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Research Article

Patient Refusal of Care: Ethical Dilemmas, Nursing Practices, and Nurses Positioning in Lebanese Hospitals

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Abstract

Background: Patient refusal of care is a common ethical and clinical challenge that requires nurses to balance respect for patient autonomy with their professional responsibility to provide safe and effective care. Information regarding this matter in Lebanon is still occasional. This research examined the experiences of nurses regarding patient refusals of care in hospitals in Lebanon.

Methods: A descriptive and analytical cross-sectional study was performed involving 180 registered nurses employed in hospitals across Lebanon. Data were gathered through a structured online survey that evaluated experiences with patient refusal, perceived motivations, management approaches, ethical issues, and training requirements. Descriptive statistics and Chi-square/Fisher's exact tests were conducted, with statistical significance established at $p < 0.05$.

Results: Overall, 87.8% of nurses reported encountering patient refusal of care. Fear and anxiety (53.3%), pain (38.9%), and fatigue (36.1%) were the most commonly perceived reasons for refusal. Communication strategies, particularly providing explanations (71.1%) and active listening (62.4%), were frequently used to manage these situations. However, 63.9% of participants had received no formal training, and only 18.3% felt competent in managing patient refusal. Significant associations were observed between nurses' characteristics and refusal management practices.

Conclusions: patient refusal of care is a challenge encountered by nurses in hospitals, in Lebanon. Strengthening ethics education communication skills and institutional support can help nurses feel more confident when managing these situations while also promoting patient- centered care.

Keywords: patient refusal of care, nursing ethics, patient autonomy, communication, moral pain, Lebanon

Introduction

Participation of patients in healthcare decisions has become as a key principle of modern clinical practice, reflecting a transition toward patient-centered care and collaborative decision-making. Respect for patient autonomy acknowledges the individual's ability to make informed choices about diagnostic procedures, treatments, and other healthcare interventions, including the right to refuse suggested care. Although this principle is recognized both ethically and legally, a patient refusal of care poses considerable difficulties for healthcare providers, especially nurses, tasked with protection patient safety, enhancing well-being, and providing high-quality care.

Patients may decline care, which can include refusing medications, diagnostic tests, nursing procedures, rehabilitation activities, or other treatment options. Rejection can be conveyed through spoken words or through non-verbal actions like retreating, resisting, or not adhering to treatment plans. Existing research shows that the rejection of care is affected by various factors, such as fear, anxiety, pain, fatigue, cultural beliefs, past negative experiences with healthcare, insufficient comprehension of treatment, and distrust in healthcare providers (Backhouse et al., 2022; Featherstone et al., 2019). These elements frequently occur together, making the rejection of care a complicated clinical and ethical issue that requires individualized evaluation and effective communication

Nurses often face ethical dilemmas when patients refuse care, as their responsibility to protect patients and avoid harm can clash with the obligation to respect patient's independent decisions. Balancing the principles of autonomy, beneficence, non-maleficence, and respect for human dignity can be especially difficult when declining treatment could lead to significant clinical outcomes. These circumstances can create emotional strain, hesitation, and moral distress among nurses, particularly when they believe that respecting a patient's choice might compromise health results (Haahr et al., 2020; Aljabery et al., 2024; Arash et al., 2024).

Therapeutic communication is generally recognized as one of the most effective methods for handling patient refusals of treatment. Active listening, empathy, clear explanations, and shared decision-making can help healthcare professionals identify patient's uncertainties, clarify misunderstandings, and strengthen trust within the nurse- patient relationship. Rather than trying to influence patients through authority, communication strategies that acknowledge patient's values and preferences are more likely to facilitate informed decision- making and improve patient satisfaction (McCabe, 2004; Lown et al., 2009).

In the Lebanese healthcare system, nurses operate in a setting marked by financial limitations, staff shortages, institutional demands, and increasing demands for healthcare services. These contextual challenges might exacerbate ethical decision-making and restrict opportunities for organized education and institutional support concerning the management of patient refusal of care (Bou Sanayeh & El Chamieh, 2023). Although the practical importance of this issue, evidence detailing nurses experiences, communication methods, ethical dilemmas, and educational requirements concerning patient refusal of care in Lebanon.

Closing this knowledge gap is crucial for enhancing nursing education, reinforcing institutional policies, and encouraging ethical clinical practice. Comprehending how nurses react to patients declining care could assist healthcare organizations in creating evidence- based approaches that promote both patient independence and quality nursing care.

Therefore, this study aimed to investigate nurse's experiences with patient refusal of care in Lebanese hospitals by inspecting the frequency and forms of refusal met in clinical practice, the perceived reasons for refusal, communication and management strategies adopted by nurses, the ethical challenges they experience, and their observed training and institutional support needs.

Materials and Methods Study Design

A descriptive and analytical cross-sectional study was conducted to observe nurse's experiences regarding patient care refusal in hospitals in Lebanon. The research examined the prevalence and types of patient refusal, perceived reasons for decline, nursing management approaches, ethical challenges, and identified training requirements.

Study Setting and Participants

The research focused on registered nurses employed in various hospitals and clinical departments throughout different Lebanese governorates. Eligible participants were nurses actively involved in direct patient care and willing to participate voluntarily in the study. Nurses who were not involved in clinical practice at the time of data collection were excluded.

Sampling and Data Collection

A non-probability snowball sampling technique was used to recruit participants. Data were collected between August 12, 2025, and October 7, 2025, using a structured online questionnaire distributed electronically through professional networks and social media platforms. Participation was voluntary, anonymous, and based on informed consent obtained before questionnaire completion.

The final sample consisted of 180 registered nurses. Study Instrument

Data were collected using a structured questionnaire designed to assess:

- Sociodemographic and professional characteristics.
- Frequency and forms of patient refusal of care.
- Perceived reasons for patient refusal.
- Nursing responses and communication strategies.
- Ethical challenges encountered during refusal situations.
- Perceived training needs and institutional support.

Statistical Analysis

Data were analyzed using the Statistical Package for the Social Sciences (SPSS). Descriptive statistics, such as frequencies and percentages, were used to summarize the characteristics of participants and the study variables. Associations between categorical variables were examined using Pearson's Chi-square test or Fisher's exact test when appropriate. Statistical significance was established at a p-value of less than 0.05.

Ethical Considerations

Participation in the study was voluntary and anonymous. All participants provided informed consent electronically before completing the questionnaire and were informed of their right to withdraw at any time without consequences.

Results

Participant Characteristics

A total of 180 registered nurses participated in the study. The sociodemographic characteristics of the participants are presented in Table 1.

The study population was predominantly female (71.7%, n = 129), whereas male nurses represented 28.3% (n = 51). Participants represented different age categories, with the largest proportion being younger than 25 years (38.3%, n = 69). Nurses aged 25–34 years accounted for 22.8% (n = 41), while those aged 45 years and above represented 22.2% (n = 40). Participants aged 35–44 years constituted the smallest age group (16.7%, n = 30).

Regarding professional experience, approximately one-third of the participants (31.7%, n = 57) reported more than ten years of nursing experience. Nurses with less than one year of experience represented 27.2% (n = 49), followed by those with one to five years of experience (26.1%, n = 47) and six to ten years of experience (15.0%, n = 27).

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Geographically, the majority of participants were employed in hospitals located in Mount Lebanon (45.0%) and Beirut (26.7%), while the remaining participants were distributed across the other Lebanese governorates.

Table 1: Sociodemographic characteristics of the participants

Variable	Characteristics	Frequency	Percentage
Age	25–34 yrs.	41	22.8
	35–44 yrs.	30	16.7
	45 yrs. and above	40	22.2
	Less than 25 yrs.	69	38.3
Gender	female	129	71.7
	Male	51	28.3
Years of experience	1–5 yrs.	47	26.1
	6–10 yrs.	27	15.0
	Less than 1 yr.	49	27.2
	Above 10 yrs.	57	31.7

Frequency and Forms of Patient Refusal of Care

Patient refusal of care was commonly encountered among participating nurses. Overall, 87.8% of respondents indicated that they had experienced at least one situation involving patient refusal during their clinical practice, suggesting that refusal of care represents a frequent component of nursing care in Lebanese hospitals.

Among the different forms of refusal, verbal refusal was the most frequently reported (60.0%), followed by partial refusal (41.1%). Nurses noted that refusal was commonly associated to technical nursing procedures (30.6%), and medication administration (26.1%), suggesting that refusal often occurs during standard clinical tasks requiring patient cooperation.

These results show that patient refusal extends beyond complete rejection of treatment and foften encompasses selective refusal of certain nursing interventions.

Perceived Reasons for Patient Refusal of Care

Participants identified several factors contributing to patient refusal of care.

The most commonly reported reason was fear and anxiety (53.3%), followed by pain (38.9%) and fatigue (36.1%). These findings indicate that emotional and physical discomfort were perceived as the primary contributors to refusal of healthcare interventions.

Over 50% of the nurses (50.6%) indicated that patients did not provide any explanation for declining care. This finding indicates that healthcare professionals often need to handle refusals without fully understanding patient's reasons or worries.

Other noted reasons were seen less frequently, further highlighting the complex nature of patient refusal.

Nursing Responses and Communication Strategies

Participants reported using a variety of approaches when managing patient refusal of care.

Communication strategies represented the most frequently adopted interventions. Specifically, 71.1% of nurses reported providing additional explanations regarding the proposed intervention, while 62.4% reported using active listening to better understand patients' concerns and encourage dialogue.

Respecting patient autonomy was highlighted as a key management approach, with 35.6% of participants indicating that they respected the patient's choice after confirming sufficient information was given.

In general, the results indicate that nurses focused mainly on communication methods instead of coercive strategies when addressing patient refusal.

Training and Perceived Competence

Despite the high occurrence of patient refusal observed in clinical settings, there seemed to be a lack of formal education on how to handle refusal of care.

Almost (63.9%) of participants indicated that they had never received formal education or professional training related to patient refusal of care.

Aligned with this finding, only 18.3% viewed themselves as proficient in handling refusal situations, indicating a significant educational deficiency among working nurses.

These results emphasize a gap between how often nurses face patient refusals and their sense of readiness to handle these situations successfully.

Inferential Analysis

Inferential statistical analyses were conducted to examine associations between nurses' demographic and professional characteristics and selected aspects of patient refusal of care. The results are summarized in Table 2.

A statistically significant association was identified between age and the frequency of encountering patient refusal ($p = 0.002$), suggesting that experiences with refusal varied across age groups.

Formal training was significantly associated with nurses' perceptions of the impact of patient refusal on the nurse–patient relationship ($p < 0.001$), indicating that education may influence how nurses perceive and respond to these situations.

Significant associations were also observed between clinical service and the management strategies adopted by nurses ($p < 0.05$). Furthermore, the geographical region in which nurses practiced was significantly associated with the reported forms of patient refusal ($p < 0.05$).

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The statistically significant associations identified in this study suggest that demographic, educational, and workplace characteristics may influence nurses' experiences and responses to patient refusal of care.

Table 2. Inferential analysis (SPSS output summary)

Association	Test result	Significance
Age vs frequency of refusal	Chi-square test	$p = 0.002$
Training vs perceived impact	Chi-square test	$p < 0.001$
Service vs strategy use	Chi-square test	$p < 0.05$
Region vs form of refusal	Fisher/Chi-square	$p < 0.05$

Discussion Discussion

This research investigated nurse's experiences with patient refusal of care in Lebanese hospitals, focusing on the occurrence of refusal, perceived motivations, communication and management techniques, ethical challenges, and training requirements. The results indicate that patient refusal of treatment frequently happens in clinical settings, as almost ninety percent of nurses have reported facing these situations. This underscores that denial of care is not an isolated incident but a regular component of nursing practice that requires both clinical skill and ethical judgment.

The important prevalence of patient refusal observed in this study aligns with previous literature underlining refusal of care as a common issue in various healthcare environments. Refusal may involve medications, diagnostic tests, nursing interventions, or rehabilitation activities and is frequently influenced by various physical, psychological, and social influences (Backhouse et al., 2022; Featherstone et al., 2019). The frequency reported in this study indicates that Lebanese nurses regularly face situations necessitating them to balance respect for patient autonomy with their professional responsibility to improve health and prevent injury.

Fear and anxiety were recognized as the most common reasons for patient's refusal, with pain and fatigue following closely. These results align with previous research indicating that emotional distress, uncertainty about treatment, and discomfort significantly contribute to the rejection of healthcare interventions. Patients facing fear or anxiety might worry about pain, potential complications, loss of autonomy, or past negative healthcare experiences, all of which could affect their readiness to accept suggested care. Correspondingly, pain and physical fatigue can reduce patient's capacity to actively participate in treatment decisions, raising the chances of declining interventions. Unexpectedly, over half of the nurses indicated that patients failed to give a reason for their refusal. This result accentuates the complexity of care refusal and highlights the significance of clear communication to better understand patient's worries and anticipations.

Communication was the primary strategy used by nurses to manage patient refusal. Most participants reported providing supplementary explanations and practicing active listening before accepting patient's decisions. These findings reinforce previous evidence signifying that therapeutic communication is vital for creating trust, correcting misunderstandings, and promoting collaborative decision-making (McCabe, 2004; Lown et al., 2009). Instead of trying to influence patients through authority, communication approaches that promote conversation and acknowledge patient's values are more effective to facilitate informed decision-making and maintaining the therapeutic relationship. These strategies are especially crucial in cases where patients maintain their ability to make decisions but choose to refuse recommended care.

An important finding of this study is the limited preparation of nurses to manage patient refusal of care. Nearly two- thirds of participants reported having received no formal education or training on this topic, and fewer than one in five considered themselves competent in managing refusal situations. These results are concerning given how often nurses face refusal in their everyday practice. Similar observations have been pronounced in previous studies, indicating that insufficient education and restricted institutional support contributed to ethical uncertainty, reduced confidence, and improved moral distress in nurses (Haahr et al., 2020; Aljabery et al., 2024). Improving undergraduate nursing curricula and ongoing professional development programs could boost nurse's confidence and capability to manage ethically challenging situations while respecting patient autonomy.

The inferential analyses also showed that demographic and professional traits of nurses were linked to specific elements of refusal management. Notable relationships between ages, training, clinical service, and management strategies indicate that education and experience might influence how nurses view and react to patient refusals. Nurses trained in ethical decision-making and communication are likely to be more skilled at identifying patient's issues, apply patient- centered communication techniques, and handling ethical challenges with increased assurance. These results highlight the necessity of focusing on organized educational programs that address both ethical thinking and practical communication abilities.

The context of the healthcare system in Lebanon must also be taken into account when analyzing these results. Healthcare organizations still experience employee's shortages, financial limitations, and rising pressures on healthcare professionals, all of which can affect nurse's capacity to dedicate adequate time to communication and collaborative decision- making. These organizational challenges could add to the emotional strain faced by nurses when dealing with patients who refuse care. Creating institutional policies, standardized protocols, and multidisciplinary support systems might aid in minimizing uncertainty and offer healthcare workers practical guidance for managing refusal cases while protecting patient's rights.

This research contributes to the limited body of evidence on patient refusal of care in Lebanon by providing insight into nurse's experiences and identifying their educational needs. The findings

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emphasize that managing patient refusal involves more than respecting patient autonomy, it also requires effective communication, ethical competencies, and institutional support. Focusing on these aspects could enhance patient- centered care, improve the quality of nurse- patient interactions, and reduce the ethical challenges associated with care refusal in clinical settings.

Limitations

This study has limitations. Employing snowball sampling might limit generalizability. Data were self-reported by individuals themselves and could be affected by recall bias or subjective interpretation. It is suggested that future multicenter research utilize probability sampling and qualitative methods.

Clinical Implications

Hospitals need to establish organized protocols for handling care refusal. Nursing curricula and continuing education programs should include ethical decision- making, communication skills, and techniques to manage moral distress.

Conclusions Conclusion

Patient refusal of care poses a common and complex ethical dilemma within nursing practice. This study emphasizes that nurses in Lebanese hospitals frequently face situations where patients decline proposed treatment, requiring a balance between respect for patient autonomy and their professional responsibility to ensure patient safety and well- being.

Despite often- using communication- focused strategies such as offering explanations and engaging in active listening, many nurses reported insufficient preparation and limited formal training in managing refusal situations. These results highlight the necessity to enhance nursing education and continuing professional development programs by integrating ethical decision-making, therapeutic communication, and strategies for addressing moral distress.

Healthcare organizations should also think about creating explicit guidelines and support systems to support nurses in navigating patient refusal of care. A well organized patient-centered strategy that integrates respect for autonomy, effective communication, and professional responsibility can enhance the quality of nurse-patient interactions and improve the management of ethically challenging situations.

Further research using multicenter designs and qualitative approaches is recommended to gain deeper insight into patient's perspectives, nurse's lived experiences, and organizational factors influencing refusal of care in the Lebanese healthcare context.

Figures and Tables

Table 1: Sociodemographic characteristics of the participants
Table 2. Inferential analysis (SPSS output summary).

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Conflicts of Interest

The author declares no conflict of interest.

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