

Psychosocial determinants of intention to seek palliative care among the public in Lebanon: A cross-sectional study

Journal of Palliative Care
2022, Vol. 37(3) 456-463
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DOI: 10.1177/08258597221094253
journals.sagepub.com/home/pal



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Abstract

Objectives: This study aimed to assess the psychosocial determinants of intention to seek palliative care for the client themselves, or intention to enroll a family member in palliative care among the public in Lebanon. **Methods:** A cross-sectional study was initiated in 2020 on a convenience sample of adults permanently living in the Greater Beirut (GB) area; people with no current or previous experience with palliative care either for themselves or for someone dear to them were included. Verbal consent was obtained before data collection, and participants received a questionnaire to be self-completed, statistical analysis was performed using SPSS statistics version 23.0. **Results:** A total of 875 participants with a mean age of 42 years were interviewed, of whom 24 participants (2.7%) had had a previous experience with PC, either personally or with someone very close to them. The best-fit multivariate predictive model for intention to use PC included older age, positive attitude, and higher perceived control on one's health. The multivariate model for intention to recommend use was significantly associated with a positive attitude, higher perceived control, and lower perceived barriers. **Conclusions:** Promotional activities should be conducted to provide the Lebanese public with accurate, detailed, and direct information about the benefits of PC, involving essentially physicians. Future research should explore the decision-making process in "real-time" situations, and within our specific psychosocial, cultural, and organizational context.

Introduction

Palliative care (PC) is defined by the World Health Organization (WHO) as "an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering, by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual".¹

Palliative care provision remains poorly appreciated and addressed in most developing countries, and in the Eastern Mediterranean Region (EMR) in which Lebanon is located.² Progress made by EMR countries in terms of recognition and development of PC vary greatly.³ Saudi Arabia reports the highest volume of PC services, followed by Egypt and Jordan, while no PC activity has ever been reported in Iraq and Palestine.⁴

In Lebanon, interest in PC has been increasing in parallel with the epidemiological and demographic transition of the country.⁵ Palliative care services in Lebanon were first introduced following a WHO-sponsored National Cancer Control Workshop in 1995, and later following the Middle East Oncology Congress held in Beirut in 1999.³ By 2000, a first undergraduate curriculum on pain and PC had been introduced in the curriculum of the American University of Beirut (AUB) medical school. This was followed by the creation of a "Pain Relief and Palliative Care Group" in 2001, which published recommendations on how to improve PC in Lebanon in 2008.³ Since then, significant progress has been made. The Ministry of Public Health (MOPH)

created a National Committee for Pain control and PC in May 2011.⁴ The Lebanese Order of Physicians recognized PC as a stand-alone specialty in 2013. A diploma in PC nursing was launched in 2016 by the Lebanese University. Graduate studies in pain management and PC for adults and children have multiplied since then in various professional institutions.⁴

Lebanon is a small (surface 10,452 km²), pluralistic democracy with an estimated population of five million. The largest portion of the health care system is composed of private fee-for-service organization, while less than half of the population remains uninsured and have to resort to out-of-pocket payment for health care obtained.⁶ More than half of the population, and almost all the economic, political, educational and cultural activity of the country is concentrated in the Greater Beirut (GB) area, in and around the capital city.⁷

The incidence of cancer in Lebanon has more than tripled since the 1960s, and the number of new cancer cases may approach 12,000 by 2030.⁸ The Lebanese population aged 65

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and above, most prone to long and cumbersome diseases now composing 11% of the total, is expected to double by 2030.⁸ Hence, PC services will be increasingly more needed to improve patients' outcomes, reduce health care costs, and ultimately enhance quality of life.⁸

Yet, there are several barriers impede the optimal delivery of palliative care in Lebanon. These include the limited integration of PC services in hospitals and the lack of trained resources for home-delivered care in parallel with an increasing demand for such services.⁵ The lack of knowledge and misconceptions among healthcare professionals and the general public are considered as additional challenges. Furthermore, the discussion of death and dying is still considered socially unacceptable and of bad omen in the Lebanese society.⁵

At the financial level, palliative care is not covered as an independent type of holistic care neither by Social Security nor by most other public or private insurance schemes. Patients who cannot afford PC services can be referred to one of two NGOs in Lebanon that provide partially free PC services (Balsam and SANAD).⁴

This study aimed to assess the psychosocial determinants of intention to seek palliative care for the client themselves, or intention to enroll a family member in palliative care among the public in Lebanon.

Several studies have investigated the association between background factors such as general attitudes, social characteristics, knowledge level, expectations, social norms and perceived behavioral control on health-related behavior. However, studies focusing specifically on the intention to obtain palliative care are extremely rare.^{9–11} In this paper, we present findings from a survey conducted among adults residing in the Greater Beirut area. The survey questions explored the knowledge, attitudes, and perceptions of the Lebanese public towards PC, and their intention to use it or recommend it for their dear ones. The association between these categories of variables and stated intentions was explored using a conceptual model largely adapted from the "Theory of Reasoned Action" (TRA) (Figure 1).¹²

According to the TRA developed by Ajzen and Fishbein in the 1970s, people's decision to perform or not to perform a certain behavior is guided primarily by three kinds of beliefs: expectancies about the negative or positive outcomes of a behavior's performance, perceived social norms that are closely related to the approval of individuals or groups, and the perceptions of personal and environmental factors that may help or impede attempts to perform a certain behavior. The perceived behavioral control, created by the balance between obstacles and facilitators, is posited to affect the decision to act.¹²

Methods

Study Design

The data collection process was started in March 2020 and ended in December 2020, it was suspended several times due to the COVID-19 pandemic. A cross-sectional study was

initiated on a convenience sample of government employees. As government agencies in Lebanon entered lockdown because of the COVID-19 pandemic, the data collection sample was complemented with eligible adults visiting the American University of Beirut Medical Center (AUBMC), to reach the planned sample size.

Setting and Participants

Arabic-speaking adults aged 20–60 years, permanently living in the Greater Beirut area, were targeted. Participants with current or previous experience with palliative care were excluded. People's attitudes towards PC differ depending on their personal experience with it. Thus, to eliminate any possible bias, these participants were not included. Cancer diagnosis, treatment, and prognosis are considered stressful experiences for cancer patients and their families.¹³ Thus, we excluded this category to prevent any aggravation of the psychological status of such participants.

Sample Size

Due to the lack of research addressing the current level of awareness towards palliative care among the public in Lebanon and the Eastern Mediterranean Region (EMR), the sample size was calculated based on a recent study conducted in Saudi Arabia in 2017.¹⁴ As such, a minimum of 294 participants had to be included in this study. The convenience nature of the sampling led us to increase the initial number almost twice.

Questionnaire/Measures

The questionnaire developed for the purposes of this study was based on various portions adapted from standardized and validated lists. It included two filters to identify those who should be excluded from the analysis:

1. Awareness of participants regarding PC was assessed by asking a direct question. If the answer was negative or unsure, a full definition was read to them. If they persist in denying awareness, they were removed from the analysis.
2. Current and previous personal experience with PC was also directly assessed. Participants with previous or current experience with PC, either for themselves or for someone very dear to them, were excluded.

Participants received a questionnaire to be self-completed in approximately 10–15 minutes, with a research assistant present to provide additional clarifications as needed.

The main dependent variable was the intention to use PC, defined as participants' intentions to enroll themselves or a family member in PC service should the need arise.¹⁵

The independent variables included:

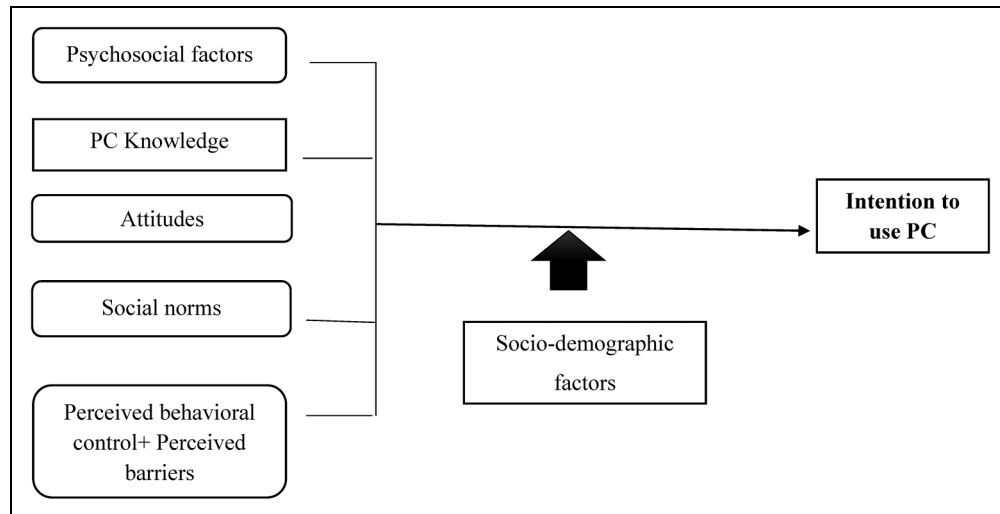


Figure 1. Intentions to use palliative care (PC) among the public in Lebanon.

- PC knowledge, assessed using the Palliative Care Knowledge Scale (PaCKS). This scale is composed of thirteen questions (true/false). Each correct answer is graded as 1, while a false or no answer is graded 0. A total score is obtained ranging from 0 to 13.¹⁶ The answers were then classified as high/low knowledge depending on the median.
- Attitudes and beliefs about PC, addressing the emotional, cognitive and behavioral attitudes towards PC.¹⁰ Questions were answered on a 6-grade Likert scale, scores were summed up into a sub-score and a total Attitude scale is then created. Depending on the median, positive/negative attitudes were then classified.
- Subjective norms defined as the expected approval of the close people in respondents' lives on PC, and the respondents' motivation to comply with the wishes of these influential people. This variable was assessed using the scale used by Park & Lee¹⁵ to assess the subjective norms towards hospice care, adjusted to assess PC. It involves 10 items, 5 items related to normative beliefs, and five items to motivation to comply. The 5-point Likert scale answers range from 1 (never) to 5 (always). The sum of normative beliefs and motivation to comply were used to calculate the subjective norm, as indicated by the authors.¹⁵
- Perceived behavioral control conceptualized as the people's overall confidence and perception of control that they can use PC service if they chose to do so.¹⁵ Perceived behavioral control was assessed using a scale developed by Mo and Mak¹⁷ to understand the intention to seek help from mental health professionals among Chinese.¹⁷ Perceived behavioral control was measured on a 3 item scale. Responses were rated on a 6-point Likert scale, with higher scores indicating higher levels of perceived behavioral control.¹⁷
- Perceived barriers are defined as the obstacles that may hinder people's intention to seek PC services.¹⁷
- Socio-demographic control factors: age, sex, educational level, perceived financial wellbeing,¹⁸ overall socio-economic status

(SES) as indicated by the Household Crowding Index (HCI),¹⁹ and social support.²⁰

Statistical Analysis

SPSS statistics version 23.0 was used in data entry and analysis. All variables were tabulated and described based on their nature: as frequencies and percentages for categorical variables, or as means and standard deviations (SD) for continuous ones. Bivariate analyses were conducted, where ANOVA or Chi-square were used to test the associations, depending on the case. The association was considered "statistically significant" when the test yielded a p-value ≤ 0.05 .

Independent variables with significant bivariate associations were entered in a multivariate ordinal regression. The associations were measured using the adjusted odds-ratios (OR_{adj}). It was considered as "significant" when the corresponding 95% confidence interval (CI) did not include the value 1.

Ethical Considerations

Institutional Review Board (IRB) approval from the standing committee at the AUB was obtained prior to conducting the study. Verbal consent was obtained from all participants, following a presentation of the aim of the study. Participation was voluntary and free, and all data obtained were unidentified. In as much as possible, interviews were held in a relatively private and comfortable environment. A pamphlet with adequate information from the PC program at AUB Medical Center was distributed at the end of the interview.

Results

A total of 920 persons were invited to participate, of whom 875 accepted, yielding a refusal rate of 4.9%. Among participants, 163 (18.6%) immediately recognized the term "palliative

care”, and 24 (2.7%) had actually had a previous experience with PC, either personally or with someone very close to them (participants with previous experience with PC were excluded). After providing PC definition, another 155 participants (17.7%) recognized the concept, yielding to a total awareness level of 34.5% (95%CI: 29.2-40). Finally, 65.5% (95% CI: 60-70.8) were totally unaware of the PC concept ($n = 557$).

The notion of palliative care is still a novice in Lebanon, and the term has not been widely integrated into the familiar vocabulary of most Lebanese. Thus, we provided participants with a PC definition. The sole aim was to assess participants’ awareness of PC and later their knowledge of it, rather than comparing between who knows the concept directly or after explanation.

Those who knew or had heard of PC were compared to those who had never heard of it, on sociodemographic characteristics. They did not differ in mean age (about 42 years). However, the percentage of women and the mean number of years of formal education were significantly higher in the former sub-group compared to the latter. Details are presented in Table 1.

The subgroup of those who had “ever heard of PC” ($n = 294$) were further analyzed. It included 28.6% from lower SES versus 49.3% from higher SES. About 30% indicated that they were either not satisfied at all or little satisfied with their income. The summative score of social support suggested a relatively high level of social support (mean = 7.3). For the rest of the analysis, this score was dichotomized at the median value into “lower” and “higher” perceived social support (PSS) (Table 1).

Among those who knew about PC ($N = 294$), 264 (90.0%) either agreed or strongly agreed to enroll a family member in PC in case of terminal illness. Regarding their intentions to seek PC for themselves, 257 (87.4%) either agreed or strongly agreed to do so. There was a significant agreement (67.3%) between the two declared intentions. Only 35 (11.4%) participants were discordant in their intentions in one way or another. Details regarding the intention to enroll a family member/seek PC are presented in Table 2.

The intention to seek PC for oneself was assessed by various psychosocial and socio-economic variables. Significant determinants of intention to use included: positive attitudes towards PC ($p < 0.01$); higher perceived self-control on one’s decisions ($p < 0.01$); lower perception of PC as a complicated process ($p < 0.01$). Older respondents were significantly more likely intend to use PC, compared to younger ones. Marginal significance was also found for perception of access to information and accessibility of services as barriers ($p = 0.05$). The majority of respondents (87.4%) declared respecting the decision of their doctors in making their decision. This variable was not further analyzed for lack of variability. All other variables were not significantly associated with this outcome except for the participant’s age ($p = 0.02$). Details are presented in Table 3.

Significant determinants associated with the intention to enroll a family member in PC included: higher knowledge on PC ($p < 0.01$); positive attitudes towards PC ($p < 0.01$); higher

Table 1. Demographic and Socioeconomic Distribution of Awareness Regarding Palliative Care (PC) in Greater Beirut in 2020 ($N = 851^*$).

Variables	Ever heard of PC**	Never heard of PC
n (%)	294 (34.5)	557 (65.5)
Mean age in years (SD)	41.7 (13.6)	43.18 (14.4)
Gender (n, %)		
Women	186 (63.3)	320 (57.5)
Men	108 (36.7)	237 (42.5)
Mean years of education (SD)	15.7 (3.6)	13.96 (3.7)
The following variables are described for the participants who ever heard of PC		
Socio-economic status		
Higher	145 (49.3)	
Middle	65 (22.1)	
Lower	84(28.6)	
Perceived satisfaction with income (SD)		
Not satisfied at all	21 (7.1)	
Satisfied a little	64 (21.8)	
Satisfied	191 (65.0)	
Very satisfied	18 (6.1)	
Perceived social support mean (SD)		
Receiving visits from friends and relatives	249 (84.7)	
Getting help for house chores	235 (79.9)	
Getting money in emergencies	211 (71.8)	
Receiving telephone calls	255 (86.7)	
Chance to talk to someone about personal problems	228 (77.6)	
Invitations to go out	241 (82.0)	
Receiving useful advice	245 (83.3)	
Getting help in transportation	228 (77.6)	
Getting help when sick	259 (88.1)	
Mean score of social support (min 0- max 9)	7.3 (1.8)	

*The remaining 24 participants had previous experience with PC, as such they were excluded from the analysis.

**Only demographic variables were analyzed for the two groups; the rest of the description involves only those aware of PC.

perceived self-control on one’s decisions ($p < 0.01$); lower perception on access to information on PC as a barrier ($p = 0.03$); lower perception of PC as a complicated process ($p < 0.01$). The majority of respondents (89.7%) declared respecting the opinion of their doctor. This variable was not further analyzed for lack of variability. All other variables were not significantly associated with this outcome except for the participant’s age ($p < 0.01$). Details are presented in Table 3. The multivariate linear regression analysis indicated that the following variables were significant predictors of higher intention to use PC: older age, positive attitude, and higher perceived control over the decision. The significant predictors of “intention to refer others to PC” included: positive attitude, higher perceived control on decision, easier access to information, and perceived PC as non-complicated process. Details are presented in table 4.

Table 2. Correlations Between Both Intentions (N=294).

Outcome	n (%)
Intentions to enroll a family member in PC	
Strongly disagree, disagree or undecided	30 (10.2)
Agree	131 (44.6)
Strongly agree	133 (45.2)
Intention to seek PC for themselves	
Strongly disagree, disagree or undecided	37 (12.6)
Agree	108 (36.7)
Strongly agree	149 (50.7)
Kappa agreement between the two intentions: 67.3%	
($p < 0.01$)	

Discussion

This cross-sectional survey of psychosocial determinants predicting intentions to use PC is one of the few studies ever conducted on this topic in Arab or Islamic countries, which share similar cultural and social structures with Lebanon. A review of the literature shows only one study conducted in Saudi Arabia, which addressed the awareness, knowledge, and beliefs of the Saudi adult population about PC.¹⁴

Our survey conducted in Greater Beirut (GB) in 2020 showed that 2.7% of 875 respondents had actually have a direct experience of PC for themselves or for dear ones. This lower experience may be partially attributed to the limited availability of PC stand-alone services across Lebanon. Among those with no direct experience, about 35% had some partial or complete knowledge of the existence and use of PC, mostly among the more educated participants. However, when the concept is explained, it elicits a large declared adherence. This increase following explanations indicates that the technical term of ‘palliative care’ in Arabic had not penetrated yet the usual vocabulary of most Lebanese, which may create some miscommunication when the issue is discussed with specialists. More importantly, even after explanations, still a majority (65%) had never heard or were totally unaware of PC. This unawareness level is higher than in more westernized populations,²¹ yet lower than in some neighboring countries,¹⁴ which corresponds to the usual sociological transition of Lebanon as a cultural bridge for concepts and practices between East and West. The lack of awareness regarding PC may lead to unnecessary suffering for a person or his/her dependents, when faced with a serious and potentially deadly disease. From the outset, the pedagogical responsibility of healthcare providers appears to be crucial in explaining, orienting and providing PC to patients who are not spontaneously able to require it. Notwithstanding, only 10% indicated not wanting to use palliative care for themselves if needed, and 13% did not desire to recommend it to dear ones who may need it. This higher unwillingness to recommend PC for others could be related to the perception of these respondents to PC referral as a personal decision of the people who require it.

The relatively younger sample (mean age around 42 years), still much in control over their own destiny, indicated a higher perception of control over a situation which may

require PC. The intention to seek PC for oneself may or may not increase as the participants grow older. A study from the USA on a sample of varying ages indicated that the intention of using PC actually increased with older age, when less control is exerted on one’s life or that of others.¹¹ Nevertheless, elderly persons in Western societies have currently had more control over their lives than elderly ones in traditional family-oriented societies such as in Lebanon. It would be interesting to revisit the concept in a few years to explore the evolution on this issue. Conversely, in this study age was not found to be associated with the intention to enroll a family member in PC. This difference could be related to the fact that PC decision in that case is believed to be the patient’s first, albeit with the acceptance of other family members.

A positive attitude strongly predicted the intention to use and to refer to PC services. This finding is consistent with what was found by Park and Lee¹⁵ in a study conducted to investigate the relationship between attitudes and subjective norms to seek hospice care among the Korean public. The study showed that attitudes towards hospice care in the intender group were generally higher than that in the non-intender group.¹⁵ Another study conducted by Mo & Mak¹⁷ showed that holding a positive attitude towards seeking mental health treatment was a strong and significant predictor of intention to seek help for mental health symptoms.¹⁷

The positive attitude towards PC among the participants of this study was based on the belief that PC may prolong life, decrease the sense of loss associated with end-of-life disease, and improve the quality of survival. Participants seemed unsure about the cost, length, complexity, and location of PC services, should they ever need to access them. This uncertainty did not affect their stated intention to seek PC. However, the perception of two specific barriers significantly affected their intention to refer to PC: low information to be shared, and high complexity of the process when others are involved.

Social norms toward PC has been posited as affecting the intention to use it. However, this hypothesis was not supported in this analysis, very likely in view of the lower experience in the Lebanese society regarding this practice. Practically all participants indicated that their doctor’s preference would make a significant difference on their intentions. While opinions of friends and family also mattered, that of religious leaders did not. The opposite had been found in the Korean culture,¹⁵ where religious leaders were considered most influential in health-related decisions. This finding in Lebanon seems to suggest that the more educated and urbanized Lebanese are, the more they tend to deny a role to religious leaders where health decisions are concerned.

Several limitations may have affected this survey. The selection of participants from the urbanized population of Greater Beirut with a relatively higher socio-demographic homogeneity may cause an under-estimation of the national prevalence of unawareness, if this prevalence is generalized to the whole population in Lebanon. The most serious limitation of this study, however, is the fact that it speculates on “hypothetical” situations, which may not always reflect the actual behaviors in the

Table 3. Different Psychosocial Determinants by Choice Intention (N=294).

Variables	Intention to seek PC				Intention to enroll a family member in PC				
	n (%)	Disagree	Agree	Strongly agree	p-value	Disagree	Agree	Strongly agree	p-value
Knowledge (n,%)									
Lower (37.2)	37 (12.6)	108 (36.7)	149 (50.7)		0.15	30 (10.2)	131 (44.6)	133 (45.2)	<0.01
Higher (62.8)	19 (17.4)	39 (35.8)	51 (46.8)			19 (17.4)	48 (44.0)	42 (38.5)	
Attitudes (n,%)									
Negative (39.5)	18 (9.7)	69 (37.3)	98 (53.0)		<0.01	11 (5.9)	83 (44.9)	91 (49.2)	<0.01
Positive (60.5)	25 (21.6)	44 (37.9)	47 (40.5)			18 (15.5)	58 (50.0)	40 (34.5)	
	12 (6.7)	64 (36.0)	102 (57.3)			12 (6.7)	73 (41.0)	93 (52.2)	
Social norms (opinions of significant entities affecting the intention to seek PC)*									
Family members	23 (10.9)	77 (36.5)	111 (52.6)		0.56	18 (8.5)	91 (43.1)	102 (48.3)	0.38
Friends/respected persons	19 (108)	66 (37.5)	91 (51.7)		0.70	15 (8.5)	72 (40.9)	89 (50.6)	0.12
Religious person(s)	14 (13.9)	36 (35.6)	51 (50.5)		0.78	10 (9.9)	38 (37.6)	53 (52.5)	0.36
Doctor(s)	34 (12.1)	100 (35.7)	146 (52.1)		0.07	27 (9.6)	122 (43.6)	131 (46.8)	0.04
n (%)	37 (12.6)	108 (36.7)	149 (50.7)			30 (10.2)	131 (44.6)	133 (45.2)	
Perceived behavioral control									
Perceived control on decision to seek PC	Low (12.6)	15 (40.5)	7 (18.9)		<0.01	12 (32.4)	20 (54.1)	5 (13.5)	<0.01
	High (87.4)	22 (8.6)	93 (36.2)			18 (7.0)	111 (43.2)	128 (49.8)	
Perceived barriers									
Access to information on PC	Easy (64.3)	25 (13.2)	60 (31.7)	104 (55.0)	0.05	14 (7.4)	81 (42.9)	94 (49.7)	0.03
	Not easy (35.7)	12 (1.4)	48 (45.7)	45 (42.9)		16 (15.2)	50 (47.6)	39 (37.1)	
Location of services	Easy (57.1)	24 (14.3)	66 (39.3)	78 (46.4)	0.22	20 (11.9)	80 (47.6)	68 (40.5)	0.14
	Not easy (42.9)	13 (10.3)	42 (33.3)	71 (56.3)		10 (7.9)	51 (40.5)	65 (51.6)	
Perceived cost	Low (69.4)	26 (12.7)	80 (39.2)	98 (48.0)	0.35	23 (11.3)	94 (46.1)	87 (42.6)	0.35
	High (30.6)	11 (12.2)	28 (31.1)	51 (56.7)		7 (7.8)	37 (41.1)	46 (51.1)	
Lengthy process	Acceptable (56.5)	22 (13.3)	62 (37.3)	82 (49.4)	0.86	18 (10.8)	76 (45.8)	72 (43.4)	
	Not acceptable (43.5)	15 (11.7)	46 (35.9)	67 (52.3)		12 (9.4)	55 (43.0)	61 (47.7)	
Complicated process	Low (36.7)	9 (8.3)	31 (28.7)	68 (63.0)	<0.01	9 (8.3)	37 (34.3)	62 (57.4)	<0.01
	Unsure (39.8)	16 (13.7)	55 (47.0)	46 (39.3)		10 (8.5)	64 (54.7)	43 (36.8)	
	High (23.5)	12 (17.4)	22 (31.9)	35 (50.7)		11 (15.9)	30 (43.5)	28 (40.6)	
Socio-demographic variables									
Age (mean in years, SD)	108 (36.7)	34.3 (11.2)	40.9 (13.3)	44.1 (13.6)	<0.01	35.6 (12.7)	41.8 (13.8)	43.02 (13.3)	<0.01
Gender		15 (13.9)	43 (39.8)	50 (46.3)	0.51	15 (13.9)	43 (39.8)	50 (46.3)	0.51
Men (n, %)									
Women (n, %)									
Socio-economic status	186 (63.3)	22 (11.8)	65 (34.9)	99 (53.2)	0.33	22 (11.8)	65 (34.9)	99 (53.2)	0.33
	Higher (49.3)	14 (9.7)	49 (33.8)	82 (56.6)		14 (9.7)	49 (33.8)	82 (56.6)	
	Middle (22.1)	10 (15.4)	26 (40.0)	29 (44.6)		10 (15.4)	26 (40.0)	29 (44.6)	
	Lower (28.6)	13 (15.5)	33 (39.3)	38 (45.2)		13 (15.5)	33 (39.3)	38 (45.2)	
Perceived social support in general	Lower (43.9)	19 (14.7)	46 (35.7)	64 (49.6)	0.60	19 (14.7)	46 (35.7)	64 (49.6)	0.60
	Higher (56.1)	18 (10.9)	62 (37.6)	85 (51.5)		18 (10.9)	62 (37.6)	85 (51.5)	
Perceived financial satisfaction	Lower (28.9)	9 (10.6)	32 (37.6)	44 (51.8)	0.80	9 (10.6)	32 (37.6)	44 (51.8)	0.80
	Higher (71.1)	28 (13.4)	76 (36.4)	105 (50.2)		28 (13.4)	76 (36.4)	105 (50.2)	

*Percent high.

Table 4. Multivariate Regression: Correlates of Intentions Regarding Palliative Care in a Sample of Lebanese Adults in 2020 (N = 294).

Variables OR _{adj} (95% CI)	Intention for oneself	Intention for others
Constant	0.851	1.193
Age	0.007 (0.002–0.013)	NS
Knowledge about PC	NS	NS
General attitude	0.263 (0.107–0.420)	0.214 (0.066–0.362)
Perceived control on decision	0.574 (0.346–0.803)	0.519 (0.302–0.735)
Perceived access to information	NS	–0.169 (–0.315, –0.020)
Perception of process as complicated	NS	–0.095 (–0.18, –0.002)

NS = Not significant.

fullness of the “real” experience. Some predictors that did not emerge in this analysis may become more prominent if the decision is required in real conditions.

Conclusions

While more dedicated and free PC services are needed in Lebanon, parallel promotional activities should be conducted to provide the Lebanese public with accurate, detailed, and direct information about the benefits of PC. The role of physicians in this raising awareness process has been highlighted in our findings, and it is recommended that more doctors add to their PC knowledge, and their willingness to share the information as needed with patients and their families.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interests with respect to the authorship and/or publication of this article.

Ethical Approval

Not applicable, because this article does not contain any studies with human or animal subjects.

Funding

The author(s) received no financial support for the research and/or authorship of this article.

Informed Consent

Not applicable, because this article does not contain any studies with human or animal subjects.

Trial Registration

Not applicable, because this article does not contain any clinical trials.

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