Published in final edited form as:

J Transcult Nurs. 2013 October ; 24(4): . doi:10.1177/1043659613493439.

Palliative Care Nursing Interventions in Thailand

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Abstract

Purpose—This study aimed to describe the nursing interventions that nurses in Thailand identify as most important in promoting dignified dying.

Design—This study used a cross-sectional descriptive design.

Method—A total of 247 Thai nurses completed a paper-and-pencil survey written in Thai. The survey included both demographic questions and palliative care interventions, listed with summative rating scales, from the International Classification for Nursing Practice (ICNP) catalogue *Palliative Care for Dignified Dying*. Descriptive statistics were used to analyze the data.

Findings—The five most important nursing interventions to promote dignified dying, ranked by average importance rating, were (a) maintain dignity and privacy, (b) establish trust, (c) manage pain, (d) establish rapport, and (e) manage dyspnea.

Conclusions—This research identified the palliative care nursing interventions considered most important by nurses in Thailand to promote dignified dying.

Implications for Practice—The ICNP catalogue *Palliative Care for Dignified Dying* can be used for planning and managing palliative nursing care in Thailand.

Keywords

dignified dying; end-of-life care; international classification for nursing practice oncology/hematology; survey design; Thai nurses

Introduction

Dying persons and their families deserve competent and compassionate care at end-of-life (International Council of Nurses [ICN], 2010). Preserving patient dignity is an essential aspect of palliative care. The desire to be treated with dignity at end-of-life is a fairly universal preference found in most cultures (McDonald, 2004). Promoting dignified dying is part of nursing practice in different countries and cultures (Gelfand, Raspa, Briller, & Schim, 2005; Jo & Doorenbos, 2009).

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Declaration of Conflicting Interests

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

The International Classification for Nursing Practice (ICNP) is a unified nursing language system for standardizing documentation in the health care record (Coenen & Bartz, 2006; Coenen & Kim 2010). The ICNP facilitates the comparison and integration of nursing phenomena, interventions, and outcomes at an international level. It does this in part by developing catalogues, or clinically relevant subsets of terminology, for nurses to integrate the ICNP into their specialty area. The ICNP catalogue *Palliative Care for Dignified Dying* guides nurses who provide palliative care to promote dignified dying, and it supports the systematic documentation of palliative care (Doorenbos et al., 2009).

Palliative Care for Dignified Dying: The ICNP Catalogue

The ICNP has classified dignified dying as a phenomenon of nursing interest: an aspect of health care that is relevant to nursing practice (ICN, 2010). Previous studies have described a range of issues associated with the phenomenon of dignified dying in a variety of countries, including nurses' perceptions of the characteristics of dignified dying and nursing terminology used to describe the phenomenon (Doorenbos, Wilson, & Coenen, 2006; Doorenbos, Wilson, Coenen, & Borse, 2006; Vosit-Steller, White, Barron, Gerzevitz, & Morse, 2010; Wilson, Coenen, & Doorenbos, 2006).

The ICNP's understanding of the dignified dying phenomenon has been guided by the Dignity-Conserving Care Model (Chochinov, 2002; Chochinov, Hack, McClement, Kristjanson, & Harlos, 2002; McClement, Chochinov, Hack, Kristjanson, & Harlos, 2004). This model assists health care providers in considering dignity from the patient's perspective. It specifies three major categories related to dignity at the end-of-life: (a) illness-related concerns, (b) dignity-conserving repertoire, and (c) social dignity inventory. Illness-related concerns are those factors caused by or associated with the underlying illness, such as pain and dyspnea, requiring the need for symptomatic relief in order to preserve dignity. Dignity-conserving repertoire comprises the psychological and spiritual considerations—such as hopefulness and a sense of meaning—for maintaining a sense of dignity during the illness experience. Social dignity inventory includes socially or externally mediated factors—such as privacy and family support—that foster a sense of dignity. The model helps identify appropriate nursing diagnoses, interventions, and outcomes that will support dignified dying in palliative care.

Prior to the development of the ICNP catalogue *Palliative Care for Dignified Dying* (Doorenbos et al., 2009), nursing interventions used to promote dignified dying in Ethiopia, India, Kenya, and the United States were identified using the Dignity-Conserving Care Model (Coenen, Doorenbos, & Wilson, 2007). These findings increased the understanding of dignified dying from an international perspective and were important in developing the catalogue (Doorenbos et al., 2011). Further understanding of the palliative care interventions used to promote dignified dying throughout the world is needed for improving the terminology included in the catalogue. The following literature review provides the history and current practice of palliative care in Thailand.

Palliative Care in Thailand

Thailand has a population of 67 million (U.S. Department of State, Bureau of East Asian and Pacific Affairs, 2010). In Thailand, the leading cause of death is cancer. As a result of the number of cancer-related deaths in Thailand, palliative care has become an important aspect of health care and is now recognized as a quality indicator by the Thailand National Hospital Accreditation Authority (Nilmanat et al., 2010; Nilmanat & Phunggrassami, 2006). Since cancer patients have been the recipients of the majority of palliative care in Thailand, it would be important to explore if there are differences in the palliative care interventions rated as important by nurses in cancer center versus noncancer center settings.

In Thailand, palliative care is provided at government facilities (tertiary hospitals and cancer centers), private hospitals, and faith-based institutions. Although most patients die at home, palliative care and hospice services in the home are limited (Nilmanat et al., 2010). Challenges related to palliative care in Thailand include lack of research, lack of community- and home-based palliative care, lack of volunteer training, and inadequate training for health care personnel on caring for dying patients (P. Juntasopeepun, personal communication, 2010).

There is very limited published information on palliative care nursing interventions used to promote dignified dying in Thailand. Suffering has been reported as a dominant theme found in interviews with 15 patients with terminal advanced cancer in Thailand. Subthemes included physical symptom distress, feeling of alienation, sense of worthlessness, sense of burden to others, and desire for hastened death (Nilmanat et al., 2010). The need for palliative care nursing interventions to relieve suffering was highlighted in this article and specifically noted the need to manage and control symptom distress and provide psychosocial and spiritual interventions.

Palliative Care and Religion in Thailand

Nilmanat and Street (2007) found acknowledgment of spiritual, religious, and cultural values to be central to palliative care nursing practice in Thailand. A study that surveyed 538 Thai nurses found spiritual care to be their greatest concern. These nurses, who were providing end-of-life care at six general hospitals, perceived the three most important problems in end-of-life care to be (a) inability to meet patients' spiritual needs, (b) patients' loneliness, and (c) control of pain (Manosilapakorn, 2003).

In Thailand, 94.6% of the population is Buddhist, 4.6% is Muslim, and 0.7% is Christian (Burnard & Naiyapatana, 2004). Thoughts about death in Thai society are based on Buddhist doctrine (Nilmanat & Street, 2007). Nurses have been found to play an important role in promoting life satisfaction and dignified dying among Thai Buddhists by providing physical, psychosocial, and also spiritual comfort (Kongsuwan & Touhy, 2009; Othaganont, Sinthuvorakan, & Jensupakarn, 2002). An example of how Thai nurses supported Buddhist religious beliefs was found in a study conducted in a Thai intensive care unit. When Buddhists perform good acts and thoughts, their minds are at peace and they feel they will go to a good place (Kongsuwan & Locsin, 2009). Research in a Thai intensive care unit showed that nurses supported this religious belief by repeating patients' good merits into their ears even when the patients were unconscious. Nurses in this study also promoted dignified dying by providing opportunities for patients and families to discuss and manage family affairs. Nurses encouraged patients' family members to say good-bye, to show gratitude for the patient's life, and to show their love to the dying patients (Kongsuwan & Locsin, 2009). This last finding from this study suggests that supporting family involvement is also an important role for nurses in promoting dignified dying.

It has been reported that family plays a vital role in care (Kongsuwan & Touhy, 2009; Subgranon & Lund, 2000). Patients usually want a family member or loved one to help them with physical comfort, physical care, and activities of daily living. Thai nurses in hospitals typically allow a patient's family members or loved ones to stay with and care for the patient. This allows the family to provide care both for physical comfort and for psychosocial and spiritual comfort (Kongsuwan & Touhy, 2009). In summary, from the reported studies, important palliative care nursing interventions in Thailand include supporting the family and supporting spiritual and religious beliefs, as well as providing symptom management.

The purpose of this study was to identify the palliative care nursing interventions that nurses in Thailand rate as most important using descriptive statistics. Additionally, to explore if there were significant differences in ratings of palliative care nursing interventions between nurses in cancer center settings compared with nurses in noncancer center settings using *t* tests.

Method

This study used a cross-sectional mixed methods design with a paper-and-pencil survey as the data collection method. The survey included open-ended questions so nurses could provide additional data regarding palliative care nursing interventions used in Thailand. Human subjects approval was obtained from university institutional review boards and recommendations for conducting transcultural research in Thailand were followed (Jenkins, 2011). Permission for data collection was requested and received from private hospital, university-based hospital, or cancer center directors before eligible nurses at that organization were recruited.

Sample and Setting

A convenience sample of Thai registered nurses at health care settings in Thailand was recruited. Nurses were asked to participate in this study if they met the eligibility criteria of (a) being a practicing nurse in a hospital or clinical setting in Thailand, (b) being experienced in caring for dying patients, and (c) being able to read and write Thai. Based on sample size calculation, it was recommended that we have 200 nurses respond to the survey. The final sample included 247 nurses from 10 health care sites, including private hospitals, university hospitals, and cancer hospitals in four different regions of Thailand (North, Northeast, Central, and South).

Procedure

Recruitment was through face-to-face contact and through announcements during in-service meetings at the participating health care settings in Thailand by the research nurse. Interested nurses who met the eligibility criteria were provided with a copy of the survey and asked to complete the survey and return it directly to the research nurse. An information sheet attached to the front of the survey clearly outlined the purpose of the study and stated that participation was voluntary, anonymous, and could be discontinued at any time. Completion and return of the survey indicated informed consent.

Survey

The ICNP catalogue, *Palliative Care for Dignified Dying*, is a palliative care terminology subset of the ICNP. The development of the palliative care intervention terminology subset included having palliative care clinical experts participate in developing content sets based on evidence and clinical expertise. Then the terms and concepts were mapped to the ICNP terminology. The intervention terminology was then reviewed by palliative care nurses with more than 20 years of experience providing palliative nursing care. These expert reviewers participated in a modified Delphi process for reviewing original and refined subsets of the ICNP terminology, which provided content and face validity (Coenen & Kim, 2010). For the purposes of this study, we took the international nursing intervention classification listing of the 105 palliative care interventions to create the survey. Nurses were asked to rate each intervention on a 4-point summative rating scale (4 = *very important* and 1 = *not at all important*). An open-ended question asked participants to name any other palliative care interventions used to promote dignified dying. The survey also included seven demographic items, including educational level and number of years in nursing practice.

The survey was originally developed in English. The survey was translated into Thai using the back-translation technique (Brislin, 1970, 1980). First, the forward translation from English to Thai was performed by a bilingual Thai translator. Subsequently, and without access to the original version, another independent translator fluent in both Thai and English back-translated the survey into English. The back-translated version was compared with the original English version to see if any item or term discrepancy had occurred. The back-translated text was found to be almost identical to the original version. Two reviewers proficient in both English and Thai compared the English and Thai versions and made slight modifications in the Thai version to obtain a suitable translation of the survey. The cultural appropriateness of the translated scale was evaluated by the translators. These translators reported that the translated version was culturally appropriate.

After translation, a pilot study was conducted with 30 nurses in Thailand. This pilot study was conducted to determine whether the survey was understandable, acceptable, and culturally appropriate, and to test the feasibility of recruitment and survey administration. Nurses in this pilot study took approximately 30 to 45 minutes to complete the survey, and items were reported as easy to understand and culturally appropriate.

Data Analysis

Descriptive statistics including frequencies, percentages, means, and standard deviations were obtained for the 247 participants' responses. An average importance rating was calculated for each of the 105 intervention items on a summative rating scale using the following numeric codes: 1 = *not at all important*, 2 = *slightly important*, 3 = *moderately important*, and 4 = *very important*. The interventions were then ranked by average importance rating. In addition to the overall ranking, separate intervention rankings were obtained from the subset of surveys returned from the two cancer center hospitals ($n = 45$) and compared with surveys from the noncancer hospitals using t tests. All calculations were performed using SAS 9.1 (SAS Institute, Cary, NC).

A content analysis method guided by the Dignity-Conserving Care Model was used to analyze responses to the open-ended question (Hsieh & Shannon, 2005; Sandelowski, 2000). The responses to the open-ended question about nursing interventions used to promote dignified dying were written in Thai by the respondents and then translated into English by a translator, who was fluent in both Thai and English. Once the responses were translated, they were entered into Atlas.ti (Berlin, Germany), a qualitative data management program for analysis. The coding involved two investigators reading the responses and coding each response into the categories of the Dignity-Conserving Care Model: illness-related concerns, dignity-conserving repertoire, and social dignity inventory. To establish inter-rater reliability, any differences in coding between the two investigators were brought to the research team for discussion at a research team meeting.

Results

A total of 247 surveys were returned for an overall response rate of 78%. Between 15 and 37 completed surveys were obtained from each of the 10 sites: in the Northern region, three sites with 65 nurses; in the Northeastern region, two sites with 65 nurses; in the Central region, two sites with 52 nurses; and in the Southern region, three sites with 65 nurses. Two of the 10 sites were cancer center hospitals. Participant response rates were high for each item, with only 0 to 2 missing responses per item across the sample. All the participants worked full time. Most participants worked with dying patients frequently: 91.8% of participants reported frequency as *very often* or *often*. The demographic characteristics of the sample are presented in Table 1.

The 10 top-ranked interventions, based on the overall sample, and the Dignity-Conserving Model themes they represent are displayed in Table 2. The five most important nursing interventions to promote dignified dying, listed according to how they ranked by average importance rating in this study, were (a) “maintain dignity and privacy,” (b) “establish trust,” (c) “manage pain,” (d) “establish rapport,” and (e) “manage dyspnea.”

Using *t* tests, there were no significant differences between the subset of nurses from the two cancer center sites' (*n* = 45) top-10 rankings (Table 3) compared with the sample of nurses who worked in noncancer center settings (Table 4); however, nurses in the cancer centers identified “teach about managing pain,” “administer pain medication,” and “support caregivers” in their top-10 rankings. The nurses who worked in noncancer center settings had in their top-10 ranking three items that were not identified by the cancer center nurses: “encourage rest,” “respect belief system,” and “facilitate family meetings.” There were also no significant differences among the four regions in Thailand.

The interventions ranked the lowest by the total sample were “refer to physical therapy,” “implement humor,” “collaborate with social work,” and “manage exercise regime” (average importance ratings = 2.79–2.86). The “support use of traditional therapies” intervention also ranked low (94 out of 105; average importance rating = 3.09); however, the subset of cancer center nurses ranked it even lower (100 out of 105; average importance rating = 2.86).

Forty-six participants responded to the open-ended question about other interventions used to promote dignified dying. These responses addressed all three categories of the Dignity-Conserving Care Model: illness-related concerns (*n* = 10), dignity-conserving repertoire (*n* = 18), and social dignity inventory (*n* = 7).

Discussion

The current study specifically focuses on the nursing interventions used by nurses in Thailand to promote dignified dying. The majority of the nurses had a bachelor's degree in nursing, which is the typical educational level of nurses in Thailand (P. Juntasopeepun, personal communication, 2012).

The five palliative care interventions ranked highest by participants addressed two of the three Dignity-Conserving Care Model categories: illness-related concerns and social dignity inventory. “Manage pain” and “establish rapport” are both interventions that address illness-related concerns. “Maintain dignity and privacy” and “establish trust” are interventions that address the social dignity inventory. Surprisingly, interventions to support the dignity-conserving repertoire were not highly ranked. Only one dignity-conserving repertoire intervention, “respect belief system,” was ranked in the top 10, and then only by the nurses in noncancer center settings.

These five palliative care interventions also support the Buddhist belief that one should help and respect others and try to make them feel comfortable (Burnard & Naiyapatana, 2004). In addition, establishing rapport and trust is paramount to delivering quality palliative care, since the nurse must understand a patient's needs and desires in order to effectively care for the patient at end of life. The responses to the open-ended question about other interventions used to promote dignified dying added many more specific Buddhist-related interventions, such as “read Dharma book,” “make offering of items or food to Buddhist monk,” and “keep Buddha image at the bedside.”

As cancer is the most common cause of death in Thailand, we thought it important to compare the differences between the subsample of nurses from the two cancer hospitals and

the subsample of nurses who worked in other, noncancer-related settings. The list of the 10 most important interventions among nurses who worked in noncancer center settings (Table 4) was not significantly different to the top-10 list identified by those employed at the two cancer centers (Table 3). The additional interventions listed by the cancer nurses—teaching pain management, administering pain medication, and supporting caregivers—are interventions commonly used with cancer patients during both active treatment and palliative care at end of life and illustrate the slightly greater emphasis by cancer nurses on interventions focused on illness-related concerns. However, “administer pain medication” and “teach about managing pain” were not among the 10 top-ranked interventions among nurses who did not work at cancer settings. This may be an area for further exploration. Pain is a common symptom for patients at end of life, even for those dying with noncancer diagnoses.

The intervention “respect belief system” was ranked among the top 10 by nurses who worked in the noncancer center settings. That supporting spiritual beliefs or religious practices or other dignity-conserving repertoire interventions were not found to be more important among the total sample or the subsample of cancer nurses contrasts with Manosilapakorn’s (2003) research, which identified spiritual care as the most important concern in improving end-of-life nursing care in Thailand. Lundberg and Kerdonfag (2010) found spiritual care to be an important focus of holistic care provided by Thai nurses in an intensive care unit. This difference in findings may be due to how spiritual care was defined. In Lundberg and Kerdonfag’s (2010) study, spiritual care was defined as supporting spiritual beliefs and rituals, giving mental support, showing respect, and communicating with patients and families. The ICNP interventions defined as spiritual care were “encourage patient to express spiritual concerns,” “provide privacy for spiritual behavior,” “provide spiritual support,” “refer to spiritual care,” and “support spiritual rituals.” A possible explanation for the divergent results is that the Lundberg and Kerdonfag (2010) study included respect and communication as spiritual care, where the ICNP interventions more narrowly defined spiritual care as spiritual behavior, care, and rituals. Both respect and communication were highly ranked by nurses participating in the current study. Although participants did not rank spiritual-care interventions as the most important nursing interventions, a high number of the responses to the open-ended question regarding specific interventions used to promote dignified dying did address spiritual care.

Limitations

This study did not assess if nurses had further education about death and dying care beyond what is provided in basic education. As additional education about death and dying care may be a factor that influences the ranked importance of palliative care interventions, future studies should consider collecting information regarding additional specialized education. A further limitation of this study was that although we obtained data from all four regions of Thailand, this study used self-selected nurses as participants rather than using a random sample of nurses or institutions. Thus, the study results are unable to be generalized.

This study established the relevance and usefulness of the ICNP catalogue *Palliative Care for Dignified Dying* by documenting that interventions listed in the ICNP catalogue are rated as important palliative care interventions in Thailand. This result demonstrates the importance of providing a unified nursing language at an international level (Coenen & Bartz, 2006). Increased understanding of interventions specific to the Thai culture is enhanced by the sample representing nurses from the four regions of Thailand.

Conclusions and Implications for Practice

The Dignity-Conserving Care Model is a helpful guide to organizing palliative care interventions. However, the interventions are not necessarily exclusive to one theme or sub-theme of the model. Likewise, interventions could be in different themes of the model depending on the framework or cultural context of the patient, or nurse. Further research is needed to test the theory with larger samples. Also, future research should explore dignified dying from the perspectives of family member and patients to validate this theory.

Using a nursing language common to countries throughout the world positively affects patient care since nurses will understand what nursing interventions are being used to promote dignified dying. To implement the ICNP as an international nursing language system, it is necessary to understand the palliative care interventions that nurses in Thailand consider to be important to promote dignified dying. This study showed that many of the top-rated palliative care interventions are focused on pain and symptom management. Thus, palliative care nursing education that emphasizes preparation and training in pain and symptom management needs to be developed in Thailand. Religion and culture also played a role while providing palliative care. Therefore, nurses and other health care providers should integrate religious and cultural knowledge into their clinical practice for promoting dignified dying.

The ICNP can be used worldwide for planning and managing palliative nursing care to promote dignified dying. Further testing of the ICNP catalogue *Palliative Care for Dignified Dying* will increase its applicability to the nursing profession in other countries.

Acknowledgments

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: Research reported in this publication was supported by *the University of Washington Royalty Research Fund and the National Institute of Nursing Research* of the National Institutes of Health under award numbers R21NR010725 and R21NR010896. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.

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Table 1

Demographic Characteristics of Nurse Participants.

Characteristic	Nurses in cancer centers; n = 45		Nurses in noncancer center settings; n = 202		Nurses; total N = 247	
	n	%	n	%	n	%
Work experience (in years)						
1–10	17	36.4	98	48	115	47.1
11–20	24	54.6	78	39	102	41.8
21+	3	6.8	24	12	27	11.1
Missing data	2	2.2	2	1	3	
Nursing education						
Diploma	3	6.7	8	4	11	4.5
Bachelor's degree	41	91.1	175	86.6	216	87.4
Master's degree	1	2.2	19	9.4	20	8.1
Age (in years)						
20–30	7	15.6	62	35.7	69	28.3
31–40	29	64.4	94	44.2	123	50.4
41–50	8	17.8	38	15.6	46	18.8
51–60	1	2.2	5	3	6	2.5
Missing data	0	0	3	1.5	3	
Caring for dying patients						
Very often	13	28.9	76	37.6	89	36.3
Often	21	46.7	115	56.9	136	55.5
Sometimes	11	24.4	9	4.5	20	8.3
Never	0	0	0	0	0	0
Missing data	2		1		3	

Table 2

Top 10 Interventions Ranked by Average Importance (Total Sample).

Rank	Intervention	N	Minimum	Maximum	M	SD	Dignity-Conserving Model theme
1	Maintain dignity and privacy	247	3	4	3.95	0.21	Social dignity inventory
2	Establish trust	246	3	4	3.94	0.22	Social dignity inventory
3	Manage pain	247	2	4	3.93	0.26	Illness-related concerns
4	Establish rapport	246	3	4	3.92	0.26	Illness-related concerns
5	Manage dyspnea	247	2	4	3.90	0.30	Illness-related concerns
6	Protect confidentiality	247	2	4	3.90	0.32	Social dignity inventory
7	Implement pain guidelines	247	3	4	3.89	0.30	Illness-related concerns
8	Protect patient rights	247	2	4	3.89	0.33	Social dignity inventory
9	Collaborate with physician	247	2	4	3.89	0.32	Illness-related concerns
10	Encourage rest	246	3	4	3.89	0.31	Illness-related concerns

Table 3

Top 10 Interventions Ranked by Average Importance Rating (Nurses in Cancer Center Settings).

Rank	Intervention	N	Minimum	Maximum	M	SD	Dignity-Conserving Model theme
1	Maintain dignity and privacy	45	3	4	3.95	0.20	Social dignity inventory
2	Implement pain guidelines	45	3	4	3.93	0.25	Illness-related concerns
3	Teach about managing pain	44	3	4	3.93	0.25	Illness-related concerns
4	Administer pain medication	45	3	4	3.91	0.28	Illness-related concerns
5	Establish trust	45	3	4	3.91	0.28	Social dignity inventory
6	Manage pain	45	2	4	3.91	0.35	Illness-related concerns
7	Establish rapport	45	3	4	3.88	0.31	Illness-related concerns
8	Manage dyspnea	45	3	4	3.88	0.31	Illness-related concerns
9	Support caregivers	45	3	4	3.88	0.31	Social dignity inventory
10	Collaborate with physician	45	3	4	3.84	0.36	Illness-related concerns

Top 10 Interventions Ranked by Average Importance Rating (Nurses in Noncancer Center Settings).

Table 4

Rank	Intervention	N	Minimum	Maximum	M	SD	Dignity-Conserving Model theme
1	Establish trust	201	3	4	3.96	0.20	Social dignity inventory
2	Maintain dignity and privacy	202	3	4	3.95	0.21	Social dignity inventory
3	Establish rapport	201	3	4	3.94	0.24	Illness-related concerns
4	Manage pain	202	3	4	3.94	0.24	Illness-related concerns
5	Encourage rest	201	3	4	3.93	0.25	Illness-related concerns
6	Manage dyspnea	202	2	4	3.91	0.30	Illness-related concerns
7	Collaborate with physician	202	2	4	3.90	0.31	Illness-related concerns
8	Respect belief system	202	3	4	3.89	0.31	Dignity-conserving repertoire
9	Implement pain guidelines	202	3	4	3.89	0.31	Illness-related concerns
10	Facilitate family meetings	202	3	4	3.89	0.31	Social dignity inventory