continuing education in palliative care: 9.8% ($n = 12$) of surgical and 38.5% ($n = 20$) of non-clinical nurses ($P < 0.001$).

Nurses of different specialties varied significantly in their response profile with regard to some knowledge (*Table 2*), attitudes (*Table 3*), practices (*Table 4*) and palliative care services questions.

In general, non-clinical nurses had better knowledge on some outcomes of palliative care compared with other specialties: 'death without pain and suffering' ($P = 0.003$), and 'living with dignity and respect' ($P = 0.048$); however, these nurses also had the highest rates of mistakenly reporting 'prolonged life' ($P = 0.006$) as a palliative care outcome (*Table 2*). Oncology nurses (88.7%; $n = 47$) were the least likely to consider 'living with dignity and respect' as one outcome of palliative care ($P = 0.048$), and more likely (24.4%; $n = 11$) to consider that 'palliative care destroys hope and leads to despair and depression' ($P = 0.027$) (*Table 2*).

ACC nurses were more likely to believe 'patients should be informed about their prognosis' (90.8%; $n = 168$ [$P = 0.019$]), while oncology nurses were more likely to believe 'patients should be informed of their diagnosis' (100%; $n = 54$ [$P < 0.001$]) (*Table 3*). In addition, oncology nurses were more likely to consider that 'patients should be involved in treatment choice' ($P = 0.001$), 'have the right for DNR' ($P < 0.001$), 'that it is preferable for them to die at home' ($P = 0.009$), and that 'having the same religious belief enhances the caring process' ($P = 0.026$). Significantly more paediatric nurses believed that family should be involved in the treatment choice (91%; $n = 81$ [$P = 0.007$]) and obstetrics/gynaecology nurses were the least likely to consider patients' wishes to seek alternative medicine (84.2%; $n = 32$ [$P = 0.011$]), and the most likely (73.3%; $n = 22$ [$P = 0.005$]) to consider it preferable for terminally ill patients to die at the hospital (*Table 3*).

Majority of nurses do not tell patients about ıeir diagnosis, consider it to be dependent on ımilies' wishes, or is not applicable to them $P = 0.003$) (*Table 4*). All obstetrics/gynaecology urses (100%) take into consideration the ultural ($P = 0.001$) and spiritual-religious ackground ($P = 0.014$) of terminally ill patients.

In terms of perception of practice, the ıajority of non-clinical nurses (95.2%; $n = 40$) iew a terminally ill patient's outburst as a ebellion against the situation compared with '9.5% ($n = 35$) of oncology nurses ($P = 0.012$); urgical nurses (32.1%; $n = 18$) were more likely han other specialties to view a family's outburst s an attack against them ($P = 0.036$), and to ›erceive terminally ill patients' and families' uestions and concerns as doubting their ›rofessionalism and as a threat (28.1% [$n = 16$] $P = 0.019$]; 52.6% [$n = 30$] $P = 0.006$). On the ›ther hand, 45.4% ($n = 64$) of ACC nurses onsidered patients' questions and concerns as a hreat ($P = 0.014$) and 80% ($n = 12$) of obstetrics/ ;ynaecology nurses as attention-seeking ›ehaviour ($P = 0.027$) (*Table 4*).

Majority of nurses considered that palliative are should be initiated when a patient's disease ›ecomes incurable, with obstetrics/gynaecology ıurses scoring the lowest (68.1% ($n = 32$] $P = 0.011$]). Similarly, obstetrics/gynaecology ıurses were significantly the least likely to onsider that palliative care may be provided at ıome by homecare agencies (88.9% [$n = 40$], $P = 0.028$). Almost all nurses believed that a uccessful palliative care service should have npatient units; oncology nurses were less likely han others (87% [$n = 47$] [$P < 0.001$]). All ıurses, irrespective of specialty, believed that a :ontinuing education program in palliative care ıeeds to be developed in Lebanon.

Discussion

.n this study, oncology nurses were found to be the youngest and have the least years of experience, ınd non-clinical nurses were the oldest with the greatest years of experience. Oncology nurses ıaving the least years of experience can be attributed to the stressful work environment and the high turnover rate among oncology nurses (de Carvalho et al, 2005) compared with non-clinical nurses, who are mostly nurse managers, supervisors, and administrators.

Although only a small percentage of nurses across specialties were found to have received continuing education in palliative care, the majority was able to correctly identify the goals, components and assumptions of palliative care. Similar results have been reported in other

Table 2. Nurses' knowledge* of palliative care

	Nurses by specialty								
	Clinical services n (%)	Non-clinical n (%)	Medical n (%)	Surgical n (%)	Acute critical care n (%)	Obstetrics gynaecology n (%)	Paediatrics n (%)	Oncology n (%)	P-value
Outcomes of palliative care:									
Death without pain and suffering	191 (94.1)	48 (98.0)	101 (94.4)	109 (94.8)	204 (96.2)	41 (89.1)	74 (84.1)	51 (98.1)	0.003
Prolonged life	28 (15.6)	18 (45.0)	24 (26.1)	19 (20.2)	40 (22.5)	6 (14.6)	14 (18.7)	10 (23.3)	0.006
Living with dignity and respect	200 (96.6)	47 (100.0)	96 (89.7)	107 (90.7)	179 (90.9)	42 (95.5)	86 (94.5)	47 (88.7)	0.048
Palliative care includes:									
Social care	140 (74.1)	40 (93.0)	90 (85.7)	87 (82.9)	171 (88.1)	36 (80.0)	84 (89.4)	44 (89.8)	0.002
Spiritual care	205 (96.2)	51 (98.1)	104 (93.70)	108 (95.6)	204 (99.0)	44 (97.8)	87 (90.6)	50 (94.3)	0.024
Palliative care destroys hope and leads to despair and depression	18 (9.3)	2 (4.4)	13 (12.5)	11 (10.6)	20 (10.3)	2 (4.5)	5 (5.9)	11 (24.4)	0.027
Palliative care supports patients in living as actively and creatively as possible	180 (85.3)	45 (91.8)	93 (84.5)	113 (96.6)	191 (92.3)	43 (95.6)	80 (93.0)	44 (84.6)	0.006

* Missing data not included; displayed results are for people who agreed with the statements

'Majority of nurses considered that palliative care should be initiated when a patient's disease becomes incurable'

studies (White et al, 2001; Wotton et al, 2005). In this study, 24.4% of oncology nurses believe that palliative care destroys hope and leads to despair and depression. This finding has not been reported in other studies; it emphasizes the need for palliative care education in Lebanon, especially in oncology care where nurses are more likely to deal with terminally ill patients. On the other hand, oncology nurses and non-clinical nurses were more likely than other specialties to view the outcomes of palliative care as 'death without pain and suffering'. This may be attributed to increased emphasis in clinical practice on pain management in cancer nursing care (Gordon et al, 2005; Bernardi et al, 2007; Efstahiou et al, 2007). Non-clinical nurses, on the other hand, have reported receiving continuing education significantly more than other specialties.

Oncology nurses had more favourable attitudes than other specialties with regard to informing patients about their diagnosis, patients having the right for DNR, involving patients in treatment choice, and respecting their wishes for alternative therapy. This can be attributed again to more exposure to terminally ill patients. However, 17.8% of nurses in general think that patients do not have the right for DNR; this finding is similar to the work of Yazigi et al (2005). It is most likely secondary to lack of legal guidelines in Lebanon regarding end-of-life decisions (Yazigi et al, 2005) and the fact that the majority of Lebanese people are very religious, value life, and believe in the power of God in giving and taking life (Brushin et al, 1997; Doumit et al, 2007; Bejjani-Gebara et al, 2008).

With regard to their perceptions of practice, surgical, ACC, and obstetrics/gynaecology nurses viewed patients' and families' questions and concerns negatively; they considered them as a threat, doubting their professionalism, or attention-seeking behaviour. Such results have not been reported previously and a possible explanation can be the lack of knowledge and communication skills, and to nurses' inability to deal with emotional outbursts in stressful situations. Although similar results have not been reported, in the study by Boyle et al (2005) ICU nurses believed good communication among physicians, nurses, patients, and family to be the most important factor in end-of-life care in ICUs, but found it to be the least accomplished. Similarly, the study by Feudtner et al (2007) found paediatric nurses to be least competent in talking to patients and family about death, dying, and end-of-life care. These

Table 3 Nurses' attitudes* towards palliative care

	Nurses by specialty								
Question	**Clinical services n (%)**	**non-clinical n (%)**	**Medical n (%)**	**Surgical n (%)**	**Acute critical care n (%)**	**Obstetrics/ gynaecology n (%)**	**Paediatrics n (%)**	**Oncology n (%)**	**P-value**
Patient should be informed about:									
His/her diagnosis	192 (96.5)	46 (88.5)	104 (96.3)	99 (86.1)	193 (98.0)	40 (93.0)	80 (93.0)	53 (100.0)	<.0001
His/her prognosis	153 (83.2)	40 (87.0)	93 (86.9)	83 (76.9)	168 (90.8)	27 (71.1)	67 (84.8)	43 (86.0)	0.019
Patient should be involved in treatment choice	175 (87.5)	45 (95.7)	101 (97.1)	96 (86.5)	190 (96.0)	36 (85.7)	78 (91.8)	52 (98.1)	0.001
Family should be involved in the treatment choice	150 (79.8)	38 (86.4)	87 (90.6)	90 (82.6)	176 (91.7)	32 (76.2)	81 (91.0)	36 (83.7)	0.007
Terminally ill patients have the right to choose 'do not resuscitate'	160 (85.6)	38 (84.4)	87 (87.9)	64 (62.7)	158 (91.9)	30 (68.2)	64 (78.0)	47 (92.2)	< .001
Terminally ill patients' wishes to seek alternative medicine should be respected	196 (97.0)	49 (96.1)	96 (97.0)	102 (96.2)	194 (98.5)	32 (84.2)	86 (98.9)	49 (100.0)	0.011
Having same religious belief with patients enhances the caring process	118 (63.1)	35 (68.6)	73 (74.5)	75 (69.4)	120 (63.8)	24 (53.3)	59 (72.8)	40 (83.3)	0.026
It is preferable for terminally ill patients to die:									
At the hospital	96 (69.1)	20 (62.5)	41 (52.6)	55 (64.7)	79 (56.4)	22 (73.3)	29 (43.3)	18 (47.4)	0.005
At home	157 (89.7)	39 (95.1)	87 (93.5)	87 (93.5)	165 (93.8)	27 (75.0)	76 (91.6)	47 (97.9)	0.009

* Missing data not included; displayed results are for people who agreed with the statements

Table 4. Nurses' palliative care practices*

	Nurses by specialty								
	Clinical services *n* (%)	Non-clinical *n* (%)	Medical *n* (%)	Surgical *n* (%)	Acute critical care *n* (%)	Obstetrics/ gynaecology *n* (%)	Paediatrics *n* (%)	Oncology *n* (%)	*P*-value
Do you tell your terminally ill patient about their diagnosis?									
Yes	5 (3.0)	5 (12.2)	11 (11.6)	11 (14.9)	13 (8.1)	2 (8.0)	5 (6.7)	1 (2.1)	
No	72 (42.6)	11 (26.8)	35 (36.8)	20 (27.0)	47 (29.4)	14 (56.0)	30 (40.0)	19 (40.4)	
Depending on family's wishes	60 (35.5)	14 (34.1)	42 (44.2)	26 (35.1)	64 (40.0)	7 (28.0)	23 (30.7)	22 (46.8)	
Inapplicable	32 9 (18.9)	11 (26.8)	7 (7.4)	17 (23.0)	36 (22.5)	2 (8.0)	17 (22.7)	5 (10.6)	0.003
Information communicated to terminally ill patient depends on:									
Patient's involvement in decision making	119 (83.2)	35 (100.0)	84 (91.3)	65 (91.5)	123 (83.1)	15 (83.3)	67 (91.8)	41 (89.1)	0.050
Information communicated to family of terminally ill patients depends on:									
Their involvement in decision making	138 (93.2)	30 (83.3)	88 (96.7)	68 (94.4)	144 (92.3)	17 (81.0)	73 (92.4)	49 (98.0)	0.051
Factors taken into consideration when dealing with a terminally ill patient are:									
Cultural background	136 (81.4)	38 (92.7)	86 (92.5)	64 (94.1)	153 (91.1)	20 (100.0)	75 (96.2)	46 (95.8)	0.001
Socio-economic background	91 (58.7)	33 (80.5)	66 (77.6)	47 (66.2)	115 (72.8)	17 (81.0)	54 (80.6)	37 (82.2)	0.002
Spiritual-religious background	134 (82.2)	39 (90.7)	81 (93.1)	56 (87.5)	147 (88.6)	20 (100.0)	75 (96.2)	46 (93.9)	0.014
Integral to care management of terminally ill patients:									
Psychological support	167 (100.0)	45 (100.0)	97 (100.0)	76 (98.7)	169 (98.3)	21 (91.3)	84 (100.0)	48 (98.0)	0.018
You provide terminally ill patients with alternative choices of treatment	88 (69.8)	23 (76.7)	60 (83.3)	44 (83.0)	83 (69.2)	13 (100.0)	47 (77.0)	31 (83.8)	0.041
You perceive terminally ill patient outburst as:									
Rebellion against the situation	164 (92.1)	40 (95.2)	71 (80.7)	54 (94.7)	137 (89.0)	18 (85.7)	62 (81.6)	35 (79.5)	0.012
You perceive the family's outburst as:									
An attack against you	38 (23.6)	4 (11.4)	15 (16.9)	18 (32.1)	33 (22.9)	1 (5.3)	8 (11.4)	8 (19.5)	0.036
You perceive the terminally ill patients' questions and concerns as:									
Threat	54 (38.6)	9 (29.0)	26 (28.9)	25 (43.1)	64 (45.4)	5 (23.8)	18 (27.3)	9 (20.9)	0.014
Doubting your professionalism	25 (16.8)	3 (8.3)	18 (20.7)	16 (28.1)	34 (23.1)	2 (11.1)	6 (8.3)	4 (9.5)	0.019
Attention-seeking behaviour	80 (56.7)	16 (51.6)	51 (63.8)	46 (78.0)	79 (59.8)	12 (80.0)	38 (55.1)	33 (73.3)	0.027
You perceive the family's questions and concerns as:									
Threat	55 (39.3)	9 (28.1)	27 (29.7)	30 (52.6)	63 (43.8)	7 (33.3)	16 (24.2)	10 (24.4)	0.006

* Missing data not included; displayed results are for people who agreed with the statements

"Lebanese patients are becoming empowered and as such increasingly knowledgeable on diseases and treatment modalities"

results emphasize the importance of palliative care knowledge and communication techniques in the educational preparation of nurses. Clinical service nurses working in outpatient and kidney dialysis units were the least likely to take into consideration the cultural, socio-economic, and spiritual-religious backgrounds of patients, although 85.6% reported being exposed to terminally ill patients. This again highlights the need for continuing education programs addressing specific skills and competencies in palliative care. In general, however, all nurses took these factors into consideration when dealing with terminally ill patients. This could be attributed to the high importance given to culture, tradition, and religion in Lebanon (Brushin et al, 1997; Doumit et al, 2007; Bejjani-Gebara et al, 2008).

Although the majority of nurses believed that patients should be informed about their diagnosis and prognosis, only 7.6% of nurses reported informing patients of their diagnosis, with oncology nurses being significantly the least (2.1%, $P=0.003$). In general, the attitudes of nurses favoured informing and involving the family more than the patient. These results are not surprising because in Lebanon the family plays an important protective role in the life of individuals; in addition, social attitudes and prevailing societal norms regarding communication and truth-telling are known to be affected by cultural beliefs and norms. In Lebanon, the patient's family is usually informed first about the diagnosis and prognosis of cancer before communicating with the patient. Family members may keep the diagnosis and prognosis a secret in order to protect the patient from emotional trauma. Similar explanations have been provided in other studies conducted in Lebanon (Hamadeh and Adib, 1998; 2001; Doumit et al, 2007).

Lebanon is an open country with extensive connections to the rest of the world, either via the media, today's internet technology, or the numerous Lebanese people living abroad. In addition, with the advancement in education and technology, Lebanese patients are becoming empowered and as such increasingly knowledgeable on diseases and treatment modalities, leading to their increased involvement in the decision-making process.

The results of the needs assessment for palliative care services and continuing education and training in palliative care are similar to the results of other studies (Ury et al, 2000; Ersek et al, 2005) where nurses emphasized the importance of service development and their willingness to participate in continuing education programs.

Limitations

The low response rate (51%) may be a limitation of this study. In addition, reliability testing of the questionnaire was not performed in view of the time constraints and logistics. In hindsight, it would have been useful to ask nurses to complete the questionnaire at two different points in time.

Conclusion

The results of this study underscore the need to develop palliative care services in Lebanon as well as educational programs for the training of nurses in this field. For quality palliative care services to be provided, palliative care should be an integral part of all nursing school curricula and continuing nursing education offerings. Public information campaigns to inform and empower patients and families are a must if palliative care is to develop and be placed on the national health agenda in Lebanon. IJPN

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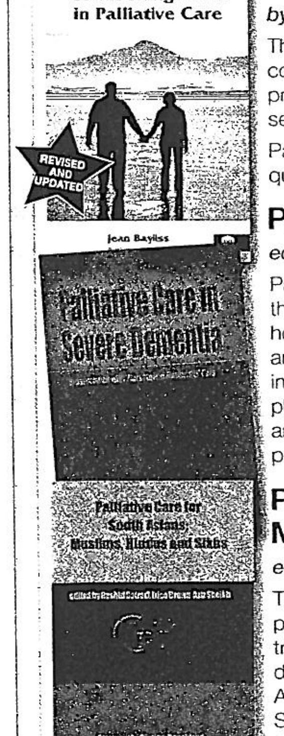

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