

**PALLIATIVE CARE IN LEBANON : KNOWLEDGE, ATTITUDES AND PRACTICES OF PHYSICIANS AND NURSES**

Huda ABU-SAAD HUIJER<sup>1</sup>, Hani DIMASSI<sup>2</sup>

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**ABSTRACT :** Palliative care (PC) is defined by the World Health Organization as “*an approach that improves the quality of life of patients and their families facing the problems associated with life-threatening illness...*” In Lebanon, PC is new to the health care field and as such very little is known about type of services offered and the preparedness of health care professionals to provide PC.

The purpose of this study is to determine the knowledge, attitudes, and practices of physicians and nurses towards PC in Lebanon, and to assess the need and model for service delivery.

**DESIGN :** A cross-sectional descriptive survey using self-administered questionnaire sent to 15 hospitals in Lebanon was used ; 1873 nurses and 1884 physicians participated in the study.

**RESULTS :** The response rate was 32% ; 51% for nurses and 13% for physicians. Around 93% of nurses and 96% of physicians were able to identify the goals of PC. The majority (94% to 99%) believes terminally ill patients and their families should be informed of the diagnosis and prognosis. Only 19% percent of physicians routinely inform terminally ill patients about their diagnosis. Around 100% of the respondents believe that PC services need to be developed in Lebanon warranting the need for continuing education in this field.

#### 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 problems 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, psychological and spiritual*” [1]. The need for PC is on the increase. Unfortunately, in Lebanon, PC is new to the health care

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School of Nursing, American University of Beirut, Lebanon.

Corresponding author : Huda Abu-Saad Huijer, PhD. School of Nursing, American University of Beirut. POBox 11-0236. Beirut, Lebanon.

Tel. : +961 1 374 374 ext 5952/3 Fax : +961 1 744 476  
e-mail : hh35@aub.edu.lb

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**RÉSUMÉ :** L'Organisation mondiale de la santé définit les soins palliatifs comme « *une approche qui améliore la qualité de vie des patients et des familles devant les problèmes liés aux maladies mortelles...* ». Au Liban, la notion de soins palliatifs est nouvelle dans le domaine des soins : à ce titre, les connaissances en termes de services proposés et de l'éducation des professionnels de santé à procurer des soins palliatifs sont limitées.

Le but de cette étude est de déterminer l'état des connaissances, des attitudes et des pratiques des médecins et des infirmières en matière de soins palliatifs au Liban, d'évaluer les besoins, ainsi que les meilleurs modèles pour rendre de tels services.

**PROCÉDURE :** Etude descriptive échantillonnée basée sur un questionnaire d'auto-évaluation auprès de 15 hôpitaux du Liban : 1873 infirmières et 1884 médecins ont participé à cette étude.

**RÉSULTATS :** Le taux global de réponse est de 32% : 51% des infirmières et 13% des médecins. 93% des infirmières et 96% des médecins ont identifié correctement les principaux objectifs des soins palliatifs. La majorité (94 à 99%) estime que les patients en phase terminale et leurs familles devraient être informés du diagnostic et du pronostic. Seuls 19% des médecins informent de façon systématique les patients en phase terminale de leur diagnostic. Tous les professionnels de santé interrogés jugent que les services de soins palliatifs doivent être développés au Liban, justifiant ainsi la nécessité de continuer les programmes d'éducation et de formation continue.

field. It was first introduced in 1995 at the WHO National Cancer Control Workshop and in 1999 at the Middle East Oncology Congress [2-3]. Despite the interest in this field, very little is known about the knowledge, attitudes, and practices of nurses and physicians of PC.

Several studies have been conducted to evaluate the knowledge and understanding of physicians and nurses of PC. Hanratty et al. [4] reported that physicians consider PC to be a holistic approach where management of the dying takes place. In New Zealand, Walker & MacLeod [5] found that although the majority of general practitioners had a good understanding of PC, they lacked knowledge regarding the reasons to refer patients to PC. This finding is similar to the review on PC by

**TABLE I**  
GENERAL CHARACTERISTICS OF SURVEY RESPONDENTS

	TOTAL SAMPLE N (%)	PROFESSION		<i>p-value</i>
		NURSES N (%)	PHYSICIANS N (%)	
<b>Total</b>	1205 (100.0)	956 (79.9)	240 (20.1)	
<b>Gender</b>				
Men	351 (29.4)	160 (16.8)	191 (79.9)	
Women	843 (70.6)	793 (83.2)	48 (20.1)	<b>.000</b>
<b>Age</b>				
X ± SD	34.0 ± 11.4	30.7 ± 8.4	47.6 ± 11.6	<b>.000</b>
<b>Years of Experience</b>				
X ± SD	10.5 ± 9.3	9.0 ± 7.9	16.9 ± 11.7	<b>.000</b>
<b>Type of Experience</b>				
Oncology	241 (20.2)	205 (21.5)	36 (15.2)	
Medical/Surgical	517 (43.3)	409 (42.9)	106 (44.7)	
CCU/ICU	498 (31.7)	424 (44.4)	69 (29.1)	
ER	232 (19.4)	171 (17.9)	60 (25.3)	<b>.000</b>
<b>Exposure to terminally ill patients</b>	969 (82.7)	758 (81.4)	207 (87.7)	<b>.022</b>
<b>Numbers seen in the past 12 months</b>	5.0	6.0	4.0	<b>.003</b>
<b>Ever heard of PC*</b>	1065 (91.7)	845 (91.7)	215 (91.5)	<b>.898</b>
<b>Education received in PC</b>	184 (15.8)	154 (16.7)	29 (12.3)	<b>.098</b>

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 to 300 terminally ill patients seen in the past 12 months.

\* Palliative care.

Abu-Saad Huijer [6] where information regarding the role of PC specialists was found to be lacking, mainly the nature of the work performed, the competencies needed, and how outcomes are evaluated.

Concerning knowledge of PC, Liu et al. [7] found that 93.4% of the physicians correctly answered questions on principles and philosophy of PC and 57.3% questions on clinical practice in PC. Other studies reported lack of knowledge and skills in PC, as well as in pain and symptom management [8-9]. Hospice training was found to be positively associated with nurses' PC practice. [10-11]. In China, 72% of nurses and physicians evaluated their symptom management skills as effective when dealing with dying patients; however, they were not able to manage patients with shortness of breath, anorexia and depression [12].

Regarding the practice of PC, Wang et al. [12] reported that although 81% of physicians and nurses believe that patients should know about their diagnosis and prognosis, less than 44% apply it in practice. Wotton et al. [13] found the main barrier to providing adequate PC among nurses to be the unwillingness of physicians to discuss with patients end-of-life care. In Lebanon, Yazigi et al. [14] reported that nursing staff was not involved in the decision making process of 26% of terminally ill patients, whereas families were not involved in 21% of the cases.

Several studies stressed the importance of cultural issues when practicing PC. Concepts such as decision making, life support and advance directives, family involvement in the care, suffering and expression of pain, as well as religion and faith differ from one culture to another, and play important roles in how end-of-life care is perceived [15-17]. In Lebanon, an End-of-Life Communication Protocol was developed to guide health care providers when confronted with end-of-life issues specially when dealing with culturally and religiously diverse patients [18].

Many studies reported improvement in the knowledge and attitudes of nurses and physicians towards PC after educational interventions on PC [11, 19-21] and several others stressed the importance of integrating PC in undergraduate curricula [22-23]. In Lebanon, plans are underway to modify the undergraduate medical and nursing curricula to include pain and palliative care in order to prepare future physicians and nurses to deal with end-of-life issues [2].

PC needs a holistic approach which emphasizes comprehensive knowledge and clinical skills as well as changes in attitudes and practices among health care professionals. These are essential for developing PC services in Lebanon. For such reasons, and due to the minimal number of studies in Lebanon on PC, the purpose of this study was to determine the knowledge, attitudes,

and practices of physicians and nurses towards PC in Lebanon, and to assess the need for PC and the best model to provide the services.

The following research questions were addressed in this study :

1. Do physicians and nurses have adequate knowledge and training for the provision of palliative care ?
2. What are the views of physicians and nurses on palliative care ?
3. Do physicians and nurses provide palliative care for terminally ill patients ?
4. What recommendations can be made for service provision ?

## METHODS

### Study design

A cross-sectional descriptive survey using self-administered questionnaire was used. The independent variables were age, gender, professional degree, years of experience, and area of specialty. The dependent variables included knowledge, attitudes and practice.

### Subjects

The target population was nurses and physicians currently working in hospitals in Lebanon. Participants were chosen from 15 hospitals geographically spread in Lebanon. Four of the 15 were major hospitals located in Beirut and serving a large socioeconomically diverse catchment area. The other 11 hospitals were chosen from the North, South, Mount Lebanon, and Bekaa areas, in order to ensure geographic distribution.

A contact person was designated per hospital to coordinate the project and to distribute and collect the questionnaires. This was done in close collaboration with the syndicate of private hospitals in Lebanon.

IRB (Institutional Review Board) approval was sought and granted by all participating hospitals.

### Data collection procedures

The sample size determination was based on a power of 80%, alpha of 5%, and a precision (effect size) of 3%, with a baseline proportion of 0.5 (used when the proportion is not known). The calculated sample size was 1056. For simplicity and to account for non-response rates, all nurses and physicians in the selected hospitals were considered for the study. A total of 3757 (1873 nurses and 1884 physicians) questionnaires were sent to the contact persons in each hospital.

The questionnaires were sent to the contact persons with a cover letter written by the primary investigator describing the goals of the study, name of contact person, and time frame of two weeks for completing and returning the questionnaire. A reminder was sent after two weeks, but due to the low response rate, deadline was extended to one month.

### Questionnaire

The structured questionnaire was designed for this study. It was developed based on a review of the literature and the information gained from a qualitative study conducted by the first author. It was tested for content validity and appropriateness for use in Lebanon by a team of experts, and pilot-tested for feasibility and clarity.

The questionnaire was developed in English and French and has six sections : general information ; perception and knowledge ; attitudes, practice, and needs assessment for palliative care services, all measured using a 5-item Likert scale (ranging from strongly agree to strongly disagree) ; and two open-ended questions on best model for delivering palliative care and general comments.

### Statistical analysis

Statistical analysis was done using SPSS version 14. Perceptions, Attitudes, Practices, Services, and Needs Assessment questions were measured on the categorical scale and tested using Chi-square for differences between nurses and physicians. Comparisons of mean years of age and of experience between nurses and physicians were done using t-test. All analysis was carried at the 0.05 significance level.

## RESULTS

A total of 3757 questionnaires were sent to nurses and physicians ; 1873 nurses and 1884 physicians. The total number of completed and returned questionnaires was 1205 resulting in a 32% response rate ; 51% nurses and 12.7% physicians.

Table I displays the general characteristics of the respondents. Eighty percent of the sample that completed the questionnaire was nurses (RN) and 20% physicians (MD). The gender distribution among nurses and physicians was almost a mirror image ; 80% of the nurses were females and 80% of the physicians were males ( $p = .000$ ). Physicians were older and had more years of experience than nurses ( $p = .000$ ). The majority of the sample had Medical/Surgical experience (44.7% of MDs and 42.9% of RNs). More than 80% of both RNs and MDs have been exposed to terminally ill patients ; RNs reported being exposed to more terminally ill patients in the past 12 months as compared to MDs ( $p = .003$ ).

Table II summarizes responses reflecting the knowledge of Lebanese RNs and MDs on PC. The first set of questions relates to the outcomes of PC. The majority of nurses and physicians were able to identify correctly the main goals of PC. Nurses and physicians responses were significantly different on the "Living in dignity and respect" outcome ; only 1% of MDs did not see PC promoting living in dignity and respect compared to 7% of RNs ( $p = .000$ ). The second set of questions required identifying the components of PC. More RNs than MDs failed to consider medical care ( $p = .006$ ), social care

**TABLE II**  
PHYSICIANS AND NURSES KNOWLEDGE OF PALLIATIVE CARE (N = 1205)

	PROFESSION				p-value
	NURSES (N = 956)		PHYSICIANS (N = 240)		
	Yes N (%)	No N (%)	Yes N (%)	No N (%)	
To your knowledge, what would be the outcome of palliative care ?					
➤ Living with dignity and respect	832 (93.1)	62 (6.90)	229 (99.1)	2 (.9)	.000
To your knowledge palliative care includes					
➤ Medical care	842 (92.0)	73 (8.0)	231 (97.1)	7 (2.9)	.006
➤ Social care	715 (83.3)	138 (16.2)	217 (94.3)	13 (5.7)	.000
➤ Physical care	847 (93.2)	68 (6.8)	233 (99.1)	2 (.9)	.000
According to you, palliative care					
➤ Affirms life and regards dying as a normal process	721 (84.6)	131 (15.4)	214 (95.1)	11 (4.9)	.000
➤ Promotes quality of life of patients	806 (89.0)	100 (11.0)	223 (96.5)	8 (3.5)	.000
➤ Destroys hope and leads to despair and depression	91 (10.7)	756 (89.3)	11 (4.9)	214 (95.1)	.007

(p = .000) and physical care (p = .000) as components of PC. Additionally, when considering the assumptions underlying PC, RNs were three times more likely than MDs to say that palliative care does not affirm life and regards death as a normal process (p = .000), that it doesn't promote quality of life of the terminally ill patient (p = .000), and two times more likely to say that palliative care destroys hope and leads to despair and depression (p = .007).

Attitudes of RNs and MDs towards PC are summarized in table III. Nurses were twice as likely as physicians to disagree to give the right of "Do not resuscitate"

to terminally ill patients (17.8% vs. 8.6% ; p = .001) whereas MDs were twice as likely as RNs to disagree with giving hope to terminally ill patients against all odds (7.5% vs. 3.6% ; p = .011). Though most of RNs and MDs agreed that having the same religious background as the patients enhances the caring process, the percent among RNs (67.3%) was significantly higher than among MDs (59.6% ; p = .036). The preferred place of death was reported by both RNs and MDs to be the home of the patient (91.7% and 91.0%). It is interesting to note that 40% of RNs and MDs did not consider the hospital as a right place to die and 66.9% of RNS and

**TABLE III**  
PHYSICIANS AND NURSES ATTITUDES TOWARDS PALLIATIVE CARE (N = 1205)

	PROFESSION				p-value
	NURSES (N = 956)		PHYSICIANS (N = 240)		
	Agree N (%)	Disagree N (%)	Agree N (%)	Disagree N (%)	
The patient should be informed about					
➤ his/her Diagnosis	834 (94.5)	49 (5.5)	214 (94.7)	12 (5.3)	.888
➤ his/her Prognosis	668 (83.9)	128 (16.1)	157 (83.1)	32 (16.9)	.776
Terminally ill patients have the right to choose "Do not resuscitate (DNR)"	665 (82.2)	144 (17.8)	192 (91.4)	18 (8.6)	.001
Terminally ill patients should be encouraged to have hope against all odds	854 (96.4)	32 (3.6)	210 (92.5)	17 (7.5)	.011
Having same religious belief with patients enhances the caring process	564 (67.3)	274 (32.7)	124 (59.6)	84 (40.4)	.036
It is preferable for the terminally ill patient to die					
➤ At the hospital	380 (60.0)	253 (40.0)	86 (59.7)	58 (40.3)	.945
➤ At home	715 (91.7)	65 (8.3)	171 (91.0)	17 (9.0)	.754
➤ At a hospice	348 (33.1)	172 (66.9)	49 (39.8)	74 (60.2)	.156

60.2% of MDs did not consider hospice as a good place to die.

Table IV shows 19% of MDs routinely tell terminally ill patients about their diagnosis, 33.3% routinely don't, and 37.7% said it would depend on families' wishes.

Current practice of RNs and MDs is displayed in table V. 97% of RNs and MDs reported that the medical condition of the terminally ill patients guides their practice. MDs were more likely than RNs to disregard the spiritual-religious background of the patient (18.9% vs. 11.9% ;  $p = .018$ ). About 12% of MDs do not provide their terminally ill patients with alternative choice of treatment compared to 24.1% of the RNs ( $p = .001$ ). MDs were more likely than RNs to involve the patient ( $p = .000$ ) and the family ( $p = .005$ ) in the decision-making process. RNs were three times more likely than MDs to perceive the patients' outburst as a personal attack (16.9% vs. 5.9% ;  $p = .001$ ) and 17.9% of the RNs considered it unacceptable compared to 6.3% of MDs ( $p = .000$ ). MDs were more likely than RNs to consider the family's outburst as unacceptable given the condition (15.5% vs. 9.8% ;  $p = .039$ ). A considerable proportion of RNs (36.2%) and MDs (23.1%) perceived the patients questions as a threat ( $p = .003$ ). Even a higher proportion of RNs (62.3%) and MDs (50.7%) perceived questions and concerns as attention seeking behavior ( $p = .013$ ). Furthermore, 18% of RNs and 6.7% of MDs said that they perceived these questions as a sign of doubting their professionalism ( $p = .001$ ).

As for service delivery, almost 100% of the respondents reported that PC services need to be developed in Lebanon. The most frequently proposed models were specialized PC units in hospitals, hospices, and home care. RNs and MDs were in agreement that continuing education programs in PC are needed in Lebanon (99%), and 82.3% of MDs compared to 93.2% of RNs ( $p = .000$ ) expressed interest in attending such programs.

## DISCUSSION

Only 16.7% of nurses and 12.3% of physicians received education in PC. This number is very low compared to results from other studies. In Wales, 89.3% of general practitioners were found to have training in pain control, 67.7% in bereavement, and 70.2% in communication [24]. However, in the recent survey among physi-

cians in the US, only 36% reported receiving training in PC [16]. Similar results were found among nurses as reported in two different studies namely 30% [11] and 48.3% [10].

Despite the lack of formal education in PC, nurses and physicians scored well on most questions dealing with knowledge of PC and especially as they relate to goals, components, and assumptions of care. This is similar to what was reported in studies done in UK, New Zealand, and Taiwan where doctors were found to have a general good understanding of PC [4-5, 7]. However, significant differences between nurses and physicians were found in perception of the contribution of different disciplines to PC. This finding might be due to the deficiency in formal education and well structured programs in PC, leading to confusion regarding who to involve in end-of-life care.

Regarding the attitudes of nurses and physicians towards PC, our results on informing patients about diagnosis were similar to the study conducted in China [12]. In both studies, the majority of nurses and physicians reported that the patients should be informed of their diagnosis. However, in our study, only 7.6% of nurses and 19.1% of physicians reported informing their patients of their diagnosis. This low rate found among nurses (7.6%) may reflect the fact that it is the physicians' responsibility to disclose information on diagnosis and prognosis to the patient and family. In general the attitudes of nurses and physicians favored 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. However, 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.

Noteworthy in this study is the fact that a significant percentage of nurses (17.8%) and physicians (8.6%) think that patients do not have the right to choose "do not resuscitate". This finding is in line with the work of Yazigi et al. [14]. It is most likely secondary to lack of legal guidelines in Lebanon regarding end-of-life decisions and the fact that the majority of Lebanese are very religious and as such value the sanctity of life.

**TABLE IV**  
CURRENT PRACTICE OF PHYSICIANS AND NURSES IN PALLIATIVE CARE (N =1205)

	PROFESSION		<i>p-value</i>
	NURSES (N = 956)	PHYSICIANS (N = 240)	
Do you tell your terminally ill patients about their diagnosis ?			
➤ Yes	54 (7.6)	35 (19.1)	
➤ No	261 (36.6)	61 (33.3)	
➤ Depending of family's wishes	267 (37.4)	69 (37.7)	
➤ Inapplicable	132 (18.5)	18 (9.8)	<b>.000</b>

**TABLE V**  
CURRENT PRACTICE OF PHYSICIANS AND NURSES IN PALLIATIVE CARE (N = 1205)

	PROFESSION				<i>p-value</i>
	NURSES (N = 956) Agree N (%)	Disagree N (%)	PHYSICIANS (N = 240) Agree N (%)	Disagree N (%)	
Your current practice with terminally ill is guided by					
➤ Medical condition	714 (97.3)	20 (2.7)	183 (97.3)	5 (2.7)	.961
Information communicated to the family of the terminally ill patients depends on					
➤ Family's ability to assimilate	715 (95.6)	33 (4.4)	162 (93.6)	11 (6.4)	.279
➤ Their involvement in decision making	629 (93.0)	47 (7.0)	144 (88.3)	19 (11.7)	<b>.045</b>
➤ Your willingness to disclose information	475 (76.7)	144 (23.38)	136 (80.5)	33 (19.5)	.302
Factors that you take into consideration when dealing with a terminally ill patient are					
➤ Spiritual-religious background	613 (88.1)	83 (11.9)	133 (81.1)	31 (18.9)	<b>.018</b>
➤ Medical situation	703 (96.0)	29 (4.0)	179 (98.4)	3 (1.6)	.129
In your current practice					
➤ You provide terminally ill patient with alternative choices of treatment	407 (75.9)	129 (24.1)	136 (88.3)	18 (11.7)	<b>.001</b>
In your current practice you involve the following in the decision-making process					
➤ Patient	537 (84.2)	101 (15.8)	164 (94.8)	9 (5.2)	<b>.000</b>
➤ Family	619 (92.3)	52 (7.7)	177 (97.8)	4 (2.2)	<b>.008</b>
You perceive terminally ill patient outburst as					
➤ An attack against you	110 (16.9)	541 (83.1)	9 (5.9)	144 (94.1)	<b>.001</b>
➤ Unacceptable	113 (17.9)	519 (82.1)	10.0 (6.3)	148 (93.7)	<b>.000</b>
You perceive the family's outburst as					
➤ Acceptable given the patient's condition	578 (90.2)	63 (9.8)	136 (84.5)	25 (15.5)	<b>.039</b>
You perceive the terminally ill patients' questions and concerns as (a)					
➤ Right	745 (99.2)	6 (.8)	188 (100.0)	0 (.0)	.219
➤ Threat	220 (36.2)	388 (63.8)	36 (23.4)	118 (76.6)	<b>.003</b>
➤ Doubting your professionalism	113 (18.0)	516 (82.0)	10 (6.7)	139 (93.3)	<b>.001</b>
➤ Attention seeking behavior	367 (62.3)	222 (37.7)	69 (50.7)	67 (49.3)	<b>.013</b>

Our results showed that 11.3% of physicians didn't involve nurses in the decision-making process compared to 26% reported by Yazigi et al. [14]. This improvement may be due to better understanding of palliative care principles and the need to involve other health professionals in the decision-making process. In addition, developments in the nursing profession in Lebanon are empowering and enabling nurses to be actively involved in the decision-making process. Our study showed that the majority of nurses and physicians took into consideration the cultural, socio-economic, and spiritual-religious background of the patient. This is in contrast to results reported in the US where physicians considered themselves weak in addressing these aspects in PC [16]. This could be due again to the Lebanese mentality which gives high importance to culture, tradition, and religion. Furthermore, many

nurses (67.3%) and physicians (59.6%) considered having the same religious beliefs as the patient's to enhance the caring process. This finding alludes to the importance of understanding others' religious beliefs when discussing life and death issues.

Some nurses found the outbursts of patients (17.9%) and families (27.1%) to be unacceptable. This finding has not been reported in other studies. It is conceivable that these results could be attributed to lack of knowledge and to the nurses' inability perhaps to deal with emotional outbursts in difficult situations. Similarly, physicians' (27.1%) and nurses' (38.0%) perceiving families' questions and concerns as a personal threat could be explained in the same fashion.

The results of the needs assessment for PC services and continuing education and training in PC are consistent

with the results of other studies [19-23]. Both nurses and physicians indicated willingness to participate in continuing education programs with nurses scoring significantly more. This is consistent with the results of other studies in this field [19, 23, 25].

## CONCLUSION

The low response rate among physicians is a limitation of this study.

The results of this study emphasize the need for developing PC services in Lebanon. The provision of quality PC services requires however the education and training of health professionals in this field. PC needs to become an integral part of all nursing and medical school curricula as well as continuing nursing and medical education program offerings. The development of this new field in Lebanon requires the commitment of governments and policy makers at all levels and as such the allocation of budget and other resources to make it happen. Other challenges facing this field include establishing practice guidelines and policies on end-of-life care such as advanced directives, breaking bad news, and withholding and withdrawing life-sustaining treatments. Further studies are needed in this area to clearly understand the problems encountered in the practice setting and to guide the adoption of a PC delivery model that is culturally sensitive and meets the needs of the Lebanese population.

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### العناية الملطفة في لبنان. معرفة وتصرف وعمل الاطباء والمرضات

موجز : حددت منظمة الصحة العالمية العناية الملطفة كخطوة لتحسين حياة المرضى وعائلاتهم تجاه حالات متعلقة بالامراض المميتة، في لبنان العناية الملطفة جديدة في ميدان العناية والمعلومات عن الخدمات المقترحة وثقافة الاختصاصيين في الصحة لديهم معلومات محدودة. هدف هذه المقالة هو تحديد المعلومات والتصرفات العملية للاطباء والمرضات في ما يتعلق بالعناية الملطفة في لبنان ولتقدير الاحتياجات وافضل الطرق للقيام بهذه المهمة. الخطة دراسة وصفية نموذجية مستندة الى استبيان تقدير ذاتي من 15 مستشفى في لبنان، 1873 ممرضة و1884 طبيباً ساهموا في الدراسة.

النتائج النتيجة الاجمالية للاجوبة 32% : 51% من المرضات و13% من الاطباء. 23% من المرضات و96% من الاطباء حددوا بصورة جيدة حقيقية المواضيع المهمة للعناية الملطفة. اغلبهم ( 94 و 99% ) يعتقدون بان المرضى في اواخر مرضهم وعائلاتهم يجب ان يعرفوا الحقيقة عن التشخيص والانداز. 19% فقط من الاطباء يعلمون بشكل واضح المرض في مرحلتهم النهائية عن التشخيص. كل العاملين في مجال الصحة الذين روجعوا بالامر كانوا موافقين على اقتراح فريق العناية الملطفة. هذا الامر يجب ان يتطور وينمو في لبنان، وهذا ضروري لمتابعة برنامج التثقيف والدراسة المتتابة.