THAI NURSES’ LIVED EXPERIENCE OF CARING FOR PERSONS WHO HAD A
PEACEFUL DEATH IN INTENSIVE CARE UNITS

by

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This dissertation was prepared under the direction of the candidate’s dissertation advisor, Dr. Kathryn B. Keller, and has been approved by the members of her supervisory committee. It was submitted to the faculty of the Christine E. Lynn College of Nursing and was accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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ABSTRACT

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The objective of this study was to describe the lived experience of caring for persons who had a peaceful death in the intensive care units in Thailand. A qualitative research design informed by hermeneutic phenomenology was used to analyze data. Participants were 10 intensive care nurses working at adult intensive care units in south Thailand. A snowball purposive sampling method was used to select the participants. Participant inclusion criteria were at least six months’ critical care nursing experience, experience in caring for a person who had peaceful death, able to describe peaceful death, and willing to participate in this study. Participants who met the inclusion criteria were interviewed. Face-to-face individual verbal interviews were conducted in the Thai language. These interviews were audiotape recorded. Descriptions were transcribed and translated for data analysis. Van Manen’s (1990) hermeneutic phenomenological
approach was used to analyze and interpret the data. The findings of this study were presented in each of 4 categories of the lived world of temporality, of spatiality, of corporeality, and of relationality. The description of the lived experience of caring for persons who had a peaceful death in ICU was, “understanding the other through the valuing of experience and enhancing relations with others by recognizing time is short and is a priority.”

This study may contribute to nursing knowledge of the end-of-life care to enhance a peaceful death in intensive care units congruently with Thai culture and society. In addition, this study directs the translations of its knowledge into implications that will benefit in helping Thai nursing to move forward. The implications of this study in advance will benefit terminally ill persons and family members regarding receiving good quality end-of-life care.
To my uncle “Nub” and all persons who died in the Intensive Care Units.

“We cared for you with our wholeness.”
THAI NURSES’ LIVED EXPERIENCE OF CARING FOR PERSONS WHO HAD A PEACEFUL DEATH IN INTENSIVE CARE UNITS

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CHAPTER 1

INTRODUCTION

Promotion of a peaceful death is a goal of care for persons at the end of life. Thai intensive care nurses provide care for dying persons and assist them towards peaceful death. However, in helping dying persons to approach a peaceful death in an intensive care unit (ICU), intensive care nurses deal with many difficulties such as communicating bad news, counseling the persons’ families, and facilitating a peaceful death when time is limited. It is not often that a person dies peacefully in the ICU (Beckstrand, Callister, & Kirchhoff, 2006). Nevertheless, some ICU nurses have had the experience of caring for dying persons and believed that the persons for whom they cared had a peaceful death (Kongsuwan & Locsin, 2009). Yet, the phenomenon of caring for persons who had a peaceful death in ICU in Thailand is not understood fully. This study will describe the lived experience of caring for persons who had a peaceful death in the ICUs in Thailand.

Background

End-of-life Care in Thailand

The population of Thailand is approximately 63.5 million people. Life expectancy has risen to 67.9 years in men and 75.0 years among women. Most leading causes of death are cancer, accidents, heart diseases, and AIDS (Phungrassami, 2005). The demand for care at the end of life is increasing due to the growing number of terminally ill persons seeking optimal care. Also, people are becoming increasingly aware of quality of
care at the end of life. Recently, the provision of palliative and end-of-life care has been introduced as a quality indicator by the Thailand National Hospital Accreditation authority (Nilmanat & Phungrassami, 2006). “The right to refuse treatment” also was announced in the National Health Act in 2007 (National Health Act, 2007).

Thailand does not have hospice units in every hospital for dying patients. A few university hospitals have opened palliative-hospice care units with 5-10 beds. Government-run hospice care for dying patients does not exist. Several temples in Thailand provide convenient places for dying patients, particularly those patients with AIDS. Few hospitals provide home palliative care services, and bereavement services are not formally provided for families (Nilmanat & Phungrassami, 2006; Phungrassami, 2005). The Thai family has an important role in decision making and caring for terminally ill persons. Most terminally ill Thai people die at their home or at hospitals in ward units and intensive care units.

*Dying in the ICUs*

The intensive care unit in Thailand is a place where nurses provide end-of-life care (Chealeawsak, 2001; Manosilapakorn, 2003). Often, the terminally ill dying persons are in the ICU for a certain period of time receiving terminal nursing care while waiting to be discharged to their homes and to their relatives, or to the general ward units, or to die in the ICU. The latest death rate in an ICU reported in Thailand was 14% of the patients admitted to the ICU (Personal Communication, May 29, 2008). This death rate is nearly the death rate reported in the United States, Canada, and Sweden, which is 10-20% (Beckstrand et al., 2006; Cook, Rocker, & Heyland, 2004).
Patients who are critically ill and dying in ICUs usually receive life-saving technological and medical treatments in an attempt to prevent premature death. These patients may receive ventilator support, cardiac massage, and/or life-sustaining medications and therapies. They usually remain comatose and unable to communicate their needs and wishes. Dying in the ICU is recognized as a lonely and an unnatural occurrence in an unfamiliar setting with unusual technology, especially without the family members being allowed to be at the patient’s bedside (Halcomb, Daly, Jackson, & Davidson, 2004; Kirchhoff et al., 2000).

A Peaceful Death

The review of literature revealed that the terms “peaceful death” and “good death” are often used synonymously, that is as terms to describe the same experience (Lackie, 2003; Van der Greest, 2004; Vig & Pearlman, 2004; Winland-Brown, 2001). However, the literature (Hattori, McCubbin, & Ishida, 2006; Van der Greest; Vig & Pearlman) supports that there is no universal definition of “peaceful death”; it is an individual experience and perception based on socio-cultural factors. In Thailand, Buddhism is the main religion. More than 90% of Thai people are Buddhists (Lundberg & Trichorb, 2001; Manosilapakorn, 2003). Islam is the second most practiced religion for Thai people. Approximately 4% of Thai people are Muslims and most of Thai Muslims live in the south of Thailand (Thailand Health Profile, 2001-2004). Having a peaceful death is a common wish among Thai people (Manosilapakorn; Visalo, 2004). Approaching a peaceful death is related to religious practice (Manosilapakorn; Matetanonto, 2005; Visalo). This provided an understanding that a study related to a peaceful death should be framed in each society, and a peaceful death is an individual’s perception.
**A Peaceful Death in ICU: Experience of Caring**

The review of literature about a peaceful death or a good death in ICUs found few studies that dealt with the nurses’ experience of caring for these patients (Beckstrand et al., 2006; Kirchhoff et al., 2000; Lackie, 2003). These studies were conducted in the United States and in Canada and provided some relevant information. Most ICU nurses in the United States recognize a good death was not routinely encountered in most ICUs. Many deaths in ICUs were not considered a “good death” because of inherent problems within a culture of care that usually strives to prolong life and prevent death, inadequate communication between physicians and families, treatment decisions based on physicians’ needs, and the constraints on nursing time (Beckstrand et al.; Kirchhoff et al.).

ICU nurses are usually involved in situations that involve aggressive curative treatments and withhold/withdrawn treatments. The transition point between cure and comfort care is still unclear and an uncertainty for ICU nurses, depending on the consensus between patients, families, and staff, which has many factors involved in the decision-making process and requires time (Badger, 2005; Kirchhoff et al., 2000). Caring for critically ill dying patients can cause tension, conflict, moral distress, grief, and suffering for critical care nurses that affect job satisfaction and lead nurses to feel burned out (Elpern, Covert, & Kleinpell, 2005; Halcomb et al., 2004).

ICU nurses were in the difficult situation of caring for dying patients, in terms of providing quality end-of-life care and enhancing a good death. Nevertheless, Canadian critical care nurses shared their experiences in providing care for a good death stating that open and honest communication with patient, family, and physician was significant.
Several studies (Beckstrand et al., 2006; Kirchhoff et al., 2000) explored the experiences of ICU nurses in the United States about a good death in ICU. These nurses understood that in order to have a good death in the ICU, physicians, families, and nurses must accept the inevitability of death, have a decision to cease treatment, focus on comfort care, and promote death with dignity. In addition, the nurses suggested that following patients’ wishes for end-of-life care, being with the dying patients, and communicating effectively contributed to having a good death in the ICU.

On reviewing the literature, no published nursing study exists relating to a peaceful death in Thai ICU or the lived experience of nurses caring for persons who had a peaceful death in an ICU. Several studies focused on nurses’ experience of care at the end of life in the hospital setting (Chealeawsak, 2001; Labhanpakul, 2000; Manosilapakorn, 2003). Other studies found from the review of the literature about end of life were among the terminally ill patients, terminally ill patients’ families, and caregivers. Many of these studies dealt with decision making and ethics at the end of life and did not specifically deal with the ICU setting (Neuonoi, 2005; Njiniikaree, 2003; Sarunayiam, 1998; Sittisombut, Love, & Sithi-amorn, 2005). Yet, the experience of Thai ICU nurses caring for persons who had a peaceful death remains unexamined.

A Preliminary Study

Kongsuwan and Locsin (2009) conducted a preliminary study in 2007 to determine the descriptions of a peaceful death among Thai nurses in ICUs in a hospital in the south of Thailand. Three ICU nurses voluntarily participated in this study. After receiving Institutional Review Board approval and obtaining informed consent, data were collected. The interview transcripts were coded and analyzed.
In this study, the participants admitted that it was difficult to have a peaceful death in ICU, as nurses in the United States have disclosed (Beckstrand et al., 2006). However, all participants believed that they had the experience of caring for persons who had a peaceful death. Three thematic statements emerged to illustrate promoting a peaceful death in ICUs. These include starting care through raising awareness of dying, creating a caring environment in which to allow patients to die without aggressive treatment; and promoting end-of-life care in line with patients’ beliefs. This study also revealed that the participants having to deal with the difficulty of promoting a peaceful death in ICUs alone. Interdisciplinary teamwork did not function well as when participants had to deal with physicians who lacked palliative care concepts. This preliminary study provided some insight about the descriptions of the ways that Thai nurses in the ICU promoted a peaceful death.

The Need for Further Study

The review of existing literature and the preliminary study related to promotion of a peaceful death in ICU showed the researcher what should be studied at this current time. Knowledge about a peaceful death in ICU in Thailand is scarce. This area of nursing has not been fully explored. The phenomenon of caring for persons who had a peaceful death should be understood as fundamental nursing knowledge. Although a peaceful death in ICU is difficult to ensure, there are some Thai nurses who have experienced caring for persons who had a peaceful death in ICU. Hence, the descriptions of the lived experience of these nurses are a valuable source of knowledge. Exploration of the lived worlds of Thai intensive care nurses who cared for persons who had a
peaceful death is needed to illuminate the structure of the experience and to understand the experience clearly.

Purpose of Research

The purpose of this study was to describe the lived experience of caring for persons who had a peaceful death in the ICUs in Thailand.

Significance

The findings of the study will be significant in their ability to enhance the understanding of the experience of nurses caring for patients who had a peaceful death in the ICU. Understanding this experience will facilitate the development of nursing care processes and interventions, which will be crucial and influential in attaining quality human care. Particularly important is the understanding of the experience as this relates to Thai nurses who will care for patients who terminally ill for the purpose of facilitating a peaceful death. This knowledge will allow the nurses to imagine, create, and implement nursing care responses that will lead to greater understanding of a Thai nurse’s experience of caring for a person during end-of-life towards a peaceful death, taking into consideration the culture and societal norms.

The insights and experiences offered by the participants could prove valuable in the development of healthcare policies, standards of care, and services in the practice of nursing during end-of-life care in the ICU in Thailand. Greater understanding of the meaning of the experience and its context will provide fundamental contributions to the body of knowledge of nursing, particularly in end-of-life care, which are necessary for the development of appropriate undergraduate and graduate nursing curricula, as well as the information for continuing the education of practicing nurses. Furthermore, the
understanding of this experience will provide directions for future research in end-of-life care to improve the quality of care and promote a peaceful death. Finally, the findings of this study will most benefit the people and the society of Thailand, in an effort to meet their wishes to die peacefully even though they are dying in the ICU, instead of with their loved ones in their respective homes.

To the participants, this study may make them feel that they have accomplished something in their lives - in sharing their experiences with others through a research process. In sharing their experiences, the participants can understand more of themselves when in situations of caring for a person who had a peaceful death in the ICU.

Research Question

The research question guiding the study was: What is the lived experience of caring for persons who had a peaceful death in the ICU?

Definition of Terms

*Intensive care nurse* refers to a Thai registered nurse who practices on a unit that is designated as intensive care either as a cardiac, medical, surgical, neurological, or trauma unit.

*Intensive care unit* refers to a designated unit in the hospitals in Thailand with a population of adult persons who require life sustaining therapies due to cardiac, medical, surgical, neurological, or trauma processes.

*Lived experience* refers to a human experience of being a nurse who cared for a person who had a peaceful death in the ICU as lived and perceived by the intensive care nurse.
“Peaceful death” is synonymous with the term “good death.” Peaceful death is an individual experience and a perception of the nurse caring for the dying person. A person who had a peaceful death refers to an adult person who has died while the nurse was in attendance and responsible for the care of that person at that time.

Chapter Summary

Thai people have a common wish for a peaceful death. In Thailand, many deaths occur in ICU. However, the knowledge of nursing care at the end of life about a peaceful death is not so prevalent. Understanding Thai nurses’ lived experience in the situation of caring for persons who had a peaceful death in ICU is necessary in providing quality end-of-life care and promotion a peaceful death in ICU. This study will explore the descriptions of the lived experience of nurses caring for persons who had a peaceful death in ICU in Thailand. The descriptions of the experience in this study will contribute to nursing knowledge at the end of life to enhance a peaceful death congruent with Thai culture and will provide implications for nursing practice, policy, education, and research.
CHAPTER 2

REVIEW OF THE LITERATURE

This study aimed to describe the nurses’ lived experience of caring for persons who had a peaceful death in ICU in Thailand. This section focused on reviewing the literature to provide a general understanding of the phenomenon nurses’ caring for persons who had a peaceful death. Specifically, this study aimed at describing the experience of ICU nurses who cared for persons who had a peaceful death in Thailand.

There are three sections that make up Chapter 2. The first section provides a review of studies describing the term “peaceful death” assisting the researcher to understand the concept of peaceful death within the phenomenon of nurses caring for persons who had a peaceful death. The second section provides the review of existing research and related literature that alluded to experiences of persons who cared for persons who may have had a peaceful death. The third section provides the horizon of meaning from the researcher’s personal experience related to the phenomenon of the study. The theory of Nursing as Caring by Boykin and Schoenhofer (2001a) provides the lens through which the researcher views the personal appreciation of the meaningfulness of the phenomenon relative to the horizon of meaning.

Descriptions of a Peaceful Death

Peaceful death is defined as “the calm end of life of a person without any worry or excitement” (Longman Dictionary of Contemporary English, 2003, p. 402, 1215). To
gain understanding of the meaning of peaceful death, a review of the concept of peaceful death from various perspectives was conducted. The following sections describe a peaceful death.

In Kwahu-Tafo society, people understand that the term “good death” is incorporated in the term “peaceful death.” Five aspects of peace achieved in the event of a good death are being at peace with others, being at peace with one’s own life and soul (spiritual), dying in the fullness of time, and dying at home, and being surrounded by relatives. Dying peacefully also suggests the idea of a natural death after a long and well spent life, and not the result of aggression (Van der Greest, 2004).

In Japanese society, a good death as a multidimensional, and individual experience based on personal and socio-cultural domains of life that incorporate the person’s past, present, and future (Hattori et al., 2006). Antecedents that are features of a good death are: the person’s experience of dying (freedom from pain and other symptoms, living a full life, and an acceptance of death), the social context (coherent relationships with family members and significant others and keeping the decision-making ability), the patient’s autonomy and control over the dying process (a natural way of dying, physical and mental comfort, clear decision-making, and advanced care planning), and quality of end-of-life health care. The consequences of good death are family satisfaction, a positive bereavement process, and work satisfaction on the part of the health professionals.

In American society, Weisman (1979) provides a definition of a good death from perspectives of terminally ill patients with cancer as one in which there are no sickness or economic concerns, there is continuing emotional support, and self-regard remains high.
Good deaths do not require ideal conditions. A good death will feature a good family relationship which was calm, respectful, and supportive. A good death is keeping all informed about the prognosis and provides the opportunity for the individual to follow his/her wish and to choose to die in his own way. A good death includes having family and friends around you during the time of dying.

Winland-Brown (2001) studied American adults’ perceptions of a good death and described a good death as one that is peaceful and is accepted and the person has fond memories after life’s goals have been met. A good death includes respect for the individual’s autonomy with open communication among family members.

Another study of American society (Vig & Pearlman, 2004) examined the meaning of good death as expected by terminally ill patients. Vig and Pearlman concluded that a good death has an individual meaning, and does not have a consensual meaning. Terminally ill patients each defined a good death differently. The components of a good death included: during sleep, being quick, without pain, without suffering, being at peace with God, being peaceful, and without knowledge of impending death.

In Norway, Ruland and Moore (1998) developed a theory about the peaceful end of life. The theory provided five major concepts for nurses when fostering a peaceful experience for persons at the end of life. The concepts include: not being in pain, experience of comfort, experience of dignity/respect, being at peace, and closeness to significant others/persons who care.

In Thai society, “peaceful death” is a common term used by Thai people rather than the term “good death.” Thai people always use the following phrases: to pass away peacefully, or to have a peaceful death and related to religion (Manosilapakorn, 2003;
Matetanonto, 2005; Visalo, 2004). At the end of life, Buddhists share a common wish to die peacefully (Barham, 2003; Manosilapakorn). This is based on the belief that a peaceful death will occur when a person accepts death as a natural law of life. There is no clinging to the body and things, no worrying, there is peace of mind, and the person is in a quiet place (Matetanonto; Visalo). Issues of spirituality, serenity and peacefulness in dying are very important to Buddhist persons, as these ensure a peaceful death and a good rebirth (Barham; Visalo).

For Muslims, Sareming (1997) indicates that Muslims are taught that Allah gives man birth and death. Allah determines the appointed term for every man. Only Allah knows when, where, and how a person will die. Death for Muslims is considered to be good news and brings happiness to them. Muslims emphasize the importance of reminding the dying person of Allah. Relatives or religiously educated people will give the dying person good wishes and tell him/her particular phrases in the Islamic language which remind them of Allah. Manosilapakorn (2003) suggests that, for Thai Muslims, a peaceful death means an absence of technology and invasive treatments, the withdrawing of ventilation support, and an emphasis that resuscitation is not desirable. In addition, the Islamic faith requires that the deceased must be buried within 24 hours after death.

The review of literature about the concept of peaceful death clarifies the understanding that there is no universal definition of peaceful death and that it is based on religious and socio-cultural factors. However, from the review literature the core qualities of a peaceful death or a good death across several cultures is related to accepting death (Barham, 2003; Hattori et al., 2006; Manosilapakorn, 2003; Van der Greest, 2004; Winland-Brown, 2001); being at peace (Matetanonto, 2005; Ruland & Moore, 1998; Van
der Greest; Vig & Pearlman, 2004; Visalo, 2004; Winland-Brown); being comfortable (Hattori et al.; Ruland & Moore; Vig & Pearlman); dying at home (Van der Greest); being with loved ones (Hattori et al.; Ruland & Moore; Van der Greest; Weisman, 1979); following an individual’s wishes and religious tradition (Hattori et al.; Weisman); taking place at an appropriate time (Hattori et al.; Van der Greest); and being natural and dignified (Hattori et al.; Ruland & Moore; Van der Greest; Weisman; Winland-Brown).

This summary of concepts comprising peaceful death could be employed as a general guide to understanding the phenomenon of a peaceful death.

Related Literature

Nurses’ Experiences in Other Countries

There were a few related studies about nurses’ experience of caring for persons who had a peaceful death or a good death. These studies were conducted in the United States of America and in Canada. Findings in these studies raised some relevant information.

Similarly, intensive care nurses’ experiences with end-of-life care in the United States were examined by Kirchhoff et al. (2000). The objective of this study was to describe end-of-life care in ICUs as perceived by critical care nurses who took care of dying patients. A qualitative research method was used to study the nurses’ experiences. A semi-structured interview guide was developed. Four focus groups were held with randomly selected nurses from four intensive care units in two hospitals. The participants had two years or more of experience and were working half-time or more. Twenty-four nurses participated from each hospital. Participants in this study described good end-of-life care in an ICU as ensuring that patients were pain-free and that the patient’s comfort
and dignity were maintained. Involvement of the patient’s family, a clear and accurate prognosis, and continuity of care were the themes emerging from this study. Additionally, participants in this study felt that taking care of self was important to the provision of good end-of-life care because caring for the dying patient can be distressing, stressful, and overwhelming.

The provision of a good death by critical care nurses was also examined (Beckstrand et al., 2006). Returns from a random sample of 1,409 members of the American Association of Critical Care Nurses were obtained by sending out a 72-item questionnaire on perceptions of end-of-life care that also requested suggestions for improving end-of-life care. In all 485 (56%) of the total number gave their suggestions in responses to an open-ended question. The suggestions were coded and synthesized by two critical care nurse researchers with expertise in qualitative inquiry. The participants suggested facilitators to providing a good death included: making environmental changes to promote dying with dignity; being present; managing patients’ pain and discomfort; knowing and following patients’ wishes for end-of-life care; promoting earlier cessation of treatment or not initiating aggressive treatment at all; and communicating effectively as a healthcare team.

Lackie (2003) studied Canadian critical care nurses’ lived experiences of providing a “good” death. A phenomenological methodology was used for the study. Participants had ICU experience that ranged from 7-20 years and each had completed a post RN critical care certificate course. Three themes emerged from interviewing; reconciling death, family as focus, and the role of the nurse.
In the theme of reconciling death, participants shared a perception of a good death as peaceful, dignified, pain free, and with unrestricted family presence. Participants believed that they could provide a good death when they were involved in open, honest communication with the patient, family and physician. In addition, depending on the patient’s age and acuity, death was not always perceived as a loss, but sometimes it was an event that was welcomed in an otherwise distressing situation. Shared support and comfort for each other between nurses and nurse administrators was needed to release uncomfortable feelings. Faith was also described as a factor by participants. Believing that a higher power was in control helped participants adjust to the death of the patients. Spiritual nursing care was necessary to help patients accept uncertainty and find meaning in their illness. A patient’s age and the severity of an illness were factors that could affect ICU nurses in providing end-of-life care. This meant that it was easier to reconcile death when the patient was elderly or extremely ill; in these situations, nurses did not experience a sense of failure when death occurred (Lackie, 2003).

In the theme of family as focus, participants described psychological care as the predominant type of care needed for the families as well as patients. In the theme of the role of the nurse, participants articulated the deep responsibility that was inherent in managing the dying process. As director of death, nurses function as caregivers and teachers, thus assisting others to gain knowledge of what constitutes a good death (Lackie, 2003).

The findings of these studies (Beckstrand et al.; Kirchhoff et al, 2000; Lackie, 2003) in the United States and in Canada relate to the experience of nurses. They demonstrated that, in providing a good death in ICUs, nurses: interact with the patient,
family and physician to maintain comfort; keep the dying person free from pain; promote the ending of aggressive treatment; promote dying with dignity and peacefulness; and permit unrestricted family presence. In addition, psychosocial care and spiritual care were the focus of care in providing a good death in ICUs. The nurses’ roles are to be a coordinator of death and a teacher to all involved. Also, caring for one’s self and caring for each other on the part of nurses is important in providing a good death.

**Nurses’ Experience in Thailand**

Upon reviewing the literature in Thailand, no published study was located relating to a peaceful death in an ICU or the lived experience of nurses in caring for persons who had a peaceful death in an ICU. The only work that has been conducted is a study on a peaceful death in an ICU (Kongsuwan & Locsin, 2009).

A preliminary study by Kongsuwan and Locsin (2009) was conducted to determine the description of a peaceful death among Thai nurses in an ICU in the south of Thailand. Three ICU nurses were interviewed and the transcripts were analyzed. This pilot study revealed three thematic statements illustrating the concept of peaceful death in an ICU. These themes were: awareness of dying; creating a caring environment; and promoting end-of-life care.

Awareness of dying is the initial process or experience in promoting a peaceful death in the ICU. While there was no “doctor’s order” or prescription for palliative care, participants used their own experiences to monitor the impending deaths of patients who showed the signs and symptoms of impending death such as becoming unresponsive to communications and to treatment; showing declining vital signs; change in physical and

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psychological signs and symptoms; and becoming physiologically-challenged by having repeated cardiac arrests (Kongsuwan & Locsin, 2009).

In the second theme, creating a caring environment, the participants found it difficult to have a peaceful death in an ICU. In creating a caring environment mutual acceptance of death, and managing and promoting the patient’s care and comfort are paramount features in accepting death, particularly because caring environment is a family affair that is integral to promoting a peaceful death possible. The patients’ family members need to listen to the concerns of relatives regarding the dying patients’ situation. In managing care and promoting comfort, the participants must review the plan of care, provide relief from pain and comfort (Kongsuwan & Locsin, 2009).

The third theme, promoting end-of-life care, stressed that the participants needed some time to prepare for a peaceful death. The participants prepared patients’ families, dying patients, and fostered an environment that underpinned the patients’ beliefs and wishes. The participants assessed and followed the patients’ wishes such as: allowing their family members to be with them, giving water and giving food and supplies to the monks. Buddhists believe that giving food and supplies to a monk is one way of doing good deeds. When Buddhists do good acts and have good thoughts, their minds are at peace and they then hope to go to a good place. Buddhists have a religious ceremony that is performed at the end of life by a monk. The participants in the study would advise the Buddhist families to invite the monk to conduct a ritual for the dying patients in the ICU. As for Muslims, there is a belief that it is a good thing if they die in God (Allah)’s arms. The participants arranged for the patients’ family members to read passages from Our’an to the dying patients (Kongsuwan & Locsin, 2009).
To promote end-of-life care, the participants fostered a proper environment for
dying patients. The participants believed that a calm, non hurried, private, and familiar
environment assisted the dying patients to be at peace so that they could focus their
minds on their goodness and their faith. The participants created the quiet environment in
the ICU by not talking loudly thus showing concern that the dying patients could still
hear. The participants created a placid atmosphere by not hurrying to do things when
providing nursing care for dying patients. At the time of the patient’s death, the
participants fostered a private and familiar environment by letting the patient’s family
members stay beside the dying patient and to close the curtain around the bed
(Kongsuwan & Locsin, 2009).

In after-death, care was seen to be important. This was recognized as a supporting
theme within the category of promoting end-of-life care. Caring after death involved
beliefs and gender bias, that is religious beliefs and gender of the nurse and of the
deceased were integral considerations in providing after-death care. The activities
involved in caring after death were cleaning and dressing the body and respecting the
deceased. For Thai Muslims, the gender and the religious belief of the person who
cleaned and dressed the body must be the same as was the deceased. Muslims were
serious about the cleaning of the body and they clean the body inside by evacuating the
feces. One participant, a Muslim, stated that Muslims believed that if the body was
cleaned this way the deceased would pass away peacefully. The participants explained
that, at the moment of death, they believed that the deceased still heard. The participants
showed respect to the deceased by talking to them as if they were alive, whether they
were Thai Buddhists or Thai Muslims. For the deceased who were Buddhists, the nurses
in the study guided them near their ears to go to a good place or rebirth in a good place (Kongsuwan & Locsin, 2009).

Several studies that involved nurses’ experience of care at the end of life, including ICU nurses as participants, were found from a review (Chealeawsak, 2001; Labhanpakul, 2000; Manosilapakorn, 2003). Manosilapakorn examined Thai nurses’ attitudes, knowledge, clinical judgment, and ethical dilemmas at the end of life. This study used both quantitative and qualitative research designs. A purpose of the qualitative design was to explore the lived experience of Thai nurses in providing end-of-life care. The research question was: What is Thai nurses’ lived experience in providing end-of-life care in Thailand? Semi-structured interviews were conducted with 12 Thai nurses working in general hospitals in six main regions of Thailand. Three of the 12 participants worked in ICUs. The rest of the participants worked in medical, surgical, and emergency rooms, units that have many patients at the end of their lives. Data were analyzed by Van Manen’s (1990) method and Benner’s Clinical Judgment. Three interpretive themes were identified: helping dying patients to have a peaceful death; nurses placed in the middle; and home versus hospital.

In the theme of helping dying patients to have a peaceful death, a holistic approach in end-of-life care was an essential component. The holistic care given was in relation to the provision of physical, psychosocial, and spiritual comfort to dying patients. The participants believed that following the patients’ needs and supporting cultural traditions and religious activities could help dying patients to have a peaceful death. In addition, enhancing families’ decision making on behalf of the patients was supported. This included the notion that what they knew would be best for their loved one to have a
peaceful death, and that this would help dying patients to have a peaceful death (Manosilapakorn, 2003).

The theme of nurses being placed in the middle meant that the participants found themselves in the middle between the wishes of patients, families, and physicians. The experience whereby the participants felt they were in the middle included giving out information about treatment, medication, prognosis, and patients’ symptoms. Other experiences of being a middle person were concerned with the use of alternative therapies and request for spiritual and religious practices. Families of the dying patients asked the nurses for permission to use herbal medicines, ointment therapies, and meditation. Nurses were unable to make a decision as physicians had to give permission for these alternatives. Therefore, nurses acted as advocates for patients when recommending alternative treatments to the physicians. When the families requested spiritual and religious practices, the request would place nurses in the middle because some of these practices, such as burning candles and praying by monks, could disturb other patients. Nurses have to consider carefully about allowing families to conduct spiritual practices (Manosilapakorn, 2003).

The theme, home versus hospital, reflected that the nurse participants felt that the life sustaining interventions may not be as important as psychosocial and spiritual support. The participants perceived that culture care, spiritual care, and religious practices can be provided more suitably in the home (Manosilapakorn, 2003).

The two studies by Kongsuwan and Locsin (2009) and Manosilapakorn (2003) described how Thai nurses promote a peaceful death for terminally ill Thai persons. The result of preliminary study by Kongsuwan and Locsin demonstrates ways of promoting a
peaceful death in ICUs in the south of Thailand. These include: starting care through raising awareness of dying; creating a caring environment to allow patients to die without aggressive treatment; and promoting end-of-life care congruent with patients’ beliefs. Manosilapakorn suggests strategies to enable dying Thai patients in the hospitals in Thailand to die peacefully. The knowledge generated in the study of Manosilapakorn relates to the hospital units that involve many deaths, such as the medical and surgical wards, the intensive care units, and the emergency rooms. These two studies show similarities in the way that Thai nurses focused their care to promote a peaceful death. They encouraged the involvement of family members in care and decision making, in providing comfort, and in preparing for death, including the spiritual aspects and the location in which death should take place.

Another example of qualitative research relating to nurses’ experience was a study of ethical dilemmas in providing care for terminally ill patients (Chealeawsak, 2001). This phenomenological study aimed at describing and explaining the experiences of nurses in relation to ethical dilemmas when providing care for terminally ill patients. The setting of the study was the south of Thailand. The participants were 10 nurses in medical and surgical wards, including intensive care units. The study found four themes in the ethical dilemmas experienced by participants. The themes were: to prolong life or to end life; maintaining patient confidentiality or telling the truth to participants’ families; the difficulty of using criteria when dealing with value judgments; and deciding who should receive scarce resources. The participants resolved these ethical dilemmas by accepting the reality, consulting/discussing relevant matters, positive thinking, adhering to religious principles, and protecting patients’ rights. The nurses thought that a positive
consequence of resolving ethical dilemmas was that patients received good care. This dimension involved the participants having a good relationship with others, and taking pride in their professional role. The negative consequences were the feelings of stress and anxiety concerning outcomes and actions thought to be worthless.

The study (Chealeawsak, 2001) relates to the issue of the emotional stress of providing care at the end of life, and describes the strategies Thai nurses used to resolve this stress and cared for self. Caring through the development of positive self concepts is also vital for Thai nurses, as well as American nurses, and is a factor that can be used for providing a good death as described in the study of Kirchhoff et al. (2000).

The review of literature also identified a qualitative study about nurses’ experience related to care at the end of life in medical units (Labhanpakul, 2000). Labhanpakul described what is meant by “dying patients” and outlined the behavior necessary for their care from a nurse’s point of view. The data were collected through focus groups and individual in-depth interviews with 19 nurses working in a medical unit. The results showed that “dying patients” can be placed in three categories: trend to die patient, life-threatening patient, and the hopeless incurable patient. There were four care behaviors demonstrated by nurses. The first involved monitoring the patient's signs and symptoms. The second care behavior was following the treatment prescribed by doctors. In the third care behavior, nurses responded to the dying patient's physio-psychological needs. This meant providing physical comfort, meeting their need for happiness and satisfaction, allowing the patient to die at home, encouraging the patient to spend the rest of their lives with their family, helping the patient meet death peaceably, and allowing the
patient to practice their spiritual beliefs. The fourth care behavior was the provision of necessary information by nurses about the dying process.

Other studies identified in the review of the literature about end of life were the studies among the terminally ill patients, terminally ill patients’ families, and caregivers. The focus of many of these studies was concerned with decision making and ethics at the end of life (Neuonoi, 2005; Nijinikaree, 2003; Sarunayiam, 1998; Sittisombut et al., 2005). One of the studies focused on perceptions of palliative care for terminally ill AIDS patients (Seachit, 2004). However, all of these studies on the perspectives of patients, families, and caregivers were not specifically about a peaceful death and care at the end of life in any ICU setting.

It can be summarized that there is a dearth of studies on Thai nurses’ experience related to a peaceful death/good death and end-of-life nursing care in ICU settings. A preliminary study by Kongsuwan and Locsin (2009) begins to provide some insight about caring for the dying patient and promoting a peaceful death in an ICU. However, further research is necessary to gain greater understanding of the nurses’ experience of caring for dying persons to enhance a peaceful death in ICU.

Horizon of Meaning

Personal Horizon of Meaning

The following narrative is the lived experience of caring for a person whom the researcher believes experienced a peaceful death in an ICU.

I (researcher) had the opportunity to care for Mrs. A, a 44-year-old patient. Her diagnosis was brain hemorrhage and severe brain swelling. She had underlying hypertension and had had a stroke. She fell in the bathroom and was found unconscious.
She underwent a craniectomy operation. After the operation, she was admitted into the intensive care unit and was dependent on a ventilator. Her prognosis was very poor. She was in a deep coma. Both pupils were fixed and dilated. She had signs of increased intracranial pressure and her electrocardiographic rhythm was *sinus tachycardia*. As I cared for this person, I knew well that she was dying and was going to leave her loved ones. The doctor talked to her husband about her prognosis. I was not involved in that conversation, but I could see and imagine how her husband felt. After he talked with the doctor, her husband walked to his sons and held his sons’ hands. I saw three men clasping hands with each other as if they were transferring their feelings. I could not describe those feelings, but I understood how they felt. Suddenly, my intention was that I had to assist in the short end-of-life time for this family, both for one who was departing forever and for the three who were still alive and suffering.

I walked over to speak to them. Mrs. A’s husband said to me that the doctor wanted him to make the decision to withhold or withdraw treatment. I knew that it was very hard for him to make the decision at that time. If he decided to withdraw treatment, it meant that his wife would soon be dead. He felt like he was a murderer. If he decided to withhold, he said, his wife might be like a vegetable and she would be an unconscious person that needed nurturing. He stated that he could not make a decision and asked why he had to make such a decision. She was his wife and he loved her very much. She was a good wife and good mother and he asked why this event had happened to them. Mr. A told his story with tears in his eyes. I gave him the opportunity to release his feelings. I thought he needed time to make his decisions, and I agreed to tell the doctor about this. I thought he might not be able to make any further decisions. In a way, Mrs. A. might
make the decision for him because her symptoms were getting worse. From the monitor I saw the rising of intracranial pressure and that her heart rate was very fast. I reported this to the doctor, and he asked Mr. A to decide again about resuscitation if his wife had cardiac arrest. The husband’s face was very pale, and he could not stand. I helped him to sit on the chair. He asked me if his wife would be in pain or not if she received resuscitation. I told him she would be. He asked me many questions about the effects of resuscitation. After he had been given the information, he took his wife’s hand and cried. I did not know what to say. I just remained silent and stood beside him. I knew it was very hard for him to accept the death which was coming soon. Finally, he decided against resuscitation. I informed the doctor that the husband wanted Mrs. A. to pass away peacefully.

I allowed the family to stay with Mrs. A. throughout. I advised them how to be with the patient. They should say some things close to her ears. They could pray for her. They could conduct a religious ceremony. Around two hours later, her blood pressure dropped and her heart rate decreased. During the religious ceremony she passed away calmly and with dignity. There was no resuscitation or aggressive treatment. She passed away with her love ones at her side. I noted her face looked peaceful with a little smile.

Nursing Horizon of Meaning

The theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) focuses on nursing as “nurturing persons living caring and growing in caring” (p. 11). This focus requires that the nurse knows the person seeking nursing as caring person and that the nursing action be directed toward nurturing the nursed in their living caring and growing
in caring. Boykin and Schoenhofer (2001a) view caring as the central value of nursing. The meaning of caring is in the reflection on the caring experience.

The assumptions of the theory of Nursing as Caring are persons are caring by virtue of their humanness, persons are whole and complete in the moment, persons live caring from moment to moment, personhood is a way of living grounded in caring, personhood is enhanced through participation in nurturing relationships with caring others, and nursing is both a discipline and a profession (Boykin & Schoenhofer, 2001a, p. 1). Each assumption is described in the following:

**Persons are caring by virtue of their humanness.** All persons are caring. Caring is an essential feature and expression of being human. Being a person means living caring. Each person grows in his or her competency to express self as caring person. Boykin and Schoenhofer (2001a) believe that each person is caring and grows in caring throughout life.

**Persons are whole and complete in the moment.** Persons are whole, complete and live caring from moment to moment. This assumption offers a lens of being with another in order to prevent the segmenting of person into a component of parts.

**Persons live caring from moment to moment.** Boykin and Schoenhofer (2001a) state that “caring is lived moment to moment and constantly unfolding” (p. 2). When persons call for nursing, the nurse as caring person comes to know that person in the moment. The development of competency in caring occurs over a lifetime. Throughout life, a caring person comes to understand what it means to be a caring person, to live caring, and to nurture each other as caring.
Personhood is a way of living grounded in caring. Boykin and Schoenhofer (2001a) belief that “personhood is the process of living grounded in caring and implies living out who we are, demonstrating congruence between beliefs and behaviors, and living the meaning of one’s life” (p. 4). Personhood is “the universal human call” (Boykin & Schoenhofer, 2001b, p. 393).

Personhood is enhanced through participation in nurturing relationships with caring others. As the process, personhood acknowledges person as having continuous potential for further caring. Personhood is being authentic, being who I am as caring person in the moment. This process is enhanced through participation in nurturing relationship with others. Personhood is the outcome of caring.

Nursing is both a discipline and a profession. In the theory of nursing as caring, nursing is viewed as both a discipline and a profession. As a discipline, nursing is a unity of science, art, and ethics. Discipline relates to all aspects of the development of nursing knowledge. This theory focuses on the knowledge needed to understand the fullness of what it means to be human and on the methods to verify this knowledge. Knowledge of nursing comes from within the situation. As a profession, nurses use that knowledge in response to human needs.

The nursing situation is a key concept of the theory of nursing as caring. The nursing situation is defined by Boykin and Schoenhofer (2001a) as “a shared lived experience in which the caring between nurse and nursed enhances personhood” (p. 13). The practical knowledge of nursing lives in the context of person with person caring. The nursing situation involves particular values, intentions, and actions of two or more persons choosing to live a nursing relationship. The nurse and nursed are connected in
relationship (I & Thou), caring between occurs as the source and ground of nursing. Nursing is created in the caring between. All knowledge of nursing is created and understood within the nursing situation. Any single nursing situation has the potential to illuminate the depth and complexity of nursing knowledge. Value is included in outcomes and expanded personhood.

The theory of Nursing as Caring also provides a concept of a caring environment. Boykin and Schoenhofer’s (2001a) view was that to create a caring environment, all persons who directly or indirectly involve the person being cared for must know the self as a caring person. Each person has an important contribution to make to create a caring environment. The importance of this perspective is illustrated in the model of the “Dance of Caring Persons” (Boykin & Schoenhofer, 2001a, p. 36). The image of this circle of dancers is used to show a pattern of being in a relationship in which each person is known, respected, and valued. There is no hierarchy to convey power or position in this model; rather, each dancer in the circle is honored for the unique contribution made in his or her role. Each person brings particular gifts at different points to the one being nursed.

The works of Boykin and Schoenhofer were about the nursing administrator’s role in creating caring environments in the healthcare system and transforming practice by a model grounded in caring in an acute care setting (Boykin & Schoenhofer, 2001c; Boykin, Schoenhofer, Smith & Aleman, 2003). These works focus on implementation of their theory into the practice setting. The fundamental assumptions, the “Dance of Caring Persons,” and other key themes of their theory were used as a framework in the study.

The research question of this study was to describe the experience of nurses who cared for persons who had a peaceful death in ICU. The theory of Nursing as Caring
(Boykin & Schoenhofer, 2001a) provides the nursing horizon of meaning that can be used to explain the findings of this study. The assumptions of the theory have been developed for this study as follows:

1. Intensive care nurses, dying persons, and families are caring by virtue of their humanness. Intensive care nurses, dying persons, and families are caring and grow in caring throughout their lives. All of these persons have the potential to promote peaceful death in the intensive care unit.

2. Intensive care nurses, dying persons, and families are whole or complete in the moment. Person is subjective, not objective. Person cannot be separated.

3. Intensive care nurses, dying persons, and families live caring, moment to moment. Intensive care nurses know self in each moment as caring persons and express unique ways of promoting peaceful death over a life-time of dying persons. Intensive care nurses and families exist with dying persons and live caring in promoting a peaceful death moment to moment.

4. Personhood is a way of living grounded in caring. Personhood is a way of living grounded in caring for persons who had a peaceful death. Intensive care nurses provide humanistic care for dying persons and their families.

5. Personhood is enhanced through participation in nurturing relationships with caring others. In nurturing dying persons and living caring in promoting peaceful death, intensive care nurses have a relationship (I & Thou) with dying persons and their families from moment to moment. Intensive care nurses, dying persons, and families have responsibility to themselves as caring persons and interact honestly to promote peaceful death continuously for the dying persons throughout their life time.
6. Nursing is both a discipline and a profession. The researcher believes that nursing is both a discipline and a profession. In accord with the discipline of nursing, this study focuses on the development of the knowledge of caring for dying persons and promoting persons’ experiences of a peaceful death from the lived experience of intensive care nurses. As part of the profession of nursing, intensive care nurses use the knowledge of caring for persons who had a peaceful death.

Chapter Summary

The review of the literature provided significant information regarding the term of a peaceful death and the phenomenon of nurses caring for related to a peaceful death in ICU. That is a peaceful death is the term that could be named in a term of a good death and used to describe the same experience. Thai people used the term of a peaceful death more commonly than the term of a good death. Peaceful death was valued as individuals’ meaning or perception embedded on religious, belief, and culture in each society. Core attributes of a peaceful death from many societies were summarized in this chapter for overview understanding of its phenomenon. Studies related to nurses’ experiences of caring for persons who had a peaceful death in ICU in Thailand and other countries provided evidences to support the need of this study. The preliminary study of Kongsuwan and Locsin (2009) initiated an exploration of the nurses’ experience of promoting a peaceful death in ICU in Thailand and further study was recommended. The final section, horizon of meaning, researcher’s personal experience of caring for persons who had a peaceful death in ICU in Thailand and the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) were served as sources of knowledge to use in explanations the findings.
CHAPTER 3

METHODOLOGY

The research question was “What is the lived experience of caring for persons who had a peaceful death in ICUs?” To obtain the descriptions of the experience, the methodology of qualitative research specified to phenomenology is employed. In the beginning of this chapter, Van Manen’s (1990) hermeneutic phenomenological human science approach is described. After that, the steps of phenomenological methodology, which are included setting of the study, inclusion criteria, ethical considerations, data generation, data synthesis, rigor of qualitative research, and delimitation are described respectively.

Van Manen’s Approach

Van Manen’s (1990) hermeneutic phenomenological human science approach was used to arrive at description(s) of the meaning of the experience. This approach is appropriate for this study because the research question focused on searching for the description of human experience, which is the description of nurses’ lived experience of caring for persons who had a peaceful death in ICUs.

Van Manen’s approach attempts to draw out the meaning of the experience as it is lived by an interpretation of the text of life. In this approach, the way of knowing through the interpretive text is congruent with a hermeneutic philosophical framework. Van Manen’s (1990) human science approach provides the research process; these include
raising questions, gathering data, describing a phenomenon, and constructing textual interpretations which direct the researcher to comprehend the meaning of the lived experience of nurses. Furthermore, this approach offers the guides to describe the lived worlds reflecting on the interpretive texts of life thus assisting the researcher to distinguish the lived structure of the meanings of caring for persons who experienced a peaceful death in an ICU in everyday existence.

Van Manen’s (1990) hermeneutic phenomenological human science approach is comprised of the perspectives of human science, phenomenology, and hermeneutics. Six methodological activities of human science research are introduced by Van Manen, which allowed the researcher to select or create appropriate research methods, techniques, and procedures for a particular research question. Van Manen described that hermeneutic phenomenological research as a dynamic interplay among six research activities of human science. The six research activities are (Van Manen, pp. 31-34):

1. Turning to the nature of lived experience.
2. Investigating experience as we live it.
3. Reflecting on the essential themes which characterize the phenomenon.
4. Describing the phenomenon through the art of writing and re-writing.
5. Maintaining a strong and oriented relation to phenomenon.
6. Balancing the research context by considering parts and whole.

*Turning to the nature of lived experience.* Van Manen (1990) describes phenomenological research is driven by a commitment of turning to an abiding concern. Turning to the phenomena of interest will offer the researcher on the full of thought of wholeness of life and the sense of certain aspect of human existence. The researcher will
gain a deep question of the essential nature of the phenomena and describe phenomena with insightfulness.

*Investigating experience as we live it.* In this theme, Van Manen (1990) provides the importance of investigating experience that phenomenological research believes that the practical wisdom is in the understanding of the nature of lived experience itself. “Being experienced is a wisdom of the practice of living which results from having lived life deeply” (p. 32). Van Manen suggests the researcher to explore the lived experience and conduct personal description of a lived experience as a starting point of the study.

*Reflecting on the essential themes which characterize the phenomenon.* Van Manen (1990) states that “phenomenological research, unlike any other kind of research, makes a distinction between appearance and essence, between the things of our experience and that which grounds the things of our experience” (p. 32). Van Manen proposes that true reflection on lived experience is achieved by asking “What is it that constitutes the nature of this lived experience?” (p. 32).

In reflecting on the essential themes which characterize the phenomenon, Van Manen (1990) offers the activities of isolating themes, interpreting themes, reflecting on themes, and determining incidental and essential themes. Van Manen also suggests three approaches for isolating themes from the transcript: the wholistic or sententious approach; the selective or highlighting approach; and the detailed or line-by-line approach.

Van Manen (1990) asserts that hermeneutic phenomenological human science research attempts to explore the structure of the human lifeworld. The structure of the human lifeworld as described by Van Manen consists of four fundamental lifeworlds or
four existentials. The four existentials are lived space (spatiality), lived body (corporeality), lived time (temporality), and lived human relations (relationality). The details of four lived worlds are described as follows:

Lived space includes both the internal feeling of the formation of lived space and also the external feeling of being relation to place. We may feel small in a large space. Some place is special space of being. Lived space is a category for inquiring into the ways we experience the affairs of our day to day existence and helps us uncover more fundamental meaning dimensions of lived life. Lived body refers to the fact that we are always bodily in the world. Our physical or bodily presence we both reveal something about ourselves and conceal something at the same time. Lived body includes emotional, psychological and physiological dimensions. Lived time is subjective time as opposed to objective time. The time will speed up or slow down depended on our feeling of being in the world. This includes our time perception in relation to the dimensions of past, present, and future. Lived relation is the way that we maintain relation with others in the interpersonal space that we share with them. As we meet the other we approach the other in a corporal way. As we meet the other we are able to develop a conversational relation which allows us to transcend ourselves. Nursing researchers (Locsin & Matua, 2002; Moene, Bergborm, & Skott, 2006) brought four lived worlds to guide the reflection of the lived experience of human under study.

Describing the phenomenon through the art of writing and re-writing. Van Manen (1990) suggests that to do research in a phenomenological sense is rendering something into language. In order to do this, writing is undertaken. Language and responsiveness to phenomena will be used to transform the phenomena precisely as it shows itself. The
researcher will write and re-write as further reflection, so that through expressing the meaning or the essences of the experience will be better known through illuminating the meaning of the lived experience.

*Maintaining a strong and oriented relation to phenomenon.* Through this activity Van Manen (1990) indicates that the researcher should remain strongly related to the research question and the phenomena under study in order to guard against aimlessness. Being fully oriented in relation to the phenomena will assist the researcher to gain full and human insight.

*Balancing the research context by considering parts and whole.* Van Manen (1990) suggests that the researcher needs to constantly measure the overall design of the study in order to maintain the balance of all the parts in the total structure. It is necessary to step back and look at the totality of the text to consider how each of the parts contributes towards the whole.

**Setting of the Study**

The study was conducted in the southern region of Thailand, because this provided greater opportunity to gain access to participants who have had the desired experience. The university hospital in the south was the foremost Thai hospital with respect to improving and developing care at the end of life in Thailand. Furthermore, the hospitals located near the university hospital were developing end-of-life nursing care. Practice guidelines for the care of terminally ill persons have been created and developed in these hospitals. Therefore, participants were recruited from the university hospital and the hospitals around the university hospital in the southern region.
Inclusion Criteria

The target participants were Thai registered nurses who are currently working in a medical, surgical, respiratory, trauma, or neurological ICU in the hospitals in the southern region of Thailand. Target participants were nurses who have cared for adult dying persons and believe that the persons they cared for had a peaceful death. Target participants have to have at least 6 months of ICU experience because during first six months, new nurses are in the ICU training program and adapting themselves on critical care skill. The new nurses may not have a good skill to care for critically ill dying persons in ICU. All target participants are Thai speakers and be willing to articulate and reflect on their experience. Gender, age, religion, education level, years of work, and income of participants are not considered as criteria for identifying the participants in this study. The researcher focused on Thai ICU nurses who have had the experience being studied.

Ethical Considerations

The research study was approved by the Florida Atlantic University Institutional Review Board. A detailed description of the study, the risks and benefits, confidentiality, and the informed consent procedures were explained during the initial phone contact with prospective participants prior to their participation. Each participant was informed that a second interview would be requested at a later date to clarify information specific to the first interview and to confirm the credibility of the data analysis. Participants were asked to describe their lived experience in their own words to ascertain the comprehension and autonomy of the individual. The researcher set up an appointment for the initial interview
after the person had expressed an interest in participating in the study and had met the sample selection criteria.

While there is always a minimal risk associated with research, the level of risk involved in completing this interview is not greater than those ordinarily encountered in daily life. If the participants feel sad or are having a difficult time accepting the situations of the dying patients, the researcher will provide support and may refer for counseling.

The informed consent form (Appendix A) was signed before the initial interview was conducted. A copy of the signed consent form was sent to each participant. Written consent was obtained after the participant has agreed to participate in the study. Whilst there was always the possible risk of loss of confidentiality, every effort was made to protect the confidentiality of the participant. A pseudonym was assigned to each participant and recorded in a code-book located in a locked cabinet at the researcher’s home. Assigning the pseudonym to the transcribed text kept in the computer file should also ensure confidentiality. The real identities of the participants were not used in any verbal or written presentations and/or reports.

Each interview was audio tape-recorded. This commenced after receiving written consent from participants to participate in this study, and permission to audio record the interview. Participants were informed that they can withdraw from the interview without negative consequences and to decline to answer any questions posed by the researcher at any time. The consent form described the right to review the transcript of the interview data and to elect to not have it used as part of the data base for the study.
Data Generation

After the Florida Atlantic University Institutional Review Broad approved the proposal, the research process of data generation was undertaken. Van Manen’s (1990) hermeneutic phenomenological human science approach was adapted to analyze and interpret the data.

Sampling

A snowball purposive sampling method was used to select the participants. As there was no critical care association or end-of-life nursing care association in Thailand, the participants were recruited through personal networking and by word of mouth. ICU nurses who were known to have experience in caring for persons whom they perceived had a peaceful death were contacted personally and asked by the researcher to voluntarily participate in the interview.

Interview

After contacting the participants, the researcher and the participant mutually agreed upon the setting for the interview. All interviews were provided in a quiet, private, comfortable, and convenient location. These settings were either in a private home, or a private area in the hospital, or another area outside the ICUs. Individual interviews were conducted in Thai language using interview question. The duration of the interviews ranged from 30 to 60 minutes.

The question posited in the interviews was “Please tell me about your experience of caring for persons whom you believe had a peaceful death.”

Other questions were directed to the participants to encourage them to continue reflecting on their past experiences. These included, “Please tell me more,” “Can you
give an example?” “How did you feel/think about that?” “What was it like?” and “You said that . . . ?” The researcher used “silence” as a tactful way to prompt the participants to recall and tell their experiences.

In concluding the interview, the researcher asked “Is there anything else you wish to share with me?” After the interview, the researcher indicated her availability to the participants. The researcher asked the participants to telephone the researcher if they feel the need to talk further about their experience. In addition to the interview, the researcher collected demographic information about each participant (Appendix B).

*Descriptions of Participants*

Ten intensive care nurses who met the criteria of study participated in the interviews willingly. The demographic characteristics of the participants were that the ages of participants ranged from 28 to 51 years old, with a mean of 40 years old. All participants were women and believed in the Buddhist religion. Six participants reported that they have baccalaureate degrees as their highest level of education and four participants reported that they have a master’s degree. Eight participants worked in a university hospital, while two participants worked in a provincial government hospital. Both of these hospitals are tertiary hospitals located in the south of Thailand. Five participants worked in medical ICU. Three participants worked in surgical ICU. Two participants worked in respiratory ICU. The years of experience of working in ICU ranged from 5 to 28 years, with a mean of 12 years. Seven participants had attended a two to three day end-of-life care course organized by the hospital. All 10 participants had experienced caring for persons who had a peaceful death in ICU.
Transcription and Translation

To analyze the data, audiotapes were transcribed in Thai language. Upon the suggestion of the dissertation committee, 5 of 10 transcriptions were translated from Thai to English to analyze the data with a dissertation committee member who used English. This was to show the researcher the process of analyzing the data and to assist the dissertation committee to understand the analysis procedure and the description of findings of the phenomenon under study. Another five transcriptions were analyzed in Thai by the researcher of which only significant thematic statements were translated into English.

All translations were done by the researcher and were validated by two bi-lingual nursing professors who are proficient in both Thai and English languages. Both translators are qualitative researchers and one is an expert in end-of-life care. During this analysis phase, the researcher continued to journal her reflections, thoughts and feelings about the participants’ experiences of the phenomenon under study.

Data Synthesis

Van Manen’s (1990) hermeneutic phenomenological approach was used in the process of data synthesis. There are four processes in this approach, namely isolating themes, reflecting in the four lived worlds, formulating thematic categories, and phenomenological writing.

Isolating Themes

Themes were isolated from narrative transcriptions by a wholistic approach and the highlighting approach as suggested by Van Manen (1990). The wholistic approach followed by the researcher included listening to the taped interviews and attending to the
written transcripts to capture the main significance of the data as a whole. The highlight approach followed by the researcher consisted of reading the transcriptions several times and highlighting particular essential statement(s) or phrase(s).

New participants were added until the data gathered did not add any new information or saturation of data has been reached (Streubert-Speziale & Carpenter, 2003). Saturation of data is the point at which the researcher has conducted an exhaustive exploration and further data reveals redundancy and duplication of content and similar meanings compared with the previous participants.

Each particular essential statement or phrase was conceptualized and the meaning changed into nursing language or doing linguistic transformation. The statement or phrase that was transformed to nursing language was named as a theme.

Reflecting Themes Within the Four Lived Worlds

All themes were reflected in the four lived worlds, namely: spatiality or lived space, corporeality or lived body, temporality or lived time, and relationality or lived relation.

Formulating Thematic Categories

The themes in each lived world that provided the same meanings were grouped into thematic categories. Van Manen (1990) suggests that not all meanings of significance are encountered in reflecting on a phenomenon under study. It is necessary to determine the themes that can be seen as meaningful to the phenomenon. To do this, the researcher differentiated between essential themes or themes that relate to the phenomenon, and themes that are of less significance to the phenomenon. To make a distinction between these two types of themes, the researcher asked herself: “Is this
phenomenon stills the same if we conceptually change or delete this theme from the phenomenon? Does the phenomenon without this theme lose its fundamental meaning?” (Van Manen, p. 107). If it is found that a theme that could affect the meaning of the experience when changed or deleted, the theme was considered to be an essential theme. If it was found that the theme did not affect the meaning of the phenomenon when changed or deleted, the theme was considered to be an incidental theme or of lesser significance. The researcher deleted the incidental themes. In the case of essential themes, the researcher used them as the thematic structure of the phenomenon.

*Phenomenological Writing*

When the initial thematic structure of the phenomenon was formulated, the researcher started writing and rewriting the descriptions of meanings within each thematic category or essential theme in each lived world. In addition, the researcher also had hermeneutic conversations between participants, colleagues, and an expert of end-of-life care in Thailand to gain more understanding of the phenomenon as it was. Consequently, the researcher reconsidered the thematic categories and did further analysis with the dissertation committee members.

The researcher wrote, rewrote, and revised the thematic categories. In this process, the researcher used relevant literature and theories to explain and discuss the essential themes in each lived world. Consulting each theme with the literature and theory assisted the researcher to clearly understand the phenomenon as Van Manen (1990) declared. The final process was writing a description of the experience of caring for persons who had a peaceful death in the ICU. In this process, aesthetic expression was used as a way to assist the researcher to fully understand the phenomenon. These
processes were suggested by Van Manen (1990) as essential in the hermeneutic phenomenological approach.

Rigor of the Study

Lincoln and Guba (1985) provided four constructs in establishing the rigor of qualitative research. These are credibility, transferability, dependability, and confirmability.

Credibility guarantees that the descriptions and interpretations of the experience reflect accurately what participants shared. The credibility of this study was accomplished by recruiting the participants who were able to describe their experience under study. In addition, credibility was reinforced by having hermeneutic conversations with the participants to assist the researcher to understand their experience as it was.

Transferability or “fittingness” incorporates the expectation for determining that the findings can be transferred to another similar context or situation and still preserves the particular meanings. Efforts to achieve the transferability of this study were sought by providing the audience with rich in-depth descriptions that depict the meaning of the nurses’ lived experiences. Aesthetic expression was used to provide rich in-depth descriptions of meanings of the experience.

Dependability is the examination of the process of the study. The study demonstrated dependability or be auditable when another researcher can follow the decision trail of the study and without contradicting the findings. In this study, auditability was specifically achieved through the dissertation committees who assisted in assessing all methods used in the study, and who collaborated to analyze data with the researcher.
Confirmability is the criterion that upholds neutrality. This was accomplished through the researcher using the audit trial to demonstrate the thought processes followed. To do this the researcher kept a journal to record thoughts and all activities relating to the phenomenon under study.

Delimitation

This study described the lived experience of Thai nurses in the south of Thailand and understood the meanings in Thai and then translated the meanings into English. Some meanings of the experience could be lost in the translations. The researcher realized this limitation and has attempted to delimit this by using bi-lingual experts in both English and Thai language in the process of translations. However, the researcher has to accept that some terms in Thai language could not have good terms in the English language that best describes the essence of the word. Therefore, the researcher preferred to present these Thai words along with the translated English words to particularly provide authenticity to the translated essential words, phrases, or sentences.

Chapter Summary

This chapter presented Van Manen’s (1990) hermeneutic phenomenological approach for describing the lived experience of Thai nurses who cared for persons who had a peaceful death in ICU. Van Manen’s approach provided a way to assist the researcher and the audiences to understand the structure of phenomenon under study more clearly. Reflection of the thematic statements of the experience with in the categories of four lived worlds of lived body, lived relation, lived space, and lived time was the way that suggested by Van Manen. The research methods presented in this chapter included the setting of the study, inclusion criteria, the ethical considerations,
description of the participants, the generation and synthesis of data, the rigor of study, and delimitation.
CHAPTER 4
PRESENTATION OF FINDINGS

This chapter presents the findings of the study. The research question used in the study was: “What is the lived experience of caring for persons who had a peaceful death in an ICU?” There are two sections that follow: findings relating to the uncovering of the thematic aspects and thematic categories within the four lived worlds.

The first section is the findings dealing with uncovering the thematic aspects. It presents the results of the analysis that were used to arrive at the structure of the phenomenon of caring for persons who had a peaceful death in the ICU. The second section is provides the thematic categories within the four lived worlds. It presents the themes and interpretive descriptions of the phenomenon of caring for persons who had a peaceful death in the ICU. These four life worlds are: corporeality, relationality, spatiality, and temporality (Van Manen, 1990).

Findings of Uncovering Thematic Aspects

This section contains the data drawn from the results of the interview question “Please tell me about your experience of caring for persons whom you believe had a peaceful death.” These results were transcribed, translated and presented according to the appropriate levels of analysis, starting from the initial step of isolating themes, reflecting on the themes within the four lived worlds, and formulating thematic categories. From
these essential themes or thematic categories, the lived experience of caring for persons who had a peaceful death was structured and described.

**Isolating Themes**

In isolating themes, the researcher used two approaches - the holistic approach and the selective or highlighting approach (Van Manen, 1990). In the holistic approach, the researcher attended to each participant’s description of experience. This was done by reviewing the transcriptions and establishing the meaning of the experience without making judgments about specific textual data that reflects the phenomenon being studied. From this initial reading/review, the researcher was able to capture the fundamental meaning of the experience through a formulated phrase. What follows are statements, expressions derived from understanding the captured general meanings of phenomenon of caring for persons who had a peaceful death in the ICU. These are the captured general meanings from the transcriptions of all the interviews of the 10 participants:

1. It is the experience of being an expert at the end-of-life care.
2. It is the experience of being a spiritual director at the last hour of the patients’ lives.
3. It is the experience of being with the dying persons and their family members authentically as if being a relative.
4. It is the experience of knowing and understanding the dying persons and family members during their times of need and wishes, and knowing how to respond to their needs and wishes.
5. It is the experience of mutual care for others.
6. It is the experience of transforming hope of living to accepting impending death and to let go of the patient.

Having identified the initial meanings, subsequent data analysis proceeded using the highlighting approach to identify and select the significant words, phrases or statements from each transcription that describe the phenomenon being studied. The selected phrases and statements (highlighted texts) were conceptualized according to meanings and transformed into the language of nursing. These transformed meanings were called themes. Code numbers were used for each selected phrase and statement and linguistic transformations. The following examples are shown to illustrate the process of isolating themes by using the highlighting approach:

Example 1

Highlighted text in Thai:

Translated text into English: (highlighted words are italicized)

I felt that I did my best as far as I could. We had to work with our hearts and we should do like this with other cases. Then this is a success. [P111L10-12]

Linguistic transformation (theme):

Doing the best and working from the heart leads to successful care (P1A1)

Example 2

Highlighted text in Thai:

Philip will act in the movie. We all must know the meaning of the soldier's life. 35
Translated highlighted text in English:

We will arrange what we can do, that is, close a curtain. I close a curtain on both sides of the dying patient’s bed. [P71L163-165]

Linguistic transformation (theme):

Creating private space for the patient and family—closing a curtain (P7A27)

Example 3

Highlighted text in Thai:

หลังจากหมอคุยแล้ว ที่ผ่านมาการรักษาทุกอย่างหมด แต่เราไม่หยุดการดูแล

Translated highlighted text into English:

After doctor talked to relatives, *all treatment was stopped*. But I did *not stop my nursing care*. [P11L39-40]

Linguistic transformation (theme):

Continuing care for the dying patient (P1A11)

Reflecting Themes Within the Four Lived Worlds

The transformed language or themes from the highlighting approach were reflected within each lived world of corporeality (lived body), relationality (lived relation), spatiality (lived space), and temporality (lived time) (Van Manen, 1990). The following examples illustrate the results reflecting themes in each lived world. These results are from the data analysis of the translated transcriptions of three participants, namely Participants 1, 7, and 9. Results of another two participants, namely Participants 2 and 3 are presented in Appendix E.

*Themes in lived body:*

Participant 1
Doing the best and working from the heart that leads to successful care (P1A1)
Satisfaction that the best has been done for the patient and relatives (P1A5, A41)
Readiness to care for the patient who is near-death (P1A17)
Rewarding the self for accomplishment in care (P1A23)
Being with the dying patients - spiritual guiding, comforting, touching (P1A15, P1A21, P1A33, P1A39)
Understanding the patient’s situation as with ‘waiting for someone’ (P1A27)
Participant 7
Being with patient - touching, talking, providing care activities (P7A3, P7A5, P7A36)
Being with a dying patient’s family - genuine listening (P7A46)
Do the best for the dying patient (P7A10, A23)
Being ready to care all time (P7A21)
Caring with the heart, sincerity (P7A25, P7A39, A40)
Personal experience to trust dying patient - having experience with my father (P7A33)
Compassion to dying patient - feeling empathy and good wishes (A22, P7A41, A45)
Understanding self to care - knowing self as to quality of life (P7A42)
Participant 9
Self-reward - feeling good with success in care (P9A6, P9A32)
Being with dying patient - saying positive words to the patient (P9A7)
Being with patient’s family - supporting and giving time (P9A38)
Being with patient’s family - seeing them often, holding hands, offering self to help, and giving time (P9A39, A40)

Being concerned about the patient’s family members about the feelings when dealing with their lived one dying (P9A48)

Intention and experience of loss and being with patients and relatives (P9A55)

Having experience of loss and understanding dying patient’s relatives (P9A56)

*Themes in lived relation:*

Participant 1

Showing respect for dying patient (P1A14, P1A20)

Recognizing family struggles (P1A13)

Concern about other’s relationship with patient (P1A28, A29)

Participant 7

Doing forgiveness for the dying patient (P7A3)

Knowing the patient - sudden dyspnea is waiting for someone (P7A12)

Knowing the patient – need to be conscious for doing religious rituals (P7A15)

Awareness of patient’s belief (P7A20)

Believe a dying person’s communications and knowing he or she is about to die (P7A29, P7A30, P7A32, P7A34)

Respect dying patient - being aware of seniority (P7A37)

Participant 9

Knowing the patients that they know they are to die (P9A3)

Caring for the dying persons and their families as if they are my relative (P9A15, P9A41)
Knowing the family cares - worry, fear, hope (P9A11)

Knowing family care - understanding family’s need to care (P9A28)

Mutual care - sharing information with doctor about care (P9A19)

Mutual care - relative as a coordinator and supporter of the others (P9A26)

Team working with doctor - coordinator between doctor and patient’s relatives (P9A52)

Knowing the culture of care activities and giving to and taking from the parent (P9A29)

Changing work pattern by using family participation in care (P9A30)

Relationship with relatives - going to their ceremonies (P9A63)

Preparing cloth, making up the deceased’s face, doing a ceremony (P9A59)

Themes in lived space:

Participant 1

Providing privacy – adjusting environment of care for the patient who is near death (P1A9)

Fostering an environment of care (P1A36, A37)

Participant 7

Creating private space for patient and family - closing a curtain, letting them be together (P7A16, A26, A27)

Participant 9

Fostering private space for dying a patient and the family - providing a curtain and chairs (P9A23, A34)

Satisfying atmosphere - happiness, respect, love, no guilt (P9A37, A44)
Satisfied atmosphere - being happy or saying good bye, thanking you, no tears (P9A62)

Themes in lived time:

Participant 1
Continuing care for the dying patient (P1A11)
Giving opportunity to relatives to care for the patient and considering that care from relatives is a priority (P1A4)

Participant 7
Applying care appropriately with time and alternating rhythm of care (P7A43)
Judgment to respond to needs and flexible time to be with patient (P7A11)
Preparing relatives to accept patient’s death (P7A8, A9)
Preparing dying patient a few day before his death (P7A48)
Continuing to preparing the family relatives (P7A49)
Last time of patient’s life for doing religious rituals (P7A50)

Participant 9
Preparing relatives’ mind about impending death of the patient (P9A2)
Start caring early (P9A1)
Doing orientation of relatives in the first 24 hours (P9A10)
Continuing to talk to relative (P9A24, A53)
Significance of time such as having time to prepare death, to be with and to care for (P9A54)
Formulating Initial Thematic Categories

The identified themes, grouped according to their reference to a particular life world, were further grouped, this time according to an identified essential theme or thematic category. Following the grouping of thematic categories according to the life world, the researcher proceeded with determining descriptions of the phenomenon of caring for persons who had a peaceful death in the ICU. All themes in each lived world from all 10 participants were critically and carefully considered. This was done to capture the exhaustive description of the lived experience of caring for persons who had a peaceful death. The researcher continued to ask essential questions. One particularly question was: ‘If this specific theme was deleted, will the phenomenon be the same?’ When the thematic categories were selected, the researcher generated the thematic structures of the phenomenon. The following are the results of formulating the initial thematic categories and their corresponding themes.

Lived relation:

Thematic category: Knowing the person as a caring person

Three corresponding themes were identified: expert care and knowing in nursing; knowing a dying person; knowing the family

Thematic category: Authentic presence

Two corresponding themes were identified: as a relative; as a spiritual director

Thematic category: Mutual care

Two corresponding themes were identified: collaboration in care; compromise in care
Lived body:

Thematic category: Self-knowing as caring person

Two corresponding themes were identified: knowing self to care for other persons; knowing self to care for own self

Thematic category: Ready mind to care

Two corresponding themes were identified: focused mind, intention of caring

Thematic category: Self-positive

Two corresponding themes were identified: rewarding to the self as a caring person, self satisfaction with care

Thematic category: Self-doubting

Two corresponding themes were identified: self-doubt from doubtful knowing, self-doubt as a knowledgeable practitioner

Lived space:

Thematic category: No space

Two corresponding themes were identified: no room for dying, being in the complexity ICU environment

Thematic category: Adjust space

Two corresponding themes were identified: fostering private space to care, creating quiet space to care

Thematic category: Happiness space

Two corresponding themes were identified: being in the midst of satisfaction, being in the midst of a peaceful family
Lived time:

Thematic category: Opportunity

Three corresponding themes were identified: opportunity to die, opportunity to prepare family’s mind, opportunity for family to be with dying person

Thematic category: Continuing

Two corresponding themes were identified: continuing to inform the family, continuing care for dying person

As these initial thematic categories were identified, the researcher started writing descriptions of the meanings within the thematic categories. The researcher wrote and rewrote to review and refine the many versions of these thematic categories. In addition the researcher returned to the experience of the participants by continuing to read the interview transcriptions and listen to the recorded interviews. Rewriting thematic categories based on new reflections derived from prolonging immersion into the data helped the researcher to understand the meanings of the experience much more clearly. Further new meanings of the experiences of the participants were also discovered.

The researcher held collaborative discussion or hermeneutic conversations (Van Manen, 1990) on themes and thematic descriptions with a Thai professor of nursing who is an expert in end-of-life care in Thailand. Two colleagues from the Faculty of Nursing in southern Thailand were also included in these discussion. Furthermore, the researcher had conversations about the findings with some participants as they are co-researchers in the study (Van Manen, 1990). The questions, interpretations, confirmations, and clarifications were used during the process of hermeneutic conversations. The results of
collaborative analysis on the identification of themes and development of thematic descriptions greatly assisted the researcher. It became possible to generate a clear and insightful appreciation of the phenomenon of caring for as it was lived by those nurses experienced caring for persons who had a peaceful death.

The researcher consequently organized and reorganized the thematic categories within each lived world. Some themes were added based on the hermeneutic conversations, while some themes were deleted from thematic categories, or moved when if found to better reflect another life world. A bi-lingual nursing professor who is an expert in end-of-life care read all thematic categories. She validated the participants’ translated excerpts from Thai to English. This expert also provided some clarifications and suggestions about the translation of themes from Thai language to English and the identification of thematic categories. The researcher undertook further analysis with the assistance of dissertation committee members in the United States of America and completed the writing up of the findings.

Summary of Findings of Uncovering Thematic Aspects

This section presented the results of the data analysis - from isolating themes, reflecting themes within the four lived world, and formulating thematic categories. The presentations of the results illuminated the progression and development of the generation of data following the hermeneutic phenomenological approach (Van Manen, 1990).

Thematic Categories Within the Four Lived Worlds

The following thematic categories resulted from various analytic iterations using the hermeneutic phenomenological approach (Van Manen, 1990). Although, the
description of the lived world is presented separately and individually, these four life worlds form an intricate unity as the description of the lived world of nurses who cared for persons who had a peaceful death.

Corporeality (Lived Body)

Van Manen (1990) states we are always bodily in the world. This lived world refers to descriptions of bodily relationships between persons. In the practice of nursing, the nurse uses her body to care for persons, often by performing physical care, including those who have just died in ICUs. Appreciating this lived body is critical to the realization of a lived world. This world fosters the view of a peaceful death as an experience that challenges and eventually enhances the nurses’ recognition of promoting a peaceful death.

In this study, four thematic categories reflected the lived world of corporeality. These four themes are mindful readiness to care, offering self authentically for others, communicating caring through touch, and honoring the self for giving care. The following are descriptions of the thematic statements with supporting translations from the participants.

Mindful Readiness to Care

The experience of mindful readiness to care allowed the participants to express their prior experiences, knowledge, ability to judge, confidence, maturity, and preparing of information regarding the dying persons and their families, and being mindful about the patient’s care. One participant stated that: “Being ready is having the knowledge, experience and the abilities for clinical judgment in this situation” [P4, Malee]. The participant’s own experience of personal loss is expressed in the loss of her own patients.
These experiences were impacted upon by the participant’s knowledge about the influences of beliefs and religious practices during a person’s dying process. A participant explained that:

Prior experiences are helpful, both directly and indirectly ...that our experiences of losing someone or whom we have been taking care of as patients for a long time...we have witnessed activities on many occasions...so we pick up those experiences and use them and use (beliefs and guidelines) religious practices to support our understanding of the experience. [P7, Oranut]

Another participant reported her conscious readiness to care because of her knowledge and experiences in caring for persons who had a peaceful death.

I think I am ready to approach cases like these, through my experience and knowledge. But I have to prepare information and understand the relatives’ reaction to treatment or may be that relatives have some concerns...if so, I will be able to help and assist them in their care of the loved one [P2, Areerat].

This participant revealed that with experiences such as this, her competency to care was enhanced. “Actually, the reason that we are able to do is that we have been growing in this caring for some time now” [P2, Areerat].

Regarding mindful or conscious readiness, the practice was described by the participants as increased confidence in trusting themselves to be able to help the dying persons and families by caring. A participant expressed this:

It is like that we come to see them, like we are not concerned that we cannot manage. It is like we know that we will seek for options to help them. But even if
we don’t know, we will be able to find someone who does know and is keen to help us manage. [P6, Sirinthra]

Furthermore, this participant reported about her readiness, confidence and competency. Mindful readiness to care was an experience described by a participant when she said:

We are ready to give counseling to them, like sometimes relatives were confused, but we aren’t. We are able to see the way forward and guide them, and give them some advice. [P6, Sirinthra]

The meaning of being mindful and ready to care is significant to the participants who care for the dying persons. This assurance of peaceful death is providing with a ready mind, or a peaceful mind, a focused mind, a strong mind. There are thoughts of goodness and meritorious deeds or having good intentions, to experience the provision of care and to assist the person who had a peaceful death. One participant expressed the idea that: “I realized my importance in caring for the patients who had a peaceful death” [P4, Malee].

Further, the participant described her experience of mindful readiness as: “Being ready in terms of our focused intentions because we are the ones who participate in the care” [P2, Areerat].

Mindful readiness is an experience in caring—in which the nurse takes care of both the relatives and the patient. In situations such as this, the nurse may find that the relatives may not accept death and may be in denial. Therefore it was the participants’ experience that the nurse must have a focused appreciation of the value of the relatives, expressing every good wish for a meritorious dying process. Similarly, another
participant affirmed: “Peaceful mind and good wishes will become caring power and will be sent out to the persons who are dying to be peaceful and comfortable” [P4, Malee].

Offering Self Authentically for the Other

Offering self authentically for the other is the offering of self to be with the dying person and his/her family members with good intention to care with sincerity, empathic understanding, and concern and insight. The participants understood that anguished family members could not set their minds to think and remember at this time of loss; therefore, the participants offered themselves to be with them.

Thinking that if it were us the best way will be to ask questions, the person should have someone to talk to. In that situation perhaps they might have an idea. If we are with them, and if they have something, they would ask. Perhaps it is like we provide for them the opportunity to ask whether they have something to ask or whether they need some help. Because those who have lost someone, often they cannot think about things to do. Therefore, it is better to be there waiting for them to ask. [P2, Areerat]

Even though the participants could not do anything for the relatives, they think that at least the relatives are not alone. A participant expressed the feeling that: “I feel that I want to help them. If I cannot help them with anything, being there with them will be good as well, especially when they don’t have any person to be with [P2, Areerat].

Being with the dying persons and their families, the participants provided understanding that they were the embodiment of good intentions to care. As a participant stated:
We come to care for the dying patients sincerely. We have good thoughts that we want to help them to get well and to comfort them. Our thoughts are not about bad things happening to them. [P6, Sirinthra]

The participants presented themselves as having empathetic understanding for the dying persons and their families. The participants stated that they understood the families’ feelings as similar to theirs given the same situation. A participant thought that:

We must understand their feelings as we take their heart to our heart. Supposing that we are in a situation the same as them, how will we feel? [P4, Malee]

Another participant stated that: “How would we have felt if our parents were in this situation?” [P1, Supit]

Some participants shared the idea that their understanding of how their own experience of loss influenced them to feel for the other, particularly the members of the family of the person who had a peaceful death. “We had experienced similar loss so that we can empathize with them” [P7, Oranut]. Another participant expressed her empathetic understanding from own experience of loss:

We cannot see through the relatives’ eyes because we never have experienced this event before. It is not that we don’t want to care…but it may not be a relevant feeling…doesn’t really understand them. I told the juniors that ‘If you used to lose someone, you will do better. [P9, Jaidee]

Offering self as an authentic presence for the other is a worthy description of the participant’s experience of caring for a person who had a peaceful death. Furthermore, the participants explored other dynamics that they felt were important in expressing authenticity of self for the other. In offering self, a participant reported: “We understand
how the persons who had peaceful death suffered, but we do not let ourselves be ‘in’ the situation and cry with them” [P3, Wanpen].

In addition, in offering self, the participants presented themselves for the person and his/her family. A participant thought:

I must be concerned about how they are, are they o.k.? It is like we have to look at them often and find out that they need help or not. But in nearing death we become more concerned about comforting them rather than focusing activities about the (biological life) by taking vital signs. We become more concerned about the relatives’ feeling. [P4, Malee]

A participant provided an understanding of her concern and insight when being with the dying persons:

We know that all patients know themselves before they die. They provide ‘warning signs’ [in Thai ‘้ำนิ่ง/lang-bok’]. However, sometimes, we are distracted by little things and become unaware, while sometimes losing interest in what they are trying to tell such as they want to go home to see their children, to see their grandchildren, or to see the persons that they have not seen before.

[P9, Jaidee]

Communicating Caring Through Touch

Touch is significant to communicate sincerity, good wishes, gentle care, and warmth to the person who is dying and his/her family. A participant stated: “I think that both relatives and patients need touch because it communicates that the nurses want to care for them either sincerely or not. Touch is important.” [P7, Oranut] This was also expressed by one participant who described her experience as:
Transferring our good wishes, concern, sincerity, warmth to the dying patients and their families. We communicate our feelings through touch. [P3, Wanpen]

Touching and talking conveyed caring to the dying persons and their families. A participant stated: “We use both talk and touch with the dying patients and we also touch the relatives. Talking only is not enough in caring” [P3, Wanpen]. Also, touching and talking communicates to the dying person that the nurse is there to care for her/him and to comfort him/her. A participant stated:

I held his hand, touched his chest and said ‘Please breathe slowly, don’t be afraid. I am here.’ ...When we touch the patients, they will not be fearful of dying alone. They will feel relaxed. They are comforted by the thought that someone is with them. [P7, Oranut]

Another participant reported her thoughts regarding touching as communicating: “Caring into the heart” to the dying person.

Touching the forehead made her feel warm. Thinking that someone is touching us makes us feel that we are not alone. It is like that person is giving a good will for us. Touching a forehead represents a soft/gentle caring and approach into heart. When we touch the forehead, dying patients look peaceful and relaxed. [P4, Malee]

Honor Self for Giving Care

Honor self for giving care was described by the participants as the active psychological feelings of pride and happiness. This happens when the participants achieve through providing care, complete their responsibilities as a professional nurse, and as a giver to the dying persons and family members. The participants are happy and
proud of working with their hearts and that the dying persons had a peaceful death. A participant expresses her satisfaction when she claimed:

I felt that I did the best I could. We had to work with our ‘heart.’ We should do like this with other cases. It indicates that the dying patients died peacefully. I felt happy and satisfied that I have rendered the best care for the person who had a peaceful death. [P1, Supit]

Another signified her happiness after she did her best in caring: “We will feel happy after we made our entire attempt” [P10, Nipaporn].

In addition, some participants experience the honoring of the self for giving care. They helped the dying persons and families get through the various situations, starting with aggressive treatment and the prolonging of the dying process, until they were allowed to die peacefully. A participant stated: “We felt good to ourselves that I talked to the dying patient’s husband until he understood and could accept this loss and let go of the patient to die peacefully” [P4, Malee].

A participant explained:

We feel proud as we can help them get through that hump. It feels like we are a giver. We feel satisfied as we take the full responsibility of being a nurse. We not only record vital signs, we also provide spiritual care. [P1, Supit]

Description of Corporeality (Lived Body)

The lived experience of nurses within the world of corporeality (lived body) is described as mindful readiness to care and offering self authentically for the other, and by communicating caring through touch, with honoring self for giving care.
Relationality (Lived Relation)

Lived relation is the way that we maintain associations with others in the space that we share with them (Van Manen, 1990). Descriptions of the experience reflected in lived relation provided meanings within the encounters of the nurse and the one nursed. Five thematic categories reflect the lived world of relationality. These are understanding relationships as vital for dying persons and family members, understanding family members as the one nursed, valuing person who has died as person, enhancing nurses’ relationships with others, and valuing ending relationships (karma) at the moment of death. The following are descriptions of the thematic categories and the corresponding themes with supporting translated statements from the participants.

Understanding Relationships as Vital for Dying Persons and Family Members

The thematic category of understanding relationships as vital for dying persons and family members provides descriptions of the participants’ experiences. Thus the importance of family members is recognized as integral to the dying persons having a peaceful death. The roles that cultural beliefs exert on influencing relationships between dying persons and family members are significant to having a peaceful death. The recognition of these roles is evident because of the presence and input of the family members.

Family members are significant to dying persons. The participants understand that family members are the persons that the dying persons are most familiar with and know best the dying persons’ needs and wishes. A participant thought: “The families/relatives are more important to having a peaceful death of the patient than the nurses and doctors” [P4, Malee]. This participant explained further that the dying persons will perceive the
caring of family members is more than the participants do for them since the family members are familiar persons for them. An example of this experience is “We feel that the relatives are closer to the dying patient than us. What they do for the dying patient is perceived as more than we do. We are persons that the patients are unfamiliar with” [P4, Malee].

Family members are the persons who understand the dying persons and know their needs and wishes more accurately than the participants. A participant described her struggle:

We have to depend on the relatives so as to know the dying patients’ needs from them. If there is no relative, we can provide care but we don’t know that the care is consistent with the needs of the dying patient or not. [P4, Malee]

Another participant affirmed the significance of the relationship between family members and the dying persons when she claimed that:

Family members are the important persons to the dying patient. We understand that the persons who have the most understanding of the dying patient are the patient’s family members/relatives. [P10, Nipaporn]

Cultural beliefs and family members. The participants shared their experiences that Thai cultural beliefs influence the family members in their desire to be with the dying persons and to provide care for them. A participant reported that the Thai cultural belief of ‘doing for as giving back’ empowers the children to care for the dying parents. An example supports this experience:

At the end of life, all children want to do things for their parents. They want to clean their parents’ body. They feel a relief. They feel like they do the good thing
back to their parents...Some family’s members want to care for their parents very much. [P9, Jaidee]

In addition, the participants had the experience that Thai cultural belief associated with being with the dying persons for the last time causes the family members to visit the dying persons.

A participant suggested that Thai Buddhists come to visit dying persons at the time of death for their happiness and for the dying persons’ peace. An example of this cultural belief is:

In our culture as Buddhists, if you come to visit the dying patient [in Thai ‘มด-เจ้า’] you will feel good, happy, the patient will also go peacefully, you don’t have any worry. [P9, Jaidee]

Another participant shared the experience of a Thai Muslim in visiting the dying persons regardless of for getting merit. This excerpt supports this experience:

For Islam, most of village members will visit the dying patient. I heard from their relatives and my Muslim friend said that the result of this visiting was getting merit [in Thai ‘บู’]. The more they get together, the more they receive ‘บู’.

They will perform praying for the dying patient. [P1, Supit]

The participants have to understand this culture and allow their loved one, family members, friends, relatives, and village members to stay around the bedside and pray for the dying persons. However, the participants felt that allowing these persons to be at bedsides also interfered with the environment of the other patients, particularly Thai Buddhists who prefer being in a peaceful environment. A participant explained her struggle about the different cultural values and beliefs:
It interfered with the patient in the next bed. We must have a period of time for them. There were two beds, a Muslim near death and a Buddhist near death. These two beds were right next to each other. At the Muslim’s bed, there were a lot of people visiting to pray and generate noise. But Buddhists needed to be in a quiet environment. It is an opposite way. [P1, Supit]

*Understanding Family Members as the Nursed*

The thematic category of understanding family members by the nurses describes the participants’ experience with family members whose relative had a peaceful death. In this situation, the nurse recognizes that family members also need to be supported, regardless of their loss. That is, in a situation of loss, the family members will experience bereavement and grief, and psychological reactions such as denial, anger, and depression. The significance of this thematic category focuses on the lived experience of the nurse in relation to the family members’ reactions to their relative’s death. This can affect the experience of the person having a peaceful death for. The following themes further describe this category.

*Understanding family members’ experience of their loss.* The participants understood that in the situation of death and loss, the family members need to be supported. The participants experienced that the family members have many psychological stresses. A participant expressed it thus: “Because in that situation, relatives will have many stressors, and will think about many things” [P5, Janjira]. The participants share the experience related to families’ emotional stresses that *fear, worry, guilty,* and *hope* are the feelings that have occurred.
It is fear, not bravery to stop (treatment). They will feel they are doing wrong or doing harm [in Thai ‘วินิจฉัย’ or ‘doing bad karma.’ [P10, Nipaporn]

Another participant thought: “We know that they are worried, afraid, and want to have hope” [P9, Oranut]. The participants understood that the family members who had never experienced loss would have difficulty in dealing with the situation of death and loss. A participant explained “Since, the relatives may not have the experience of a prior family death, then the relatives could not think how to manage things during their experience of grief and loss” [P3, Wanpen].

The participants understood that they had to include the family members in their care. A participant stated: “At the end of life, we have to care for both the dying patient and relatives” [P6, Sirinthra]. The participants understood the significance of providing care for the mourning family members as a priority. A participant thought: “I will provide support to the relatives first and then the dying person” [P9, Jaidee].

*Family members’ reactions influence having a peaceful death.* The participants shared their experience about the need to care for the family members. They realized that the family members’ reactions can affect a dying person’s calmness and peaceful dying. A participant explained her experience:

A reaction from the relatives can affect the patient. That is…the patient is going to die but the relatives want the dying patient to stay with them. They think that the dying patient will get better tomorrow. The dying patient will hear this and become agitated. [P2, Areerat]

This participant went further: “When the relatives are calm the dying patients will perceive this calmness although they are unconscious, and then they will calm down as
well” [P2, Areerat]. Another participant affirmed: “When the family members are calm, the dying patients will be calm” [P4, Malee].

Valuing the Person Who Has Died as Person

Valuing the person who has died as person was described by the participants as having a relationship with the person who has died by caring for the dead person as a human being. When the person dies the person is kept in the unit for two hours, according to the hospital’s policy. Apparently this rule is to confirm that death has occurred. During this time, nurses continue to care for the deceased as a human being by continuing to provide care activities after death, such as cleaning the body, dressing the body, and providing facial make up. A participant stated that: “The respect does not stop when the patient died otherwise the patient will not have human value” [P3, Wanpen]. Valuing the person who has died as a person is demonstrated in after-death care. The participants will clean the dead body and dress it. For the women, the participants will ask the family members to permit the participants to apply make up to the face. A participant expressed her valuing of the person who has died as person in the following manner,

If the patient does not have any relative present during his death, we will provide …for the patient. In the past, we used only one piece of hospital cloth to wrap the deceased. It is as if we did not honor the deceased as person because they could be exposed. In cases where the doctors had performed many procedures and the patient looked unkempt, when the relatives want to see them we would change their clothes. If we could not change the clothes, we would hide the dirty areas. We will clean the patients’ faces and make them look good. [P2, Areerat]
For Thai Buddhists, the participants will place a flower with candle and ceremonial stick in the dead person’s hand to pay respect to Buddha on the way to the heaven.

*Enhancing Nurses’ Relations With Others*

Enhancing nurses’ relations with other describes the participants’ experience as being a coordinator of relationships, connecting as a relative, and maintaining a good relationship with family members.

*Being a coordinator of relationships.* The participants reveal their experience as a coordinator of relationships. Being a coordinator of relations identifies the participants as significant persons participating in the care for the patient, his/her doctors and nurses, and his/her relatives. The participants understand that family members are afraid to visit their relatives in ICU units. Furthermore, the visiting time policy is often limited and strictly enforced. The participants understand that they are the persons who need to contact the patient’s family members and facilitate their coming to the ICU and be with their loved one. This was explained by a participant who claimed that: “The nurse contacts family members to visit and stay with the dying persons. Some families are afraid to come to the ICU. Visiting hours are limited” [P3, Wanpen].

Similarly, the participants explained that their experience pointed to the value of facilitating the visit of the patient’s family, as well as enhancing relations between the doctor and family members. A participant explained that: “If the nurse does not talk (to the doctor and the family members), the value of establishing good relationships will not happen” [P6, Sirinthra].

*Being connected like a relative.* Connection as a relative describes the participants’ experience as the feeling of attachment to the dying persons as if the dying
person is a relative. A participant who experienced her father’s loss expressed her attachment to the dying person, “When I see the seniors, I mostly think about my father. They are like my relatives. What they all want, I will do for them” [P7, Oranut]. Another participant who experienced her parents’ death expressed the perspective of caring for the patients as her relative when she said:

    I think in this way…I will care for patients as if they are my relative. What I need, and what patients and patients’ relatives need will be the same as us. I will not think too much. This is my idea. [P9, Jaidee]

This participant expressed further about her lived relationship—the connection that she had with the dying persons. Sometimes, because of this, she goes to their funeral ceremony. She observed: “For some patients who have been in our unit for a long time, we feel a certain close connection and when they die, we usually go to their ceremony” [P9, Jaidee].

    A different participant shared her experience of connection as a relative. Her connection is in the relationship with the dying persons as her relatives when she has known the family members. “If I have known the persons who are losing their loved ones, I will care as if the person is a family member. The person becomes like a relative” [P2, Areerat].

    Maintaining good relationships with family members. The participants share their experience that they could have a good relationship with the family members in the long term. The participants understand that a good relationship is a result of caring for family members during end-of-life care. A participant explained that:
I think that I provided support to the grieving family members. The consequence is continuing a very good relationship with many family members in the long term.

[P2, Areerat]

Another participant understands that family members who accept death and loss may continue a relationship with the nurses. The family members may come back to the unit and give souvenirs from the burning ceremony to the nurses. She described her experience in this situation:

If the relatives can accept death, they will come back to see us and to say good bye. If the relatives cannot accept it, they will go and will not want to see us or to see the hospital. But some relatives come back to see us. Sometimes, they bring souvenirs from the burning ceremony for us or donate money [P9, Jaidee].

*Valuing Ending Relationship at the Moment of Death*

Valuing the ending of a relationship at the moment of death describes the participants’ experience as ending ‘karma’ between the participants and dying persons or the dead persons. Ending karma between the dying persons at the moment of death is a practical way of approaching death at the end of life among Thai Buddhists. This is valued as ending relations with the dying persons or the dead persons in this earthly life. In this part of Thailand, most of the citizens are Buddhists. Buddhists have a perspective on ‘karma’ or ‘deed’. It can be explained as the law of cause and effect - that if a person makes good karma, then good karma will come back to the person, now, and in the hereafter. However, if a person has bad karma, then bad karma will come to him/her now, and in the hereafter (Dhammanada, 1987). Thai Buddhists believe that if they acted with good karma, they will be reborn in a good place or will have a good life in the next life.
At the time of death the dying persons should fill their minds with thoughts of good merits and should not have any remaining bad feelings towards others or worries left in their minds. If they do they need to have the opportunity to seek forgiveness so that they can have peace of mind and therefore go to a good place when they die. This is the wish of all Thai Buddhists - to have a peaceful death. The participants in this study valued this religious belief and its rituals - of asking for forgiveness at the time of death in order to create a meaningful next life for the dead person.

The participants shared the experience that sometimes they perform actions with good intentions towards the patient yet the actions may cause pain or discomfort to the patient, thereby initiating bad karma. The participants valued ending the ‘bad karma’ by asking the dying persons for forgiveness prior to the person’s moment of death and thus making merit for them. It is believed that the karma will be ended in this present life and will not be held against the participants and the dying persons in the next life. A participant expressed the idea that:

It is like sometimes we did things for the dying patients. And it feels like there is karma clinging between us and this karma will follow us to the next life. When we pray and make merit for the dying patients then our karma will be ended from each other. [P8, Daonapa]

Another participant affirmed that “We might do some deeds with our good intention but it makes the dying patient feel unsatisfied. If we ask for forgiveness, this will end the matter” [P1, Supit].
Description of Relationality (Lived Relation)

The lived experience of nurses in relationality (lived relation) is described by the participants as understanding the relations as vital for the dying persons and their family members and family members as like the one nursed with valuing the dead as person through enhancing nurses’ relations with other while valuing ending relationship with dying persons at the moment of death.

Spatiality (Lived Space)

The lived world of spatiality describes how one feels or relates with one another in the world in which we live (Van Manen, 1990). The nurses use ICU space in caring for the persons who had a peaceful death in the ICU. Two thematic categories reflect the world of lived space. The lived experience of nurses who cared for persons who had a peaceful death includes enabling peace of mind (solace) despite space constraints and contentment in the creation of caring environment for the death. The following are descriptions of the thematic statements and the supporting translated statements from the recorded interviews of the participants.

Enabling Peace of Mind (Solace) Despite Space Constraints

The participants in the study practiced in hospitals under the auspices of the Thai government. The structure of the ICUs in these hospitals was designed so that they were one big general room holding 10-15 patient beds. Usually, this would include 2-3 small rooms for patients in isolation due to communicable diseases, and for patients with cardiac ailments or disease. Patients and family members congregate around their loved one’s bed during end-of-life care.
The environment in ICUs featured cure and care activities. The activities in the ICU included various saving life procedures provided by many doctors and routine ICU care activities. The patients’ vital signs and symptoms were recorded at least every hour. Comforting care, the giving of drugs, and changing intravenous fluids all took place regularly. The ICU was usually very busy with tasks and crowded with people during the day time. The participants generally agreed that it was difficult to promote quiet in ICUs. As one participant expressed it:

We do not have a special room to care for the dying person. The atmosphere in an ICU is crowded with people and activities. It is not peaceful. If we can create a peaceful atmosphere for a short time, that will be good. [P6, Sirinthra]

Another participant affirmed these thoughts and explained further that

Managing the environment is difficult. It must be applied. The night shift is fine but on the day shift, the doctors will prescribe treatment procedures. It is hard to foster quiet in the environment. We will not move the dying patient into a separate room. The number of separate rooms is limited and they are always occupied. Therefore we don’t have a room to care for the dying patient. [P1, Supit]

Fostering an environment around the dying persons’ beds that was peaceful and private at the moment of death was thought to be significant. A participant stated:

We will close the curtain to make a private environment. It will be good if each ICU can have a room for each patient so that the relative can perform any religious ceremony with more privacy. Now we can only arrange the environment
around the dying patients’ beds...close the curtain and lower our loud voices and music during a time of death. [P3, Wanpen]

Another participant stated that:

I will tell the relatives of the other patients to stay at their beds and please avoid bothering the dying patient. We will arrange this as best as we can, that is, close a curtain around the dying patients’ beds. [P7, Oranut]

Contentment in the Creation of Caring Environments for the Death

Contentment in the creation of caring environment for the death was described by the participants as providing a temporary space around the dying persons’ beds. This would lead to the patient being surrounded by his/her family, relatives, friends who are all expressing their love, respect, and gratitude. As a participant claimed:

I felt everyone was happy. When the patient died, I saw that everybody showed respect to dad [in Thai ‘นิ้ว’ and hugged ‘นิ้ว’]. Everyone felt that they did some good things, held the patient, stayed at the bedside, and saw the patient until he/she died. The relatives did not feel guilty...I felt happy because the relatives were able to say good bye and express gratitude to nurses. There were no tears. [P9, Jaidee]

Another expression of contentment with the creation of a caring environment for death is not crying, for crying is not valued at the time of death. A participant stated that “There was no loud crying. An environment such as this is better” [P6, Sirinthra]. Crying is an expression of deep mourning and doing this around the dying person is not helpful. Thai Buddhists have a belief that the dying persons will be suffering and will not have a peaceful death when their families and relatives are crying near the dying persons. The
crying relatives were invited to go outside and were supported by the nurses. As a participant explained:

If a relative is not calm, then the patient will be not be calm as well. For example, in one situation when the patient died, his mom cried a lot and nobody could deal with her. I had to take her outside and told her ‘Please don’t cry. When you cry, your son will be suffering. It is like you are making him suffer and he will not be calm.’ After that, she was better. [P7, Oranut]

*Description of Spatiality (Lived Space)*

The lived experience of nurses in lived world of spatiality (lived space) is described by the participants as enabling peace of mind (solace) despite space constraints and the contentment in the creation of caring environment for the death.

*Temporality (Lived Time)*

The lived world of temporality is described as the subjective lived time reflecting the nurses’ feelings or perceptions of the time while being in the world, including the dimensions of past, present, and future (Van Manen, 1990). Descriptions of the experience reflected in lived time provided meanings about the participants’ perception of time while being a nurse caring for persons who had a peaceful death in the ICU. Five thematic categories reflected the lived world of temporality. These are: time is short and a priority; open opportunity to care for the other; valuing on-going care regardless of time; valuing a proper time to care; and accepting time of death as natural and unpredictable. The following are descriptions of the thematic categories with derived themes supported by statements translated from the interview data of the participants.
Time is Short and is a Priority

The participant’s experience focused on descriptions that illuminated the thematic category of time as being short and as a priority for the patient and family. This was expressed by the participants as the experience that family members have when their loved ones are dying. The limited time available to be with their relative becomes a main family concern. Similarly, the participants understood that life was short for the dying person, similarly giving them a short time to prioritize and provide quality end-of-life care. As a participant declared: “The time available to care for the patient is quite short. We realize that when the patient dies, we will not be able to move time back” [P7, Oranut]. This participant explained further that: “When their patient’s time to live is over, their time for care is over as well. She thought that if the nurse will only have time to care for the dying person for a second then the nurse should give this time to them” [P7, Oranut].

Time is recognized as being short for the patient and the family. The participants gave priority to care for the person to have a peaceful death, and to ensure the inclusion of the family in the patient’s care. Caring for their loved ones was viewed by the family as the most vital expression of the moment. One participant reported that: “Some of the activities that are not significant will be done later. We think that it is most important to give priority to caring for the dying person and the family” [P6, Sirinthra].

In the lived experience of time as a priority, another participant explained, there may be a situation that when the ‘task’ is to complete the patient’s chart, I choose to do other activities pertaining to the care of the person, and do the (task of completing the) patient’s
chart later. I will focus on the patient and family first since we know that they
don’t have much time. Whatever I can do for them, I will do as a priority. It is
alright to do my stuff last. [P7, Oranut]

*Open Opportunity to Care for the Other*

Time as an open opportunity to care for the other was described as time provided
by the participants for the dying persons and their families to be together as long as
possible. When the approaching death is unavoidable or certain, the participants
understood that this was going to be the last opportunity for the dying person to be in this
world and to ‘stay/be’ with their loved ones. The participants recognized that the family
is the most significant part of the dying person’s life, especially at a time nearing death.
As a participant exclaimed:

> This time, persons who are dying want to be surrounded by loved-ones rather than
> by us. It is good care to provide this person and his/her family the chance to be
> with each other during this critical time. [P10, Nipaporn]

The experience of providing the opportunity for the dying persons’ families/
relatives to be with the dying person without limiting their time was critical. This
experience was facilitated when the visiting time rule of ICUs was made flexible for the
family. The families/relatives could come into the unit and stay with the dying person,
often surrounding the person’s bed for as long as they wanted. As a participant described
it: “We will provide opportunities for them to see the patient, to be with the patient, and
do activities that will not bother other patients” [P3, Wanpen].

Another participant explained that:
In this case, we allowed the relatives to stay with the patient all the time. Since we know that the patient at the end-of-life stage needs to be with his/her parents and relatives as long as possible. [P7, Oranut]

Valuing On-Going Care Regardless of Time

Valuing on-going care regardless of time was described by the participants as the attention to care that they provided without considering the length of time spent caring for persons experiencing peaceful death. At times, after physicians decide to let go of the dying person who eventually dies peacefully, they do not continue any treatment. In such situations, participants have claimed that they continue to provide care for the dying persons and their families rather than letting the patient just simply and passively wait to die. Care activities are continually provided to the dying persons and their families until the person actually dies. As one participant claimed: “After the doctor talked to the relatives, every treatment was stopped. But I did not stop my nursing care” [P1, Supit].

Another participant expressed the view that:

While some dying patients took a long time to die, some lasted a day, while other patients only lasted a few hours or sometimes only an hour. But my care did not end when the patient died. I cared for them until their relatives took the person home. [P9, Jaidee]

At the same time, caring for families was valued as a continuing experience. Appreciating the unstable and changing conditions of their patients allowed the participants to continue giving information to the families. Continually giving information to the family members by talking to them was found to be a significant and learning experience for the participants. As one participant reported:
It doesn’t mean that we did not do anything. We intend to assist the patient as much as we can. However, if their condition is too serious, the doctor and nurse will continue to talk to the relatives to prepare them to accept death. [P9, Jaidee]

Another participant claimed that: “Caring for the families is about talking and informing them that the patient is nearing death. We must continue to give information to them” [P4, Malee].

Valuing a Proper Time to Care

Valuing a proper time to care was described by the participants as time to do care activities for the dying person and his/her families with the right timing. Preparing the patient for his/her eventual death can proceed after reconciling the terminal nature of the patient’s condition, and the physician’s and family members’ decision to proceed with end-of-life care. Otherwise, the simple gesture of care indicating letting go, when the patient, his/her family and the physician have not come into terms with this situation, will have unfortunate outcomes. It will only trigger the family members’ unforgivable feeling of relinquishing the patient’s life to death. As a participant explained,

If the patient’s time to die doesn’t arrive, I cannot prepare the patient. Suppose the patient has not reconciled his dying and I already talked to him/her about death and then the patient’s situation worsens, it will put me and the relatives in a bad situation. Therefore, I can’t prepare the patient for his death in advance. [P7, Oranut]

In estimating the valuing of proper time to care, the participants had to keenly observe and use their judgment to consider the best fit between performing end-of-life
care and the preparedness of the family. Oftentimes, the family’s emotions at a particular moment provide the best clue. As a participant stated:

When the relatives came in, the junior nurse talked to them and asked them to bring the set of clothes that the patient will wear when he dies. I felt that this was not an appropriate time to talk about this. We can talk about this later on, perhaps after the patient has passed away peacefully, because then the relatives can have closure regarding their loved one’s dying. [P6, Sirinthra]

Similarly, another participant observed that:

It is not the best time to ask relatives about what the patient used to say before his/her death, especially when the relatives have not accepted the patient’s death. We have to wait until the doctor tells the relatives to ‘let go’ and that is the time that we can assess what the patient’s wishes or needs are from the relatives. Nevertheless, the time to do this is often very limited. After the doctor tells the relatives to ‘let go’, the patient may die quickly. Asking the relatives about the patient’s wishes requires that we observe closely the relatives’ emotional state at the moment. [P4, Malee]

Accepting Death as Unpredictable and Natural

Accepting the time of death as natural was described by the participants as death being certain although the exact time is unpredictable. A participant expressed her ‘acceptance of death’ experience of a critically ill patient dying at any moment.

It is a critical situation and death can come at any moment. For example in the case of post-operative open heart surgery, in the first 8 hours sometimes patients
have good vital signs and good symptoms but they may have massive bleeding and then die unexpectedly. [P2, Areerat]

The participants accepted that they could not predict the time of death and that death happens regardless of its expected time. A participant explained:

We must accept that the time of death cannot be hastened nor can it be slowed down. We have to remind ourselves that patients will die in their own time. We cannot predict the time of death to be in the next hour or that this patient is taking a long time to die. We must understand that the time of death will come naturally. We cannot predict with certainty the time of death of the patient. [P3, Wanpen]

In another experience, a participant explained that death happens regardless of the family’s expectations—that death will occur in its own time.

The relative mentioned that when they were ‘chanting’ for the dying patient, it was as if the dying patient did not want to ‘let go’ and pass away. I encouraged the family to be calm. If it is not his time, the patient will not die, but if it is his time, he will die naturally. [P7, Oranut]

Still another participant affirmed the situation of accepting the time of death as unpredictable and natural.

The relatives want to prolong the dying patient’s life and decided to ‘let go’ the patient after Wednesday (a specified day). I told the relatives that I cannot set the time that the patient will die as death can happen at any time. The dying patient may die on Wednesday if it is his time. [P5, Janjira]
Description of Temporality (Lived Time)

The lived experience of nurses in temporality (lived time) is described as time is short and a priority to open opportunity for other by valuing on-going care with a proper time, and accepting death as unpredictable and natural.

Chapter Summary

This chapter presented the findings of uncovering thematic aspects and thematic categories within four lived worlds. The findings of uncovering thematic categories provided understanding how the researcher attained to thematic categories. The findings of thematic categories within four lived worlds provided thematic categories and corresponding themes with their descriptive meanings and excerpts. Presentation of the themes, descriptions of meanings, and excerpts assisted in understanding the lived worlds of the nurses caring for persons who had a peaceful death in ICUs.
CHAPTER 5

DISCUSSION AND IMPLICATIONS

Chapter 5 presents two main sections. The first section is the discussion of findings from the research question. The findings are explained and discussed in relation to the existing literature and in the context of the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a). In the second section, the implications, the knowledge from the findings and the discussion are converted to implications for nursing practice, nursing education, healthcare policy, and further nursing research.

Discussion of Findings From the Research Question

The aim of this section is to explain and discuss the findings of the research question: “What is the lived experience of caring for persons who had a peaceful death in an ICU?” In this discussion, the thematic categories are discussed in relation to current or existing literature, including the major assumptions and concepts of the theory of Nursing as Caring by Boykin and Schoenhofer (2001a). This theory offers broad concepts about caring that can be used in a variety of nursing situations. This should facilitate an understanding of the descriptions of the nurses’ lived experience of caring for persons who had a peaceful death in ICUs in Thailand. The major assumptions and concepts of the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) are used as the lens through which the discussion of the findings is viewed.
There are six major assumptions of the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a, p. 1-9).

1. Persons are caring by virtue of their humanness. Caring is an essential feature and expression of being human. Each person grows in his or her competency to express the self as a caring person. All persons commit to know the self and the other as a caring person.

2. Persons are whole and complete in the moment. Persons are whole, complete and live in a caring way from moment to moment. There is no insufficiency, no brokenness, and no absence of something in a person. This assumption offers a lens for viewing the essence of being with another to prevent the segmenting of a person into component parts.

3. Persons live in a caring way from moment to moment. Boykin and Schoenhofer (2001) state that “Caring is lived moment to moment and constantly unfolding” (p. 2). When a person calls for nursing, the nurse as a caring person comes to know that person in the moment. The development of competency in caring occurs over a lifetime. Throughout life, a caring person comes to understand what it means to be a caring person, to live in a caring way, and to nurture others.

4. Personhood is a way of living grounded in caring. Boykin and Schoenhofer (2001) believe that “Personhood is the process of living grounded in caring and implies living out who we are, demonstrating congruence between beliefs and behaviors, and living the meaning of one’s life” (p. 4).

5. Personhood is enhanced through participation in nurturing relationships with caring others. As a process, personhood acknowledges a person as having continuous
potential for further caring. Personhood is being authentic, being who I am as a caring person in the moment. This process is enhanced through participation in nurturing relationships with others. Personhood is the outcome of caring.

6. Nursing is both a discipline and a profession. As a discipline, it relates to all aspects of the development of nursing knowledge. This theory focuses on the knowledge needed to understand the fullness of what it means to be human and on the methods to verify this knowledge. Knowledge of nursing comes from within the situation. As a profession, nurses use knowledge of nursing in response to human needs. As a human science, knowledge of nursing is in the realms of empirical, ethical, aesthetic, and personal knowledge (Carper, 1978).

Van Manen (1990) expressly declared that consequent to the use of existing literature and theory, discussion can provide a clearer understanding of the lived experience. In addition, through the use of literature and theoretical viewpoints, discussion can ascertain the understanding of the findings of the lived experience of caring for persons who had a peaceful death in ICUs. With a discussion of these lived experiences, insights into the implications of the study are made clear.

Corporeality

There are four themes in the lived word of corporeality (lived body): mindful readiness to care, offering self authentically for the other, communicating caring through touch, and honoring self for giving care. Themes in corporeality found in existing literature were discussed, followed by a discussion of those themes in relation to the theory of Nursing as Caring (Boykin & Schoenhofer, 2001).
Discussion of Themes in Corporeality in Existing Literature

Mindful readiness to care. The participants understood that the following contributed to their readiness to care: prior experiences of their own family members’ loss and clinical experience of dealing with deaths and loss in an ICU, knowledge, judgment ability, confidence, maturity, and preparing information relating to the dying persons and their families. This description of mindful readiness to care is similar to the findings of Chaipet (2007). These findings revealed the experiences of intensive care nurses caring for dying patients. The direct experience of caring for dying patients in clinical practice and experience of their own family members’ loss was significant to the intensive care nurses. These experiences assisted the intensive care nurses in understanding the dying patients’ and their families’ reactions to loss and death.

Similarly, in this current study, the prior experience of their own family members’ loss and clinical experience was valued by the nurses in ICU. This is consistent with the findings in two studies about end-of-life care. Tyree, Long, and Greenberg (2005) explored how nurse practitioners approach end-of-life care and found that experience and education contributed to the comfort level and the abilities of nurse practitioners to initiate end-of-life care discussion. Another study by Lange, Thom, and Kline (2008) found that registered nurses (RNs) with more years of work experience had more positive attitudes toward caring for the dying patients. The findings of two studies are similar to finding in the current study in that experience and knowledge are significant and contribute to the readiness of nurses to care.

Mindful readiness to care also meant having a peaceful mind, a focused mind, a strong mind, and thoughts of goodness and meritorious deeds or having good intentions.
The intensive care nurse in the Chaipet (2007) study described a ready mind to care as good intention to care. Good intention to care was fostered by love, understanding, and compassion for the dying patients and their family members. The consequence of good intention to care was caring for the dying persons and family members using their entire competency. Hirsti (2003) proposed that mindfulness from Buddhism’s perspective to be an awareness of being, which required attention and concentration to be present in the current moment. Mindfulness in Buddhism is similar to mindful readiness in the current study in that the participants were aware of the self, ready to care, and had focused minds to provide care in the moment.

*Offering self authentically for the other.* The participants offered their selves to the dying persons and family members with sincere intentions. Empathetic understanding, concern and insight while being with them and caring for them were demonstrated. This offering of the self authentically for the other has some similarities to “being with” (Chaipet, 2007) or “being present” (Beckstrand, Callister, and Kirchhoff, 2006). The intensive care nurses desired that the dying persons not be alone. Chaipet (2007) found that the intensive care nurses showed concern by being with dying patient when their family members did not stay/be at the dying patients’ beds. Beckstrand et al. described the providing of a good death from the perspective of critical care nurses. “Being present” was the emergent theme. Critical care nurses defined being present as having someone there with the dying patient at the moment of death to touch and tell them “It’s OK to go.”

Zerwekh (2006) presented the phrase “practice of caring presence,” defined as “the intentional authentic responsiveness of the nurse to another human being. The nurse
is sincere and expresses genuine caring feelings” (p.125). This description is similar to the description of offering one’s self authentically for the other, the presenting of self in caring with intention and with an authentic being with another. An excerpt that can affirm this is “We come to care for the dying patients sincerely. We have good thoughts that we want to help them to get well and to comfort them. Our thoughts are not about bad things happening to them” [P6, Sirinthra].

Communicating caring through touch. The participants described that touch conveyed their caring to the dying persons and the family members. That is, touch communicated the participants’ sincerity, good wishes, gentle care, and warmth to the dying persons and the family members. Touch communicated that the nurse is there to care for and to comfort the dying persons and family members. Touch communicated “caring into heart” to the dying persons and family members. This can be explained further in that most dying persons in ICU were in a comatose state and their perceptions were decreasing. To communicate caring for these unconscious and dying persons, touch is essential. The description of communicating caring through touch has similarities with the description of a term “comfort touch” (Newson, 2008). Newson described comfort touch as “Holding someone’s hand and making eye contact at the same time to convey caring, understanding and willingness to be with the person” (p. 270). The review of the literature found a term “pathic touch” that can be related to communicating caring through touch in this current study. Kleiman (2005) defined “pathic touch” as touching the self as a whole person. Kleiman clarified that “pathic touch” was not limited to physical touch but was intended to increase understanding of the others’ emotional
feelings as human beings. This definition is similar to communicating caring through touch that includes both physical and feelings in touching the person.

Honoring self for giving care. Honoring self for giving care was described as the active psychological feelings of pride and happiness. This happens when: the participants in the current study achieved promoting a peaceful death; have taken their professional role completely by providing holistic care; and have taken a role as giver to the dying persons and family members. Rooyen, Roux, and Kotze (2008) described the world of oncology nurses and described the concept of a rewarding relationship with a patient. In a rewarding relationship, the nurses experienced feelings of satisfaction and fulfillment. An example was:

That which I do for my oncology patients is a need deep from within my heart.
When I go home at night, I want to say to myself that I have given my patient a 100%. Then I have job satisfaction.

This excerpt from the study of Rooyen et al. (2008) is similar to the descriptions offered by the participants in the current study. This was expressed as follows in the current study:

I felt that I did my best that I could. We had to work with our ‘heart.’ We should do like this with other cases. It indicates that the dying patients died peacefully. I felt happy and satisfied that I have rendered the best care for the person who had a peaceful death. (Explained in Chapter 4)

Furthermore, another participant claimed that:

We feel proud as we can help them get through that hump. It feels like we are givers. We feel satisfied as we take the full responsibility of being a nurse. It is
not only to record vital signs but also to provide spiritual care. (Explained in Chapter 4)

Similarly, intensive care nurses in the study by Chaipet (2007) had good feelings and contentment with their part in helping the patients die peacefully. Chealeawsak (2001) described nurses’ experiences of facing ethical dilemmas in providing care for terminally ill patients. This study reported about feeling pride in their professional role as a consequence of resolving ethical dilemmas.

Discussion of Themes in Corporeality in the Theory of Nursing as Caring

The theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) provides the concept of knowing self as a caring person that can be related to corporeality (lived body). Knowing self as a caring person is the concept in the major assumption that “persons are caring by virtue of their humanness” (Boykin & Schoenhofer, p. 1). Knowing self as a caring person requires genuine awareness of the self by having a relationship with the self to know the self from inside as a caring person. Knowing the self as a caring person prepares the self to enter the world of the other and come to know the other and be with the other intentionally and authentically as a caring person. Nurses develop sensitivity and expertise in hearing a call for nursing from having intentionality and authentic presence (Boykin & Schoenhofer).

The concept of knowing self as a caring person is part of the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a). It can be used to explain that the participants came to be in the situation of caring for persons who had a peaceful death by preparing the self to have “mindful readiness to care.” Mindful readiness to care is congruent with the expression of the intentionality of the theory of Nursing as Caring (Boykin &
Schoenhofer, 2001a). Boykin and Schoenhofer (1997, 2001a) explain the ways of the expression of intentionality that the nurse commits to enter the world of the others to come to know the other and nurture the other as a caring person. The nurse creates appropriate nursing care with the uniqueness of each person and the situation. Schoenhofer (2002) points out that intentionality shares common characteristics with personhood. Personhood is “unity, the creative evolving of a unifying, consistent, whole awareness, wholeness, creative unfolding of recognizable self; and intention, blending desire and purpose” (Boykin & Schoenhofer, 1997, p. 61). Intentionality is consistently choosing personhood as a way of life and is the aim of nursing (Schoenhofer, 2002, p. 36). These meanings in relation to the expression of intentionality can be used to explain the findings of the theme “mindful readiness to care.” The participants had good intentions to care by choosing personhood to prepare the self to have experience and knowledge to care, clinical judgment, and maturity. In addition, the participants had intention by valuing having a peaceful, focused mind, and good wishes to come to know and to create nursing care for the dying persons.

Another theme in the lived world of corporeality, “offering self authentically for the other,” is similar to “authentic presence” with the other in the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a). Boykin and Schoenhofer (2001a) think authentic presence is developed through the nurses’ intention to care and desire to be there with another. Caring is intentional and requires the authentic presence of the nurse with another (Boykin & Schoenhofer, 1993, p. 24). This perspective can be explained through the participants having mindful readiness to care that was guided by having good intention to care. Having good intention to care, the participants deliberated about their
efforts to come to know the dying persons and their family members as caring persons. The participants offered self authentically for the other and have the sensitivity to hear the others’ calls for caring.

Relationality

There are five themes in the lived world of relationality (lived relation):
understanding the relationships as vital for the dying persons and their family members;
understanding the family members as the nursed; valuing the dead person as person;
enhancing nurses’ relationships with other; and valuing ending relationships with dying persons at the moment of death. The followings are discussion of themes in relationality in relation to existing literature and the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a).

Discussion of Themes in Relationality in Existing Literature

Understanding relationships as vital for dying persons and family members. The participants had relationships with the dying persons and their family members/relatives. In these relationships, the participants understood that family members were the most significant persons to the dying persons. The family members knew the dying persons’ needs and wishes. In addition, the participants understood that the family members needed to be there and to provide some care activities for the dying persons within their culture and beliefs. This is similar to the findings of the study by Chaipet (2007) who suggested that the dying patients’ relatives were the most important persons in the ICU.

It should be noted further that in Thai culture, family members are the significant persons to care for the terminally ill and to make crucial decisions. In Thailand, home or hospital are places where Thai people die. There are few palliative and hospice
institutions in Thailand. The family members will take on the role of providing comfort and care for the terminally ill persons in their home. The terminally ill persons will be surrounded by their family members, relatives, and friends. At home, a Buddhist family will invite the monks to perform religious rituals to help the dying persons’ minds to be at peace. For Muslims, the family members, friends, people in their villages will come to pray for them and to remember them to Allah. When the persons have died, Thai Buddhists will have ceremonies for them at their home or at the temple. For Thai Muslims, a person who has died will be buried before the sundown. These are appropriate ways to approach the end of life with a peaceful death that are based on Thai culture and religious beliefs.

The participants in the current study understood these ways of providing a peaceful death in accordance with their culture and beliefs. When terminally ill persons came to die in ICUs, the participants integrated these ways of approaching a peaceful death to provide nursing as if the dying persons were at home. The family members were allowed to stay/be with the dying persons and care for the dying persons. In addition, the relatives, friends, and other people of the village could gather around the dying persons’ beds. These persons could perform religious rituals and pray for the dying persons.

Valuing the person who has died as person. The participants in the current study had relationships with persons who had died and provided holistic care for them as humans. The findings were congruent with the study of Kongsuwan and Locsin (2009) in that intensive care nurses valued the persons who had died as if they were alive. Similarly, valuing the person who has died as person by providing after death care was
described in the study of Beckstrand and Kirchhoff (2005). In this study intensive care nurses ensured peaceful and dignified bedside scenes after death.

*Understanding family members as the one nursed.* In having relationships with the family members, the participants understood that the family members would be grieving and have some psychological reactions through losing their loved ones. The family members’ reactions could affect the peaceful death of their loved ones. The participants understood that they had to support the family members and include the family members as well as the one nursed. This description is similar to the intensive care nurses’ experience in the study of Chaipet (2007). In that study the intensive care nurses understood that taking care of the dying patients’ relatives helped them (the dying patients) to accept death. Similarly, Lackie (2003) studied critical care nurses’ lived experiences of providing a good death and developed the theme “family as focus.” This theme of family as focus is similar to the findings of the current study in that the critical care nurses understood that the families needed psychological support.

*Enhancing nurses’ relationships with others.* The participants’ relationships between the dying persons, family members, and the doctors were enhanced. The participants were “coordinators of relations” between dying persons and family members and family members and the doctors. The description of the theme “enhancing nurses’ relationships with others” has some similarities with the finding in the study by Manosilapakorn (2003). In the study, Thai nurses understood their role in the relationships between the family members, dying persons, and doctors as being “in the middle.” The nurses had to connect the relationships with family members, dying persons, and the doctors in order to respond to the needs and wishes of these persons.
Being in the middle of the relationships is similar to “being a coordinator of relations” in this study. Lackie (2003) posited the term “a manager of death” as part of the experience of critical care nurses in providing a good death in an ICU. “A manager of death,” “a middle person,” and “a coordinator of relations” are all similar. The phrases mean that critical care nurses are significant persons in relationships with others in enhancing a peaceful death. Goodride, Bond, Cameron, and McKean (2005) also explored end-of-life care in a nursing home and “coordination of care” emerged as a theme. Coordination of care was described as the need for nurses to coordinate care with family members, other nursing staff, and interdisciplinary team members to ensure all aspects of care.

In addition, “being connected as if a relative” is the finding that emerged in the study of Kongsuwan and Locsin (2009). Intensive care nurses revealed that they valued a relationship as if they were a relative of the person who had died. Relationship as being a part of family also described in the study of Touhy, Strews, and Brown (2005). Nurse assistants connected relationships with residents in nursing home as if the residents were their parents.

*Valuing the ending of a relationship at the moment of death.* Valuing the ending of a relationship with dying persons at the moment of death describes the participants’ experience as ending karma between the participants and dying persons. Karma is inferred as action/deed whereby the participants acted/interacted with the dying persons. Thai Buddhists valued performing the pouring water ritual to ask for forgiveness from the dying persons and those who died. Thai Buddhists believe that the karma between them and the dying persons or persons who died will not persist to the next life. The participants used Buddhists’ religious belief of ending karma to create the meaning of
ending relationships to dying persons or the persons who died at a time of caring in this life. Some participants performed the pouring water ritual to ask for forgiveness at the patient’s bed. The family members also participated in this ritual. Some participants only asked for forgiveness without performing the pouring water ritual.

From the review of relevant existing literature, forgiveness is a concept related to spirituality. Mauk and Schmidt (2004) described forgiveness as the internal release of emotions attached to past experiences. Forgiveness could resolve issues from the past and could advance patients toward a peaceful state of mind for the approach of death. In the current study this concept of forgiveness can be explained as finding the value in ending a relationship at the moment of death. That is, when participants asked for forgiveness and the dying persons forgave them, the internal emotions or karma that attached them to each other was perceived as ended. Both the participants and the dying persons could then have peace of mind. The significance is that the dying person will have a peaceful death.

Discussion of Themes in Relationality in the Theory of Nursing as Caring

The lived world of relationality (lived relation) refers to the nurse entering and maintaining relationships with others in a situation of caring for persons who had a peaceful death in an ICU. The theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) focuses on nursing situations that can be related to the lived world of relationality. Boykin and Schoenhofer described the nursing situation as “a shared lived experience in which the caring between nurse and nursed enhances personhood” (p. 13). The practical knowledge of nursing lives in the context of caring persons. The nursing situation involves particular values, intentions, and actions of two or more persons who choose to
live a nursing relationship. The nurse and nursed are connected through a relationship, *caring between* occurs and is viewed as the source and grounding of nursing knowledge. Nursing is created in the caring between the two. All knowledge of nursing is created and understood within the nursing situation. Value is included in the outcomes and expanded personhood.

Boykin and Schoenhofer (2001a) provide the image of the Dance of Caring Persons to describe a way of relating to person nursed or persons who were involved in care. Each person is known, respected, and valued. There is no hierarchy to convey power or position in this model; rather, each dancer in the circle is honored for the unique contribution made in his or her role. Each person brings particular services at different points to the one being nursed.

Through the focus on the nursing situation and the Dance of Caring Persons in the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a), the meanings in relationality can be explained. In this study, the participants entered the nursing situation of caring for dying persons to promote a peaceful death. The participants developed and maintained relationships with dying persons, persons who died, and family members as they would for a relative. In the *caring between*, the participants understood the relationships as vital for the dying persons and their family members and valued their cultural beliefs when caring.

Boykin and Schoenhofer (2006) also assist us to understand that in *caring between* when the nurse cares for the person who is unconscious, it requires use of Carper’s patterns of knowing (Carper, 1978) and use of Mayeroff’s caring ingredients (Mayeroff, 1971). Carper’s patterns of knowing are empirical, ethical, aesthetic, and
personal knowing. Mayeroff’s caring ingredients are knowing, trust, courage, honesty, alternating rhythms, hope, patience, and humility. In addition, the nurse needs to use past and present experiences of the unconscious person to create caring in the moment.

These understandings provided by Boykin and Schoenhofer (2006) are used to explain the findings of theme “valuing the person who has died as person” that the participants knew self as caring persons and committed to know about the persons who were unconscious or the persons who died. The participants recognized the call for caring from these persons. The participants used their ethical knowing to care for them as subjects instead of allowing them to feel helpless. The participants offered self authentically to be with the persons who died and provided holistic care for them as human beings. The participants used empirical knowing and personal knowing that the persons who died still hear. The participants talked to them and guided them in going to a good place. In addition, the participants used aesthetic knowing to create nursing interventions congruently with culture and beliefs of the persons who died. The participants expressed the use of aesthetic knowing by dressing the body, making up the face, and putting flowers in hands of the Thai Buddhist persons who died.

The model of the Dance of Caring Persons (Boykin & Schoenhofer, 2001a) can be used to explain the meanings in lived relation in this current study. Hence the participants, family members, nurses’ assistants, the doctors, the persons in the palliative care team, and the hospital administrators were each valued in the dance of caring for the dying persons and the persons who died in an ICU. These persons used their abilities to collaborate in the promotion of a peaceful death in an ICU.
Valuing the ending of relationships with dying persons is explained by Boykin and Schoenhofer (2001a) as the caring relationship valued in providing care for persons. Persons live caring in the moment and live endings in the moment.

Spatiality

There are two themes in the lived world of spatiality (lived space): enabling peace of mind (solace) despite space constraints, and the contentment of creating caring environments for the dying. Following is the discussion of themes in spatiality in the existing literature and the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a).

Discussion of Themes in Spatiality in Existing Literature

Enabling peace of mind (solace) despite space constraints. The participants understood that the ICU physical space was not a private and quiet environment for dying persons and family members. Kirchhoff et al. (2000) explored intensive care nurses’ experiences with end-of-life care. Participants in the Kirchhoff study provided similar understandings relating to ICU space to those in the current study. Thus the physical plan of the ICU setting was limited with respect to providing good end-of-life care; there was no space and privacy for family members. Similar experiences were reported by participants in a study by Beckstrand et al. (2006). In this study, the nurses understood that ICU was “no place to die” and that the ICU was “not quiet” and provided “no spacious room” for dying persons. In a study by Eggenberger and Nelms (2005), family members in ICU shared similar concerns about relatives dying in an ICU. Family members described ICU space as “a place of being on guard, a confusing and frightening place” (p. 1622). This family experience is similar to findings in the current study in that the physical space of ICU has no peace and privacy.
In the current study, the participants had to promote a peaceful and private environment for the dying persons and their family members. This was done by closing curtains around the beds of the dying persons and encouraging other nurses to be quiet during this time. Through these interventions, the participants felt that the ICU space around the dying persons’ beds at the time of death brought about peace of mind.

The findings of enabling peace of mind (solace) despite space constraints are similar to findings from a prior study by Kongsuwan and Locsin (2009). This study explored the promotion of a peaceful death in ICUs in Thailand using grounded theory. Findings suggest that a quiet environment was understood by the intensive care nurses as a proper environment to promote peace of mind. In the Buddhist religion, serene space is a significant concept in approaching a peaceful death in the last hours of life. All participants in the current study were Buddhists and their understandings of space related to end-of-life care were based on their religious beliefs and the beliefs of those for whom they cared.

**Contentment in creating a caring environment for death.** The participants in the current study felt that it was important for the dying person to be surrounded by their loved ones, family members, friends, and other significant persons during their time of death. These persons expressed their love, respect, and gratitude to the dying persons. The participants were glad that every person was in the midst of happiness and satisfaction when around the dying person’s bed. The family members and relatives could say farewell to the dying person and see the dying person in their last moments. It is explained further that contentment about creating a caring environment for death is
valued by Buddhists. Buddhists value happiness and a peaceful life, thereby creating a peaceful death (Barham, 2003).

Buddhists’ family members and other persons will visit and be with the dying persons, and create happiness and a peaceful environment. This is done by talking about the dying person’s goodness and pride, showing gratitude and love to the dying person, praying/chanting, and by not crying. Buddhists believe that the dying person’s mind should focus on his/her goodness, happiness, and faith without worrying in that last moment of passing from this life to the next life. If this environment is true, that person will have a peaceful death and go to a good place (Matetanonto, 2005; Visalo, 2004). The theme of contentment in creating a caring environment for death is similar to findings of the exploratory study by Kongsuwan and Locsin (2009). They found that Thai intensive care nurses valued enhancing a calm and familiar environment to assist dying persons to be at peace. The nurses allowed the family members and other significant persons to stay with the dying persons at the time of death and encouraged family members not to cry.

Discussion of Themes in Spatiality in the Theory of Nursing as Caring

The lived world of spatiality (lived space) can be related to the concept of caring between in the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a). They view caring between as the place where nursing is created. That is the person who knows the self as a caring person hears the person who is calling for caring. The person establishes relationships with that person, and caring between occurs. Nursing is provided in caring between. In caring between, interconnectedness can occur; that is, the nurse and the nursed have a connected relationship and may become as one while retaining individual identities (Boykin & Schoenhofer, 2001a; Schoenhofer, 2002).
The concept of caring between explains the findings in spatiality that caring between occurred when the participants created relationships with the dying persons. In addition, caring between also occurred when the participants promoted connected relationships with family members and other persons who came to visit. The participants knew that the dying person, family members and friends needed to stay in quiet and private spaces even though an ICU environment has constraints. The family members and friends could stay together and provide care for the dying persons and support for each other. When this kind of environment existed, the participants felt peaceful and happy that all received what they needed. Thus, the participants became as one with those persons.

In addition, the findings in spatiality can be explained by the concept of a caring environment in the theory of Nursing as Caring (Boykin & Schoенhofer, 2001a). Their view is that all persons involved with the person being cared for must know the self as a caring person and contribute to help create a caring environment. The importance of this perspective is illustrated in the model of the Dance of Caring Persons (Boykin & Schoenhofer, 2001a, p. 36). This model describes a relationship pattern in which each person is known, respected, and valued. Each person is honored for the unique contribution made in his/her role. Through these perspectives the participants and the family members or other significant persons knew themselves as caring persons and these relationships helped to create a caring environment. The participants knew that they must play a role to promote a quiet, private space around the dying person’s bed during the time of death. This space enhanced contentment in the dying person and his or her loved ones. Family members, friends, and relatives gathered together and expressed their caring
for the dying persons with love and respect. Persons who were grieving were supported also by the participants.

*Temporality*

There are five themes for the lived world of temporality (lived time): time is short and a priority; open opportunity for other; valuing on-going care; valuing a proper time to care; and accepting death as natural and unpredictable. Following is a discussion of themes in temporality in relation to the relevant existing literature and the theory of Nursing as Caring (Boykin & Schoenhofer, 2001a).

*Discussion of Themes in Temporality in Existing Literature*

*Time is short and a priority.* In understanding the other, the focus is the realization that life is shortened for persons who are dying. Similarly, time is also short for expressing caring among the loved ones, thus creating a sense of “priority” for providing quality end-of-life care for the dying persons. The participants knew that providing effective end-of-life care was necessary in the short time available for them to care. This “priority” was also described in the experience of families who had their loved ones in an ICU. The families arranged their activities to focus on spending time with their loved ones who were dying rather than with their other usual activities. They realized that their own personal activities were not as important as spending time with the loved ones who were critically ill (Eggenberger & Nelms, 2005).

*Open opportunity for the other.* It is important for the family members to have a last opportunity to stay/be with their loved one, and the participants provided this opportunity for them. The participants altered the ICU’s strict visiting rules by extending the time for the family to be with their loved one during the time of passing. Chaipet
(2007) described similar experiences of intensive care nurses caring for dying patients in an ICU while assisting relatives to be with their loved ones in their final hours. This is similar to the experiences of Canadian critical care nurses in providing a good death in an ICU. Nurses there also valued unrestricted family presence (Lackie, 2003). Ruland and Moore (1998) provided a sub-concept of facilitating opportunities for family closeness. This is in accord with their middle range theory of a peaceful end to life which is similar to an open opportunity for the other. Facilitating opportunity for family closeness was explained by the statement that: “Facilitating opportunities for family closeness contribute to the patient’s experience of closeness to significant others or persons who care” (p. 174).

*Valuing on-going care regardless of time.* The participants valued time to care as a continuing factor throughout the process of dying and even when death took place. Clark et al. (2004) presented six end-of-life care domains for use in ICUs and one of them was “continuing of care”. Thus the finding of the current study about valuing on-going care reaffirmed that continuing care for the persons at the end of life is important.

*Valuing a proper time to care.* Valuing a proper time to care is significant in providing good quality end-of-life care in an ICU. The participants understood the right timing for the care activities they should provide to the dying persons and their family members. Expertise was required to alter care interventions appropriately and fittingly with each caring situation at any moment in time. In this current study the participants understood that an appropriate time to start preparing for a peaceful death would be after the dying persons is reconciled to it. In addition, an appropriate time to care also depended on the family members’ emotions at the moment. Since dying, death, and loss
were sensitive matters to the ones nursed, participants especially appreciated this time of
caring. They wanted to know best how to be with the dying person and their family
members and to care for them. No relevant literature addressing valuing the proper time
to care was located in literature review.

Accepting death as unpredictable and natural. The participants understood that
the time of death was uncertain and could not be predicted by the participants for any
patient. The participants understood that death happened unavoidably but at an
unexpected time of the individual’s life. Understandings about a time of death were based
on the participants’ beliefs in Buddhism. Buddhism views life and death as follows:
“Everyone is born with the certificate of death at his birth” (Dhammamada, 1987, p. 98).
Buddhism emphasizes the inevitability of death. Death comes in a moment and its time is
unexpected (Coberly, 2003). Buddhism views uncertainty as impermanence; nothing is
permanent, absolute, eternal, or self-existing (Dhammamada, 1987). Patterns of the self
as perceptual awareness in thoughts, feelings, and emotions are constantly changing
(Thondup, 2005). This truth found in Buddhism was understood and valued by the
participants in providing end-of-life care in ICUs in this current study. The participants
understood and accepted the vacillations of the family members’ decision making
between the patient continuing to live and permitting the patient to die.

Discussion of Themes in Temporality in the Theory of Nursing as Caring

The theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) provides an
assumption that “persons live caring from moment to moment” (p. 1). They further state
that “caring is unfolding constantly from moment to moment” (p. 2). This suggests that
this theory values time in caring for the other as present time and continuing time. Boykin
and Schoenhofer (2000) also assist us to have an understanding about time to care. Time to care is not dependent on how much time the nurse has to care for another. It is how long the nurse can be present authentically with the other as caring person. That is, in the moment, the nurse sees the other as a caring person and as a whole.

In addition, Boykin and Schoenhofer (2001c) respond to the calls of nurses about time to care. In practicing nursing, time to care translates into nurse-patient ratios and as a result to nursing positions. The nurses need to have enough nurse staff in order to provide quality patient care. In Boykin and Schoenhofer’s view, it is difficult to decrease nurse-patient ratios or increase nursing positions. Thus, Boykin and Schoenhofer suggest ways for nurse administrators to support the nurses’ expressed calls for time to care and to provide the best nursing. Examples of suggested ways include recognizing self as a caring person and recognizing and supporting nurses and the others as caring persons. These ways would give the nurses a sense of satisfaction and create practice environments that support nursing and caring.

Another perspective related to time of the theory of Nursing as Caring (Boykin & Schoenhofer, 2001) is the concept of “patience.” Boykin and Schoenhofer (2001a) brought Mayeroff’s (1971) caring ingredients to use in their theory as a starting point of caring; patience is one of caring ingredients. Patience is “not waiting passively for something to happen, but is a kind of participation with the other in which we give fully of ourselves” (Mayeroff, 1971, p. 24).

Themes in temporality (lived time) that can be explained by the perspectives about time in caring are priority, valuing on-going care, and proper time to care. The participants recognized the person’s call for caring and knew themselves as caring
persons who had come to care for the dying persons as his/her priority in the moment. The participants valued time of caring as continuing care. Nursing was created to continue the providing of care until the dying persons has died and even after death. In the theme of valuing a proper time to care, it can be explained that the participants knew persons as caring persons at that time. The participants understood what should be the right moment to prepare for death and when to talk about dying and death with the family members.

Implications

The findings of the current study of the lived experience of caring for persons who had a peaceful death in ICUs have implications for nursing practice, nursing education, international healthcare policy, and further nursing research. These will be dealt with in the following sections.

Nursing Practice

In practicing nursing in ICUs, knowledge of end-of-life care is becoming more important. Given that the death rate in ICUs is 14% (Personal Communication, May 29, 2008) there is a lack of palliative care service in Thailand (Nilmanat & Phungrassami, 2006). Hence, the findings of this current study could help guide knowledge, understanding, and the development of nursing responses to end-of-life care in order to enhance peaceful death in ICUs.

The findings of this current study indicate that the essential themes grounded in caring in each lived world could serve as important components of end-of-life care in promoting a peaceful death in an ICU. Intensive care nurses can use the themes to create innovative caring models in their practice. In addition, intensive care nurses can use the
themes to develop standards for end-of-life care or practical guidelines for end-of-life care. The following are the themes that are recommended for use as important components of end-of-life care.

*Lived body:*

- Mindful readiness to care
- Offering self authentically for others
- Communicating caring through touch

*Lived relation:*

- Understanding relationships as vital for dying persons and family members
- Understanding family members as the nursed
- Valuing the person who has died as a person
- Enhancing nurses’ relationships with others
- Valuing ending relationships (karma) at the moment of death

*Lived space:*

- Enabling peace of mind (solace) despite space constraints
- Contentment in the creation of a caring environment at death

*Lived time:*

- Time is short and is a priority.
- Open opportunities to care for others
- Valuing on-going care regardless of time
- Valuing a proper time to care
- Accepting the time of death as natural and unpredictable
Recently, the quality of end-of-life care has been an indicator used for hospital accreditation in Thailand (Nilmanat & Phungrassami, 2006). Nursing administrators and hospital administrators are important persons for supporting nurses’ practice aimed at meeting quality outcomes for end-of-life care in ICUs. The findings and discussion of the current study demonstrate that relationships and the collaboration of all levels of staff including family members are significant to express their caring values to promote a peaceful death in ICU. The Dance of Caring Persons (Boykin & Schoenhofer, 2001a) can be utilized as an organizational model to respond to and support the caring that is expressed. This will assist in enhancing the quality of end-of-life care and promoting peaceful deaths in ICUs. The Dance of Caring Persons assumes that each person involved in caring for the terminally ill person in an ICU brings his/her special gifts to accomplish a common goal.

In implementing this model in practice, the work of Boykin et al. (2003) (Transforming Practice Using a Caring-Based Nursing Model) in a hospital may be used as an example. Building on the caring values of staff, patients, and families and expressions of what matters most to each in their work together, the project team collaborated with all groups to design a model to support the values expressed. In this work the intended outcomes for patients and families, for staff, and for healthcare agency were evaluated as the first process. The project team responded by designing a relevant model that included all groups directly and indirectly involved in caring. All were included in data collection so that caring matters were known by each group. Their accounts of caring in their practices and essential factors relating to the quality of care were shared and reflected upon by these groups. In the next step responses were made to
the matters raised. The staff was thus committed to work together as teams to support and live the caring model. Patient satisfaction and nurse satisfaction were evaluated as outcomes of this project.

The findings of the current study are relevant to essential issues that intensive care nurses deal with in hospitals in Thailand. The following recommendations could help guide the development of policies to help improve and enhance the quality of practicing end-of-life care in ICUs:

1. Development of nurses’ competency. The findings of the current study showed that nurses were significant in promoting quality of care at the end of life and a peaceful death in ICUs. It is recommended that hospital policy should support the development of nurses’ competency to give the end-of-life care in ICUs incorporating the multiple ways of knowing essential to such care. This will prepare the conscious readiness of nurses. The multiple ways of knowing expressed by the nurses in the current study that are important to support include knowing the dying persons and family members, enhancing relationships, fostering peaceful environment, honoring culture and religious rituals at the end-of-life, and valuing priority to care and continuing care.

2. Improving the ICU environment for end-of-life care. The findings of the current study make it clear that creating an environment of caring for dying persons was important for ensuring a peaceful death. ICUs are not peaceful units and peaceful deaths need a quiet and private environment. Thus it is necessary to bring in a policy to ensure a proper environment to promote a peaceful death in ICUs. It is recommended that a temporary space or room be provided for the dying in their last hours to be with their
loved ones, family members, friends, and significant others. A room/space may be transformed into a sacred space for Buddhists as Barham (2003) suggested.

3. Extending visiting hours. The findings of the current study identify the vital importance of relationships between dying persons and their family members in the context of promoting a peaceful death. The family is most significant to the dying person. Hospitals have set limited visiting hours for ICUs. Nurses in intensive care struggle to respond to the wishes of the dying persons to have their family members with them in the ICU. Thus it is suggested that hospital policy should be to extend visiting hours.

*Nursing Education*

Knowledge and skills are needed in providing good quality care and promoting a peaceful death for terminally ill persons. However, many Thai nurses perceive that they do not possess the knowledge needed to care for those facing the end of their lives (Manosilapakorn, 2003). It was further reported that 52% of 538 Thai nurses had a lower score for end-of-life care knowledge than the mean score. Mean score of end-of-life care knowledge that measured 538 Thai nurses was 13.22. The maximum score of the questionnaire was 20 and minimum score of the questionnaire was zero (Manosilapakorn, 2003). Nilmanat, Kongsuwan, Sastranurak, Ongphokai, and Chuaynukul (2005) revealed that the lack of knowledge and skills about end-of-life care led nurses to lack confidence in communicating with terminally ill persons and their relatives. This also caused them to avoid providing psychosocial care. The findings of this current study show that knowledge of caring in nursing and caring in the nursing of dying persons is in accord with Thai culture and beliefs. The findings of this current study could thus contribute to the curricula in nursing education. The following are therefore recommended.
1. Essential themes grounded in caring as substantive content in end-of-life care. The findings of the essential themes in each lived world serve as substantive content to be included in education about end-of-life care in an ICU. At the bachelor degree level, these themes can be addressed in an end-of-life care topic in nursing adult and elderly courses. At the master’s degree level, these themes can be added to the critical care and end-of-life care courses. In addition, these themes can be included in continuing education and in hospital education for nurses.

2. Using stories about nursing situations as sources of knowledge of caring for dying persons to promote a peaceful death. The findings of the current study indicated that personal knowledge gained from clinical experience was significant in constituting mindful readiness to care. Nursing practice about end-of-life care in real situations is difficult to arrange for the students. It is recommended that using stories from nursing situations to share the experience of caring for dying persons from nursing students, nurses, and nursing instructors be adopted as a strategy for nursing instructors. The theory of Nursing as Caring (Boykin & Schoenhofer, 2001a) provides a useful theoretical model for coming to know about and reflect on the nursing situation. Aesthetic presentations can be shared and reflected the experience. In addition, stories of nursing situations of dying, peaceful death, and loss could be available on videotape or film. The participation of the terminally ill persons and their family members is recommended for use in class teaching. By taking part in this, nursing students or nurses will appreciate the value of knowledge of caring for dying persons and promoting a peaceful death more fully.
The findings of this current study relate to caring for persons who had a peaceful death in ICUs. They could be used to extend the awareness the policy makers of the issues raised and have implications for healthcare policies. Some policy implications are identified below:

1. Enhancing the development of knowledge about the end of life. In Thailand, the incidence of care at the end-of-life is increasing due to the growing number of terminally ill persons. Phungrassami (2005) indicated that only a few medical and nursing schools included a regular palliative care curriculum. The findings of this current study provided evidence to support the idea that knowledge about the end of life is significant to achieve the promotion of peaceful deaths. Hence, it is crucial that the Thai government or some international health organizations related to end-of-life care support policies for developing education for all healthcare providers, including family members about the end of life in accord with Thai culture and society.

2. Enhancing the development of models of promoting peaceful death for Thai people. Achieving a peaceful death is a common wish for Thai people. Thailand cannot afford a national policy for building palliative and hospice care units in each hospital because it is a middle income country. Thai people die in ICUs or in ward units or at their homes. The findings of this current study indicated that an ICU might not be an appropriate place for end-of-life care. The Western model of plentifully equipped inpatient hospices is often not appropriate in countries with huge populations living in great poverty, so new models of home care or outpatient care are being explored by countries of the region (Goh, 2002). It is recommended that the Thai government or the
international health organizations introduce a policy focusing on the development of models for promoting peaceful death. This may include developing a model for modifying ward environments to enhance a peaceful death for in-patients and a model for home-based hospice care for out-patients. The model for promoting peaceful death for terminally ill Thai persons can serve as an example model for other countries that have low and middle income.

3. Establishing a care system during bereavement. The findings of the current study demonstrated that family members were persons who needed to be cared for and supported when grieving. In Thailand, services are not provided for families during bereavement (Nilmanat & Phungrassami, 2006). Nurses in ward units respond to support the mourning family members at the same time as providing care for the other patients. There is no care service to follow the family members. This is a gap in caring for family members who have lost loved ones. Hence, the Thai government should support a national healthcare policy for establishing a care system during bereavement in Thailand. In addition, international health organizations should support an international healthcare policy for creating a bereavement system for all countries. This policy will be enacted in accord with the principle that all people have an equal right to be cared for during bereavement. A bereavement program should be developed congruently with socio-culture in each region. A support group is recommended to employ the program. Support group includes persons who have experienced a significant loss. These persons will have opportunity to share and express feelings while listening how the others are learning to cope with their loss.
This current study provides the findings about caring for persons who had a peaceful death in ICUs from the lived experience of Thai intensive care nurses through using a hermeneutic phenomenological approach (van Manen, 1990). The findings thus could be more fully developed and studied through research and may contribute to the body of knowledge in nursing related to end-of-life care and caring.

A limited group of nursing participants took part in this current study. In adopting the theory of Nursing as Caring (Boykin & Scoenhofer, 2001a), the process of caring for persons who had a peaceful death in ICUs was assessed from the perspective of the nurses. To fully understanding the phenomenon of caring for persons who had a peaceful death in ICUs, further study of caring between the nurse and the nursed is recommended. The population of the study should thus include intensive care nurses, dying persons, and family members.

In addition, other units in the hospital such as medical units, surgical units, oncology units, and emergency units should be explored in order to gain more understanding in the lived experience of caring for persons who had a peaceful death. Furthermore, studying this lived experience should include in-home settings.

In this current study, all participants were Buddhists. The descriptions of the lived experience provided were based on their Buddhist beliefs. The understanding and knowledge described cannot be extended to the understanding of nurses with other belief systems. Further study of the lived experiences of nurses from other cultures and belief systems in caring for the persons who had a peaceful death in ICUs is needed.
Thailand, involving Muslim nurses is important since Islam is the second most widely practiced religion in Thailand.

Caring theory is significant to the development of nursing knowledge and nursing discipline. The findings of the current study offered themes/concepts of caring for dying persons at the end-of-life in ICUs. The themes/concepts grounded in caring in this current study should perhaps be developed and evaluated as middle range theories for end-of-life care. The grounded theory method is recommended for develop middle range theories.

Chapter Summary

Chapter 5 presented the discussion and implications of the findings from the research question. The first section offered a discussion of each theme in lived worlds in relation to the existing literature and the theory of Nursing as Caring (Boykin & Schoehofer, 2001a). This provided clearer understanding of the phenomenon of caring for persons who had a peaceful death in an ICU. In addition, the findings were analyzed using the lens of the theory of Nursing as Caring (Boykin & Schoenhofer). The outcomes affirmed that this theory is broad and can be used in a variety of caring situations and across cultures. This discussion of the findings provided insight and direct implications could then be inferred. The second section considered how the findings and implications of this study could be used for nursing practice, nursing education, international healthcare policy and further nursing research. It became clear that these implications could be used to benefit nurses and other healthcare providers, nursing students, terminally ill and dying persons, family members, hospitals, the nursing profession and nursing as a discipline.
CHAPTER 6
PHENOMENOLOGICAL WRITING

Chapter 6 presents the phenomenological writing to illustrate the essence of the phenomenon of caring for persons who had a peaceful death in the ICU. The purpose of phenomenological writing is to describe the phenomenon of interest in order to disseminate its essence within the fullness of the lived world of those who experienced caring for persons who had a peaceful death in the ICU. In this chapter, the presentation of the phenomenological writing is in the form of aesthetic expressions of poetry and artful drawings.

The first section presents a description of the process of hermeneutic phenomenological analysis in describing and explaining the phenomenon of caring for persons who had a peaceful death in the ICU. This description is an expression of the researcher’s insights that have surfaced in the process of the research.

The next section is composed of aesthetic expressions of the understanding of the experience using poetry and drawing. In the expressions, the poems are written using the four lived worlds (van Manen, 1990) as structure illuminating the experiences of the Thai intensive care nurses caring for persons who had a peaceful death in the ICU.

Description of the Experience of Caring for Persons Who Had a Peaceful Death in ICU

From the themes in each lived world, I understood the structure of the lived worlds of nurses caring for persons who had a peaceful death in ICU. I delved into the meanings of the descriptive experiences of the nurses in their four lived worlds by
immersing in the data – reading and re-reading and involving various ways of understanding including the use of hermeneutic conversations (see in Chapter 4).

From the understandings of the experience of the nurses, I wrote a description of the phenomenon of caring for persons who had a peaceful death in the ICU. Using thematic categories and corresponding themes as guide, the process of creative writing ensued. A description of the phenomenon is presented in the following paragraph.

 Appearing instantaneously and in mindful clarity as “wisdom,” the understanding of the lived world of nurses caring for persons who had a peaceful death in the ICU is described as understand the other through the valuing of experience and enhancing relations with others by recognizing time is short and is a priority. This description consciously and instantaneously capture the essence of an underlying process of “understanding the other” that is substantiated by the “values and experiences” of those nurses who have experienced the phenomenon, and the “alternating activities, although more like alternating opportunities” to live the hoped-for experience of the phenomenon of caring for persons who had a peaceful death.

 In this experience of caring, intensive care nurses understood who the dying persons or persons who had died were as well as their family members through their personal knowing of loss and clinical experience. This understanding influenced the nurses to exhibit mindful readiness to care and enter into relationships with the others in a nursing situation to provide quality and effective end-of-life care as time is short for a dying person’s life. The nurses gave priority to care and offered themselves authentically, as a relative would, to be with the dying persons or the persons who have died, and the family members. The nurses continue being with them on their journey from this current
end and to the beyond, communicating their caring holistically. The nurses valued a proper time to care and accepted the time of death as natural and yet unpredictable.

Understanding the other through valuing experiences assisted the nurses to enable a peace of mind (solace) despite the constraints of space. In this space, the nurses enhanced relations with others and coordinated the others’ relationships. The nurses understood that the relationships were vital for dying persons and family members. These are embedded in their culture and beliefs. The nurses understood that family members are given the appreciation that they too are like the one nursed, and therefore are also valued just like the valuing given to the person who has died as person. Contentment occurred in creating a caring environment for the person dying and their families and for the person who has died. In these situations, the nurses and family members concurrently showed valuing in ending relationships (karma) at the moment of a person’s death.

Understanding the other through valuing of experience and enhancing relations with others encouraged the nurses to move care forward with hope for a peaceful death. At the end, the nurses honored themselves for giving the best care proudly since they met the achievements of care. With this honor, the experience of nurses caring for persons who had a peaceful death enhanced the quality of life for persons who were dying and their families and supported the hoped for peaceful death.

These experiences are valuable sources of knowledge on end-of-life care for Thai nursing. The beautiful words and descriptions of care from the nurses enrich the lives of those caring for dying persons and those caring for persons who have died including their family members. Similarly, this will also enrich the lives of future nurses who will learn from the experience of caring for persons who had a peaceful death.
Poem

Aesthetic expressions are ways to describe the rich in-depth meanings of the phenomenon. I wrote four poems reflecting the “four worlds of caring for persons who had a peaceful death in ICUs” to reflect my understanding of the phenomenon. Each poem enlightened the meanings of the phenomenon within each lived world. In addition, I drew pictures within each lived world using lotus flowers and butterflies to represent the understandings related to the phenomenon. Lotus flowers at the higher water level symbolize the wisdom of the intensive care nurses. Intensive care nurses’ wisdom came from their personal knowing. Butterflies symbolize their expression of caring ‘freely’ since the intensive care nurses were free to care and had the wisdom in caring for persons who had a peaceful death. The wisdom made their worlds of caring be light and bright. Lotus flowers also symbolize respect. The intensive care nurses respected the other as caring person. The poems and drawings are illustrated in the following figures.
The Lived World of Readiness to Care
(Lived World of Corporeality)

I am ready to care for him with knowing self as caring person.

My heart desires to help him with my entire competency.

My wholeness is devoted for being with him sincerely.

My hand touches his hand compassionately.

I send caring power to his heart warmly.

I feel proud of self to care for him.

Figure 1. Aesthetic expression of the lived world of readiness to care.
The Lived World of Enhancing Relations with Other

(Lived World of Relationality)

I care for him as if he is my relative.

What he wants, I will do for him.

Nothing is important as his loved ones being with in this last time.

I realize.

I take a role as a coordinator of relations.

Without me,

Relationships between the others may not be connected.

Figure 2. Aesthetic expression of the lived world of enhancing relations with other
Figure 3. Aesthetic expression of the lived world of creating caring space

The Lived World of Creating Caring Space
(The Lived World of Spatality)

I understand the other, always.
I value and respect the other as caring person.
In the time of death,
I foster a private space around his bed.
In this space,
Everyone shows respect and love to him.
The one mourning is supported.
I appreciate every time I see.
Chapter Summary

Chapter 6 presented the phenomenological writing of the phenomenon of caring for persons who had a peaceful death in the ICU. The section of the description of the lived experience of caring for persons who had a peaceful death gave the understanding how the researcher attained to the description of the experience. In addition, this also
provided the understanding of the whole picture of the experience. The section of presenting poetry gave appreciation of the experience of caring for in each lived world.

The aesthetic expressions of description of the lived experience of caring for persons who had a peaceful death in ICU and poetry provided a way to enhance the full understanding of the experience of caring for persons who had a peaceful death in the ICU. In addition, phenomenological writing anticipates dissemination as a valuable contribution to the knowledge of nursing and its practice.
APPENDIX A

CONSENT FORM
Consent Form

1. **Title of Research Study:** Thai Nurses' Lived Experience of Caring for Persons Who had a Peaceful Death in Intensive Care Units.

2. **Investigator:** Kathryn Keller, RN, PhD & Waraporn Kongsuwan RN, MS, Doctoral Candidate.

3. **Purpose:** The purpose of the study is to describe the meaning of the lived experience of nurses who cared for persons who had a peaceful death in the intensive care unit.

4. **Procedures:** After explanation of the study if you decide to participate, the investigator will ask you to indicate your permission to participate and to be audio-recorded. The interview process will last approximately one hour. You will be asked to describe your experience of caring for a patient who died but had a peaceful death in the intensive care unit. The interviewer may request a follow-up interview at a later date. The follow-up interview may last between 30 minutes and 60 minutes. You may withdraw your participation from this research study at any time. You also have the right to review the transcript and elect not to have it used as data for this study.

5. **Risk:** While there is always minimal risk associated with research, the level of risk involved in completing this interview is not greater than that ordinarily encountered in daily life. If you show signs of anxiety and hesitation or feel sad or of having a difficult time accepting the situations of the dying patients, the interviewer will provide support and offer to end the interview.

6. **Benefits:** Potential benefits that you may attain from participation in this research study include a greater understanding of your own self of being a person who cared for dying persons in the intensive care unit. You may have the satisfaction of knowing that your experience may contribute to improving and developing the quality of end-of-life nursing care in the intensive care unit, congruent with culture and society.

7. **Data Collection and Storage:** The information from this interview will be audio recorded after receiving your written consent to participate in this interview. This data and audio recorded tapes will be stored in a locked file cabinet that only the researchers working with the study can open. Your name will remain confidential and will not be released without your permission, unless disclosure is required by law.

8. **Contact Information:** For related problems or questions regarding your rights as a subject, the Office of Sponsored Research of Florida Atlantic University can be contacted at (561)297-0777. For other questions about the study, you should call the principal investigator, Kathryn Keller at (561)297-2919, or Waraporn Kongsuwan MS, RN, Doctoral Candidate at (561)395-4088 in US or (074)-517-238 in Thailand.
9. **Consent statement:** I have read or had read to me the preceding information describing this study. All my questions have been answered to my satisfaction. I am 18 years of age or older and freely consent to participate. I understand that I am free to withdraw from the study at any time. I have received a copy of this consent form.

Signature of Participant: ____________________________  Date: ________________________
Signature of Investigator: __________________________  Date: ________________________
ใบจ่อมยื่นงอม

1. ชื่อโครงการวิจัย : ประสบการณ์ของพยาบาลในการสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่

2. ผู้วิจัย : Kathryn Keller RN, PhD และ กระจำะง อร์กวารน RN, MS, นักศึกษาปริญญาเอก

3. วัตถุประสงค์ : เพื่อข้อมูลความหมายของประสบการณ์ของพยาบาลในการสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่

4. ขั้นตอน : หลักฐานได้รับการขยายตัวกับเรื่องที่ที่ศึกษา หากท่านตัดสินใจในการเข้าร่วมการศึกษา ผู้ร่วมจะลงมานาที่ให้ท่านอธิบายที่จริงต่างๆ การศึกษาจะใช้เวลาอย่างมากประมาณ 12 ชั่วโมง ท่านจะถูกถามให้ข้อมูลประสบการณ์ของการสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่ ผู้มีประสบการณ์จะถูกถาม

5. ความเสี่ยง : ความเสี่ยงที่เกิดขึ้นจากการศึกษานี้จะต้องมีการสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่ หากท่านแสดงความกังวลและไม่ยินยอมให้ใช้ข้อมูลที่ได้มาจากการศึกษา

6. ประโยชน์ที่ได้รับ : ประโยชน์ที่ท่านอาจได้รับจากการเข้าร่วมในการศึกษาวิจัยนี้ คือการเพิ่มขึ้นความเข้าใจในทางท่านเองความสามารถเป็นนักปัญญาที่ได้ให้การสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่ ท่านยินยอมให้การสู้กับปัญหาที่ได้รู้ว่าประสบการณ์ของท่านจะนำไปใช้ในการปรับปรุงและพัฒนาสุขภาพของผู้สู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่ ที่มีผลกับทางวิทยาศาสตร์และสังคม

7. การกลับข้อมูลและเอกสารการรับรองข้อมูล : ข้อมูลจากการที่จะสู้กับปัญหามักที่จะเกิดขึ้นหลังจากการเข้าร่วมของท่าน ข้อมูลที่จะสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่ ที่มีผลกับทางวิทยาศาสตร์และสังคม

8. ข้อมูลการติดต่อ : หากมีปัญหาหรือคำถามใดๆ เที่ยวปัญญาที่วิจัยท่านสามารถติดต่อผู้เข้าร่วมการศึกษาที่ (Office of Sponsored Research of Florida Atlantic University) ที่เบอร์โทรศัพท์ (561)297-0777 สำหรับคำถามอื่นๆ เที่ยวปัญญาที่วิจัยท่านสามารถติดต่อผู้เข้าร่วมการศึกษาที่ (Kathryn Keller) ที่เบอร์โทรศัพท์ (561)297-2919 หรือ ที่ วาดิว คู่ทรัพยากร นักศึกษาปริญญาเอกสถานพยาบาล ที่เบอร์โทรศัพท์ (561)395-4088 หรือนักศึกษา ที่เบอร์โทรศัพท์ (751)531-238 ที่ ประเทศไทย

9. ข้อความจ่อมยื่นงอม : ขอจ่อมยื่นงอมเพื่อขอความสู้กับปัญหาที่มีการลองอย่างแรงในเหตุปัจจัยใหม่ สำหรับจ่อมยื่นงอมเงินวันที่ 14 ปี หรือมากกว่า และมีอิสริยาภิปรายในการจ่อมยื่นงอมเงินวันที่ 18 ปี หรือมากกว่า ซึ่งมีกำหนดที่จะออกตัวจากวันที่การศึกษาได้กู้มาต่อแล้ว ขอจ่อมยื่นงอมเงินวันที่ 18 ปี หรือมากกว่า และมีอิสริยาภิปรายในการจ่อมยื่นงอมเงินวันที่ 14 ปี หรือมากกว่า

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APPENDIX B

INTERVIEW QUESTIONS
Thai Nurses’ Lived Experience of Caring for Persons Who had a Peaceful Death in Intensive Care Units (ICUs)

Interview Questions Guidelines

First explain the purpose of the interview and the content of the consent form and obtain the required signature.

I. Demographic Data:

Begin the interview by asking questions relating to demographic data:

1.1 How many years have you worked in an ICU? …………….years

1.2 What type of ICU have you worked in?

- Medical ICU
- Surgical ICU
- Cardiac ICU
- Respiratory ICU
- Neurological ICU
- Trauma ICU
- Other

1.3 What is your highest educational qualification?

- Baccalaureate degree
- Master degree
- Doctoral degree

1.4 Have you received training in an end-of-life care course? □ Yes □ No

1.5 What is your age? ..................................years

1.6 What is your religion? □ Buddhism □ Islam □ Other

II. Data Generating Interview Question

The following interview question will be asked:

Please tell me about your experience(s) of caring for persons whom you believe had a peaceful death.

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APPENDIX C

RESULTS FROM DATA ANALYSIS OF TRANSLATED TRANSCRIPTIONS
Results from Data Analysis of Translated Transcriptions

Themes in Lived Body:

*Participant 2*

Knowing self to do things for others (P2A1)
Being with dying patient—comforting and providing holistic care (P2A3)
Being with relatives—informing, advising, attending conversation, explaining again and more (P2A5, P2A10, P2A12, P2A25)
Being there—listening (P2A18)
Being with relative—informing regularly (P2A23, A43)
Being with dying patient—advocating (P2A24)
Being with relative—allowing doing following religious belief (P2A27)
Being with relative—talking, offering self to help (P2A30)
Understanding self as for other (P2A19)

*Participant 3*

Honesty to care—doing the same and not making dying patient in pain (P3A7)

Themes in Lived Relation:

*Participant 2*

Allowing relatives be with dying patients all time (P2A4)
Doing follow an agreement (P2A11)
Allowing relative visit the patient at night time (P2A13)
Conscious to care—needing to be conscious to talk to relative (P2A20)
Providing the best care (P2A22)
Relative as a coordinator (P2A45)
Mutual care—thinking together in team and sharing information (P2A46)
Encouraging relative to participate care activities for the dying patient (P2A35)

*Participant 3*

Mutual care—working as a team with doctor (P3A1)
Knowing impending death and inviting relative to be with dying patient (P3A4)
Encouraging relative to participate care (P3A5)
Giving care for the deceased—dressing, making up face (P3A10)
Giving care for the deceased—telling to go home (P3A11)
Giving care for the deceased—saying good words (P3A12)

Themes in Lived Space:
Participant 2

Creating private space for dying patient and family—closing a curtain, door, or preparing area (P2A6, A8, A21)

Participant 3

Creating quiet environment—not listening music or opening very softly (P3A9)
Creating private and quiet space—closing a curtain, not talk loudly, and limiting entertain things (P3A15)

Themes in Lived Time:

Participant 2

Preparing relative in the beginning and continuing (P2A44)
Giving time to relatives in making and changing decision (P2A15)
Talking to relative oftentimes (P2A41)
Judgment to follow relatives’ needs/necessaries (P2A28, A42)
Flexible the visiting rule for relatives (P2A37)

Participant 3

Informing relatives every day (P3A2)
Promoting doing religious ritual at the last time (P3A8)
REFERENCES


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