



**Values Underlying End-of-Life Decisions of Thai Buddhist Patients and
Patients' Families**

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Doctor of Philosophy in Nursing (International Program)**

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ชื่อวิทยานิพนธ์	คุณค่าที่ผู้ป่วยและครอบครัวไทยพุทธใช้ในการตัดสินใจยืดหรือยุติการรักษาในระยะสุดท้ายของชีวิต
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บทคัดย่อ

การศึกษานี้มีวัตถุประสงค์เพื่อศึกษาการตัดสินใจที่จะยืด หรือ ยุติการรักษาในระยะสุดท้ายของชีวิตของผู้ป่วยและครอบครัวไทยพุทธ เปรียบเทียบความแตกต่างในการตัดสินใจของคนไทยพุทธสามกลุ่ม และศึกษาคุณค่าที่ใช้ในการตัดสินใจดังกล่าว กลุ่มตัวอย่างเป็นผู้ป่วยเรื้อรัง ครอบครัวผู้ป่วยที่มีประสบการณ์ และครอบครัวผู้ป่วยที่ไม่มีประสบการณ์ในการตัดสินใจดังกล่าว กลุ่มละ 70 คน โดยสุ่มตัวอย่างอย่างเป็นระบบ เก็บข้อมูลโดยการสัมภาษณ์รายบุคคลตามแบบสัมภาษณ์ซึ่งประกอบด้วยข้อมูลทั่วไปและคุณค่าที่ใช้ในการตัดสินใจตามกรณีตัวอย่างของผู้ป่วยในระยะสุดท้ายของชีวิต วิเคราะห์ข้อมูลโดยใช้สถิติเชิงบรรยาย ทดสอบไคสแควร์ และการวิเคราะห์เนื้อหา

ผลการศึกษาพบว่าผู้ป่วยและครอบครัวไทยพุทธร้อยละ 51.9 ตัดสินใจ
ยุติการรักษา ร้อยละ 28.6 ต้องการให้แพทย์ (ร้อยละ 18.1) หรือครอบครัว (ร้อยละ 10.5)
ตัดสินใจแทน มีเพียงร้อยละ 19.5 ที่ตัดสินใจรับการรักษาเพื่อยืดชีวิต และไม่พบความ
แตกต่างในการตัดสินใจที่จะยืดชีวิต หรือยุติการรักษาในระยะสุดท้ายของชีวิตของผู้ป่วย
เรื้อรังไทยพุทธ ครอบครัวผู้ป่วยที่มีประสบการณ์ และครอบครัวผู้ป่วยที่ไม่มี
ประสบการณ์ในการตัดสินใจดังกล่าว ($p > .05$)

คุณค่าซึ่งสำคัญที่สุดที่ใช้ในการตัดสินใจรับการรักษาเพื่อยืดชีวิต และยุติ
การรักษา คือ ความหวัง (ร้อยละ 92.7) และปราศจากความทรมาน (ร้อยละ 47.7)
ตามลำดับ ส่วนคุณค่าซึ่งสำคัญที่สุดที่ผู้ป่วยและครอบครัวไทยพุทธต้องการให้แพทย์
และครอบครัวเป็นผู้ตัดสินใจแทน คือ ความเชื่อถือไว้วางใจ (ร้อยละ 78.9 และ 59.1
ตามลำดับ)

ผลการศึกษานี้บ่งชี้ว่า การตระหนักถึงความต้องการและคุณค่าที่ใช้
ในการตัดสินใจของผู้ใช้บริการแต่ละราย การส่งเสริมและพิทักษ์สิทธิในการตัดสินใจ
ของผู้ใช้บริการ รวมทั้งการเคารพเอกสิทธิ์ของผู้ป่วยเป็นบทบาทที่สำคัญของทีมสุขภาพ
ที่จะช่วยให้การตัดสินใจในวาระสุดท้ายของชีวิตอยู่บนพื้นฐานคุณค่าและความเชื่อของ
ผู้ป่วยอย่างแท้จริง

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ABSTRACT

This descriptive research aimed to explore end-of-life decisions in Thai Buddhist patients and their families, to compare differences of the end-of-life decisions among three groups of Thai Buddhists, and to reveal their values underlying the end-of-life decisions. The 210-Thai Buddhists were systemic randomly recruited. The samples were three groups of Thai Buddhists: chronically-ill patients, patients' families who have and those who have no experience in end-of-life decisions of significant others, which comprised 70 samples per group. Data were collected by individual interview using an interview form including 1) the Demographic Data Form and 2) the Values Underlining End-of-Life Decisions Interview Form with a vignette of an end stage patient. Data were analyzed using descriptive statistics, chi-squared test, and content analysis.

The results revealed that 51.9% of Thai Buddhist patients and their families decided to forgo life-sustaining treatment. The 28.6% of them allowed physician (18.1%) or family (10.5%) to make the decisions for them. Only 19.5% of them decided to continue the treatment. There were no differences of the decisions among three groups ($p > .05$).

The most important values of continuing and forgoing the treatment were hope (92.7%) and free from suffering (47.7%), respectively. Respect was the most important value for Thai Buddhists who allowed physician and family to make the decisions for them (78.9% and 59.1%, respectively).

The findings indicated that recognition of patient's preference, patient's value clarification, promotion of patient autonomy and self-determination are significant roles of health care team in supporting patients' decisions at the end-of-life to be based on the patients' values.

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CHAPTER 1

OVERVIEW OF THE STUDY

Background and Significance of the Problem

Before the advent of many modern health-related technologies, people always experienced illness and the process of dying as an inevitable part of the cycle of their lives (Burkhardt & Nathaniel, 2002). Nowadays, advanced technologies save lives, alleviate suffering, and improve the quality of life for people with specific diseases (Bandman & Bandman, 1995; Burkhardt & Nathaniel, 2002). Technology has brought new sources of hope for the ill (Bandman & Bandman, 1995). However, these life sustaining technologies have created dilemmas and in particular questions related to the sustaining of life. As death becomes imminent, patients, their families, and health care providers are be challenged with difficult decisions for the following four reasons. Firstly, death is inevitable (Haisfield-Wolfe, 1996; McPhee et al., 2000) and an undesirable event for many. Secondly, decisions at the end-of-life are complex and unique. They challenge physical, spiritual, and especially emotional integrity (Bascom & Tolle, 2000; Steinhauser et al., 2000). Thirdly, end-of-life decisions involve ethical dilemmas and conflicts for health care providers, patients, and families (Dorr Goold, Williams, & Arnold, 2000). Lastly, these decisions vary from one individual to another in accord with their unique personal value system (Leichtentritt & Rettig, 2001).

Ethical dilemmas arising at the end-of-life typically related to choosing between intervening to maintain or support life or foregoing life sustaining treatments (Burkhardt & Nathaniel, 2002). Advances in modern medicine have extended life

and as well as extending the process of dying. Most patients not only want a “good life,” but are also concerned about a “good death” (Moody, 1999). Dilemmas usually arise when there are different values and wishes among the people involved in this decision making process (Burkhardt & Nathaniel, 2002; Mazanec & Tyler, 2003).

Evidently, care delivered and patient or family decisions about end-of-life were not congruent (Baggs & Schmitt, 2000; The SUPPORT Principle Investigators, 1995). In Thailand, most decisions regarding prolongation of life or foregoing life-sustaining treatment are made by physicians (Intharasombat, 2000). The decisions often against patient’s preferences, if a decision maker do not respect to patient’s values. The case of Buddhadasa Bhikkhu (Huttheerut, 2001) is a clear example of this situation. In this case, physicians continued life-sustaining treatment while Buddhadasa Bhikkhu, a famous and venerable monk of Southern Thailand, expressed his wish to die peacefully without life-sustaining treatment (Maethunguro et al., 2001). Most physicians believe that at the end-of-life they must give their full efforts to preserve patients’ lives (Maethunguro et al., 2001). This situation reflects the incongruence and ethical conflict between physician’s and client’s values of end-of-life.

Based a review of research articles published from 1990 to 2000, Baggs and Schmitt (2000) found incongruence between care delivered and patient/family decisions, and patients’ values. They described four discrepancies: 1) nearly half of all patients who preferred not to have cardio-pulmonary resuscitation (CPR) were resuscitated at the end of their lives, 2) family members believed that patients preferred comfort, but life-sustaining treatments were often used, 3) family members of deceased patients also perceived that in their dying days, patients commonly

suffered from pain, dyspnea, and fatigue, and 4) family members indicated a sense of fear that health care providers may decide unilaterally to withdraw life-support equipment before the patient agrees to withdraw. Baggs and Schmitt (2000) concluded that a need for continued research about end-of-life decisions is need and in particular attention should be given to eliciting differing values. Uhlmann and Pearlman (1991) reached similar conclusions and recommended that further investigations are needed to elucidate the relative patients' values that they placed in their decisions.

Empirical research regarding end-of-life decisions in Thailand is very limited. Only two studies were found in the literature. Nijinikaree (2004) investigated end-of-life decisions of Thai Muslim patients and factors related to their decision-making. Neuonoi (2005) studied end-of-life decision of patients and surrogates, their congruency, and reasons of the decision. Four qualitative studies were done by Thai researchers regarding ethical dilemmas in nursing practice and provided further evidence that "prolonging life" or "prolonging dying" was one of the significant ethical dilemmas experienced by nurses and nursing students (Chaleawsak, 2002; Chaowalit, Hatthakit, Nasaee, Suttharangsee, & Parker, 2002; Chaowalit, Suttharangsee, & Takviriyannun, 1999; Rakchart, Chaowalit, & Suttharangsee, 2002). Furthermore, during a 2001 national workshop for nurse educators and graduate students on nursing ethics in Thailand, ethical issues and decision making regarding end-of-life care were included as research priorities (Ketefian, Phanchaoenworakul, & Yunibhand, 2001).

Patient advocacy is a very important role for nurses in the end-of-life decisions (Fry, 1998). Nurses today are doing more than just giving comfort care to

the dying. They also are assisting patients with decision making regarding future available care and helping patients make choices regarding death by advocating and facilitating patients to clarify their understanding on end-of-life care, technology and their wishes regarding death (Haisfield-Wolfe, 1996). The Thai Nursing Professional Code of Ethics states that nurses should provide such services with charity and kindness and with respect for human values of life, health and well being (The Nurses' Association of Thailand, 2003). The American Association of Critical Care Nurses (AACN) also stated that patient advocacy is an integral component of critical care nursing practice; as a patient advocate, nurses should respect the values, beliefs, and rights of the patients (Kinney et al., 1998). In this role of advocate, nurses can assist, facilitate, and help patients to exert their autonomy in health care decisions (Gauthier & Froman, 2001). Autonomy means self-governing and denotes having freedom to make choices on issues that affect one's life and to make decisions based on personal goals (Burkhardt & Nathaniel, 2002). The concept of autonomy implies that one has freedom to take or not take control of health care decisions based on one's values and preferences (Gauthier & Froman, 2001).

All decisions are based on values. Values have a tremendous impact on making decisions, resolving conflicts, and perceiving situations (Marquis & Huston, 2000). In addition, being confused and unclear about values may affect one's decision-making ability (Huston & Marquis, 1995 cited by Marquis & Huston, 2000). Values vary among people, and the values an individual holds reflect cultural and societal influences (Potter & Perry, 1999). In Thai society, in which most people are Buddhists; there is no doubt that Buddhism has a consciously significant role in their

everyday life (Komin, 1991; Smuckarn, 1996), and also influences their values underlying end of life decisions.

Exploring the values underlying end-of-life decisions of Thai Buddhists is important for health care providers. The results would assist the providers by providing better understanding of values that affects patients and families' decision-making. In turn, this information may offer the opportunity for nurses to provide better support, harmonious care, and protect patients' rights. In Thailand, the empirical understanding of these decisions is limited. A literature review using the database of Thai Theses Online from 1960 to 2000, and the database of several universities: Chaingmai, Chulalongkorn, Khonkan, Mahidol, Prince of Songkla, and Sukhothaithammatirat University from 1987 to 1998, found no citations in this area. In the year 2004 and 2005, two thesis writers reported on end-of-life decisions (Nijinikaree, 2004; Neuonoi, 2005). Hence, the purpose of this study was to explore the values underlying end-of-life decisions in Thai Buddhist.

Objectives of the Study

1. To explore end-of-life decisions in Thai Buddhist patients and patients' families.
2. To compare differences of the end-of-life decisions among three groups of Thai Buddhists: (1) those who are chronically-ill, (2) those patients' families who have had to make these decisions, and (3) those patients' families who have no experience in end-of-life decisions making.
3. To reveal the values underlying the end-of-life decisions of Thai Buddhist patients and patients' families.

Research Questions

1. To what extent do Thai Buddhist patients and patients' families make decisions to forgo, continue, or choose to allow a physician or family to make decision regarding life-sustaining treatment at the end-of-life for them?

2. Do the end-of-life decisions differ among three groups of Thai Buddhists: (1) those who are chronically-ill, (2) those patients' families who have had to make these decisions, and (3) those patients' families who have no experience in end-of-life decisions making?

3. What are the values underlying the decisions to forgo, to continue life-sustaining treatment, and to allow physician or family to make decision for them at the end-of-life in Thai Buddhist patients and patients' families?

Conceptual Framework

Individual decisions are based on each person's value system which infers that the final choice selected is influenced by each person's value system. Everyone has different values and life experiences; each person perceives and thinks differently, therefore, everyone varies in decision-making (Marquis & Huston, 2000). Louis E. Raths pioneered the process of valuing as an approach to an individual's appraisal of values (Read, Simon & Goodman, 1977; Simon, Howe & Kirschenbaum, 1972). The valuing process (Raths, 1966) refers to three processes of choosing, prizing, and acting. Choosing consists of: 1) choosing freely, 2) choosing from alternatives, and 3) choosing after reflecting and considering all consequences. Prizing consists of: 1) prizing and cherishing the choice or being happy with the choice, and 2) publicly affirming the choice. The last process, behavior or acting

consists of: 1) making the choice part of one's behavior, and 2) acting with a pattern of consistency and repetition. Results or outcomes of the valuing process are values (Raths, 1966). Values are general guides to behavior that determine the choices people make in their lives (Raths, 1966, Read, Simon & Goodman, 1977). Therefore determining values underlying end-of-life (EOL) decisions also are based on the valuing process.

There are many factors influencing value development in Thai Buddhists. These factors include culture, Buddhist philosophy, political beliefs, education, upbringing, socio-economic class, and life experiences (Burkhardt & Nathaniel, 2002; Fry, 1994; Harvey, 1992; Komin, 1991; Shelly & Miller, 1991). Additionally, health status is one factor influencing changing values. Harvey (1992) studied the relationship of values to adjustment in illness and developed a model for nursing practice. Harvey proposed that the need for value change or reevaluation occur more frequently in adaptation to disability and chronic illness. Similarly, Lampic and colleagues (2002) studied in 517 women to investigate whether life values change after a breast cancer diagnosis. They assessed life values by the life value questionnaire and found the life values change among women diagnosed with primary breast cancer in adaptation to the diagnosis. Hence, the end-of-life decisions of healthy persons and chronic illness varies because their values are different. In addition, Nijinikaree (2004) investigated the end-of-life decisions of Thai Muslim patients. She found that the majority of subjects chose to forgo life sustaining treatment because they did not want to prolong their sufferings after having suffered from this chronic illness. Some subjects in the study decided to forgo life sustaining

treatment because they already knew about prolonged suffering from continuing life sustaining treatment by observing it in others who faced with end-of-life decisions..

In Thai culture, Buddhism has a pervasive influence on everyday life. These values of the Thai are derive from precepts of Buddhist philosophy or the Buddhist concepts of the individual (Komin, 1991; Smuckarn, 1996).The essence of Buddhist philosophy in the daily life of living things consist of the Five Aggregates of Existence or Panca-khandha, the Three Characteristics of Existence or Tri-lakkhana, Law of Dependent Origination or Paticcasamuppada, Law of Karma or Kod-hang-kam, The Middle Path or Majjhima-patipada, and The Three-fold Training (the ways of practice) or Tri-Sikkha, (Khantipalo, 1970; Kyokai, 1966; Mahachulalongornkingcollege, 1991; Payutto,1995; Prathamapeedok, 2003). These concepts of Buddhist philosophy will be explained in more depth in Chapter 2.

Values underlying end-of-life decisions of Thai Buddhists include several Buddhist doctrine expression values. These values are rebirth (Tailaaw-kertmai) or death is a transition; death is inevitable (Aniccata/ impermanence); all of the body is suffering (Dukkata); prolongation of death is impossible (Anattata); attachment is a cause of suffering or enlightenment is a way of being free from suffering, sin and merit (Bahb-boon), reciprocity to karma (Chod-chai-kam), harmony, gratitude and reciprocation (Ka-tan-you and Ka-ta-wa-tee), death with consciousness (Morana with Sati); and shortening life or prolongation of death is a sin (Cantasalo et al., 2000; Chuaprapaisilp, 2004; Komin, 1991; Mahachulalongornkingcollege, 1991; Moongngam, 1990; and Sirilai, 2001).

From the literature review, social expression values underlying end-of-life decisions were identified. These values are quality of life, quality of death or

peaceful end-of-life, prolongation of life, human dignity, life or human being, free from suffering (comfort), family concern, free from family burden or economic burden, responsibility, hope, respect, and believe in supernatural powers (Bowman & Singer, 2001; Burkhardt & Nathaniel, 2002; Konshi, Davis & Aiba, 2002; Leichtentritt & Rettig, 2001; Pongpaiboon, et al., 1999; Ruark & Raffin, 1988; Ruland & Moore, 1998; Uhlmann & Pearlman, 1991).

In end-of-life decision-making, patients have the right to forgo, continue life-sustaining treatment, or depend on decision making of other person (Asch, Hansen-Flaschen, & Laken, 1995). A conceptual framework for end-of-life decision-making based on values, proposed by the researcher is shown in Figure 1

Definition of Terms

Thai Buddhists refer to Thai Buddhists who were born and live in upper and lower of Southern Thailand. This sample was divided into three groups: chronically- ill patients, patients' families who have had experience in end-of-life decisions, and those who have no experience in end-of-life decisions of their parents, relatives or significant others. For chronically- ill patients, they were patient experiencing life threatening chronic illnesses, such as AIDS, malignant diseases, and organ failure due to illness, etc.

End-of-life decisions refer to the decision-making of Thai Buddhists regarding life-sustaining treatment at the end-of-life, which consists of forgoing (withdrawal/withholding), continuing the treatment and allowing physician or family to make decision for them. Life sustaining treatment is a treatment that is used to keep terminally ill patients alive or in existence including cardio-pulmonary resuscitation,

mechanical ventilation therapy, artificial nutrition and hydration, and antibiotic therapy.

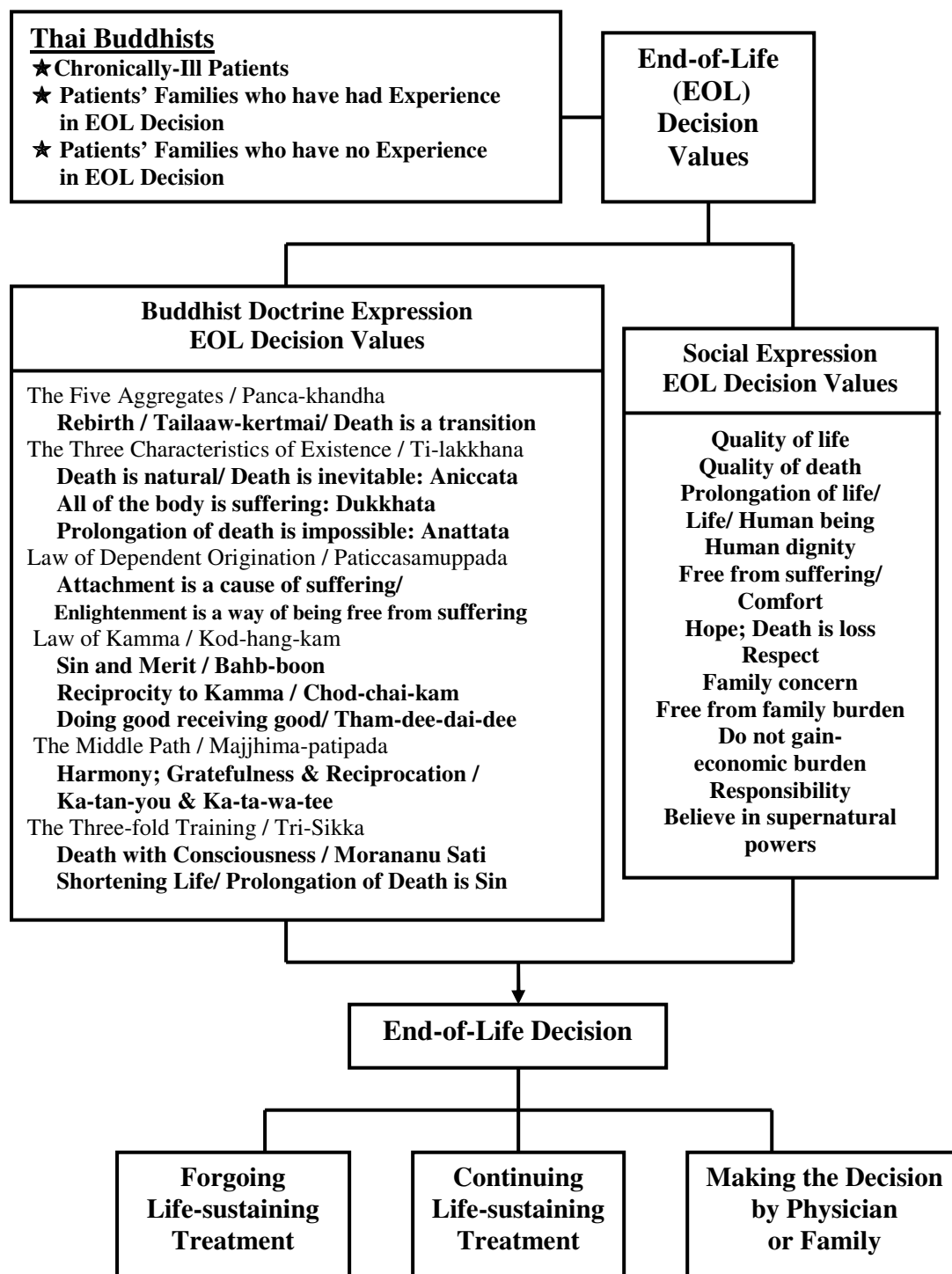


Figure 1. Conceptual framework for EOL decision-making based on values

Values underlying end-of-life decisions refer to values of Thai Buddhists that influence the decisions at the end-of-life whether to continue, forgo, and allow physician or family to make decision for them. These values consist of Buddhist values and other values, such as psycho-socio-economic values, and spiritual values. Buddhist values underlying end-of-life decisions are rebirth, death is inevitable; all of the body is suffering; prolongation of death is impossible; attachment is a cause of suffering; sin and merit, reciprocity to kamma, harmony, gratefulness and reciprocation, death with consciousness, shortening life or prolongation of death is sin. The other values of Thai Buddhists are quality of life, quality of death, prolongation of life, human dignity, life or human-being, free from suffering, family concern, free from family burden, do not gain economic burden, responsibility, hope or free from loss, death is loss, respect, and supernatural powers.

Scope of the Study

The study focused on a sample of Thai Buddhists in Southern Thailand, which consist of chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of their parents, relatives or significant others. Patient near end-of-life did not included in the study because of two reasons: 1) at the end-of-life, patient capacity to participate in the study is limited by alteration of conscious (Tilden, Tolle, Garland & Nelson, 1995), and 2) it is an ethical concern to protect subjects from harm and risk (Burns & Grove, 2001a) because end-of- life decision is a sensitive and undesirable event.

Significance of the Research

The findings would provide information for health care providers by assisting them in understanding the values underlying end-of-life decisions of Thai Buddhists. The findings may be used as a guideline for health care providers to assist patients and families on making decisions at the end-of-life and solved their ethical conflicts and dilemmas related to end-of-life decisions. Moreover, the results may be used to improve quality of care regarding end-of-life decisions of Thai Buddhists by helping them to provide care based on patient's best interest. The findings will be beneficial for nursing educators to use as data bases for curriculum development in particular nursing ethics within a particular context: value and decision making. In addition, the findings can be baseline data for further research especially research regarding values underlying end-of-life decisions scale development.

CHAPTER 2

LITERATURE REVIEW

Reviewing existing literature related to the study is a critical step in the research process. It is essential that research should be built upon methods, results, and ideas of other research predecessors (Burns & Grove, 2001b). For this study, a number of related articles and studies were reviewed and grouped under three aspects as follows:

1. Values

1.1 Definition

1.2 Significance of values

1.3 Nature of values

1.4 Factors influencing value development

2. End-of-life decision

2.1 Classification of end-of-life decision

2.2 Evolution of end-of-life decision

2.3 Significance of end-of-life decision

2.4 Nurse's roles in end-of-life decision

2.5 Values underlying end-of-life decision

3. Buddhist philosophy

3.1 Buddhist philosophy underpinning end-of-life decisions

3.2 Buddhist values underlying end-of-life decision

Values

Principled behavior flows from personal values that guide and inform our responses, behaviors, and decisions in all areas of our lives (Burkhardt & Nathaniel, 2002). Professional nursing directly relates to human life therefore, when values are known, stated, and positively affirmed the client, nurse, or health care team will be more capable of making objective decisions about health care (Potter & Perry, 1999). Hence, understanding and clarifying knowledge regarding values is very useful for patients, their families, and health care providers.

1. Definition

The term “value” comes from the Latin word “valere”, its means “to be of worth” (Pojman, 1990). The term, “value” is used in various disciplines both nursing discipline as well as many others. Many scholars have significantly contributed to the definition of the concept values. Nevertheless, from a concept analysis carried out by the investigator, five attributes of value concept and its supportive information have been identified as follows:

Firstly, value is a set of enduring beliefs. According to Rokeach’s conceptualization of value and value system, value represents the individual’s set of beliefs about what he/she believes to be true (Rokeach, 1968). It is also classified as beliefs, wherein end of action is judged to be desirable or undesirable (Komin, 1991). Values are enduring that mean although values do change throughout one’s life, they do not change overnight (Rokeach, 1973). They are sufficiently stable to provide continuity of human personality and social characteristics.

Secondly, they guide behavior. Values serve as standards or criteria to guide human thought and actions (William, 1979 cited by Komin, 1991). Potter and

Perry (1999) define values as a personal belief that sets standards and influences behavior. Values become a part of a person's conscience and worldview, providing a frame of reference and acting as pilots to guide behavior and assist people in making choices (Tappen, Weiss, & Whitehead, 1998). Moreover, Hall (1996) states that what a person values is obvious from his actions- not by what he says his beliefs are. In addition, Marquis and Huston (2000) also state that true values require that person taking action.

Thirdly, values must be freely chosen from among alternatives. Rath, Harmun, and Simon (1978 cited by Uustal, 1987) use the term values to denote those beliefs, purposes, attitudes and so on that are chosen freely and thoughtfully. Values also refer to freely chosen from among alternatives only after due reflection (DeSales University, 2002; Marquis and Huston, 2000). Therefore, value is an enduring belief that a desirable mode of conduct or end-state of existence is personally or socially preferable to an alternate choice (Rokeach, 1973). William (1970 cited by Borgatta & Borgatta, 1992) stated in the same way that values are conceptions of desirability, of how things should be. Hence, the value of a thing is dependent upon a subject's interest in that thing (Audy, 1995).

Fourthly, a value has a quality with intrinsic worth for an individual, group, and society. Values are ideals and concepts that give meaning to the individual's life (Catalano, 2003). Rath, Harmun, and Simon (1978 cited by Uustal, 1987) define values as guides to behavior that evolve and mature, are seen as worthy, and give direction to life. Hence a significant characteristic of true value is prizing and cherishing (Marquis and Huston, 2000).

Lastly, values are consciously and consistently repeated. Laitinen (2002) mentions that values can be seen as ambitions or aims that are valid for one in practically all circumstances. Values do not come true merely as words but as one's personal choices and as aims to act according to those choices made. Values are positively affirmed and enacted. Borgatta and Borgatta (1992) also stated that values indicate people share for their certain types of outcomes in their lives and for their certain types of conduct.

In conclusion, value is described as freely and thoughtfully chosen, enduring attitudes or deeply held beliefs about the worth of a person object, idea, and action that sets standards; is prized and cherished, and influences behavior consistently repeated or indicates how a person has decided to use his or her life.

2. Significance of values

Value is an important concept for human life (Komin, 1991; Tschudin, 1992). Catalano (2003) proposed that values serve as the framework for making decisions and taking action in daily life. All decisions are based on values (Potter & Perry, 1999). Values help us to choose between alternatives, and make decisions (Tschudin, 1992). So, they are the guides of human behavior. On the other hand, those with unclear sets of values seem not to have clear purposes, to know what they are for and against, and to know where they are going and why. They seem to lack direction in their lives and lack criteria for choosing what to do (Raths, Harmun, and Simon, 1978 cited by Uustal, 1987). Being confused and unclear about values may affect decision-making ability (Huston & Marquis, 1995 cited by Marquis & Huston, 2000). In addition, every nurse also makes decisions about patient care which requires her to consider facts about the patient in the context of values (Fry, 1994).

Values have aspects of being both personal and a foundation of social and ethical living. (Tschudin, 1992). First, as a personal aspect, values reflect our actual, deeply held beliefs, and determine our attitudes and behavior (Shelly & Miller, 1991). As a foundation in social life, values also reflects cultural and societal influences, relationships with others, and personal needs (Potter & Perry, 1999). Value is a principle that guides a cultural group's life (Ramachandran, 1994). as the foundation of ethical living, both individual and community ethics are usually based on shared values. For example, to decide what is ethically right to do in nursing care, one must consider factual information about the patient within a framework or context of values (Veatch & Fry, 1987 cited by Fry, 1994). Understanding one's values is the first step in preparing oneself to make ethical decisions (Fry, 1994).

Values have a tremendous impact not only on making decisions but also on resolving conflicts and even on perceiving things (Marquis & Huston, 2000). Understanding one's own value system and assessing the value systems of others may help reduce conflict during decision- making (Potter & Perry, 1999).

Hence, decision-making and one's actions are directly influenced by one's values. The important of values is guiding behavior and providing direction for person's life; offering criteria for them to choose what to do with their time and their lives; helping them to perceive, evaluate, judge, and compare what is worthwhile, and helping them to resolve their conflicts. In addition, values have a significant role as the foundation for social action and interaction, and on ethical concern.

3. Nature of values

Among people, values vary, develop, and change over time (Potter & Perry, 1999). Uustal (1987) stated that values are not seen as static; rather, they

evolve as the individual matures and changes. And their development is seen as a continuous, life-long process (Potter & Perry, 1999). Raths, Harmun, and Simon (1978 cited by Uustal, 1987) also stated that the development of values is a personal and life-long process.

Rokeach (1973) proposed the nature of value that value is a desirable belief, and a preference, which is enduring. Fry (1994) mentioned that a value is a worthwhile or desirable standard or quality. A value is a preference as well as a conception of something that is desirable or of choices that people make when confronted by a set of alternatives (Komin, 1991). In addition, it is a conception of the desirable which influences the selection from available modes, means, and ends of action (Kluckhohn, 1951 cited by Uustal, 1987). Hence, values are stable enough to reflect the fact of sameness and continuity of a unique personality socialized within a given culture and society (Rokeach, 1973).

Values can easily be identified in the everyday life experiences of any person. They can be expressed openly or demonstrated verbally in language, nonverbal through behavior, or in standards of conduct that a person endorses or tries to maintain (Omery, 1989 cited by Fry, 1994; Potter & Perry, 1997). It helps create a person's unique identity.

Moreover, the nature of values may be conscious or unconscious, shaping thoughts and actions, having motivational power, and guiding that person's choices and decisions (Fry, 1994; Potter & Perry, 1997). Other natures of values may be explicit or implicit, distinctive of an individual or characteristic of a group, are organized into a system that has meaning to the individual, and are prioritized within an individual's value system (Fry, 1994; Kluckhohn, 1951 cited by Uustal, 1987). In

addition, the hierarchy is usually fairly stable over time but certain values can replace other higher values depending on one's life experiences and on that individual's reassessment of his values (Rokeach, 1968 cited by Fry, 1994).

In summary, the significant nature of values are that they are worthwhile or desirable standard, vary among people, develop and change over time and life-long process, may be conscious or unconscious, may be expressed openly through verbal and nonverbal behaviors, be held of the greatest importance in shaping thought and action, and can easily be identified in the everyday life experiences of any person.

4. Factors influencing value development

People acquire values in many ways. People form values consciously and unconsciously through reasoning, observation, experience, and socialization. An understanding of values begins in earliest childhood and is influenced by the way a child is raised. The acquiring of values depends in large part on experiences within the family (Potter & Perry, 1999) or family ties, and childhood experiences influence value development (Shelly & Miller, 1991). Upbringing, cultural norms, religious and political beliefs, societal norms, education, economics, and life experiences also influence personal value formation (Catalano, 2003; Chen, 2001; Ellis & Hartley, 2000; Fry, 1994; Hall, 1996; Potter & Perry, 1995; Shelly & Miller, 1991). Burkhardt and Nathaniel (2002) stated that human value development is a product of the socio-cultural environment in which we live and develop a process of learning what is right and wrong within the culture. Shelly and Miller (1991) pointed out that cultural norms have a strong influence on our values. Experiences

over a lifetime cause our values to shift, weaken or strengthen, change and mature. Economics also play a large part in values formation.

Finally, values are in fact formed by a great number of influences. These factors are socio-cultural environmental factors such as culture, religious and political beliefs, education, upbringing, economics, and life experiences.

End-of-life decision

One of the most controversial areas of ethical debate involves the topic of death and dying (Ellis & Hartley, 2000). Many ethical decisions have to be made when a person reaches the end-of-life. One of the most challenging and critical ethical decisions are whether to forgo life-sustaining treatment or to withhold and withdraw life-sustaining treatment. Many articles (Bascom & Tolle, 2000; Burkhardt & Nathaniel, 2002; Burns, Mitchell, Griffith & Truog, 2001; Prendergast & Luce, 1997) stated that the incidence of end-of-life decision is more frequent than in the past. Besides, the decision whether to forgo life-sustaining treatment is now regularly weighed in terminal illness (Rothchild, 1994).

1. Classification of end-of-life decision

At the end-of-life, the choices that patients and families often face are death or the extension of life using painful and expensive treatments (Catalano, 2003). The advent of certain lifesaving procedures and mechanical devices causes them to examine the meaning of “quality of life,” and has created debates about “death with dignity.” (Ellis & Hartley, 2000a). In fact, it is universally accepted that it is a patient’s right to accept or refuse life-sustaining treatment. Thus the decisions

may be continue, forgo life-sustaining treatment, and continue or forgo depend on others' decision (Tagaya & Davis, 2000).

1.1 Continuing life-sustaining treatment is the individual decision-making to prolong their life by using life-sustaining treatment at the end-stage of life although there is no chance of regaining full viability (Flynn & Davis, 1990). Major life prolonging modalities include mechanical ventilation, dialysis, artificial nutrition and hydration, blood or blood product administration, antibiotic therapy, major surgery, etc. (Rieth, 1999).

1.2 Forgoing life-sustaining treatment or withholding and withdrawing life-sustaining treatment refers to individual decision-making to refuse life-sustaining treatment at the end-stage of life although it is known that this would likely result in their death from the underlying medical condition as the need or preference is not to prolong the dying process (Pace, 2000). Withholding life-sustaining treatment is defined as a decision not to starting or not to sustain further addition of a life prolonging treatment; withdrawing life-sustaining treatment is defined as a decision about discontinuing or removing a life prolonging treatment once started (Hall & Rocker, 2000).

1.3 Continuing or forgoing life-sustaining treatment may depend on the decision of others. This refers to the individual decision-making to accept or to refuse life-sustaining treatment, which is not made by himself but by physician or their families. In some cases, this is due to the respect for the physician's decision because those cases believe that physicians understand end-of-life decision better than them and should make appropriate decision for them based on his professional knowledge and superior experiences (Bowman & Singer, 2001). In other cases the

individual may respect to their family's decisions because he believes that his family loves him, best understands his wishes, and would choose the best thing for him (Bowman & Singer, 2001). In other cases, the individual may be uncertain to make a decision by himself so he chooses to depend on the decision of others.

End-of-life decisions regarding life-sustaining treatment varies depending on many factors. Sprung and colleague (2003) studied in 31,417 patients admitted to 37 intensive care units (ICUs) in 17 European countries from January 1, 1999 to June 30, 2000 to determine the frequency and types of actual end-of-life practices, to analyze similarities, and differences. They found that the decisions whether to continue or to forgo life-sustaining treatment was associated with age, acute and chronic diagnosis, number of days in the ICU, and geographic and religious factors. Keenan and colleague (1998) also studied in the mixed ICUs in three teaching and six community hospitals in Ontario, Canada, during a 6-month period in 1995. They found that three major factors probably accounted for the variation in the life-sustaining treatment decisions: clinical differences, willingness to forgo, and attitudes of the physicians. In addition, Harvey (1992) proposed that references to the need for value change or revaluation in adaptation to disability and chronic illness occur more frequently. Ware and Young (1976, 1979 cited by Harvey, 1992) studied value placed on health and proposed that it served as a standard for health-related decision-making. Hence, the end-of-life decisions in healthy persons and chronic illness usually vary because their values are different.

Confidence in the decision and the reasons of the family are also associated with their decisions. Boyd and colleagues (1996) found that confidence in the decision of person was increased with seniority and authority. A family may

refuse treatment for their loved one if the cost of was great but the resulting quality of life was low, knowing their loved one would not want life prolonged by a machine or other technology when recovery was not possible (Caralis, & Hammond, 1992; Tilden, Tolle, Garland, & Nelson, 1995). Other factors influence end-of-life decision are patient's wishes, potential harms, fear of litigation or breaking of the law, financial cost of society, scarce resource allocation, cost of treatment, other ethical, legal, and policy guidelines (Asai, Fukuhara, & Lo, 1995; Asch, Hansen-flachen, & Lanken, 1995; Beck, Brown, Boles, & Barrett, 2002; Burns, Mitchell, Griffith & Truog, 2001; Fetters, Churchill, & Danis, 2001; Oberle, & Hughes, 2001; Tilden, Tolle, Garland, & Nelson, 1995).

2. Evolution of end-of-life decision

In the past, a patients' autonomy was frequently violated. Paternalism was manifested in the making of decisions on behalf of patients without their full consent or knowledge. Persistent paternalistic attitudes have contributed to increased numbers of patients and families struggling with health care providers over control of health care decisions. Health care providers often believed that they understand health care decisions better than patients; that they are uniquely qualified to make the decisions by virtue of their professional knowledge (Burkhardt & Nathaniel, 2002).

In the past few decades, the physician-dominated approach to decision-making has shifted toward an approach that recognizes a patient's right, and promotes patient autonomy and self-determination (Quill & Brody, 1996; Scanlon, 2003; Sprung, et al., 2003). In December 1991, the Patient Self-Determination Act (PSDA), which was passed by the United States Congress in 1990, went into effect. It

was a major step toward acknowledging the importance of patient's right in health care decision-making (Ellis & Hartley, 2000b). The spirit of this law intended to empower patients to make autonomous, informed health care decisions and to provide patients with timely and accurate information and support in allowing those autonomous decisions to be respected (Briggs & Calvin, 2002). An advance directive is a legal document that indicates the wishes of an individual in regard to end-of-life issues (Ellis & Hartley, 2000b). Hence, health care organizations were challenged to establish policies that respect the individual's decision-making for future medical care and end-of-life treatment preferences (Briggs & Calvin, 2002).

However, the health care system became strangely fixated on the completion and activation of the legal documents so the intended outcomes of the patient's rights movement has not been realized (Briggs & Calvin, 2002). The incidence of completed advance directives remains low despite evidence that public interest is high (Romero, Lindeman, Koehler & Allen, 1997; Silverman, Tuma, Schaeffer & Singh, 1995). The directives are too vague to guide decisions; the chosen surrogate decision-maker often has not had a meaningful conversation with the patient to know what he or she would want (Teno, et al., 1994, 1997 cited by Briggs & Calvin, 2002). It is no surprise that the evolution of end-of-life shifted from advance directives to advance care planning (ACP) that can effectively influence patient and family's end-of-life decision-making by preparing them to fully participate in their decisions (Briggs & Calvin, 2002).

In Thailand, as in Japan, most end-of-life decisions are made by physicians (Intharasombat, 2000) or by physicians together with the patient's families, (Maythunguro, et al., 2001; Okuno, Tagaya, Tamura, & Davis, 1996). In Japan,

Konishi, Davis and Aiba (2002) stated that there is no systemic, recognized way for individuals to indicate their values and wishes. In Thailand, the same as Japan, there was no law to support patient self-determination for along time. In the first trimester of this year, a patient's right to refuse life-sustaining treatment in terminal stage has been enshrined in the Section 12 of Thai National Health Act, B. E. 2550, which was enacted on the 3rd day of March 2007, as follows: a person shall have the right to make a living will in writing to refuse the public health service which is supplied merely to prolong his/her terminal stage of life or to cease the severe suffering from illness (The National Health Commission Office, 2007).

Although a person has right to make the living will, he or she must waits for the Ministerial Regulation of the Section because the second paragraph of the Section proposes that the living will shall be carried out in accordance with the rules and procedure prescribed in the Ministerial Regulation, which has been in the process of regulation by The National Health Commission (Department of Mental Health, 2007; The National Health Commission Office, 2007). According to the context of this act, health care personnel should take role of advocacy to increase patient's knowing and understanding about this Section of the National Health Act and facilitate patient and family to indicate their preferences based on their values.

3. Significance of end-of-life decision

The most important issue in nursing practice is end-of-life issue (Bascom & Tolle, 2000) especially the end-of-life decision issue, because of the following reasons:

Firstly, end-of-life decisions are common because of their high incidence, which arise from various groups of clients. The incidence of end-of-life

decisions regarding forgoing life sustaining treatment have increased in frequency with recent studies indicating that up to 90% of the patients who die in ICU had forgone some life-sustaining treatment (Burkhardt & Nathaniel, 2002; Burns, Mitchell, Griffith & Truog, 2001; Diringer, Edwards, Aiyagare & Hollingsworth, 2001; Walter, et al., 1998). Foregoing life-sustaining treatment issue arises most frequently in several groups of patients such as patients who are severely and critically ill, terminally ill, permanently unconscious, or those who suffer from irreversible cognitive or physical impairment (American College of Physicians, 1989).

Secondly, decision making at the end-of-life can be particularly challenging. These cases frequently present ethical challenges to patients, families, nurses, and other health personnel for the following reasons: They involve life and death matters; when end-of-life concerns arise, the patients are often unconscious or not capable to participate in the decision-making process; and there is frequently need to involve decision-makers other than the patient (Ellis & Hartley, 2000a). Therefore, it is easy to violate the patient's autonomy in end-of-life decisions.

Thirdly, making end-of-life decisions is a painful and difficult process; one that can be intensified by cultural differences between physicians and patients, emotions, and clouded decision-making (Bowman & Singer, 2001; Scanlon, 2003).

Lastly, the decision also has a vital impact to patient, family, and health care personnel because it is related to death and dying which is a sensitive and critical issue for patient. It confronts them with complex questions, conflicts, and/ or dilemmas. Abbott and colleagues (2001) stated that 46% of all families experienced conflicts during end-of-life treatment discussions of patients in ICU. One researcher

suggested that conflict involving life-sustaining treatment (LST) decision-making arise when the preferences of the patients or their substitute decision makers differ from the recommendation of health care personnel (Fetters, Churchill & Danis, 2001). Tilden, Tolle, Garland and Nelson (1995) studied 32 family members of ICU patients using a qualitative design study who stated the behavior of physician and nurse made the families feel excluded or increased their burden in LST decisions.

4. Nurse's roles in end-of-life decision

Nurses are the main health care personnel who initiate and maintain continuous contact with patients. So nurses have frequent opportunities to facilitate and manifest many roles in helping patients in appropriate decision making by providing accurate information, teaching, counseling, or coordinating. The significant roles for nursing personnel in relation to this issue are as follows:

The most important role in end-of-life decision is the advocacy role in which nurses have several responsibilities: first, to assure that the patient and his family have adequate information and opportunities to make informed decisions and to make his or her wishes known: second, to listen to them understanding their values and their wishes regarding this issue: and lastly, to speak for the patient by effectively communicating to health team members about their needs and decisions (Bandman & Bandman, 1995; Grady, 1989; Jackonen, 1997).

Respect for patient autonomy is the primary basis for forgoing life-sustaining treatment (American Thoracic Society, 1991). It refers to the rights of patients to make important decisions about their own lives for themselves. They have the right to control what happens to their bodies, which implies that the final decision whether to use LST should be left to each patient. When a patient lacks decision-

making capacity, a surrogate decision maker must be identified by the patient, either orally or by a written advance directive, such as a living will, and the choice of the patient should be respected. The surrogate decision maker is the person most involved with the patient and most knowledgeable about the patient's wishes. Thus, another component of principle of respect for the autonomy of the individual is to recognize and accept an individual's decision.

End-of-life decision is a complex issue and nurses who are the part of the team who play several roles in helping patients make decision. Therefore, nurses need a strong sense of caring, compassion for their fellow human beings, and preserving dignity of patient and their family.

5. Values underlying end-of-life decision

Research findings regarding values underlying end-of-life decision and related concepts in various groups are as follows:

Leichtentritt and Rettig (2001) attempted to reveal the values that would receive priority attention when considering end-of-life decisions. In their study, 19 elderly Jewish Israelis and their 28 family members participated in individual interviews that were analyzed using a hermeneutic phenomenological method. Three transcendent values which crossed all four-life domains (physical-biological, socio-psychological, familial, and societal domain) are dignity, quality of life, and quality of death.

Konishi, Davis and Aiba (2002) studied 160 Japanese nurses attending a 1999 nurse leaders' seminar by having them complete questionnaires and also studied by using a semi-structured interview members of five families who had recently lost a terminally ill spouse or parent. The purpose was to ascertain how

Japanese nurses and patients' families viewed and valued the withdrawal of artificial food and fluid from those who were terminally ill. A content analysis of open-ended data revealed major themes of group agreement and group disagreement. The most dominant themes of the nurses-agree-to-withdraw group were "patient comfort," "a natural death," patient's wish," and "burdensome-dying prolonged by medical intervention." For the nurses-disagree-to-withdraw group, the major themes were "patient is alive," "patient's wish," and "patient and family's hope."

The "patient's comfort" was a primary concern for the nurses from the agree-group. They stated that "artificial food and fluid" only prolongs the patient's suffering, patients withdrawn from "artificial food and fluid" are allowed to die more peacefully than patients fed by tubes, and which may be a burden to the dying body. Their descriptions of dying patients' suffering led them to believe that "artificial food and fluid" is cruel and "burdensome-dying prolonged by medicine intervention." In this group of nurses, the "natural death" theme frequently emerged that life's ending is to go back to nature, the pathway to death must be pain free and peaceful, and not be against the law of nature by using "artificial food and fluid." The disagree-to-withdraw group was more concerned with the fact that the "patient is alive". They mentioned that "artificial food and fluid" withdrawal is killing and cruel, that patients are alive and have a right to treatment, and it is a necessary treatment. From the family interview data, the major theme was "the patient is alive." The families knew that these procedures supplied nutrition and fluid for their dying relative, and that they wanted it to be continued. In conclusion, nurses and patients' families agreed to or disagreed to withdraw artificial food and fluid based on their values.

Bowman and Singer (2001) conducted a qualitative survey with 40 Chinese seniors 65 years of age or older, in a Chinese community in Toronto, Canada. The objective of their study was to examine attitudes of Chinese seniors towards end-of-life decisions. They found that respondents based their end-of-life decision on the following factors: hope, suffering and burden, the future, emotional harmony, the life cycle, respect for doctors, and the family. These attitudes can be understood through the lens of cultural values from Confucian, Buddhist and Taoist traditions.

People not only value to end-of-life decision-making as hope but also as suffering, unknown, separation, loss and reciprocation. Chuaprapaisilp (2004) stated that AIDS patients view the meaning of death as follows: 1) death is suffering, 2) death is unknown, 3) death is reciprocity with kamma, 4) death is loss, 5) and death is separation from one's loved ones. When death comes upon us, everything in life is losing; it also causes separation from one's significant other (Chuaprapaisilp, 2004).

Although value is a significant factor underlying all decisions, empirical knowledge of values in nursing in Thailand is rare. From the literature review, twelve articles were found. Most of them focused on nurses and nursing students in the areas of nursing administration and nursing education (Kawmanee, 1999; Mesprasart, 1991; Piyasirisilp, 1996; Prasertkit, 1998; Saloa, 1998; Seetalavarang, 1998; Srisuthep, 1987; Suksawatdiporn, 2000; Suwanpatikorn, 1990; Tanabat, 1999). Only two articles focus on health promotion of adolescences (Chirakulpatana, 1992) and service workers (Yungtong, 1994). There is no study report regarding values in tertiary care including end-of-life decisions.

Komin (1991), and Komin and Samuckarn (1979) conducted two national Thai value surveys. The first was conducted with 2,469 Thai people both in

Bangkok and the rural provinces in 1978. The research objectives were: 1) to develop an instrument to measure Thai values and value system, 2) to determine the extent to which values of groups differing in socio-economic and demographic variables are differentiated, and 3) to examine the relationships between certain values, attitudes and behaviors. These studies were conducted with Thai people from different strata, stratified by cultural-geographic regions and occupations. The second study was conducted in 1981. The same scale was used again with 2,149 Thai rural people. The research findings stated that the most important values of Thai people were independence, responsibility, faithfulness, and gratitude. Thai values are different among different ages, genders, incomes, ethnic origins, education, occupations, place of residences (urban and rural region), and religion. However, these human value instruments have been developed as general measures of values with no direct link to life roles. Therefore, exploring values underlying end-of-life decisions of Thai Buddhists is significant for patients, families, and health care personnel to achieve concordance between care delivered and patient or family wishes about the decisions.

In conclusion, values underlying end-of-life decisions from the literature review consist of both cultural or religious expression values and social expression values. Religious expression values are harmony, a natural life, the life cycle or life as nature, and a natural death. Bio-social expression values are dignity, quality of life, value of life or of human beings, quality of death, value of comfort, prolonging dying burden, patient and family hope or value of hope, suffering and burden, and respect for physician and family.

Buddhist philosophy

Buddhism, the religion of the Thai nation, undoubtedly has exerted a strong influence on the people's everyday life (Komin, 1991; Samuckarn, 1996). Moongngam (1990) studied 300 Thai Buddhists from Mueng district of Ubonrachathani province and found that Buddhism still plays a role and has influence on Thai Buddhists. Approximately 95% of the total population is Buddhist (CIA World Fact book, 2003; Guest & Uden, 1994; Samuckarn, 1996). In Thai society, Buddhist doctrines are the basic of culture, tradition, and the values of the Thai people (Samuckarn, 1996; Tongprateep, Pitagsavaragon, & Panasakulkarn, 2001) affecting thought and Thai behavior patterns (Mole, 1973; Samuckarn, 1996). Therefore, decisions in everyday life of Thai Buddhists are based on values which are influenced by Buddhist philosophy (Tongprateep, Pitagsavaragon, & Panasakulkarn, 2001). Pongpaiboon (1986) also mentioned Buddhism as a compass that points the direction for all action and behavior of Southern Thai Buddhists.

1. Buddhist philosophy underpinning end-of-life decision

Buddhist perspectives on health and death derived from a documentary research based on the Tipitaka that was conducted by Paonil and Sringermyuang (2002). They proposed as follows:

The scope of health in Buddhism is wider than physical and mental aspects and includes the state of perfect mind. Physical ailments or death are only parts of diseases or sufferings, while the perspective of health expands the concept of destination of life to living with wisdom. There are more important issues to do with the body than to keep our comfortableness and to extend the end-of-life. In short, health is the state of being completely free from all kinds of human suffering while

disease involves all kinds of human suffering; especially mental suffering. An important factor for a healthy life is keeping a calm mind by living in harmony with nature and with less attachment.

In the Buddhist view, human life is so short, easy to get sick or die, and impossible to run away from ailments or death, but we can create suitable causes that lead to the state of more perfect life. Although health is a preferable condition for every life, for Buddhism, afflictions as well as death are seen as very common events of human beings. Diseases are not perceived only in a bad way. Everyone can gain an advantage from an ailment if he/she realizes its nature. The diseases remind us that this body is so fragile and impermanent. Naturally, life tends to decay and break down all the time, and contains a lot of waste and diseases. Awareness of these realities can reduce the degree of desire and attachment in our body. In addition, it alerts us to try harder and practice faster moving ourselves closer to the ultimate destination of Buddhists, nibbana, which is a state of perfect health.

Buddhist philosophy that influences Thai Buddhists in end-of-life decisions is Pancakkhandha or the Five Aggregates, Tri-lakkhana or the Three Characteristics of Existence, Paticcasamuppada or the Law of Dependent Origination which is related to two principles of the Dhamma: 1) Ariya-sacca or the Four Noble Truths, and 2) Kod-hang-kam or the Law of Karma, Sikkhattaya or the ways of practice or the Threefold Training, and Majjhima-patipada or the Middle Way.

1.1 The Five Aggregates: The Five Aggregates or Benja-kunt in Thai stated that all living things in the world are made up of one concrete element (body) and four abstract elements (mind), and they can exist only as long as the elements are still united into a composition or an entity. Life is composed of body and

mind functions normally and together, there is no longer life if the body and mind decomposes and disintegrates (Mahachulalongornkingcollege, 1991; Prathamapeedok, 1999; Raksasataya, 1987). However, it is natural that those elements change all the time thus existence and extinction is an ordinary phenomena of human life.

The Five Aggregates refers to the five causally conditioned elements of existence forming a being or entity (Prathamapeedok, 2003) that produce one's thought to turn good, bad or neutral. These elements consist of corporeality or one body element, and four mental elements, which are feeling or sensation, perception, mental formations, and consciousness (Mahachulalongornkingcollege, 1991; Prathamapeedok, 1999). Corporeality or Rupa refers to all parts of body including matter, energy, quality of matter and energy, and behavior of living things. It is the tangible component of life. Sensation or Vedana refers to emotion and feelings of the living things; it may be happy, unhappy or suffering. Perception or Sunya means remembering and knowing things. Mental formation or Sankhara refers to components or characteristics of the mind, which it forms to be bad good or neutral. Examples of this characteristic of mind are loving-kindness or Metta, compassion or Karuna, sympathetic joy or Mudita, neutrality or Upekkha, greed or Lopha, hatred or Dosa, and delusion or Moha. Thus, the mental formation of compassion, for example, will form in the human mind to be tenderness that enables us to look into other's feelings, to understand their troubles. The last component of mind is consciousness which refers to the sensibility of living things which perceives senses through the sensory organs --the eyes, ears, nose, tongue, body and mind. All four of these mental

components are intangibles they arise suddenly and are continuing processes of the mind.

1.2 The Three Characteristics of Existence: The natural law of Buddhist doctrine also mentions that life exists and is extinguished under the true nature of the world that is called the Three Characteristics of Existence or Tri-lakkhana. All living beings, without exception, are subject to this doctrine. These essential characteristics are impermanence, suffering, and non-self (Autthagorn, 1988; Mahachulalongornkingcollege, 1991; Prathamapeedok, 2001; Raksasataya, 1987). Impermanence or Aniccata is a summarized statement that in all existences there is no such thing as permanence. All kinds of life come into being when proper conditions prevail but nothing, which takes or has form, can endure for eternity. They retain their status only transitorily sooner and later they will be worn away, broken, destroyed or disintegrated and thereby providing material from which new forms come into being. Suffering or Dukkata refers to dissatisfaction, being oppressed, stress, and conflict that are involved in life. All existences face this condition because they all the time are decaying, especially living beings which possess senses that make them feel bad as they age, sicken and finally die. Non-self or Anattata is the last characteristic of this Buddhist doctrine which means that all things are not self or soulless or nothing belongs to life; state of being not self. There is no principle, and soul or self belong to any living thing.

1.3 Law of Dependent Origination: Law of Dependent Origination or Paticcasamuppada is a law or condition of reality (Payutto, 1995). It refers to the arising of all states conditioned by their dependent states or their dependence upon each other among all states conditioned by causes (Mahachulalongornkingcollege,

1991). The Chain of Causation, the Law of Causation, the Law of Dependent Arising, the Chain of Phenomenal Cause and Effect, the Conditional Arising and Cessation of All Phenomena, and the twelve links of conditioned co-production are synonyms of Patīccasamuppāda (Prathamapeedok, 2003). This essence of Buddhism consists of twelve elements as follows: 1) ignorance or avijjā, 2) mental formations or saṅkhāra, 3) consciousness or viññāna, 4) mind-and-body or nāma-rūpa, 5) six senses-bases or salāyatana, 6) contact or phassa, 7) sensation or vedāna, 8) craving or taṇhā, 9) clinging or upādāna, 10) becoming or bhava, 11) birth or jāti, and 12) decay-and-death or jara-marāṇa.

The goal of the principle of Patīccasamuppāda is to explain the arising and extinguishing of dukkha. The principle can be divided into two types: 1) the general principle that tends to be used as an introduction to the second. It states that when this exists, then this exists because this arises, this also arises; when this ceases to exist, this also ceases to exist because this ceases to exist, this also ceases to exist, and 2) the specific principle might be called the explanatory version, because it provides more details and applies to various elements of the principle while, at the same time, bringing natural processes to bear on the meaning of the general principle itself. The second type stated that a) because of ignorance, mental formations exist; because of mental formations consciousness exists; because of consciousness, mind-and-body exists--and so on, and b) because ignorance has been completely disgorged, mental formations are extinguished; because mental formations are extinguished, consciousness is extinguished--and so on. The twelve elements of dependent origination are counted from ignorance to decay-and-death as shown in Figure 2. Sorrow, lamentation, suffering, grief, and distress are simply things that follow as a

result. They arise in a person who still has impurities and unwholesome tendencies (asava, kilesa). And so, when decay-and-death occurs, the various feelings of dukkha previously listed are the cause of the accumulation of unwholesome tendencies that lead to perpetuating ignorance and the turning of the wheel and, in turn, they contribute to supporting the continuation of the same old cycle.

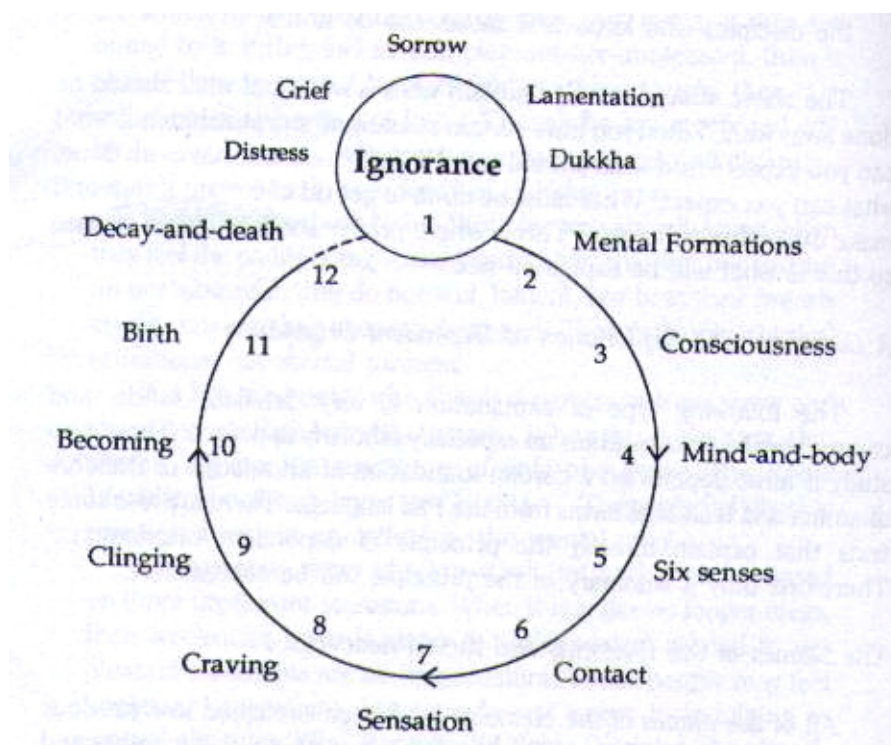


Figure 2: Diagram of Dependent Origination Buddhist doctrine

Note. From “Buddhadhamma: Natural laws and values for life,” (p. 100), by P. P. Payutto (Author) and G. A. Olson (Translator), 1995, New York: State University of New York Press. Copyright 1995 by State University of New York.

Ariya-sacca or the Four Noble Truths, and Kod-hang-kam (Law of Karma) are two principles of the Dhamma related to Dependent Origination. The Four Noble Truths is the Buddhist methods approach to solving problems, which aims

at solving problems by considering causes through the consideration of one's own action, based on the law of cause and effect (Mahachulalongornkingcollege, 1991). The truths are 1) suffering, 2) the cause or origin of suffering, 3) the cessation or extinction of suffering, and 4) the path to the cessation of suffering (Prathamapeedok, 2003). The Dependent Origination is the core of the Noble Truths, and details of the Noble Truths cover the whole scope of the Dependent Origination (Mahachulalongornkingcollege, 1991). The second is related to Dhamma, the Law of Kamma or, in other words, the law of cause and effect, which simply means, "One reaps what one sows (Autthagorn, 1988; Raksasataya, 1987)." This law declares that every effect is produced by some action so that cause and effect are closely related (Mole, 1973). No one can protect themselves from the results of their own deeds since each must suffer or benefit from one's own actions. Kamma transmits both the good and bad of the past and present. The good creates favorable conditions even while the bad can lower one's state of existence (Tongprateep, Pitagsavaragon, & Panasakulkarn, 2001). One will surely collect unpleasant rewards for wrong deeds while having compassion on all living things will bring forth good rewards (Mole, 1973). Kamma is only one part of the process of dependent origination. The principle of dependent origination explains the complete process of action and fruits of action, starting from the unwholesome tendencies that bring about kamma to the fruits received (Payutto, 1995).

1.4 The Threefold Training: Sikkhattaya or the ways of practice or the threefold learning refers to three ways of practice that must be understood and followed for those who seek enlightenment: first, sila or the moral precepts or ethics; second, samadhi or right concentration; and third, panna or wisdom (Kyokai, 1966;

Payutto, 1995). The most common sila of layman is Pancasila or the Five Precepts. The first precept of the Five Precepts or Panatipata is avoidance of killing or taking the life of living things because it is an immoral action (Mole, 1973; Sirilai, 2001). Morgan (2001) stated in his textbook regarding eastern philosophy and religion in the section of the life and teachings of Buddha that killing a person or an animal are sins or evil. Shortening life is wrong. Prolonging death is incongruous with natural law and recognized phenomena (Sirilai, 2001). Buddhism recognizes and values life as an important thing, so whatever action a person does in order to separate body from mind is an immoral action (Sirilai, 2001).

According to the Threefold Training, sila (the moral precepts) is the first step and the basis for proper behavior, which emphasizes abstention from all evil. After this, a person progresses still higher by practicing concentration meditation (samadhi) to make his or her mind pure and clear. When the mind is peaceful and focused, a person becomes accomplished enough to apply wisdom (panna) and the final fruits of the practice are attained (Payutto, 1995).

1.5 The Middle Way: Majjhima-patipada or the Middle Way of practicing the truth refers to the path leading to the cessation of suffering. It is the noble way composed of eight factors: proper understanding, proper thought, proper speech, proper action, proper livelihood, proper effort, proper mindfulness, and proper concentration (Payutto, 1995). The Noble Eightfold Path is the way leading to the end of the accumulation of kamma by applying all eight factors from proper understanding to proper concentration.

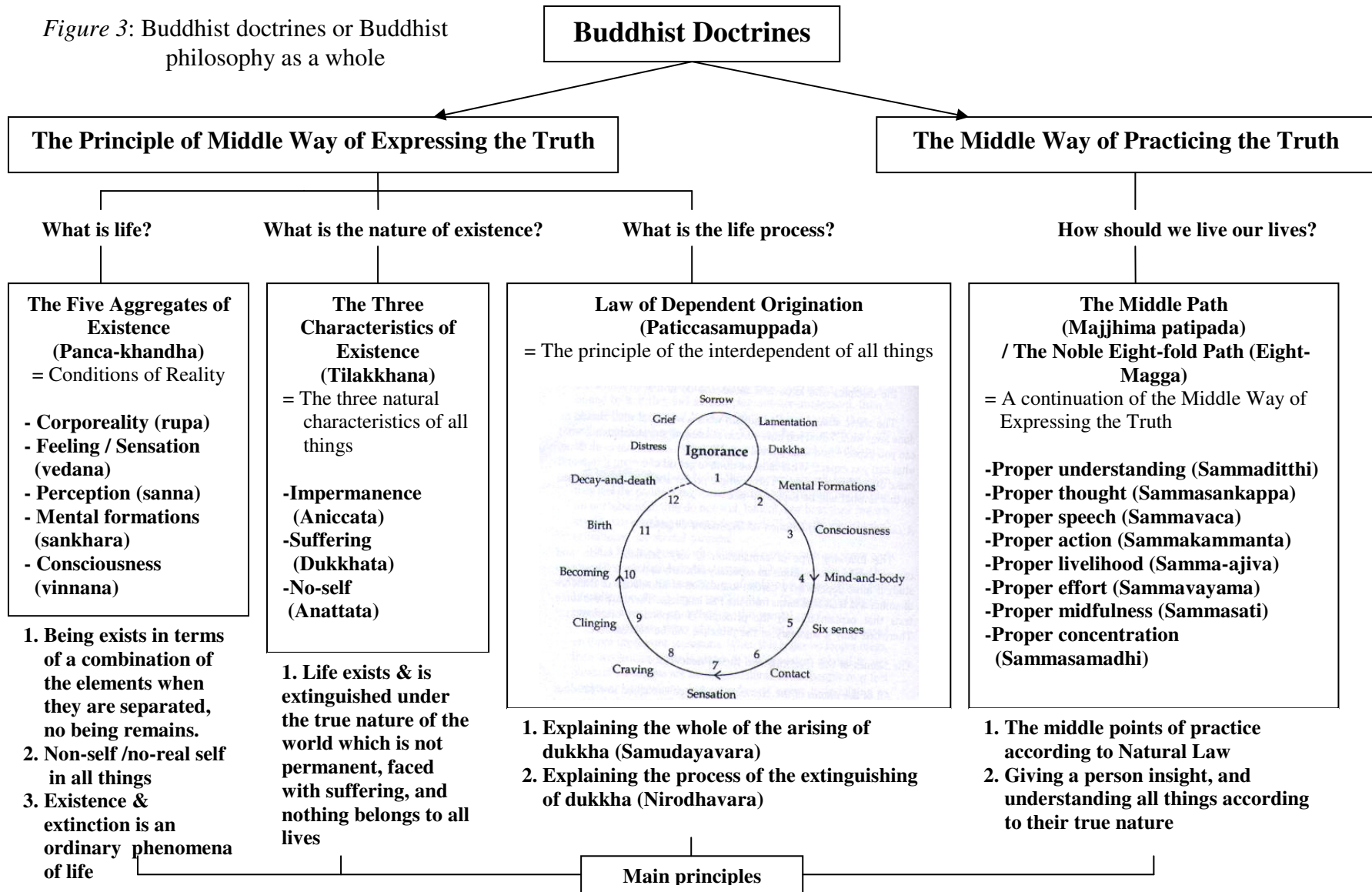
Additionally, gratitude is considered a common proper thought and proper action in Thai society. Chaijirachayakul (1986) found that one of the properties

of Thai moral values is gratitude. Buddhism stresses the virtue of gratitude, which is the endeavour to repay kindness whenever possible (The National Identity Board, 1981), as a symbol of a good person (Prathamapeedok, 1999). Gratitude is also stated as one of the thirty-eight highest blessings, the blessing for a happy life, of Buddhist doctrine (Prathamapeedok, 2003). Thus, Buddhists appreciate this tenet and being grateful to a close person especially their parents. Komin (1991), and Komin and Samuckarn (1979) found from their national Thai value surveys that gratitude is one of the most important values of Thais.

Figure 3 and 4 are summaries by the researcher based on Buddhadhamma or the original body of teachings of Lord Buddha, which was written by Phra Prayudh Payutto (1995). He divided the Buddhist doctrines into two parts of: 1) the principle of the Middle Way of expressing the truth and 2) the Middle Way of practicing the truth as shown in Figure 3. Figure 4 shows the relationship between each Buddhist doctrine.

In conclusion, all of these essences of Buddhist philosophy can explain life and death of living things like this: the Five Aggregates state that life consists of one body component and four mental components. According to the Three Characteristics of Existence, all components are impermanent: they change or exist and are eventually extinguished. This means life and death are natural for all living things, that life is a ceaseless flow of birth, growth, decay and death. Receiving good or bad thing depend on one's actions according to the Law of Kamma. Therefore, somebody who hurts or kills other people or animals, which is the first percept of the Five Percepts, will receive evil. On the other hand, somebody who demonstrates sincere gratitude to others will receive praise.

Figure 3: Buddhist doctrines or Buddhist philosophy as a whole



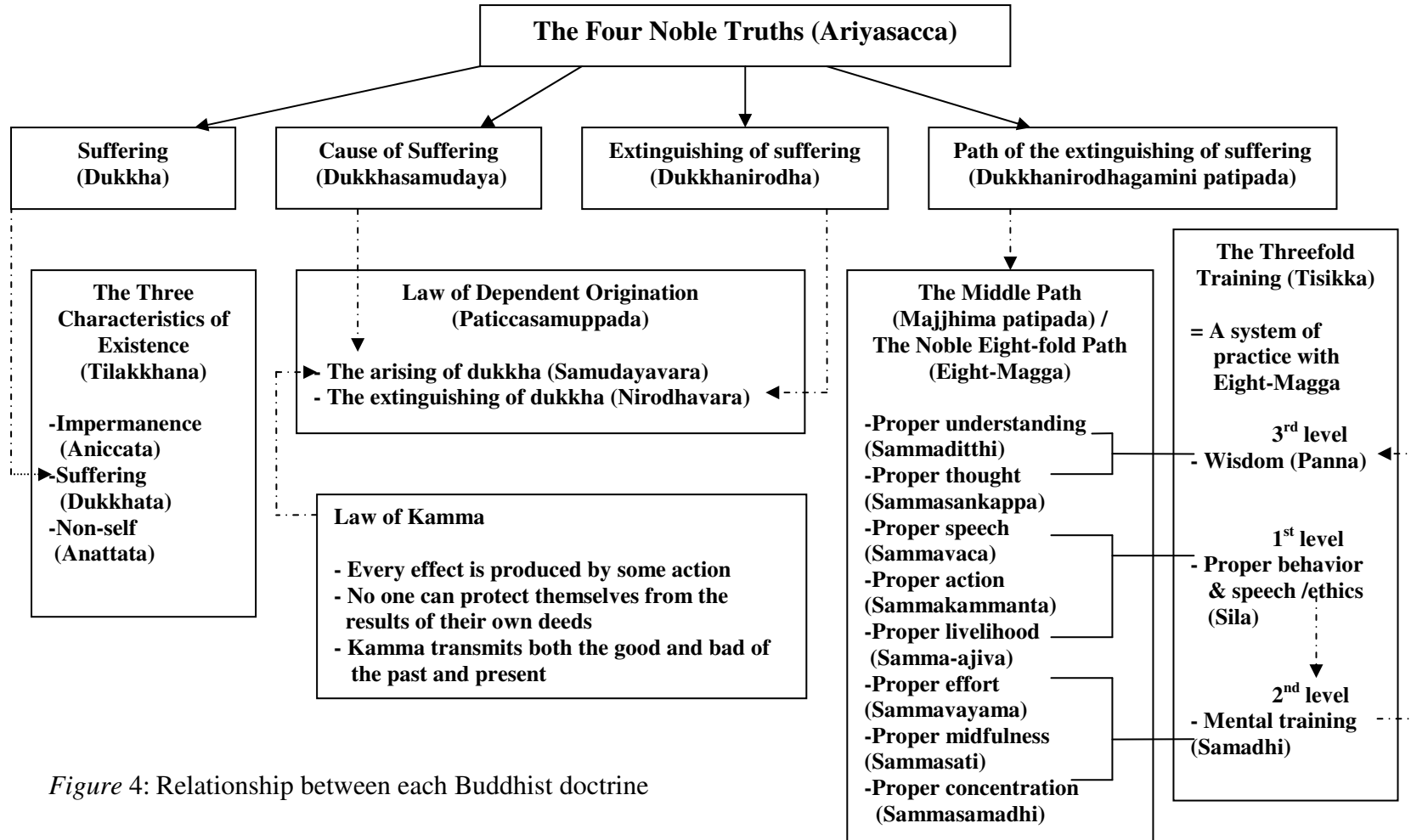


Figure 4: Relationship between each Buddhist doctrine

2. Buddhist values underlying end-of-life decision

For many people, religious teachings shape their values, attitudes, and beliefs that underpin their lives (Collins, 2002). Buddhist doctrines are essential for a valid understanding and appreciation of the relationship between Thai values and behavior patterns seen in the daily life of Thailand (Mole, 1973). As such, the essence of Buddhist philosophy influences and provides a foundation for Buddhist end-of-life values as follows:

2.1 Life is valuable and worthy; shortening life is not good, and prolonging life is not good: This group of values is based on the Law of Nature and the first precept of the Five Precepts. Buddhism values life; life is very important. Whatever action is intended to separate the body from life is wrong; shorten-life or / and prolongation of death at the end of life is a sin (Sirilai, 2001). The first precept of the Five Precepts states that killing a person and an animal is a sin (Morgan, 2001). Buddhists believe that it is not an appropriate action because it is against the Natural Law.

2.2 Living for reciprocation: Komin (1991), who conducted national studies of the Thai value survey, found that reciprocity of kindness, particularly the value of being grateful is a highly valued trait in Thai society. The Thais have been socialized to value gratefulness in a person. By being grateful (or Ka-tan-yuu in Thai), means Roo Boon-khun or to know, acknowledge, or to be constantly conscious and bear in mind the kindness done. (Komin, 1991). Reciprocation or Ka-ta-wa-tee, means Tob-than-boon-khun or to reciprocate the kindness whenever there are opportunities (Komin, 1991).

2.3 Life is doing well or merit: This one is based on belief of the Law of Kamma or the law of cause and effect. Moongngam (1990) conducted a critical study of Buddhist values and the present ways of life of 300 Buddhists from Mueng district of Ubonrachathani province. The investigator found that these Buddhists still believe in merit, evil, action and its result; they believed that bad action will bring a bad result to doer.

2.4 Suffering is a part of life: Buddhist motto states that life and suffering are born together (Cantasalo et al., 2000). Suffering is part of human nature; birth, aging, illness, and death are suffering. Therefore suffering is the nature of life (Sirilai, 2001).

2.5 Death is natural, death is a part of life, death is the last role of humanity, and prolongation of death is impossible. This group of values is based on the Three Characteristics of Existence or Tri-lakkhana, which stated that for all existing beings, there is no such thing as permanence. Mahachulalongornkingcollege (1991) proposes that from the dependency on birth arises decay and death. Birth, aging, sickness, and death are the Natural Law. All living beings, without exception, are subject to this doctrine (Bowman & Singer, 2001).

2.6 Peaceful death: The final stage of life is death and death is inevitable. So, in Buddhism a peaceful death is a good death with human dignity, a death with peaceful mind and consciousness (Sirilai, 2001).

2.7 Death is a transition: This value is base on the Three Characteristics of Existence or Tri-lakkhana. It states that in all existence there is no such thing as permanence. All kinds of life come into being when proper conditions prevail but nothing can endure for eternity. They retain their status only transitorily;

sooner and later they will be worn away, broken, destroyed or disintegrated and thereby provide material from which new forms come into being. Buddhism believes about rebirth. So death is a transit of present life to further life again and again. In Buddhism, it calls this cycle in Thai Wat-ta-song-san (Na-thalang et al, 2001).

2.8 Reciprocity to kamma (in Thai: Chod-chai kamma) is one of the Buddhist values that can be classified as both value of life and value of death. Some people believe that life is living for reciprocity to kamma while some people believe that death is dying for reciprocity to kamma. This value is based on the Law of Kamma of Buddhist doctrines.

The summary of values deriving from Buddhist doctrines are presented in Figure 5.

Finally, Buddhist values regarding life and death consists of two groups of values of life and values of death. Values of life consist of life is valuable, quality of life, living for reciprocation, life is doing well or merit, and suffering is a part of life. Values affirming the intrinsic worth of death is that death is natural, the value of a peaceful death, and death is a transition. Reciprocity to kamma is a value that can be both a value of life and value of death. Other values that related to Buddhist values affirming the value of life is that life is responsibility, living with family concern, and a good life does not gain burden. In addition, values of death related to Buddhist values are death is a frightful phenomenon, death is suffering, death is undesirable, death is loss, death is separation from one's loved ones, death is free from suffering, and death is the closing scene of life.

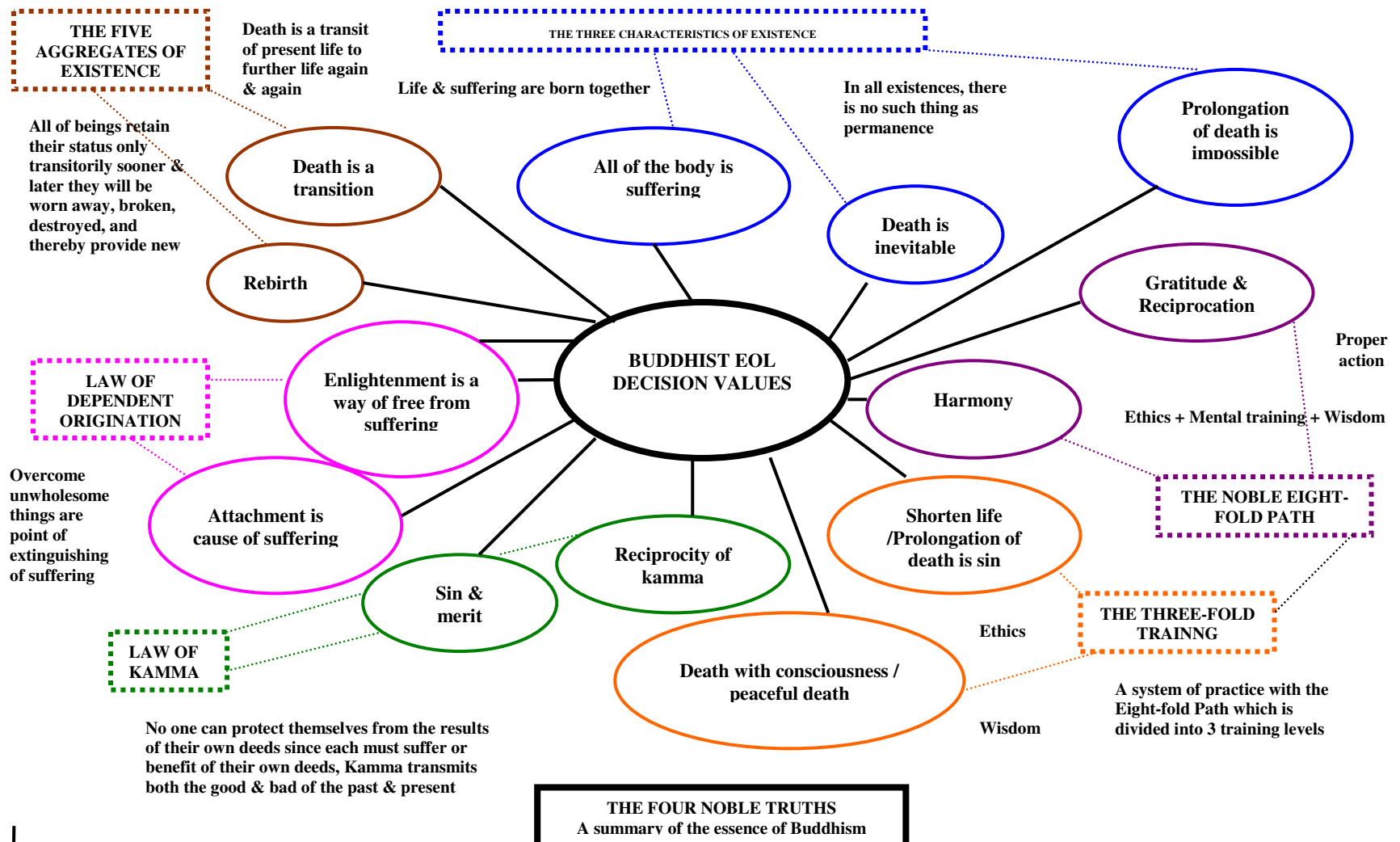


Figure 5: Values deriving from Buddhist philosophy

Summary

Values are described as freely and thoughtfully chosen, enduring attitudes or deeply held beliefs about the worth of a person, object, idea, or action that sets standards, that are prized and cherished, and that influence behavior consistently repeated or indicate how a person has decided to use his or her life. The nature of values is worthwhile or desirable standards, but will vary among people. They develop and change over time and through a life-long process and may be expressed openly through verbal and nonverbal behaviors. Values hold the greatest importance in shaping thought and action, and can easily be identified in the everyday life experiences of any person. Values are formed by a great number of socio-cultural environment factors. End-of-life decision is the most important issue in nursing practice. Accepting or refusing life-sustaining treatment is a patient's right, so their decisions may be to continue, to forgo life-sustaining treatment, and to continue or forgo depend on significant others based on their values. These decisions vary in accordance with many factors. Buddhism is one of the significant factors for Thai, which associate with their value development, so Buddhist values affect their end-of-life decisions based on Buddhist philosophy regarding life and death.

CHAPTER 3

METHODOLOGY

This descriptive research aims to explore the values underlying end-of-life decisions of Thai Buddhists, and to compare the differences of the end-of-life decisions among three groups of Thai Buddhists: chronically-ill patients, patients' families who have had experience and those who have no experience in end-of-life decisions. This chapter described the research method used inclusive of descriptions of the population, sample, research instruments, data collection, data analysis, and techniques used to protect the rights of participants.

Population

The population for this study was Thai Buddhists in Southern Thailand from the upper and lower regions.

Sample

The participant inclusion criteria consisted of the following: they were equal or over the age of 40 year and able to communicate in the Thai language. In addition, they were Thai Buddhists who were born and live in the upper and the lower regions of Southern Thailand. To form the subgroups of interest, the following additional criteria were also used: (1) they were chronically-ill at the time of their participation, or (2) they were a family member of a patient who experienced having

to make end-of-life decisions, or (3) they were individuals who have no experience in making end-of-life decisions for significant others.

Southern Thailand is divided geographically to upper and lower regions (Department of Local Administration, 2004). Simple random sampling was used to select one province from one region of Southern Thailand: one province from upper and one from lower region. From the sampling, Hadyai Regional Hospital, Songkhla province and Nakhon Sri Thammarat Regional Hospital, Nakhon Sri Thammarat province were selected in the study. Then systematic random sampling was used to select chronically-ill patients, patients' families who have experienced making an end-of-life decision and those who have had no experience in making end-of-life decisions. These participants were solicited from the chronic out-patient clinic of Hadyai Regional Hospital, Songkhla and Nakhon Sri Thammarat Regional Hospital, Nakhon Sri Thammarat. The daily list of chronically-ill patients at the chronic out-patient clinic of both regional hospitals was used. Those receiving an odd number and their families were selected to participate in the study. This method was used until 70 participants per group were obtained. In the study, chronically-ill patients were AIDS, malignant diseases, congestive heart failure, respiratory failure, renal failure, liver failure, cerebrovascular accident, epilepsy with convulsion, and diabetes mellitus with multiple complications.

The sample size for this study was estimated based on power analysis for testing differences in proportions among three groups (Cohen, 1988; Polit & Hungler, 1999d). The sample size with a power of .80, the population value of Cramer's Statistic of .20, then the total subjects for an alpha level of .05 is at least 149 (Jaccard & Becker, 2002). The 210 subjects were used in this study.

Research Instrument

The research instrument was an interview consisting of two parts: the Demographic Data Form and the Values Underlining End-of-Life Decisions Interview Form. Open-ended and close-ended questions were used. It was developed based on a review of literature, discussion with Thai Buddhists from various occupations, and focus group interviews with Buddhist experts. These experts consisted of Buddhist academic persons, monks, and secular persons from various occupations.

1. Description of the instrument

1.1 The Demographic Data Form consisted of 19 items of demographic data and general information of each subject (see appendix C). These items were related to gender, age, marital status, occupation, educational level, economic status, place of residence, role of subject in family, number of family members, Buddhist activities in daily life, significance of Buddhism for life, health status, and end-of-life decision experience. Types of questions were dichotomous, multiple-choice, and open-ended questions.

1.2 The Values Underlining End-of-Life Decisions Interview Form consisted of a vignette of an end stage patient, five pictures of using various life-sustaining treatments and 43 questions about: end-of-life decisions, values underlying the decision and reasons on each value, including the most important value used in making the decision (see appendix C). A nominal scale was used as the level of measurement. All questions were classified to four specific groups of respondents as follows:

1.2.1 Respondent who decided to receive the treatment to prolong their life (13 questions).

1.2.2 Respondent who refused the treatment (17 questions).

1.2.3 Respondent who chose allowed a physician to make the decision for them (6 questions).

1.2.4 Respondent who chose allowed their family to make the decision for them (7 questions).

2. Psychometric properties of the instrument

2.1 Validity. The instrument was tested for validity with face validity and Content Validity Index (CVI). CVI was calculated to determine content validity of the instrument (Waltz, Strickland & Lenz, 1991b). A panel of five expert judges was invited to provide content validity ratings of each item for its clarity, relevance, and conciseness. The panel of judges comprising of three health care experts in ethics and end-of-life care, and two experts in Buddhism. The investigator edited, and added items according to the experts' comments, criticisms, and suggestions. Five of 29 original close-ended items did not meet the criterion of instrument for inclusion in the final measure. The overall CVI of the original version was .83. Consequently, after editing the 5 items and adding five other items, by separating the items for the samples who allowed a physician to make the decision from the items for the samples who allowed their family to make the decision according to the suggestions of the experts, the last version comprised of 34 close-ended items which its CVI was .88.

2.2 Reliability. Before administering the instrument to the subjects, a pretest of the instrument was performed using 30 Thai Buddhists who were met the inclusion criteria of the sample characteristics. The pretest provided the opportunity to determine the clarity of questions, effectiveness of instructions, completeness of

response sets, time required to complete the interview form, and success of data collection techniques; and to assess the reliability of the instrument. The 30 Thai Buddhists were asked to complete the instrument two times over a 2-week interval. Test - retest reliability was used to determine the stability of the instrument (LoBiondo-Wood & Haber, 1998). The use of a 2-week period allows estimation of stability of response choice with little concern that recall of a previous choice will contribute unnecessarily to the responses selected (Gauthier & Froman, 2001). The percentage of agreement index was calculated and yielded acceptable value (.90).

Data Collection

This process was divided into two phases as follows:

Phase 1: A preparation phase:

1. Developing data collection forms, documents, and protocols. Many forms and documents were developed, for example, informed consent forms, documents for contacting and getting permission for collecting data from the directors of both regional hospitals, data collection protocols, and protocols for dealing with sensitive issues or possible crisis were designed.

2. Contacting the director of Hadyai Regional Hospital and Nakhon Sri Thammarat Regional Hospital for their research cooperation. The research proposal and formal letter were submitted to the directors for approval of the proposal by their Research Ethic Committee of the hospitals and for permission on collecting data. In addition, the introduction of the investigator, the objectives of the study, methodology, and significance of the research was informed.

3. Meeting and building relationship with health care personnel of the chronic out-patient clinic of Hadyai Regional Hospital, Songkhla and Nakhon Sri Thammarat Regional Hospital, Nakhon Sri Thammarat for their research cooperation.

Phase 2: A data collecting phase:

1. Collecting data from chronically ill patients and their families who have experience making end-of-life decisions and those who have no experience in end-of-life decisions of significant others was done at the Chronic Out-patient Clinic of both regional hospitals on Monday to Friday at 8.00 a.m.-16.00 p.m. from December, 2005 to March, 2006. Subjects were recruited in the study by using the inclusion criteria of sample, systematic random sampling method, and sampling frame as explained above in the section of sample.

2. Building relationship with the samples. Self introduction, research objective and significant explanation were given. The investigator assessed for health problem of the samples. They were given health care suggestions and health education based on their individual needs. In order to build the relationship, the investigator took time 1-2 hours or more for each participant depending on their health problems.

3. Data collecting was done by face-to-face interviews in accordance with the items in the instrument. Careful and specific instructions were given by the investigator to ensure the respondents from all suspicious. Quantitative and qualitative data were obtained from these self-report questionnaires, which include the Demographic Data Form, and the Values Underlining End-of-Life Decisions Interview Form.

4. Collecting of the data took 15-30 minutes for each respondent and did not inhibit or interrupt his or her queue to meet the medical doctor. In addition, permission was obtained to tape record participant's responses to the open-ended questions.

Data Analysis

All data management including coding, data entry, data screening, data cleaning, and data analysis were done. Interview forms were examined for completeness and individually numbered and then the incomplete interview forms were excluded from data analysis. A codebook was used to provide accuracy in coding. Quantitative data were entered and analyzed using computerized statistical program. For data verification, the data were entered twice and then data matching was done by using computer software.

Quantitative data including the demographic data and general information of respondents were computed using descriptive statistics: frequency and percentage. Other quantitative data of all study variables: 1) end-of-life decisions of Thai Buddhists, 2) the differences of the end-of-life decisions among the three groups of Thai Buddhists, and 3) values underlying the end-of-life decisions of Thai Buddhists were computed and analyzed by statistics as follows:

The first objective of the research was to explore the end-of-life decisions in Thai Buddhists. Frequencies and percentages of participants who decided to forgo, continue, and allow other person making decision regarding life-sustaining treatment were calculated.

The second objective was to compare the end-of-life decisions among the three groups of Thai Buddhists. It was analyzed by a using Chi-squared test for homogeneity.

The last objective of the research, describe the values underlying the end-of- life decisions made by Thai Buddhists, was a analyzed using simple descriptive analyses: frequency and percentage.

Qualitative data consisted of the reasons of choice in each value underlying the end-of-life decisions. These qualitative data were analyzed by content analysis (Polit & Hungler, 1999a; Waltz, Strickland & Lenz, 1991c). The content analysis was conducted based using a multi-step procedure described Waltz, Strickland and Lenz (2005) as follows:

1. Define the universe of content to be examined. The universe of content or the totality of recorded information included all information of face-to-face interviewed responses, all tape-recorded responses, and all investigators' notes, which consisted of all qualitative data regarding values underlying the end-of-life decisions of Thai Buddhists. After a given universe of content was proposed, its relevance to the purposes of the investigation and its completeness of the information was considered.

2. Identify the characteristics or concepts to be measured. This study aims to describe and explain values underlying end-of-life decisions of Thai Buddhists. The characteristic or concept to be measured was: the reason of each value underlying the decision of Thai Buddhists.

3. Selected the unit of analysis to be employed. Words, phrases, themes, and items were selected to be the units for analysis. Given the universe of content available and the variables to be measured, a decision was made about which

elements or subunits of the content regarding the reason of each value underlying the decision would be analyzed or categorized. The similar words, phrases, or themes were arranged or grouped together in the same unit.

4. Develop a sampling plan. In the study the entire universe was examined because unit categorization is easy to achieve by using the entire population (Waltz, Strickland & Lenz, 1991c).

5. Develop a scheme for categorizing the content. Development of the categorical scheme used inductive strategy for the information of reasons of choice in end of life decision values. The categories were derived from the data themselves by identifying clusters of similar data.

6. Pretest the categories and coding instructions. The categorical scheme and coding instructions were pretest by applying it to 15 samples. As a result of the pretest, categories or instructions had to be redefined, added, or deleted and the entire scheme was be pretest again before using with all samples in the study.

7. Train coders and establish an acceptable level of reliability. The investigator trained to be the coder. Interpretive both interrater and intrarater reliability was assessed through the training period with thesis advisor.

8. Perform the analysis. The data were coded according to prescribed procedures that were established in advance. The coded data were entered into data files and cleaned before being analyzed. The same content was processed several times to extract all of the information needed because many factors might influence coding, such as fatigue, and boredom. Periodic checks of interrater and intrarater reliability were performed throughout the coding. Then a frequency count and

percentage calculation of the recorded or observed occurrences of each category was analyzed.

Protection of Human Rights

The human rights of research subjects were recognized and protected in this study as follows:

Rights to protection from risk and harm. According to guidelines for performing a thesis of Faculty of Nursing, Prince of Songkla University, the investigator submitted the proposal to the Institutional Review Board (IRB) of the Faculty, Prince of Songkla University. The proposal was also submitted to the Research Ethic Committee of the two regional hospitals from upper and lower southern regions. The investigator conducted the study after the committee's approval. In addition, a protocol that spelt out the procedures and guidelines was used to deal with sensitive issues or possible crisis. In this type of study subjects might experience discomfort both during the study and after its termination. For example, asking subjects to describe their end-of-life decisions could precipitate feelings of fear, anger, or sadness. Early detection was very important in these cases. Therefore, the investigator was vigilant about assessing the subjects' discomfort, supported, terminated the interview and followed up after the interview. The procedures for doing list were made described in the studies protocol for data collection.

Right to self-determination. The investigator disclosed essential information to subjects such as purpose of the study, benefits, and their individual rights in order to protect them in the research process. Participation in the study was voluntary without external controls. Furthermore, all participants gave their oral

consent. In addition, the subjects were informed that they have right to withdraw from the study at all time without incurring a penalty.

Right to autonomy and confidentiality. The instrument contained no personal identification, and the data collected were kept confidential.

CHAPTER 4

RESULTS AND DISCUSSION

This research is a descriptive study of the values underlying end-of-life decisions of Thai Buddhists and the differences of the decisions among three groups of Thai Buddhists: chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of significant others at the chronic out-patient clinic of Hadyai Regional Hospital, Songkhla and Nakhon Sri Thammarat Regional Hospital, Nakhon Sri Thammarat. In this chapter, the results of this study were initially presented and followed by discussion of those results. The results consist of: (1) the characteristics of the samples and (2) the answers of the following research questions: a) To what extent do Thai Buddhists make decisions to forgo, continue, or depend on a physician's or family's decision regarding life-sustaining treatment at the end-of-life? b) Do the end-of-life decisions differ among the three groups of Thai Buddhists: chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of the significant others? and c) What are the values underlying the decisions to forgo, to continue life-sustaining treatment, and to depend on the others' decision at the end-of-life for Thai Buddhists?

Results

1. Characteristics of the participants

The 210-participants were selected by using a systemic random sampling method based on the inclusion criteria and the samples willingness to participate in the study. The participants comprised three groups of Thai Buddhists: chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of the significant others. There were 70 participants in each group.

In the collecting data process, 21 potential participants were not willing to participate in the study because of various physical, mental, and/or social reasons, for example: felt dyspnea when talking too long; were not ready to talk about an end-of-life decision, their homes were very far away from the hospital which made them want to go home early, or they hurried to go to work, etc. Therefore, the other 21 participants were added. Although some of the participants responded emotionally to the vignette: had tears in their eyes or their eyes were red while they were interviewed, they wished to continue the interview until it was finished.

In Table 1 the demographic characteristics of the participants is presented. The majority of them were females (61.9%). The ages ranged from 40 to 79 with an average age of 56.38 years (S.D. = 11.33). Most of the samples were middle aged (40-60 years, 61.0%) and followed by the elderly (61-79 years, 39.0%). Almost all of them were married (75.7%) and had a primary level education (63.8%). The majority frequently reported their occupations were agriculture (30%) and 33.8% had a house-work and had not any job. Most reported an adequate income (84.8%)

although 67.6% of them received an income less than 10,000 Baht/ month. The participants were heads of family slightly more than family members (52.9% and 47.1%, respectively). Family size ranged from 3 to 6 persons (61.4%). Average number of family members was approximately four. Families with more than 6 family members of the samples were only 7.2%. The participants perceived health status as healthy 78.6%, although the majority of them had a hospital admittance history (65.7%).

Table 1

Demographic Characteristics of the Participants (N = 210)

Demographic variables	Frequency	Percentage
Gender		
Male	80	38.1
Female	130	61.9
Age		
40- 60 years	128	61.0
61-79 years	82	39.0
(Mean 56.38; S.D. 11.33)		
Marital status		
Single	8	3.8
Married	159	75.7
Widow/ widower	43	20.5
Education		
None/ less than primary education	17	8.1
Primary education	134	63.8
Secondary education	33	15.7
Diploma	12	5.7
Bachelor's degree	14	6.7

Table 1 (*continued*)

Demographic variables	Frequency	Percentage
Occupation		
Agriculture	63	30.0
Commerce	27	12.9
Government officer	25	11.9
Employee	23	11.0
Fishery	1	0.5
None/ house-work	71	33.8
Income		
Less than 5,000 Baht	80	38.1
5,000- 10,000 Baht	62	29.5
10,001- 20,000 Baht	46	21.9
More than 20,000 Bath	22	10.5
Income sufficiency		
Sufficient	178	84.8
Not sufficient	32	15.2
Family role		
Head of a family	111	52.9
Family member	99	47.1
Number of family members		
Less than 3 persons	66	31.4
3 – 6 persons	129	61.4
More than 6 persons	15	7.2
(Mean 3.85; S.D. 1.89; Range 1-10)		
Perceived health status		
Healthy	165	78.6
Not healthy	45	21.4
Hospital admittance history		
Have	138	65.7
Do not have	72	34.3

The finding revealed that the chronically-ill patients in this study consisted of patients with various life threatening chronic illnesses as shown in Table 2. The most frequently reported chronic illnesses in the patient group were organ failure due to illness (41.4%), followed by Acquired Immune Deficiency Syndrome or AIDS (22.9%), and Diabetes Mellitus with multiple complications (21.4%).

Table 2

Life Threatening Chronic Illness of the Patient Participants (n = 70)

Chronic illness	Frequency	Percentage
Organ failure due to illnesses	29	41.4
Congestive heart failure	11	15.7
Respiratory failure	7	10.0
Renal failure	9	12.9
Liver failure	2	2.9
Acquired Immune Deficiency Syndrome	16	22.9
Diabetes Mellitus with multiple complications	15	21.4
Cerebrovascular accident / convulsion	7	10.0
Malignant diseases	3	4.3

Table 3 presents the experiences related to end-of-life of Thai Buddhists. Almost all the participants had experiences of using life-sustaining treatment or/and had encountered the experiences of other persons (96.7%), but the majority of them (61.9%) had never personally experienced end-of-life decisions of other persons.

As presented in Table 4, Buddhism was important for the majority of the participants to make decisions in daily life (87.6%). Table 4 also shows that more than half of the participants thought these Buddhist doctrines were important for

Table 3

Experiences Related to End-of-life of the Participants (N = 210)

Experiences related to end-of-life	Frequency	Percentage
Using life-sustaining treatment experiences		
Have	16	7.6
Have and have encountered experiences of using life-sustaining treatment of other persons	106	50.5
None, but have encountered experiences of using life-sustaining treatment of other persons	81	38.6
None	7	3.3
End-of-life decision experiences		
Have	73	34.8
Have encountered end-of-life decision experiences of other persons	7	3.3
None	130	61.9

decision-making in their daily lives: 1) merit and sin or boon-kam (84.8%), 2) birth, aging, and death are ordinary (66.7%), 3) The Middle Path (65.7%), and 4) reciprocity to kamma (59.0%). Moreover, the most frequently reported boon-kam was the most important Buddhist doctrine of the participants (39%), followed by The Middle Path (17%), and attachment is the cause of suffering (11%). In addition, most Buddhist activities of the participants were going to a temple (90.0%), and followed by offering Sanghadana or dedicated to monks as a whole (do not specific with anyone) (63.3%), Pindadana or offering food to the monk (62.9%), and praying (55.2%), respectively. Only 26.2% of them had Sila keeping or moral practicing and 17.1 % of them had meditation practicing. Less than 10% of the participants practiced in the other activities.

Table 4

Information Related to Buddhism of the Participants (N = 210)

Buddhist variables	Frequency	Percentage
Buddhist significance towards decision making in daily lives		
Significant	184	87.6
Not significant	26	12.4
Perceived importance of Buddhist doctrines*		
Merit and sin	178	84.8
Birth, aging, illness, and death are ordinary	140	66.7
The Middle Path	138	65.7
Reciprocity to kamma (volitional action)	124	59.0
Attachment is the cause of suffering	90	42.9
Rebirth	43	20.5
Impermanent, suffering, and non-self	37	17.6
The Five Rules of Morality	15	7.1
Moral, meditation, and wisdom	11	5.2
Non-persecution of anyone	7	3.3
The Four Noble Sentiments: Loving-kindness, compassion, sympathetic joy, and neutrality	5	2.4
Loving-kindness	3	1.4
Gratitude	3	1.4
Independent living	2	1.0
Patience	2	1.0
Faithfulness and honesty	2	1.0
The Four Noble Truths	1	0.5
Self-satisfaction	1	0.5

*One sample answered more than one doctrine

Table 4 (*continued*)

Buddhist variables	Frequency	Percentage
Most important Buddhist doctrines		
Merit and sin	82	39.0
The Middle Path	37	17.6
Attachment is the cause of suffering	23	11.0
Birth, aging, illness, and death is ordinary	11	5.2
The Five Rules of Morality	5	2.4
The Four Noble Sentiments (Brahmavihara 4)	3	1.4
Moral, meditation, and wisdom	2	1.0
Independent living	2	1.0
Rebirth	1	0.5
Impermanent, suffering, and non-self	1	0.5
The Four Noble Truths	1	0.5
Patience	1	0.5
Self-satisfaction	1	0.5
Non-persecution of anyone	1	0.5
All	10	4.8
None	29	13.8
Buddhist activities*		
Going to a temple	189	90.0
Offering Sanghadana to a monk	133	63.3
Offering food to a monk	132	62.9
Praying	116	55.2
Keeping Sila or morality	55	26.2
Practicing meditation	36	17.1
Dedicating something to a monk	8	3.8
Reading or discussing about the Buddhist doctrine	5	2.4
Buddha worship before going to bed and dedicating loving-kindness to everyone	2	1.0

*One sample answered more than one doctrine

Table 5 shows the frequency of Buddhist activities of the participants. Those Buddhist activities, which the majority of them always practice were practicing Sila (78.2%), praying (60.3%), and practicing meditation (47.2%). The Buddhist activities, which the majority of them sometimes practice, were offering food to the monk (49.2%) and going to a temple (45.5%). In addition, only one Buddhist activity, which the majority of the participants seldom practice, was offering Sanghadana to a monk (49.6%).

Table 5

*Frequency of Buddhist Activities of the Samples**

Buddhist activities	The frequency of Buddhist activity		
	Always n (%)	Sometimes n (%)	Seldom n (%)
Keeping Sila or morality (n = 55)	43 (78.2)	7 (12.7)	5 (9.1)
Praying (n = 116)	70 (60.3)	34 (29.3)	12 (10.3)
Practicing meditation (n = 36)	17 (47.2)	12 (33.3)	7 (19.4)
Going to a temple (n = 189)	72 (38.1)	86 (45.5)	31 (16.4)
Offering food to a monk (n = 132)	46 (34.9)	65 (49.2)	21 (15.9)
Offering Sanghadana to a monk (n = 133)	32 (24.1)	35 (26.3)	66 (49.6)

* n = vary according to each Buddhist activity

Personal characteristics of the chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of significant others persons are shown in Table 6. Overall, the groups were similar, except gender and family role. All groups were middle aged. The chronically-ill patient's mean age is 58.07 (S.D. 11.81). Mean ages of patients' families who have experience and those who have no experience in the decisions of the others were 55.17 (S.D. 11.51) and 55.89 (S.D. 10.59), respectively. The majority of the three

groups was married and had a primary level education. There were slightly more males (54.3%) than females (45.7%) in the patient group, while the majority of both groups of the families were females (68.6% and 71.4%). The most frequent occupations of the participants in every group were agriculture and house-work. More than 60% of the participants in all groups received income less than 10,000 Baht/month and more than 80% of them reported they had an adequate income. In the patient group, they were head of a family more than family member, while in both groups of families they were slightly more family member than head of family. The average number of family members among the three groups was the same. In all groups, more than 90% of the participants had an experience of using life-sustaining treatment. Buddhism was significant for the majority of the participants in all groups.

Table 6

Personal Characteristics of Chronically-ill Patients (n = 70), Patients' Family With and Without End-of-life Decision Experience (n = 70 per group)

Personal Characteristics	Patient n (%)	Family with end-of-life-choice experience n (%)	Family without end-of-life-choice experience n (%)
Gender			
Male	38(54.3)	20(28.6)	21(31.4)
Female	32(45.7)	50(71.4)	48(68.6)
Age			
Mean (S.D.)	58.07 (11.81)	55.17 (11.51)	55.89 (10.59)
Marital status			
Single	4(5.7)	2(2.9)	2(2.9)
Married	55(78.6)	46(65.7)	58(82.9)
Widow/ widower	11(15.7)	22(31.4)	10(14.3)

Table 6 (continued)

Personal Characteristics	Patient n (%)	Family with end-of-life-choice experience n (%)	Family without end-of-life-choice experience n (%)
Education			
None/ less than primary education	5(7.1)	4(5.7)	8(11.4)
Primary education	50(71.4)	39(55.7)	45(64.3)
Secondary education	8(11.4)	14(20.0)	11(15.7)
Diploma	3(4.3)	7(10.0)	2(2.9)
Bachelor's degree	4(5.7)	6(8.6)	4(5.7)
Occupation			
None/ house-work	27(38.6)	22(31.4)	22(31.4)
Agriculture	15(21.4)	25(35.7)	23(32.9)
Employee	13(18.6)	4(5.7)	6(8.6)
Government officer	8(11.4)	11(15.7)	6(8.6)
Commerce	6(8.6)	8(11.4)	13(18.6)
Fishery	1(1.4)	-	-
Income (Baht)			
Less than 5,000	29(41.4)	23(32.9)	28(40.0)
5,000- 10,000	15(21.4)	23(32.9)	24(34.3)
10,001- 20,000	18(25.7)	15(21.4)	13(18.6)
More than 20,000	8(11.4)	9(12.9)	5(7.1)
Income sufficiency			
Sufficient	57(81.4)	59(84.3)	62(88.6)
Not-sufficient	13(18.6)	11(15.7)	8(11.4)
Family role			
Head of a family	47(67.1)	30(42.9)	34(48.6)
Family member	23(32.9)	40(57.1)	36(51.4)

Table 6 (continued)

Personal Characteristics	Patient	Family with end-of-life-choice experience	Family without end-of-life- choice experience
	n (%)	n (%)	n (%)
Number of family member			
Mean (S.D.)	3.84 (2.12)	3.99 (1.88)	3.71 (1.64)
Using life-sustaining treatment experience			
Have	7(10.0)	4(5.7)	5(7.1)
Have and have encountered the experience of others	15(21.4)	34(48.6)	32(45.7)
None, but have encountered the experience of others	46(65.7)	29(41.4)	31(44.3)
None	2(2.9)	3(4.3)	2(2.9)
Buddhist significance			
Significant	59(84.3)	64(91.4)	40(57.1)
Not-significant	11(15.7)	6(8.6)	30(42.9)

2. To what extent do Thai Buddhist patients and patients' families make decisions to forgo, continue, or depend on physician or family's decision regarding life-sustaining treatment at the end-of-life?

A majority (51.9%) of Thai Buddhists decided to forgo life-sustaining treatment on the vignette of an end stage patient. Approximately 28% of them allowed a physician (18.1%) or family (10.5%) to make the decisions for them. Only 19.5% of Thai Buddhists decided to continue the treatment. Thai Buddhist participants' responses to the vignette are shown in Table 7.

Table 7

End-of-life Decision of Thai Buddhist patients and patients' families (N = 210)

End-of-life decision	Frequency	Percentage
Forgoing life-sustaining treatment	109	51.9
Continuing life-sustaining treatment	41	19.5
Making decision by other persons	60	28.6
Physician	38	18.1
Family	22	10.5

3. Do the end-of-life decisions differ among these three groups of the Thai Buddhists: chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions making?

The three groups of Thai Buddhists, comprising of chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of other person, gave similar responses on the vignette. As shown in Table 8, around 50% of the participants of the three groups chose to forgo the treatment at the end-of-life; around 20% of the participants of the patients and both groups of the families chose to continue the treatment

The differences of end-of-life decisions among the three groups of Thai Buddhists were analyzed by using chi-square. The findings, as shown in Table 8, indicated that there were no significant differences of end-of-life decisions among the three groups of Thai Buddhists: chronically-ill patients, patients' families who have experience and those who have no experience in end-of-life decisions of the others. There were no significant differences among the three groups of Thai Buddhists in

their affiliation with the three groups of end-of-life decisions: forgoing, continuing, and making the decisions by physician or family ($p > .05$).

Table 8

Difference of End-of-life Decisions Among the Three Groups of Thai Buddhists

(n = 70 per group)

Thai Buddhist	End-of-life decision			p - value
	Continuing n (%)	Forgoing n (%)	Others making the decision, n (%)	
Patient	17(24.3)	32(45.7)	21(30.0)	.410 ^{ns}
Family with end-of-life-choice experience	12(17.1)	42(60.0)	16(22.9)	
Family without end-of-life-choice experience	12(17.1)	35(50.0)	23(32.9)	

4. What are the values underlying the decisions to forgo, to continue life-sustaining treatment, and to allow physician or family to make decision for them at the end-of-life in Thai Buddhist patients and patients' families?

Firstly, values underlying end-of-life decisions of Thai Buddhist patients and patients' families who decided to forgo the treatment at the end-of-life as stated in the vignette are shown in Table 9. Having selected a response to the end-of-life decision question, the participants were directed to select values that correspond with that decision. They also did have an opportunity to express other values through the use of the open-ended question. The top three values, more than 90%, of Thai

Buddhists in the forgoing life-sustaining treatment group were prolongation of death is sin (Sila, 100%); quality of death (95.4%) and prolongation of death is impossible (Anattata, 92.7%). More than 50% of Thai Buddhists who forgo the treatment stated that death is inevitable (Aniccata, 89.9%); free from suffering (87.2%), family burden (85.3%), sin and merit (Law of Kamma, 82.6%), attachment is the cause of suffering (Paticcasamuppada, 76.1%), and quality of life (57.8%) were their values. Furthermore, as shown in Table 10, the top three most important values of Thai Buddhists who forgo the treatment at the end-of-life were free from suffering (47.7%), followed by quality of death (24.8%), and family burden (11.9%).

Table 9

Values Underlying End-of-life Decision of Thai Buddhists Who Decided to Forgo Life-sustaining Treatment at the End-of-life

Values underlying end-of-life decision*	Frequency	Percentage
Prolongation of death is a sin (Sila)	109	100.0
Quality of death	104	95.4
Prolongation of death is impossible (Anattata)	101	92.7
Death is inevitable (Aniccata / impermanence)	98	89.9
Free from suffering (comfort)	95	87.2
Family burden	93	85.3
Sin and merit (Law of Kamma)	90	82.6
Attachment is the cause of suffering (Paticcasamuppada)	83	76.1
Quality of life	63	57.8
Economic burden	44	40.4
Human dignity	41	37.6
All of the body is suffering (Dukkhata)	24	22.0
Death with consciousness (Samadhi)	12	11.0

*One sample answered more than one item

Table 9(*continued*)

Values underlying end-of-life decision*	Frequency	Percentage
Rebirth (Panca-khandha)	6	5.5
The Middle Path (Majjhima-patipada)	3	2.8

*One participant selected more than one item

Table 10

The Most Important Values of Thai Buddhists Who Forgo the Treatment (n =109)

The most important values of the decision	Frequency	Percentage
Free from suffering	52	47.7
Quality of death	27	24.8
Family burden	13	11.9
Prolongation of death is impossible	7	6.4
Quality of life	3	2.8
Death is inevitable	3	2.8
Human dignity	1	0.9
Economic burden	1	0.9
Comfort and Family burden	1	0.9
Family burden and Prolongation of death is inevitable	1	0.9

In addition, from the qualitative data, which were obtained from face-to-face interviews, the reasons of each value underlying the decisions of Thai Buddhists who decided to forgo the treatment at the end-of-life are shown in Table 11. The top three reasons of the top three values were: first, for the value “prolongation of death is a sin (Sila)” their reasons were a) doing against nature, b) producing of suffering, and c) suffering of body; second, for the value “quality of death” their reasons were a) need of natural death, b) need of peaceful death, and c) need of comfort death,” and last, for the value “prolongation of death is impossible

(Anattata)” the reasons were a) accepting end stage of life; b) natural law, and c) impossible.

In Table 11 the top three reasons associated with six values that more than 50% of Thai Buddhists selected to forgo the treatment at the end-of-life are shown as follows: 1) for the value “death is inevitable (Aniccata)”, the reasons were “everyone was born and should die finally”, “a time to go.”, and “natural law”; 2) for the value “free from suffering” the reasons were “fear of pain and suffering”, and “need to free from suffering”; 3) for the value “family burden”, the reasons were “do not need to gain burden to family”, “fear to make family suffer”, and “family concern”; 4) for the value “merit and sin (Law of Kamma)”, the reasons were “end of kamma”, and “following to Law of Kamma”, 5) for the value “attachment is the cause of suffering (Paticcasamuppada)”, their reasons were “acceptance truth of life”, and “prolongation of suffering”, and 6) for the value “quality of life”, their reasons were “need an independent living”, “do not need to live with suffering”, and “do not need a futile living.”

Table 11

*Top Three Reasons of Each Value Underlying the Decisions of Thai Buddhists Who Decided to Forgo the Treatment at the End-of-life**

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Prolongation of death is a sin (Sila, n = 109)	1. Doing against nature	31	28.4
	2. Producing of suffering	29	26.6
	3. Suffering of body	25	22.9

Table 11 (*continued*)

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Quality of death (n = 104)	1. Need of natural death	54	51.9
	2. Need of peaceful death	48	46.2
	3. Need of comfort death	32	30.8
Prolongation of death is impossible (Anattata, n = 101)	1. Accepting end stage of life.	55	54.5
	2. Natural law	23	22.8
	3. Impossible	7	6.9
Death is inevitable (Aniccata / Impermanence, n = 98)	1. Everyone was born and should die finally	34	34.7
	2. A time to go	29	29.6
	3. Natural law	18	18.4
Free from suffering (n = 95)	1. Fear of pain and suffering	47	49.5
	2. Need to free from suffering	46	48.9
Family burden (n = 93)	1. Do not need to gain burden to family	68	73.1
	2. Fear to make family suffer	30	32.3
	3. Family concern	16	17.2
Merit and sin (Law of Kamma, n = 90)	1. End of kamma	67	74.4
	2. Following to Law of Kamma	10	11.1

*One sample answered more than one item

Table 11 (*continued*)

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Attachment is the cause of suffering (Paticcasamuppada, n = 83)			
	1. Acceptance truth of life	42	50.6
	2. Prolongation of suffering	13	15.7
Quality of life (n = 63)			
	1. Need an independent living	25	39.7
	2. Do not need to live with suffering	24	38.1
	3. Do not need a futile living	17	26.9

*One sample answered more than one item

Secondly, in Table 12 the values underlying end-of-life decisions of Thai Buddhists who selected to continue the treatment at the end-of-life are presented. The results show that “hope” and “life is valuable” were the values of more than 90% Thai Buddhists who selected to continue the treatment (100% and 92.7%, respectively). More than 50% of them stated that “family concern” (75.6%), “responsibility” (56.1%), and “fear of death or loss from death” (51.2%) were their values. Only 19.5% of Thai Buddhists in the continuing life-sustaining treatment group reported “gratitude and reciprocity” as their values. Moreover, as shown in Table 13, almost all Thai Buddhists who decided to continue the treatment (92.7%) stated that “hope” was the most important value influencing their decisions.

Table 12

Values Underlying End-of-life Decision of Thai Buddhists Who Selected to Continue the Treatment

Values underlying end-of-life decision*	Frequency	Percentage
Hope	41	100.0
Life is valuable	38	92.7
Family concern	31	75.6
Responsibility	23	56.1
Fear of death or loss from death	21	51.2
Gratitude and reciprocity	8	19.5
Belief in supernatural power	7	17.1
Doing good receiving good	6	14.6
Reciprocity to kamma	1	2.4

*One sample answered more than one item

Table 13

The Most Important Values of Thai Buddhists Who Selected to Continue the Treatment (n =41)

The most important values of the decision	Frequency	Percentage
Hope	38	92.7
Family concern	1	2.4
Responsibility	1	2.4
Fear of death or loss from death	1	2.4

In Table 14, the top three reasons of each value underlying the decisions of Thai Buddhists who selected to continue the treatment at the end-of-life is presented. "Hope" was selected as influencing their selection because of the top three reasons: a) may be possibly to survive, b) still need to live, and c) hope to have a miracle. The top three reasons for the value "life is valuable" of most Thai Buddhists

in the continuing treatment group were “need to survive as long as possible”, “need to do the most benefit”, and “life is the most important.” It also found that the top three reasons of each value that more than 50% Thai Buddhists used to selected to continue the treatment at the end-of-life are as follow: 1) for the value “family concern”, the reasons were “worried about his or her descendant”, “passion with family”, and “wait for seeing a success of his or her descendant, 2) for the value “responsibility”, the reason was “family burden responsibility”, and 3) for the value “fear of death or loss from death”, the reasons were “to be separated from lover and significant others”, “don’t need to die”, and “worried about his or her descendant.”

Table 14

*Top Three Reasons Associated with the Value Underlying the Selections of Thai Buddhists Who Selected to Continue the Treatment at the End-of-life**

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Hope (n = 41)	1. May be possibly to survive	28	68.3
	2. Still need to live	6	14.6
	3. Hope to have a miracle	4	9.8
Life is valuable (n = 38)	1. Need to survive as long as possible	23	60.5
	2. Need to do the most benefit	2	5.3
	3. Life is the most important	2	5.3
Family concern (n = 31)	1. Worried about his or her descendant	17	54.8
	2. Passion with family	16	51.6
	3. Wait for seeing a success of his or her descendant	5	16.

*One sample answered more than one item

Table 14 (*continued*)

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Responsibility (n = 23)	1. Family burden responsibility	23	100.0
Fear of death or loss from death (n = 21)	1. To be separated from lover and significant others	12	57.1
	2. Don't need to die	6	28.6
	3. Worried about his or her Descendant	5	23.8

*One sample answered more than one item

Thirdly, the values underlying end-of-life decisions of Thai Buddhists who selected a physician to make the decisions are shown in Table 15. All of them reported their values were “respect for physician” (100%) and followed by “hope” (89.5%). The findings also revealed (See Table 16) that the most important value for their selection was “respect for physician” (84.2%).

Table 15

Values Underlying End-of-life Decisions of Thai Buddhists Who Selected a Physician to Make Decisions Regarding Life-sustaining Treatment for Them

Values underlying end-of-life decision*	Frequency	Percentage
Respect for physician	38	100.0
Hope	34	89.5
Death is loss	9	23.7

*One sample answered more than one value

Table 16

The Most Important Values of Thai Buddhists Who Selected a Physician to Make Decisions Regarding Life-sustaining Treatment for Them (n =38)

The most important values of the decision	Frequency	Percentage
Respect for physician	32	84.2
Hope	5	13.2
Death is loss	1	2.6

As shown in Table 17, all of Thai Buddhists who allowed a physician to make the decisions at the end-of-life for them use “respect for physician” as their values because of the top three reasons: a) trust in the physician’s knowledge and competence, b) confide that the physician would help a patient with his all competence, and c) trust in the physician’s experience. The reasons of the majority of Thai Buddhists (89.5%, n = 34) who selected “hope” as their values for making decisions regarding life-sustaining treatment at the end-of-life by a physician are “hope to survive” and “hope to have a miracle.”

Lastly, the values underlying end-of-life decisions of Thai Buddhists who selected their family to make the decisions for them are shown in Table 18. Their selected values were “respect for family” (100%) and “family concern” (95.5%). In addition, as shown in Table 19 the most important value influencing their selection was “respect for family” (59.1%) and “family concern” (31.8%), respectively.

Table 17

*Top Three Reasons of each Value Underlying the Decisions of Thai Buddhists Who Selected a Physician to Make the Decisions for Them**

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Respect for physician (n = 38)	1. Trust in the physician's knowledge and competence	33	86.8
	2. Confide that the physician would help a patient with his all competence	22	57.9
	3. Trust in the physician's experience	4	10.5
Hope (n = 34)	1. Hope to survive	28	82.4
	2. Hope to have a miracle	2	5.9
Death is loss (n = 9)	1. Fear to die	4	44.4
	2. Do not know where we go after death	2	22.2
	3. No confidence for self end-of-life decision	2	22.2

*One sample answered more than one item

Table 18

Values Underlying End-of-life Decisions of Thai Buddhists Who Allowed Their Family to Make the Decisions for Them

Values underlying end-of-life decision*	Frequency	Percentage
Respect for family	22	100.0
Family concern	21	95.5

*One sample answered more than one value

Table 18 (*continued*)

Values underlying end-of-life decision*	Frequency	Percentage
Hope	8	36.4
Death is loss	6	27.3

*One sample answered more than one value

Table 19

The Most Important Values of Thai Buddhists Who Allowed Their Family to Make the Decisions for Them (n = 22)

The most important values of the decision	Frequency	Percentage
Respect for family	13	59.1
Family concern	7	31.8
Hope	1	4.5
Death is loss	1	4.5

Using the qualitative data, the reasons associated with each value underlying the selection of Thai Buddhists who make the selected by their family are presented in Table 20. Among 22-Thai Buddhists, who selected a family member to make decisions regarding life-sustaining treatment at the end-of-life selected “respect for family” as the values. Reason selected associated with this value include: a) confide in the family’s decision, b) the family know what we need, and c) the family love and has a good wish for us. Of the 95.5% Thai Buddhists who selected “family concern” as their values for selecting a family member to make the decisions, their reasons were: a) close up more than others, b) love and attachment with the family, and c) care for family’s feeling.

Table 20

*Top Three Reasons of Each Value Underlying the Decisions of Thai Buddhists Who Selected Their Family to Make the Decisions for Them**

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Respect for family (n = 22)	1. Confide in the family's decision	12	54.6
	2. The family know what we need	7	31.8
	3. The family love and has a good wish for us	7	31.8
Family concern (n = 21)	1. Close up more than others	8	38.1
	2. Love and attachment with the family	8	38.1
	3. Care for family's feeling	5	23.8

*One sample answered more than one item

The end-of-life decisions of Thai Buddhists, the top three values underlying the selection, and the most important value associated with each selection is shown in Figure 6. In Figures 7-10 are the value selected and the top three reasons associated with each value underlying end-of-life decisions of Thai Buddhists.

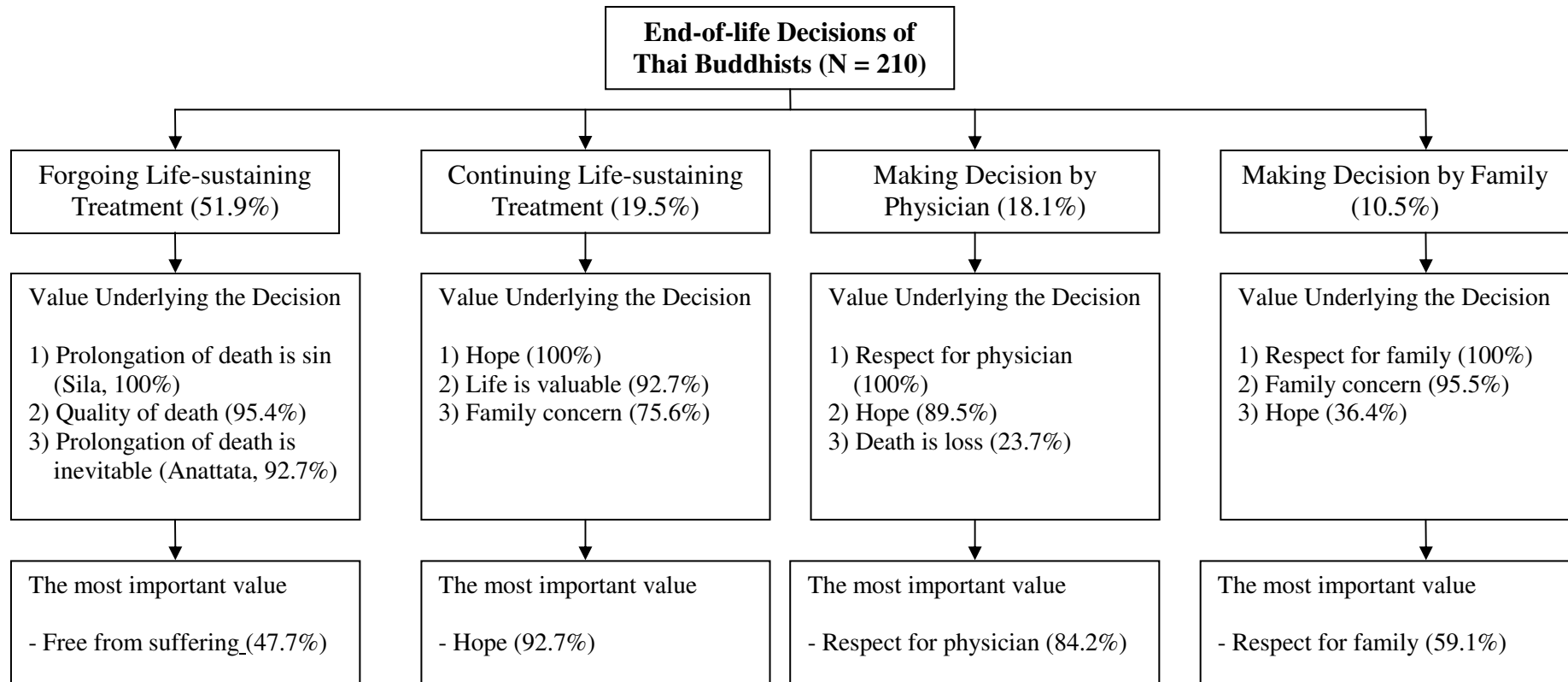


Figure 6. End-of-life Decisions of Thai Buddhists, top three values underlying the decisions, and the most important value of the decision

Note. Developed by the investigator

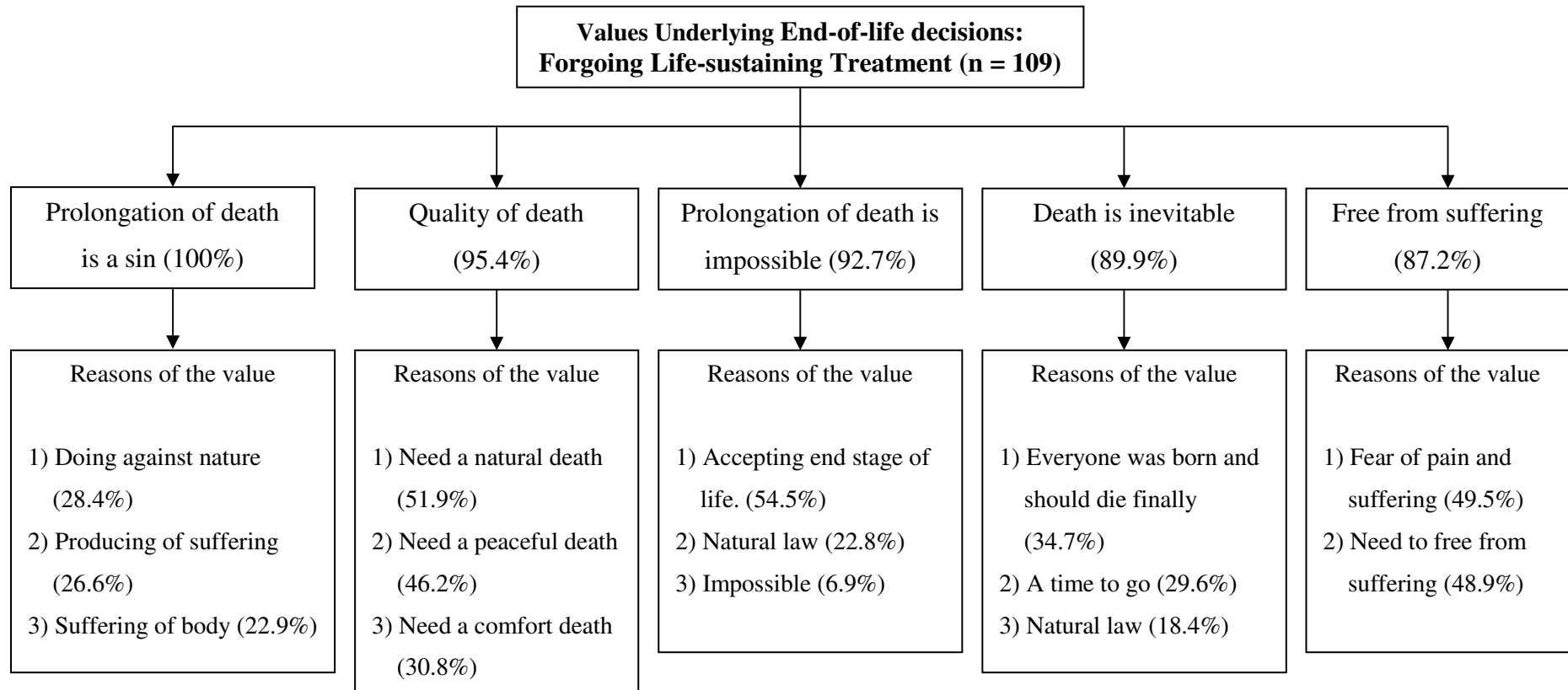


Figure 7. Top Five Values Underlying the Decisions of Thai Buddhists Who Decided to Forgo the Treatment at the End-of-life and Top Three Reasons of Each Value

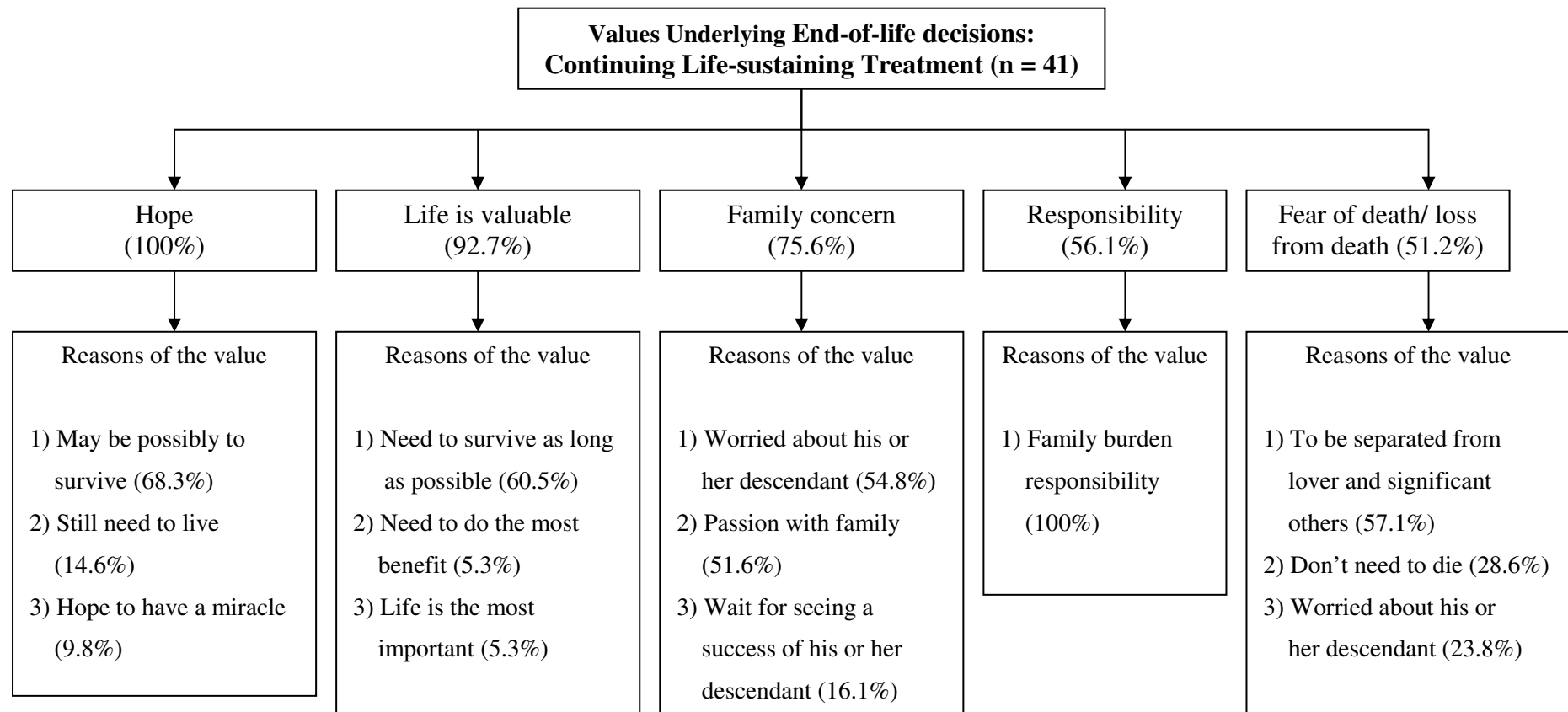


Figure 8. Top Five Values Underlying the Decisions of Thai Buddhists Who Decided to Continue the Treatment at the End-of-life and Top Three Reasons of Each Value

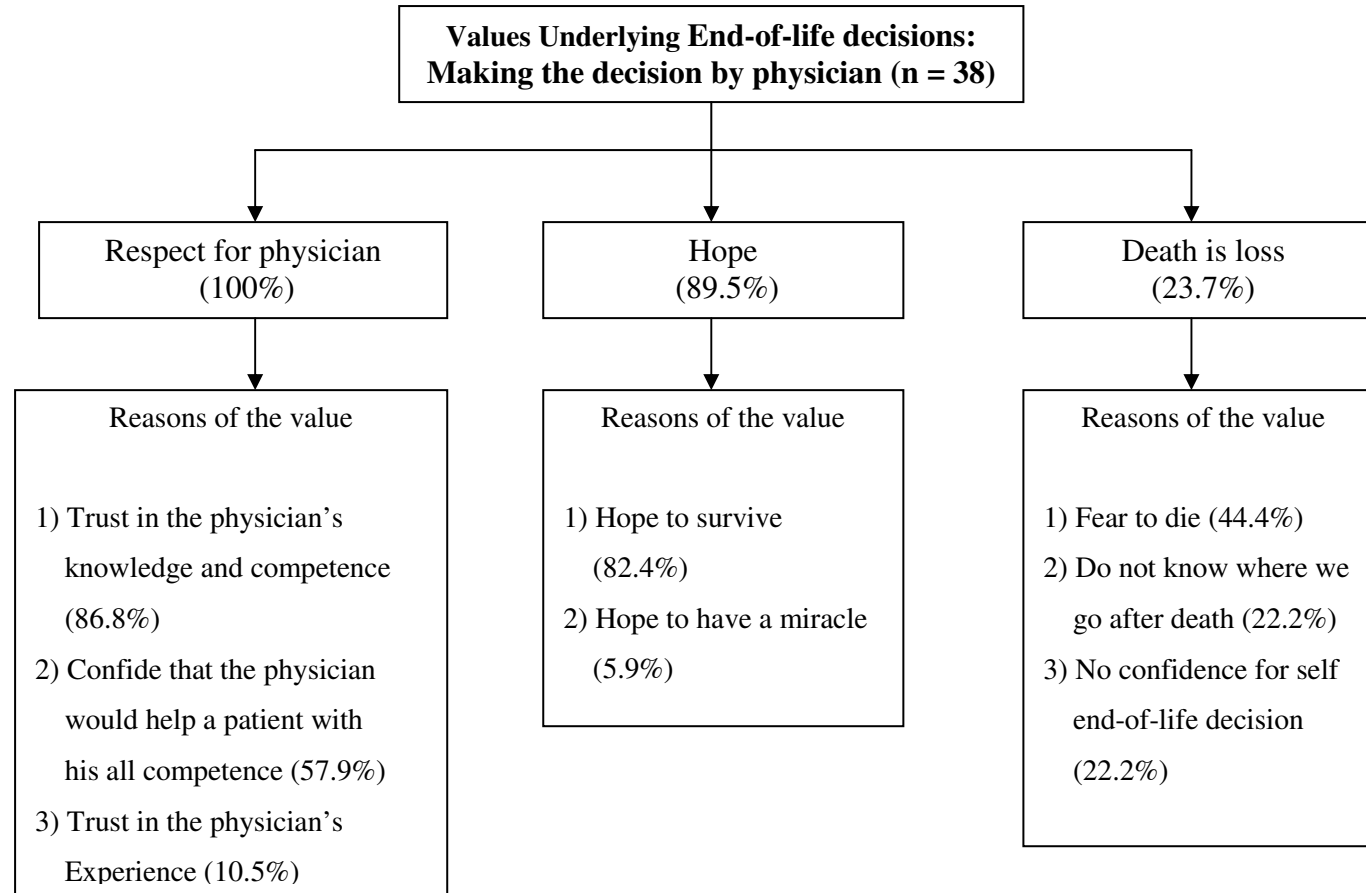


Figure 9. Values Underlying the Decisions of Thai Buddhists Who Allowed Physician to Make Decision for Them and Top Three Reasons of Each Value

Note. Developed by the investigator

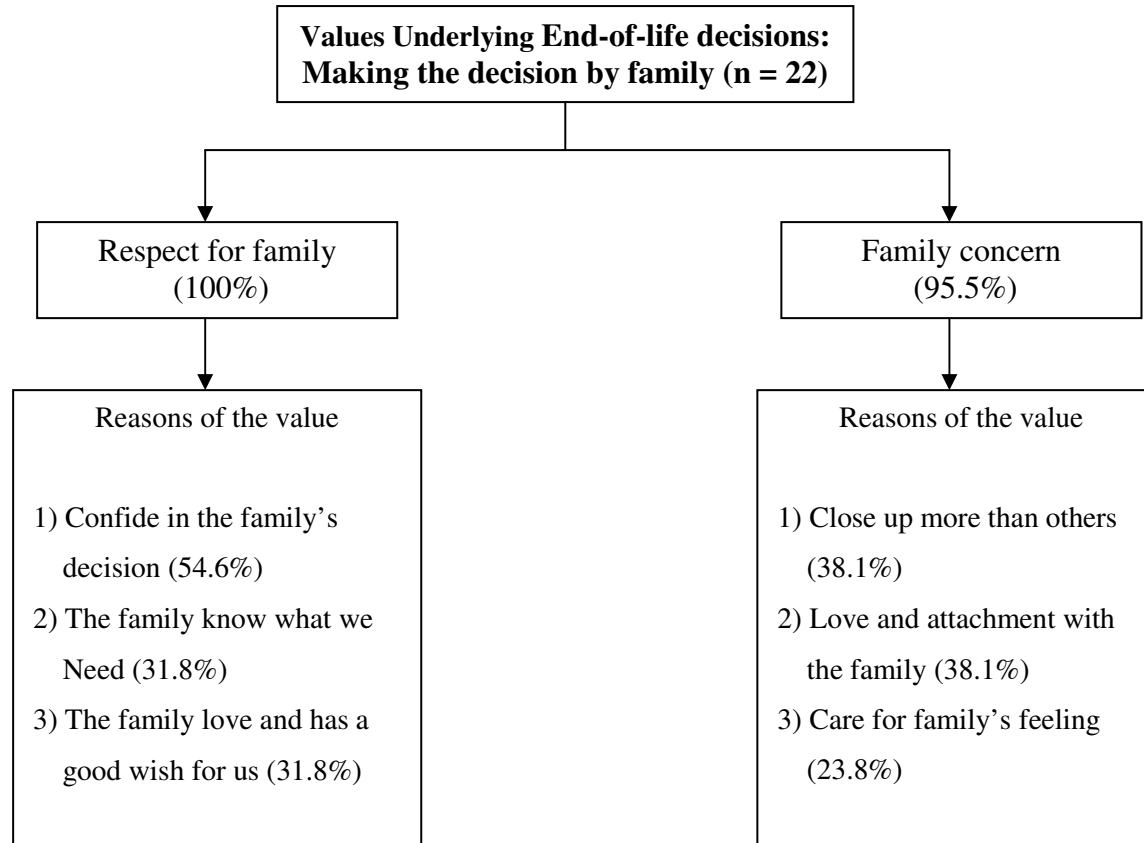


Figure 10. Values Underlying the Decisions of Thai Buddhists Who Allowed Family to Make Decision for Them and Top Three Reasons of Each Value

Note. Developed by the investigator

Discussion

This research represents the relative effort to initiate an empirical understanding of value underlying end-of-life decision in Thailand. Although Nijnikaree (2004) and Neuonoi (2005) had studied regarding end-of-life decision, Nijnikaree focused on end-of-life decision in Muslim perspective while Neuonoi focused on end-of-life decision of patient and surrogate, their congruency, and reasons of the decision. This study focused on values underlying end-of-life decision in Thai Buddhist perspective and difference of their decisions among the three groups of Thai Buddhists: chronically-ill patients, patients' families who have experience and have no experience in end-of-life decisions of others.

The discussion of the findings were presented in four parts: characteristics of the samples, end-of-life decisions of Thai Buddhists, the differences of end-of-life decisions among the three groups of Thai Buddhists, and values underlying end-of-life decisions of Thai Buddhists.

1. Characteristics of the samples

The results found that the majority of the samples, 210 Thai Buddhists, were females (61.9%). Especially in two groups of patient's family, patients' families who have experience and those who have no experience in end-of-life decisions of significant others, 71.4% and 68.6%, respectively were females. On the other hand, group of chronically-ill patient had males more than females (54.3% and 45.7%, respectively). These findings were similar to the study of Neuonoi (2005) which was studied about decisions of Southern Thai patients and surrogates on treatments at the end-of-life. Neuonoi (2005) found that in patient group there was

male 54.29% and female 45.71% while in surrogate group, 75% of them were patient's family, there was female 66.79%. This result might be explained that it reflected gendered responsibilities of care giving and familial obligation in Thai culture (Nilmanat, 2001). For gendered responsibilities of care giving, Thai families perceived that caring was suited to women and felt reluctant to let men perform care giving tasks while for familial obligation, the image of Thai women as "nurturing mother" influenced female to accept the care giving role and unable to resist this obligation. Moreover, Neunoi (2005) stated that female usually take role of caregiver because of her high patience.

In this study, an average age of Thai Buddhists were 56.38 years (SD = 11.33). The majority of them was married (75.7%) and had a primary level education (63.8%), while the majority of their occupations were agriculture (30%) and house-work or not employed in any job (28.6%). The results of educational level and occupation were supported by Komin (1991) and National Statistical Office (1995), respectively. Komin (1991) stated that the majority of Thai population has only primary education (around 75%). From the statistical reports of southern region by National Statistical Office (1995), agriculture was the most important occupation. In this study, the majority of Thai Buddhists also didn't have any occupation. They had only house-work or stay at home with their descendants. One possible explanation for this is that all of Thai Buddhists in the study was middle aged and elderly people, which was an age of retirement. Approaching retirement is one of changes and transitions, career change and transition, which take place in middle aged (LeMone & Burke, 2000).

Most reported an adequate income (84.8%) although 67.6% of them received an income less than 10,000 bath/ month. It's may be because they usually lived with their descendants whom also gave them a salary or cost of living with gratitude. Being grateful is a highly valued characteristic trait in Thai society (Komin, 1991). The majority of family members of Thai Buddhists ranged from 3 to 6 persons (61.4%) with average number of family members was approximately four persons. Families with more than 6 family members of the samples were only 7.2%. This result of family members was similar to the study of Neunoi (2005), which found that the family members of patients and their surrogates ranged from 3 to 6 persons with an average number of family members four and six persons, respectively. It might be explained by the fact that, in Thai tradition, parents are more likely to live with their daughter's family, thus the household normally includes the parents, their daughter and husband, and their grandchildren (Hatthakit, 1999). In this study, Thai Buddhists perceived health status as healthy 78.6%, although the majority of them had a hospital admittance history (65.7%). For the reason that supported their perceptions of health status, it might be because more than 50% of Thai Buddhists in the research had lived with at least one chronic illness more than five years and acquainted with the chronic illness as a part of their lives.

Almost all the samples had experience of using life-sustaining treatment or/ and had seen life-sustaining treatment experiences of other persons (96.7%). According to Aldwin and Levenson (2001) and Magai and Halpern (2001), it's possible that becoming a primary caregiver for elderly or ill family member is usually a parent, is the most common events starting in middle age, therefore it's becoming increasingly common to experience the death of their parents. Moreover,

occasion to see using life-sustaining treatment is also a common event for middle age and elderly because they usually go to a hospital as a patient, spouse or relative of a patient, and normally found physical change or health alteration since the middle adults (LeMone & Burke, 2000). From this study, although approximately 40% of Thai Buddhists had never personally experienced of using life-sustaining treatment, they had seen life-sustaining treatment experiences of other persons when they, their spouse, or their parents were admitted in the hospital.

The finding revealed that Buddhism was important for the majority of Thai Buddhists to make decisions in daily life (87.6%). Undoubtedly in Thai society, Buddhism affects thought and Thai behavior patterns, therefore decisions in everyday life of Thai Buddhists are influenced by Buddhism (Mole, 1973; Moongngam, 1990; Samuckarn, 1996; Tongprateep, Pitagsavaragon, & Panasakulkarn, 2001). Hatthakit (1999) stated in other words that the daily lives of Southern Thai Buddhists are influenced by Buddhism. Pongpaiboon (1986) also mentioned Buddhism as a compass that points the direction for all of action and behavior of Southern Thai Buddhists.

Most Buddhist activities of the samples were going to a temple (90%), followed by offering Sanghadana or dedicated to the monks as a whole (do not specific with anyone) (63.3%), Pindadana or offering food to the monk (62.9%), and praying (55.2%), respectively. Only 26.2% of them had Sila keeping or moral practicing and 17.1 % of them had meditation practicing. The results were similar to the study of National Statistical Office (2005), which found that 64.8% of Thai Buddhists offer Sanghadana, 56.5% pray, 26.6% conduct Sila, and only 14.1% practice meditation. The finding pointed out that most of Thai Buddhist usually

participates in Buddhist activity or religious ceremony more than studies deeply in Buddhist doctrine. In other words, while Thai Buddhist is seemingly overwhelmed by their perceived influence of Buddhism in their life, most of them have little deep knowledge about it (Komin, 1991).

For Buddhist doctrines, the majority of Thai Buddhists thought “merit and sin” or “boon-kam” was one of the doctrines that they use in their daily lives (84.8%) and also was the most important Buddhist doctrine for them in their daily lives (39%). The explanation for the results might be because merit and sin or Law of cause and effect or Law of kamma is a basic concept in Buddhism and the important religious belief of southern Thai Buddhist (Pongpaiboon, 1986). They believe that good actions bring about good results while bad actions bring about bad results (Autthagorn, 1988; Mole, 1973; Raksasataya, 1987). In other words, whatever kamma they perform, be it good or bad, they will reap the fruits of that kamma (Payutto, 1995). This basic concept is frequently used to teach when nurturing child in most Thai family.

2. End-of-life decisions of Thai Buddhists

Responding of all Thai Buddhists to the vignette of an end-stage patient in this study, around 50% of them decided to forgo life-sustaining treatment at the end-of-life (51.9%, N = 210). Similar results were found in chronically-ill patient, patients’ families who have experience, and those who have no experience in end-of-life decisions of their significant others chose to forgo the treatment (45.7%, 60.0%, and 50.0%, respectively). These results were supported by the studies of Diringer and colleagues (2001), Ferrand and colleagues (2001), Keenan and colleagues (1997), and

The Society of Critical Medicine Ethics Committee (1992), which found that the majority of patients in ICU forgo the treatment. The results might be explained by three reasons: Firstly, the vignette, which was used in this study, was a case of severe, hopeless and end-of-life patient; secondly, age of all Thai Buddhists was middle aged and the elderly; and lastly, most of them used to have direct or/ and indirect experience of using life-sustaining treatment.

From first and second reasons as presented above, several existing evidences stated that irreversibly stage and older age influenced to forgo life-sustaining treatment as follows: 1) Diringler and colleagues (2001) studied in 2,109 patients who were admitted to ICU of a large academic tertiary care hospital found that the severity of illness and older age were factors that independently associated with forgoing life-sustaining treatment. 2) Similarity was found in the study of The Society of Critical Medicine Ethics Committee (1992), which revealed that the majority of patients were forgo the treatment in irreversibly and terminally stage. 3) Keenan, et al. (1997) also found from their study that poor prognosis was the most common reason given for forgoing life-sustaining treatment. Based on the finding, it is possible that less likelihood of recovery reflected poor expected quality of life and futility to continue life-sustaining treatment (Libbus & Russell, 1995). As noted in research findings of Ferrand, et al. (2001). They found that futility and poor expected quality of life were the most frequently cited reasons of 53% of 1175 deaths in ICU who made decisions to limit the life-supporting therapies.

For the last reason, experience of using life-sustaining treatment should influenced to forgo life-sustaining treatment because the experience made them knew about patient suffering and fear to confront with the same suffering while

using the treatment. From this study, all of Thai Buddhists who decided to forgo the treatments had experience of using life-sustaining treatment or/ and had seen life-sustaining treatment experiences of other persons (100%). This finding was supported by the study of Keenan and colleague (1997), and Libbus and Russell (1995). They found that most of patients and their surrogates (86% and 70%, respectively) reported that the earlier experience affected to their choices (Libbus & Russell, 1995). They also concluded that patient experience and suffering were strongly influenced their choices (Keenan, et al., 1997; Libbus & Russell, 1995). Keenan, et al. (1997) and Nijnikaree (2004) also found that patient suffering was the common reason for forgoing life-sustaining treatment.

Contrastingly, although all of the subjects were Buddhist, which Buddhist philosophy believes in Law of Nature: existence and extinction is ordinary phenomena of human life (Raksasataya, 1987) and Law of Dependent Origination: the arising and extinguishing of dukkha (Prathamapeedok, 2003) such as attachment is a cause of suffering, only approximately 50% of them forgo the treatment. From Buddhist philosophy, Thai Buddhists should be enlightened and accepted in the Law of Nature at the end-of-life that nobody can avoid death and should forgo the treatment at the end stage of life. In this study, the finding pointed out that most of Thai Buddhists usually participates in Buddhist activities or religious ceremony more than studies deeply in Buddhist doctrine. Only 26.2% of them had Sila keeping or moral practicing and 17.1 % of them had meditation practicing. Most of them have little deep knowledge about Buddhist doctrine (Komin, 1991); hence they could not enlighten and accept death as a natural phenomenon. The finding from this study supported the idea that an enlightenment and acceptance of death is occurrence in

Thai Buddhist who understand deeply about the essences of Buddhist philosophy, always use them for practicing in their daily life, and then should help them enable to forgo the treatment at the end-of-life.

Besides, the finding also showed that 19.5% of Thai Buddhists decided to continue the treatments. The result might be explained that Thai Buddhists decided to continue the treatments because they still needed to survive, did not wish to die with various opinions. Most of them (92.7%) thought life was very significant for them. Hall (1996) stated that people act to preserve life if life is valuable for them. From the family interview data of five families' member who had recently lost a terminally ill spouse or parent, Konishi, Davis and Aiba (2002) found that major theme for the families who agree to continue life-sustaining treatment was "the patient is alive". They mentioned that forgoing the treatment is killing and cruel, patients are alive and have a right to treatment, and it is a necessary treatment. Moreover, some of Thai Buddhists who decided to continue the treatments thought that they feared to die, concerned with family responsibility or did not need to separate from their lover one. In Buddhism, human practice response to death is divided into three levels. For first level, people does not study deeply and does not have insight about death, so they should afraid, feel sadly, or depress when think of death of themselves or other their lover one (Maethunguro, 1993). Form the result of this study, the majority of them (approximately 80%) did not study deeply in Buddhist doctrine, which is the reason why they feared to die and decided to continue the treatment. Three of the participants mentioned their various opinions related to their wish to survive as follows:

"I fear to separate from my son and my daughter by death like my husband. I don't need to die. I pray before go to bed every night and

request for blessing from Buddha to give me a chance to living with my children. I think we are alive and should keep our lives as long as possible.”

(Participant no. 24)

“I could not die at this time because I look after my grandchild whom his parent had divorced and had a new family...living for my grandchild...I am concerned about him.”

(Participant no. 35)

“I need all treatment to prolong my life. Life is valuable. Although I exactly know that survival is impossible, I need to try for rescue...I fear regarding life after death...I don't know where we go when we die.”

(Participant no. 180)

Interestingly, the finding revealed that most of them prefer to make the decisions by themselves (71.4%: forgoing and continuing the treatments 51.9% and 19.5%, respectively). The result was similar to the study of Heyland, Tranmer, O'Callaghan and Gafni (2003) with 135 seriously ill hospitalized patients, which found that 71% of the patients preferred to participate in the decisions. Moreover, the finding was supported by Chantagul (2000) that more than 60% of patients requested nurse to ask them for patient's participation but only 30% of them were asked to participate in nursing care. The majority of Thai Buddhists chose to make decision by themselves, could explain that “right to life or right to die” is a natural right of mankind, and perception of life and body owner (Oueng-prapan, 1995). Therefore it's their righteous power to make decision by themselves with their life and their body because it's a self determination or human autonomy. These results pointed out that, if it's possible, most of Thai Buddhists preferred to have their own decisions regarding life-sustaining treatment more than allow other persons to make the decision for them.

Furthermore, the finding revealed that 28.6% of them allowed a physician (18.1%) and their family (10.5%) to make decision regarding life-sustaining treatment for them. These findings indicated that these Thai Buddhists respect for physician's and family's decisions. It's possible that they were uncertain to make decision by themselves or they had not enough confidence for making the decision. Boyd and colleagues (1996) stated that confidence associate with the decisions and was increased with authority. The finding in this study confirmed these ideas. The majority of Thai Buddhists who allowed a physician and their family to make the decision for them (63.16% and 72.7%, respectively) expressed that they couldn't make decision by themselves. They dare not to make decision. Their family including daughter and son looked after them. Their livings were under their family's care. As reported by four participants:

"I dare not to make choice. I can't choice by myself. My son gives me money for daily payment. I fear that he should blame me, if I don't ask him or don't let him to make the choice."

(Participant no. 22)

"I fear everything. Fear for pain, death, etc. I allow a doctor to make choice for me."

(Participant no. 25)

"I'm not sure that my decision is right or wrong. For me, thinking about death is an unwanted thought and unwanted to meet. Choice about death should base on talking and discussing of several persons."

(Participant no. 41)

"Choice by my self is uncertainty. I fear that it may be a mistake or wrong. I'm not sure to make the choice."

(Participant no. 188)

Conversely, Puchalski, et al. (2000) found that more than 70% of patients would prefer to have their family and physician make decisions for them

whereas around 20% would prefer to have their own stated preferences followed. Both research findings were differences because the respondents made decisions based on different conditions. In the study of Puchalski, et al. (2000), patients' choice was based on condition of losing their decision-making capacity while Thai Buddhists' choice in this study was based on condition of having decision-making capacity. However, both findings congruence with guideline for life-sustaining treatment decision-making of American Thoracic Society (1991), which stated that in case of having decision-making capacity, patients should make decision by themselves, whereas, in case of lacking decision-making capacity, surrogate decision-maker should be identified to make decision on patient preference.

However, personal values guide and inform our responses and decisions in all areas of our life or our values influence and guide the choices (Burkhardt & Nathaniel, 2002). Moreover, health status, life experience, and others, for example: socio-economic status, education level, and religion influence personal values formation (Burkhardt & Nathaniel, 2002; Catalano, 2003; Chen, 2001; Ellis & Hartley, 2000a; Fry, 1994; Hall, 1996; Harvey, 1992; Komin, 1991; Potter & Perry, 1995; Shelly & Miller, 1991). Therefore, values underlying end-of-life decisions of Thai Buddhists are a significant topic, which will be discussed in part 4 of the discussion.

3. Differences of end-of-life decisions among the three groups of Thai Buddhists

The finding indicated that there were no differences of the end-of-life decisions among the three groups of Thai Buddhists: chronically-ill patients,

patients' families who have, and those who have no experience in end-of-life decisions of significant others. This result might be explained by the reason as previously noted in the explanation of Table 6 that there were similar among three groups in several characteristics. The similar characteristics were age, marital, educational level, occupation, income, number of family member, life experience about life-sustaining treatment, and significance of Buddhism for their decision making in daily life. The majority of the three groups were: 1) middle age, 2) married, 3) primary level education, 4) agriculture and house-work, 5) low but adequate income, 6) the same number of family member, 7) having experience of using life-sustaining treatment, and 8) Buddhism was significance for their decision making in daily life. From additional analysis also found that Buddhist activities among the three groups of Thai Buddhists were similar. Chronically-ill patients, patients' families who have, and those who have no experience in end-of-life decisions of the others kept Sila 24.29%, 25.71%, and 28.71%, respectively; and practiced meditation 17.14%, 18.57%, and 15.71% respectively. Of these characteristics, they were socio-economic status, education level, life experience, and religion, which influence to personal value formation. Our values influence our decisions and behaviors (Burkhardt & Nathaniel, 2002; Catalano, 2003; Chen, 2001; Ellis & Hartley, 2000a; Fry, 1994; Hall, 1996; Harvey, 1992; Komin, 1991; Potter & Perry, 1995; Shelly & Miller, 1991). According to the same personal characteristics, they should have similar values to guide the same end-of-life decisions among the three groups of Thai Buddhists.

4. Values underlying end-of-life decisions

As stated previously that personal values provide direction, influence, and guide choices in all areas of our life. In the study values underlying end-of-life decisions were as follows:

4.1 Values underlying the forgoing treatment decisions

For forgoing the treatment at the end-of-life, the findings revealed that the eight significant values underlying the decisions among over 70% of the samples covered both cultural dimension or Buddhist doctrine expression values and bio-social expression values. However, five from eight values were Buddhist doctrine expression values: 1) prolongation of death is sin (Sila/morality), 2) prolongation of death is impossible (Anattata/non-self), 3) death is inevitable (Aniccata/impermanence), 4) sin and merit (Law of Kamma), and 5) attachment is the cause of suffering (Paticcasamuppada/ Law of Dependent Origination) (Table 9). The other three values were bio-social expression values: 1) quality of death, 2) free from suffering, and 3) family burden. Conversely, the most important values underlying the decisions were free from suffering, which was one of the bio-social expression values.

The findings above supported the idea that several Buddhist doctrine expression values underlined the forgoing treatment decisions. There is no doubt that the reasons why Buddhist doctrines are influence to the forgoing the decisions. Because, Buddhists are taught to realize, understand, and accept Law of Nature: birth, ageing, illness, and death are unavoidable; and Law of Dependent Origination: attachment is a cause of suffering (Prathamapeedok, 2003; Raksataya, 1987). Therefore, Buddhists who perceive and accept things as they really are they will be

able to accept death, will not be afraid, and will not need to prolong the death. The result of this study pointed out that more than 60% of Thai Buddhists who practice meditation forgo the treatment. This result supported that people who study deeply in Buddhist doctrine should have opportunity to accept death and forgo the treatment more than others who do not study deeply in the doctrine. On the other hand, if they are unable to accept the death, they will fear of death and choose to continue life-sustaining treatment as long as possible (Visalo, 2004).

Although the majority of the samples stated that several Buddhist doctrine expression values underlined their decisions as shown above, the most important value of their decisions was the social expression values: free from suffering. This result might be explained by two reasons: 1) enlightenment and acceptance of death should occur by practicing meditation. People can purify and calm their minds by meditation. With a peaceful and purified mind people can see and understand the real nature of existence and universal laws (Hatthakit, 1999). But in this study, the finding revealed that only 17.1 % of them had meditation practicing; and 2) patient experience and suffering were strongly influenced their forgoing life-sustaining treatment (Keenan, et al., 1997; Libbus and Russell, 1995). From the study, almost all the samples (96.7%) used to have direct or/ and indirect experience of using life-sustaining treatment, which made them know about patient suffering and fear to suffer from that treatment. Below are four expressions from 95 Thai Buddhists who stated that “free from suffering” was their values; as they clearly expressed:

“I had experience about treatment for prolonging life. I saw nurse and doctor compressed on a patient’s chest. I pitied the patient so much. It made me feel bad and fear. I walked away from that place. From this experience, I told my family that at the death time let me die, don’t compress my chest in order to sustaining my life.”

(Participant no. 21)

“Don’t allow me suffer for a long time in a hospital. I used to encounter with patient struggle and pain. He pained until lose of breath. These direct experience and life experience taught me to learn about suffering.”

(Participant no. 46)

“Fear for pain and suffering...don’t need to permit anyone inserting any kind of tube into my body and don’t need to receive chest compression. I used to see patient was compressed at his chest when I look after my older sister who was cancer patient at a hospital. I think a heavy compression on the chest like that should make the patient got severe pain thus it made me doesn’t need to face with the same situation.”

(Participant no. 107)

“Don’t need chest compression. I think it make me suffer. Comfort death is better than living with suffering. Don’t afraid to die but afraid to suffer.”

(Participant no. 191)

From the study, the majority of Thai Buddhists who decided to forgo the treatments expressed their reasons that they fear of pain and suffering (49.5%), and need to die naturally, peacefully, and comfortably (51.9%, 46.2%, and 30.8%, respectively). The finding was supported by Keenan, et al. (1997) and Nijinikaree (2004). They stated that patient suffering was the common reason for forgoing life-sustaining treatment.

For the reasons of Buddhist doctrine expression values, it’s indicated that their decisions based on Buddhist doctrine including Law of Nature, Law of Karma, and Law of Dependent Origination. For example, the reasons of value “prolongation of death is a sin (Sila)”: a) *doing against nature* based on Law of

Nature, b) *producing of suffering*, and c) *suffering of body from prolonging of death* based on Law of Dependent Origination, the reasons of value “merit and sin”, which based on Law of Kamma were a) *end of kam*, and b) *according to Law of Kamma*, etc. From this study, 74.4% of the subjects who used “merit and sin” as their values underlined the forgoing the treatment, stated that “mod wein mod kam” or “end of kam” was their reason. Phra Prayuth (Payutto, 1995) recommended that Kod-hang-kam (Law of Kamma) is one of two principles of the Dhamma related to Dependent Origination Law. Kamma is one part of the process of dependent origination (Payutto, 1995). Majority of Thai Buddhists believe in Law of Kamma (Mettanuntho, 2005) that no one can protect themselves from the results of their own deeds since each must suffer or benefit of their own deeds (Autthagorn, 1988; Raksasataya, 1987). As a common Thai idiom stated that “doing good receive good and doing bad receive bad” or in Thai: “tham-dee-dai-dee tham-sure-dai-sure” (Mettanuntho, 2005). Kongin (1998) study in 31 Thai elderly and also found that every participant believed in Law of Kamma and made a merit. Similarly, Wisersith and college (2003) explored the meaning of death of five AIDS patients and twelve family care providers and found that “mod bun mod kam” was the first theme, which means the end of merit and sin. These findings supported that Thai Buddhists usually believe in Law of Kamma, which influence to their forgoing the treatment at the end-of-life. As two participants stated:

“I think birth, ageing, illness, and death happen according to merit and sin. If I die, mean I end of kam. So, I don’t need to use any treatment to prolong my life.”

(Participant no. 76)

“I choose to quit the treatment because I think everyone who was born has a sin. Everybody is inevitable from Law of Kamma (kod-hang-kam). We will die when we end of sin.”

(Participant no.95)

Moreover, for the reasons of Buddhist doctrine expression values based on Law of Nature: prolongation of death is sin (Sila/morality) indicated that their decisions based on the first precept of the Five Precepts or Panatipata. It is avoidance to kill or take life of living things because it is an immoral action (Mole, 1973; Sirilai, 2001). In other words, killing a person and an animal are sin or shortening life is wrong (Morgan, 2001). Prolonging death is incongruous with natural law (Sirilai, 2001). People infringe upon the first precept of the Five Percepts when his or her act consist of five compositions: 1) living thing is alive, 2) know that it is a living thing, 3) it is an intent killing, 4) try and pay an effort to kill, and 5) a living thing was died by killing (Sirilai, 2001). This principle supports an opinion of some participants, which they thought that choice to forgo the treatments was not an effort and intent killing. As one of them mentioned:

“Stop the treatments is not a sin because we don’t kill ourselves. If we prolong a hopeless life, it makes us like falling into a hell.”

(Participant no. 102)

Other three subjects also expressed their opinions:

“An agreement of using the treatment at the end-of-life is sin because it gain suffering to patient body. It’s a time to die but rescues stills go on that make me to prolonging reciprocation to kam.”

(Participant no. 83)

“It’s a sin because don’t let me die comfortably according to nature.”

(Participant no. 118)

“Living as a death person is more suffer. Don’t force to prolong suffering. I think it’s a sin because it’s a time to die and also against nature.”

(Participant no. 125)

Additionally, the reasons of other two Buddhist doctrine expression values based on Law of Nature included 1) prolongation of death is impossible (Anattata/non-self): a) it’s an end stage of life; b) natural law, and c) impossible and 2) death is inevitable (Aniccata/ impermanence): a) everyone was born and should die finally; b) it’s a time to go; and c) natural law. The finding indicated that their decisions based on the Three Characteristics of Existence (Tri-lakkhana). Impermanence or Aniccata is all existences there is no such thing as permanence. All kinds of life come to being when proper condition prevails but nothing when proper condition does not prevail. Non-self or Anattata means nothing belongs to all life, there is no principle, and soul or self belong to any living thing. Four participants expressed about the reason of value “prolongation of death is impossible” as follows:

“A doctor can help only living person but he can not help a dying person. At the end stage of life, nobody can resists his or her fate (her Thai word: cha-ta)

(Participant no. 48)

“I am in the corner. (her Thai word: sood-moong). I think that it’s out of mankind control to against nature.”

(Participant no. 83)

“Don’t have an opportunity to survive. It’s a time to leave the world. We can’t resist death although we try to sustain life.”

(Participant no. 113)

“At the end-of-life, to resist or to prolong life is not success (her Thai words: ma-thium-nhai-pai-thium-nhun).”

(Participant no. 155)

Three participants said about the reasons of value “death is inevitable”:

“Everybody was born and then must die later the same as a falling leaf when its color changes from green to yellow.”

(Participant no. 26)

“No one can avoid death (his Thai words: mai-mae-krai-ma-laiw-mai-pai). Being born, aging, ailing, and death are common phenomena. It occurs according to natural law.”

(Participant no. 67)

“When end stage of life is coming, it’s like an overripe fruit so it must fall down to the ground.”

(Participant no. 118)

For the social expression values: quality of death, Leichtentritt and Rettig (2001), studied in 19 elderly and their 28 family members, also found that “quality of death” was one of their value underlying end-of-life decision. The reasons for the value “quality of death” were: a) need of natural death, b) need of peaceful death, and c) need of comfort death. These findings indicated that they made the decisions based on value of death. The findings were supported by the idea of Hall (1996), which stated that when one values death about dying and death, one will stop or refuse life-sustaining treatment, or will not want the treatment. Furthermore, the findings regarding quality-of-death-value and the reasons were supported by Theory of the Peaceful End-of-life of two nursing theorists: Ruland and Moore (1998) and Higgins (2006). The theory is a middle range theory, which states that peaceful end-of-life consist of five major concepts: 1) not being in pain, 2) the experience of comfort, 3) the experience of dignity and respect, 4) being at peace, and 5) closeness to significant others. In addition, the finding also was supported by Forbes, Bern-Klug, and Gessert (2000). They studied in twenty-eight family members of home

residents with moderately severe to severe dementia and found that the participants wanted themselves to have a “natural death.”

Three subjects clearly expressed:

“I wish to die at home with calm, peaceful, and comfort death. Death at a hospital, I will be inserted several kind of tubes into my nose and mouth. I don’t prefer it because it make me feel discomfort, distress, and difficult to breath.”

(Participant no. 31)

“Let me die. I prefer to die naturally and calmly. At near death or critical illness, please take me home. Death among my family and other loved ones including saying farewell with them are my wishes.”

(Participant no. 46)

“Natural death at home is better. Home is my birth place so death at the same place with birth is well and happily.”

(Participant no. 133)

Family burden was also one of the social expression values of the study.

The reasons underlined this value were: a) do not need to gain burden to family, b) fear to make family suffer, and c) family concern. The subjects concerned about their family feeling as supported by opinion of three participants of them:

“I feel guilty, if I am a cause of burdens to my family members and lovedt ones around me.”

(Participant no. 51)

“Don’t need to be a cause of burden for my family. Don’t make them lose their time and distress from several burdens.”

(Participant no. 154)

“I fear to be a burden for my family and significant others. I love and pity my son and my daughter. If I decide to prolong my dying, my family members should take time for look after me at a hospital, hence their incomes are lost by leaving from their jobs.”

(Participant no. 155)

In conclusion, although Buddhist doctrine expression values were not the most significant values underlined the forgoing life-sustaining treatment decisions,

several Buddhist doctrine expression values guided the decisions. The most important value of their decisions was: free from suffering, which reflects bio-social expression value. Buddhist doctrine expression values were: 1) prolongation of death is sin (Sila/morality), 2) prolongation of death is impossible (Anattata/non-self), 3) death is inevitable (Aniccata/impermanence), 4) sin and merit (Law of Kamma), and 5) attachment is the cause of suffering (Paticcasamuppada/Law of Dependent Origination).

4.2 Values underlying the continuing treatment decisions

For continuing the treatment at the end-of-life, the findings revealed that the significant values underlying the decisions (value of > 70% of the samples) were “hope”, “life is valuable”, and “family concern”. The values for continuing treatments were similar to existing research (Bowman and Singer, 2001; Konishi, Davis & Aiba, 2002). Schonwetter and colleagues (1996) explored life values in 132 older populations. They found that life values are related to resuscitation preference, one kind of life-sustaining treatment, which emphasizes the importance of eliciting and including life values when discussing and making end-of-life decision. People in every society usually think that life is good but end-of-life or death is an inauspicious (in Thai word: up-pa-mong-kol) and undesirable thing (Mettanuntho, 2005). Therefore, people who value his or her life act to preserve their life (Hall, 1996).

However, this study revealed that only 56.1% and 19.5% of the subjects stated that responsibility and gratitude respectively were their values underlying the decisions. Conversely, Komin (1991), studied in 2,149 Thai rural people and stated that responsibility, and gratitude were two of the most important values of Thai people. The findings indicated that, responsibility and gratitude were

not the top three values underlying the decisions in the study. It might be explained that all of the subjects in this study were older-age and most of their parents died already therefore, responsibility, and gratitude were not the values underlying the decisions, presently.

The reasons for the value “life” were a) need to survive as long as possible, b) need to do the most benefit, and c) life is the most important. As reported by three participants:

“Life is valuable for me, so I need to try to prolonging life until the last second.”

(Participant no. 32)

“I wish to live for reciprocation to my home town. I think I was born and should gain benefit to central party and community as much as possible.”

(Participant no. 33)

“Life is important for everyone therefore, I wish to live as long as possible. It should be a worth-while life”

(Participant no. 135)

The reasons for the value “hope” were a) may be possibly to survive, b) still need to live, and c) hope to have a miracle. Hope was also the most important value underlying continuing the treatment in the study. It is possible that although all of Thai Buddhists in the study were elder and majority of them had a hospital admittance history (65.7%), they perceived their health status were healthy. The finding supported the idea that although the decision based on the vignette of end-stage-patient, the hopeful subjects still chose to continue the treatment. As five participants expressed:

“Uncertainty, I hope that it may be survived (her Thai words: mai-tueng-tee-tai-mai-wai-che-wa-wad).”

(Participant no. 33)

“Hope to recover and survive again because I have the experience in case of my wife, my father, or others. Although they were very sick patients, they were escaped from death by help of a doctor.”

(Participant no. 30, 57, 151, and 185)

The reasons for the value “family concern” were a) worried about his or her descendant, b) passion with family, and c) wait for seeing a success of his or her descendant. It might be because when the death is coming, everything in his or her life is losing; especially make them separate from their family or significant others (Chuaprapaisilp, 2004). Sirikarn (1996) supports this idea that people in Thai society, usually feel inauspiciously with death. Death is a symbol of loss, separation, and grief that the reason why Thais usually teach their children and grand child avoiding any induced-death action. Therefore, some of Thai Buddhists in the study might be influenced by the above idea and decided to continue the treatment in order to avoid the separation. As reported by participants:

“I love, concern, and care for my father and my family member. I prefer to stay with them and fear to separate from them.”

(Participant no. 99)

“I don’t desire to separate or leave my children and my grand child. I concern about their daily living and need to live with them as long as possible.”

(Participant no. 181)

4.3 The values for making the decisions by a physician

For making the decisions by a physician at the end-of-life, their values were “respect for physician” (100%) and followed by “hope” (89.5%). Their reasons for the value “respect for physician” were a) trust in the physician’s knowledge and competence; b) confide that the physician would help a patient with his all competence, and c) trust in the physician’s experience. Besides, their reasons for the value “hope” were: a) hope to survive, and b) hope to have a miracle.

The finding in this study was supported by Bowman and Singer (2001) who conducted a qualitative survey with 40 Chinese seniors 65 years of age or older and found that respondents based their end-of-life decision on the value “respect” and “hope”. They proposed that respondents respected to physicians’ decisions because they believe in physicians’ competency, their professional knowledge and their experiences (Bowman & Singer, 2001). They also stated that a medical paternalism influence to Chinese so their relationship between physicians and patients is the trustworthiness of the physician. Fleming (2001) confirmed the finding that end-of-life decision in Asian cultures is based on a paternalistic model of trust and have been less focused on individual autonomy. A prevailing paternalistic attitude that promotes a dependent role of a patient manifests in the decision making on behalf of patients because of a decision maker’s belief that they know what is best for the patient (Burkhardt & Nathaniel, 2002). Moreover, “biomedical model” is one of three models of paradigm and concept of death, which is a main current and strong influence to health care personnel and society presently (Nilchaigovit et al., 2002). According to this paradigm and concept of death, a doctor takes role to repair an impairment part of patient and should be a decision-maker about patient death. Based

on this paradigm, death should be prolonged by an advanced technology. It is possible that this model also influence to the subjects who underlined their decision by respect-value.

For the value “respect,” the subjects confide to physician’s competency, professional knowledge and experience. As these participants stated:

“I confide to my doctor. I believe in his ability, because he has special knowledge in this area and also has lots of experiences.”

(Participant no. 3)

“I leave my life in hands of a doctor. I think he can help me with his ability.”

(Participant no. 14)

“If I do not respect for a physician, I don’t come to visit him.”

(Participant no. 59)

“Doctor like a god: he gives me a life or survives me.”

(Participant no. 114)

For the reason of value “hope,” it should be explained with the same reason as stated in the value “hope” of Thai Buddhists who decided to continue the treatments that 78.6% of them perceived their health status were healthy. So, they hope to survive and have a miracle.

4.4 The values for making the decisions by family

For making the decisions by family at the end-of-life in the study, their values were “respect for family” (100%) and “family concern” (95.5%). Their reasons for the value “respect” were: a) confide in the family’s decision, b) the family know what we need, and c) the family love and has a good wish for us. Their reasons for the value “family concern” were: a) close up more than others, b) love and

attachment with the family, and c) care for family's feeling. Bowman and Singer (2001) found the same result from their studied. They found that respondents stated that "respect for family" underlined their end-of-life decisions. The respondents respect to their families' decisions because they believe that their families love them, best understand their wishes, and should choose the best one for them. Furthermore, in Asian culture, the individual is considered an integral part of the family thus, the accomplishments and choices of individual are not theirs alone, but belong to the family (Bowman & Singer, 2001).

For the value "respect," as three subjects stated:

"I confide to my family because I believe that they should select the best thing for me."

(Participant no. 44 and 201)

"I love my family. My family also loves me. We live together and clearly understand each other. They give me the best desire and the one."

(Participant no. 115)

For the value "family concern", their reasons indicated that family was their significant person or the most important person for them. As example participants expressed:

"For me, my life belongs to my daughter and my son. At the end-of-life, the decision is depended on my daughter and my son. I care for their feeling."

(Participant no. 23)

"I love, concern, and close up with my family. If I make the decision by myself, it should be made my family sorrow."

(Participant no. 179)

Summary

This chapter presented the results and discussion of the sample characteristics and three research questions. Research question 1 studied for end-of-life decisions of Thai Buddhists. The findings revealed that most Thai Buddhists (51.9%) decided to forgo life-sustaining treatment on the vignette. The 28.6% of them choose to make the decisions by physician or family. Only 19.5% of them decided to continue the treatment. Research question 2 asked for the differences among three groups of Thai Buddhists: chronically-ill patients, patients' families who have, and those who have no experienced end-of-life decisions of the others. The finding was found that there were no differences of the decisions among the three groups ($p > .05$). Last research question explored values underlying the decisions. The findings stated that: 1) values underlying the forgoing treatment decisions were Buddhist doctrine expression values more than social expression values, however the most important value was social expression values: free from suffering, 2) the values underlying the continuing treatment decisions were hope, life is valuable; and family concern, 3) for making the decisions by a physician, the values of Thai Buddhists were respect and hope, and 4) for making the decisions by family respect and family concern. The finding shows that values underlying the continuing treatment decisions and values underlying the decisions by other persons were social expression values only.

In brief, based on all descriptive knowledge emerged from the study, it can be used to guide and understand values underlying end-of-life decisions in Thai Buddhists. However, a need for further research about end-of-life decisions should be continued.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

This chapter provides a summary of the study. It presents conclusions, strengths of the study, limitations of the study, recommendations for nursing practice, nursing administration, nursing education, further research, and other health care team.

Conclusions

The purposes of this study were to explore end-of-life decisions in Thai Buddhists, to compare differences of the end-of-life decisions among Thai Buddhists, and to reveal the values underlying the end-of-life decisions of Thai Buddhists.

This descriptive study was conducted with 210 Thai Buddhists: chronically-ill patients, patients' families who have and have no experience end-of-life decisions of other person at the chronic out-patient clinic of Hadyai Regional Hospital, Songkhla and Nakhon Sri Thammarat Regional Hospital, Nakhon Sri Thammarat, comprised 70 samples per group. They were randomly recruited according to inclusion criteria and face-to-face interviewed with tape recorded using the Demographic Data Form and the Values Underlining End-of-Life Decisions Interview Form. The instrument was tested face validity and employed test-retest reliability. The Content Validity Index and the percentage of agreement index was .88 and .90, respectively.

Data were analyzed using descriptive statistics, chi-squared test, and content analysis. Quantitative data were analyzed using computerized statistic program to compute descriptive statistics including frequency and percentage, and chi-squared test. The qualitative data were analyzed using content analysis.

The findings revealed that most Thai Buddhists (51.9%) decided to forgo life-sustaining treatment on the vignette. The 28.6% of them choose to make the decisions by physician or family. Only 19.5% of them decided to continue the treatment. There were no differences of the decisions among the three groups ($p > .05$).

Based on above findings, the summary of emerged descriptive knowledge from the study was as follows:

Firstly, the findings confirmed that older age patients usually forgo the treatment in irreversibly and terminally stage because of poor prognosis, futility, patient suffering and poor expected quality of life.

Secondly in conversely, although all of the subjects were Buddhist, which Buddhist philosophy believes in Law of Nature: existence and extinction is ordinary phenomena of human life and Law of Dependent Origination: the arising and extinguishing of dukkha such as attachment is a cause of suffering, only approximately 50% of them forgo the treatment. In this study, the finding pointed out that most of Thai Buddhists usually participates in Buddhist activities or religious ceremony more than studies deeply in Buddhist doctrine hence they could not enlighten and accept death as a natural phenomenon. The finding from this study supported that an enlightenment and acceptance of death is occurrence in Thai Buddhist who understand deeply about the essences of Buddhist philosophy, always

use them for practicing in their daily life, and then should help them enable to forgo the treatment at the end-of-life. This finding also provides additional suggestion that the holistic approach of nursing should facilitate understanding whether the religious practices play role in end-of-life of each Thai Buddhist.

Thirdly, although all of subjects were Buddhist; the majority of them was similar in several personal characteristics, such as their age, educational level, occupation, income, and etc.; and all of them were supposed to be the same end-of-life patient; their end-of-life decisions were various including forgoing, continuing, and choosing to make the decisions by physician or family. Therefore, the recognition of patient's preference assessment is an important strategy for nurse and health care personnel to protect patients' rights, and provide harmonious care regarding the end-of-life decision.

Lastly, although an average age of the subjects was nearly 60 years; an educational level was primary level; they were lay persons, and were supposed to confront with terminally stage, more than 70% of them still preferred to have their own decisions. This result provides evidence that if it's possible, patient wish to have self-determination. Therefore, nurse and health care personnel should be more recognized and respect for patient autonomy.

The other findings were stated regarding the values underlying the end-of-life decisions of Thai Buddhists and the reasons of each value. When they forgo the treatment, their top three values were 1) prolongation of death is sin: their reasons were a) doing against nature, b) producing of suffering, and c) suffering of body; 2) quality of death: their reasons were a) need of natural death, b) need of peaceful

death, and c) need of comfort death, and 3) prolongation of death is impossible: the reasons were a) it's an end stage of life; b) natural law, and c) impossible.

Next for the continuing treatment, the top three values were 1) hope: the reasons were a) may be possibly to survive, b) still need to live, and c) hope to have a miracle, 2) life is valuable: the reasons were a) need to survive as long as possible, b) need to do the most benefit, and c) life is the most important, and 3) family concern: the reasons were a) worried about his or her descendant, b) to be in love with family, and c) wait for seeing a success of his or her descendant.

Moreover, for making the decisions by a physician, the values of Thai Buddhists were 1) respect for physician: their reasons were a) trust in the physician's knowledge and competence, b) confide that the physician would help a patient with his all competence, and c) trust in the physician's experience, and 2) hope: the reasons were a) hope to survive, and b) hope to have a miracle.

Last, for making the decisions by family, the values of Thai Buddhists were 1) respect for family: their reasons were a) confide in the family's decision, b) the family know what we need, and c) the family love and has a good wish for us and 2) family concern: the reasons were a) close up more than others, b) love and attachment with the family, and c) care for family's feeling.

In addition, most important value for forgoing and continuing the treatment were free from suffering and hope, respectively. Respect was the most important value for Thai Buddhists who request a physician and family for making the decisions.

According to the findings regarding values underlying the end-of-life decisions of Thai Buddhists stated that their various end-of-life decisions usually

based on various values. Therefore, recognition of patient's value clarification is a significant role of nurse and health care team to assist patients and families make decisions at the end-of-life by helping them to understand their values and to provide congruence care base on patient's best interest.

Furthermore, the findings regarding values underlying the decisions also revealed that Buddhist doctrine expression values, which related to forgoing the treatment, composed of: prolongation of death is a sin (Sila), prolongation of death is impossible (Anattata); death is inevitable (Aniccata); merit and sin (Law of Kamma), and attachment is the cause of suffering. These findings indicated that Buddhist doctrines that related to the end-of-life decisions were: 1) The Threefold Training (Sikkhattaya or Tisikka): the first precept of the Five Percepts (Sila), 2) Three Characteristics of Existence or Tri-lakkhana: a) impermanence (Aniccata) and b) non-self (Anattata), 3) Law of Kamma: merit and sin, and 4) Law of Dependent Origination: attachment is the cause of suffering. Therefore, health care providers should be aware about the influencing of Buddhist doctrine to the decision because of its affects to thought and Thai behavior patterns.

In conclusion, the results of this study indicated that although the majority of them forgo the treatment, their end-of-life decisions were various, which consist of forgoing, continuing, and choosing to make the decisions by physician or family. Most of them wished to have their own decisions. The various end-of-life decisions usually were based on the various values. Moreover, each value was based on various reasons. In addition, the decision is also influenced by Buddhist doctrine. Based on these results, the recognition of patient's preference and value assessment, patient's values clarification, an influence of Buddhist doctrine to the decision, and

respect for patient autonomy are necessary for health care team to help them confront with the end-of-life decision congruently.

Strengths of the study

Values underlying end-of-life decisions of Thai Buddhists is a challenge topic for research conduction because of two reasons. First, end-of-life decision is a sensitive issue and taboo topic for Thai culture. Most of Thai people avoid talking and hearing regarding death and dying because they think and believe that it is a prohibitive, inauspicious, and self-cursed issue (Mettanando, 2005). It is not only a limitation and difficulty to study, but also can study only by an investigator who works in health care profession. Hence, it's no doubt that the empirical understanding of this issue is rare in Thailand. Another reason, this study was conduct in order to reveal values underlying the end-of-life decisions in Buddhist perspective, which is the most group of Thai. Approximately 95% of the total population is Buddhist (CIA World Fact book, 2003).

Combination of data collection techniques, quantitative and qualitative data collection, was used in the study. Quantitative data only could not describe values underlying end-of-life decisions of Thai Buddhists deeply. The subjects could express their ideas through qualitative data from open-ended question stronger than quantitative data from close-ended question because qualitative data can offer new and revised knowledge through their deep and rich description of context, lived experience, and subjectivity (Roberts & Taylor, 2002).

The sample size for this study was estimated base on power analysis for testing differences in proportions among three groups (Cohen, 1988; Polit &

Hungler, 1999d). The subjects also were recruited by probability sampling technique. Therefore, the samples were representing the population. Polit and colleague (2001a). support that probability sampling technique is the only reliable method of obtaining representative samples in quantitative study.

Limitations of the study

Values underlying end-of-life decisions in the study were not the values of patients who are in the end stage. Since, focusing in end stage patients should have some issues, such as 1) talking about death and dying is a taboo issue in Thai culture, particularly at the end-of-life, 2) it might be risk and harm to the patients from the sensitive issue: end-of-life decision, and 3) competency to participate in the study of end stage patient is limited by an alteration of their conscious. Most of patients at the end-of-life have a level of conscious change: confusion, semiconscious, and unconscious (Boonchalermwipas, 2004; Tilden, Tolle, Garland & Nelson, 1995).

The issues were compensated by studying in older-age Thai Buddhist including patients with various life threatening chronic illnesses, such as Acquired Immune Deficiency Syndrome, Malignant diseases, and etc. Confronting with the death of a parent is one of the most common stressful life experiences for adults that start in their midlife (Lachman, 2001). In this age many changes take place, risk for alternations in health from many chronic diseases, and becoming the primary caregiver for an elderly or ill family member (Lachman, 2001; LeMone & Burke, 2000). Therefore, starting to concern about death and dying is usually common for older-age and serious ill patients.

Recommendations

1. Recommendations for nursing practice

The findings provide basic information for health care providers to assist patients and families make decisions at the end-of-life. Because the findings of this study showed that the majority of older-age Thai Buddhist usually forgoes the treatment in end stage of life; the decision is also influenced by Buddhist doctrine in Thai Buddhist who understands deeply about an essence of the Buddhist doctrine and always uses it for practicing in daily life. The nursing practice recommendations are as follows:

Firstly, nurses are needed to emphasize about cultural diversity especially Buddhism in Thai and to elucidate in advocating and facilitating patients clarify their decision making in end-of-life and encouraging religious activities in nursing practices.

Secondly, nurses should recognize a necessary of value assessment in nursing practices, an important of values clarification, and use them in the practices.

Thirdly, in order to provide harmonious care while avoiding ethical conflicts and dilemmas for patients and families regarding end-of-life decisions, staff nurses should be encouraged to take course work or to study additional program about end-of-life decision, value assessment, values clarification, and respecting patient autonomy.

Fourthly, nurses should be trained to use assessment tools for assess patient's values and preferences, and guidelines for values clarification in end-of-life

decision with respect for patient autonomy and based on patient's best interest in nursing practices.

Fifthly, ethics rounds about end-of-life decision should be established as a method to encourage nurses aware and enhance skills of the ethical decision making and ethical sensitivity in nursing practices.

Lastly, family involvement in end-of-life decisions and all nursing practices still needed. Nurses should be aware and facilitated them to participate in the decision and all nursing practices.

2. Recommendations for nursing administration

The results of this study suggest that the end-of-life decision making of patient and family should be respect by nurse and health care personnel. Policies and support or promote end-of-life decision of patients are essential in Thailand in order to protect patient autonomy and enhance self-determination of patient. Therefore, in national level, end-of-life decision policy and law should be pushed to state clearly in The National Health Development Plan and The Thai National Health Act, respectively. In local or hospital level, nursing administrators should develop ethical practice guidelines and create effective training programs, such as patient preference assessment program, guideline for values clarification, patient autonomy, and ethical decision making, etc. Other recommendation is to include these guidelines and programs in the training of nursing student and nursing novice to encourage them for realizing and respecting patient autonomy. In addition, nursing administrators or organizational leaders should emphasize and integrate an influence of religion on individuals' end-of-life decision-making.

3. Recommendations for nursing education

The findings as stated above are beneficial for nursing educators to use as data bases for curriculum development in particular nursing ethics within a particular context: value and ethical decision making, and use in teaching ethics for nursing students and also for other staff nurses. It is recommended that the results encourages the nursing educators to include a values clarification process and ethical end-of-life decision making in a nursing curriculum as a part of the nursing process. For other recommendation, nursing educators should provide students with values clarification and ethical decision making skills and provide exercises regarding end-of-life decisions in order to make sure that the students could apply it in the nursing practice. These educational approaches continue to require monitoring for effectiveness and needed improvements nursing competence in end-of-life decision-making.

4. Recommendations for further research

For nursing research, the findings provide data that can be used in developing instruments to assess values underlying end-of-life decisions for future research. Creation or development of protocol or guideline or plan for making decision at the end-of-life of patient and surrogate is also recommended. Interestingly, a comparative study should be conducted to investigating the decisions among patient, surrogate, and health care personnel in order to protect and advocate patient's right. Moreover, further research involving a longitudinal study should be conducted to confirm the stability of the decision of the same subjects at difference periods in order to provide basic guideline for reassessment of the end-of-life decisions and patient preferences. In addition, a various age of serious ill patients in the same settings or

other settings such as community hospitals, university hospitals or hospitals in other regions of country is recommended to conduct a research project for revealing the differences of the decisions and values underlying their decision and the influence of Buddhist doctrine on various ages of Thai Buddhists in order to expand the boundaries of knowledge and to generalize results to the larger population.

5. Recommendations to other health care team

As, the findings revealed that “respect for physician” was values underlying end-of-life decisions of all Thai Buddhists who allowed a physician to make the decisions for them. Therefore, assisting patients and families on making decisions at the end-of-life and solving their ethical conflicts and dilemmas related to the decisions, including an improving a quality of care regarding end-of-life decisions need an involvement of multidisciplinary health care team, especially a physician, such as: 1) ethics rounds about end-of-life decision should be established as a method to encourage not only nurses but also the other health care team to aware and enhance skills of the ethical decision making and ethical sensitivity, 2) the ethics rounds should be pushed to state in health care policy that should be include physician and other health care team, 3) the health care team should encourage or give an opportunity for patient and family to involve/participate in the decision, and 4) patient advocacy to refuse life-sustaining treatment in terminal stage, following the Section 12 of Thai National Health Act, B. E. 2550, should be a responsibility of the health care team.

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APPENDIX A
PROTECTION OF HUMAN SUBJECTS' RIGHT

Informed Consent Form

การพิทักษ์สิทธิของผู้เข้าร่วมให้ข้อมูล

สวัสดิ์ค่ะ ดิฉัน นางจรรุวรรณ มานะสุรการ กำลังศึกษาในระดับปริญญาเอก สาขาพยาบาลศาสตร์ ที่คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ และขณะนี้กำลังทำการศึกษาวิจัย เรื่อง คุณค่า และความเชื่อ ที่คนไทยพุทธในภาคใต้ให้ความสำคัญและใช้ในการตัดสินใจในวาระสุดท้ายของชีวิต โดยมีความประสงค์เพื่อศึกษาเกี่ยวกับการตัดสินใจในวาระสุดท้ายของชีวิตของคนไทยพุทธในภาคใต้ว่าเป็นอย่างไร? และคุณค่าใดอยู่ภายใต้การตัดสินใจดังกล่าว หรือทำให้คนไทยพุทธในภาคใต้ตัดสินใจอย่างนั้น? เพื่อนำข้อมูลที่ได้อไปใช้ประโยชน์ในการวางแผนพัฒนาคุณภาพการพยาบาลผู้ป่วยในวาระสุดท้ายของชีวิตให้สอดคล้องกับความต้องการตามคุณค่าและความเชื่อของผู้ป่วยต่อไป

จึงใคร่ขอความร่วมมือจากท่านในการให้ข้อมูลดังกล่าว หากท่านยินดีที่จะเข้าร่วมในการศึกษาวิจัยครั้งนี้ ท่านสามารถตอบตกลงด้วยวาจา หรือลงนามในหนังสือฉบับนี้ และตอบแบบสัมภาษณ์ซึ่งใช้เวลาประมาณ 30 นาที ทั้งนี้ขณะสัมภาษณ์จะขอจดบันทึกและบันทึกเทปเพื่อความถูกต้องและครบถ้วนของข้อมูลตามเนื้อหาที่ได้ โดยไม่ระบุชื่อของผู้เข้าร่วมให้ข้อมูล ท่านจึงสามารถแสดงความคิดเห็น และตอบแบบสัมภาษณ์ได้อย่างอิสระ ข้อมูลทั้งหมดจะถูกเก็บไว้เป็นความลับ และนำมาใช้เฉพาะในงานวิจัยครั้งนี้เท่านั้น

ในระหว่างเข้าร่วมให้ข้อมูล หากท่านมีข้อสงสัยใดๆ ดิฉันยินดีตอบข้อสงสัยของท่านตลอดเวลา ท่านมีสิทธิที่จะตอบรับหรือปฏิเสธการเข้าร่วมในการวิจัยครั้งนี้โดยอิสระ และไม่ว่าท่านจะเข้าร่วมในการวิจัยครั้งนี้หรือไม่ก็ตาม จะไม่เกิดผลเสียใดๆ ท่านยังคงได้รับการบริการจากเจ้าหน้าที่ของโรงพยาบาลเป็นอย่างดี และถึงแม้ท่านจะยินยอมเข้าร่วมการวิจัยแล้ว ท่านยังมีสิทธิที่จะขอยกเลิกการเข้าร่วมการวิจัยนี้ได้ตลอดเวลาตามที่ท่านต้องการ โดยไม่มีผลกระทบใดๆต่อท่านและบุคคลอื่นๆแต่ประการใดเช่นกัน

ผู้วิจัยขอขอบคุณที่ท่านให้ความร่วมมือในการศึกษาวิจัยในครั้งนี้

ยินดีเข้าร่วมให้ข้อมูล

ขอแสดงความนับถือ

ลงชื่อ.....

ลงชื่อ.....

(ผู้เข้าร่วมให้ข้อมูล)

(นางจรรุวรรณ มานะสุรการ)

วันที่.....เดือน.....พ. ศ... ..

ผู้วิจัย

APPENDIX B
LIST OF EXPERTS

List of the experts for research instrument validation

1. Associated Professor Siwali Sirilai
Associated Professor Emeritus, Department of Humanities, Faculty of Social Sciences and Humanities, Mahidol University
2. Associated Professor Prakong Intrarasombat
Department of Nursing, Faculty of Medicine, Mahidol University
3. Associated Professor Dr. Somparn Promta
Department of Philosophy, Faculty of Arts, Chulalongkorn University
4. Associated Professor Dr. Tirawuth Pratumnopharat
Associated Professor Emeritus, Department of Educational Administration, Faculty of Education, Sri-Nakarintrarawiroj University, Songkhla
5. Associated Professor Dr. Arporn Choaprapaisilp
Department of Medical Nursing, Faculty of Nursing, Prince of Songkla University

List of the experts for conceptual framework validation

1. Pra Doossadee Maethunguro

The abbacy of Bamboo-Field Temple, Chum-porn province

2. Associated Professor Dr. Somparn Promta

Department of Philosophy, Faculty of Arts, Chulalongkorn University

3. Associated Professor Dr. Tirawuth Pratumnopharat

Associated Professor Emeritus, Department of Educational Administration, Faculty of Education, Sri-Nakarintrarawiroj University, Songkhla

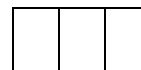
4. Dr. Buncha Pongpanich

Non government organization academic expert; Former Vice President for Student Development, Walailak University

5. Associated Professor Dr. Arporn Choaprapaisilp

Department of Medical Nursing, Faculty of Nursing, Prince of Songkla University

APPENDIX C
RESEARCH INSTRUMENT



Research Instrument (Thai Version)

แบบสัมภาษณ์เกี่ยวกับคุณค่าที่ใช้ในการตัดสินใจ ในวาระสุดท้ายของชีวิตของคนไทยพุทธ

คำชี้แจง

แบบสัมภาษณ์นี้เป็นส่วนหนึ่งของการศึกษาวิจัยในหลักสูตรปรัชญาดุษฎีบัณฑิต (การพยาบาล) คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ เรื่องคุณค่าที่มีความสำคัญต่อการตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิตหรือยุติการรักษาในวาระสุดท้ายของชีวิตของคนไทยพุทธ ประกอบด้วยข้อมูล 2 ส่วน คือ

ส่วนที่ 1 แบบบันทึกข้อมูลทั่วไปของคนไทยพุทธ จำนวน 19 ข้อ

ส่วนที่ 2 แบบสัมภาษณ์เกี่ยวกับคุณค่าที่ใช้ในการตัดสินใจในวาระสุดท้ายของชีวิต ประกอบด้วย กรณีผู้ป่วย คำถามเกี่ยวกับการตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิตหรือยุติการรักษาในวาระสุดท้ายของชีวิต และ คุณค่าที่มีความสำคัญต่อการตัดสินใจ รวมทั้งคุณค่าที่สำคัญที่สุดที่ใช้ในการตัดสินใจดังกล่าว จำนวน 43 ข้อ โดยจำนวนข้อของแบบสัมภาษณ์ที่ผู้เข้าร่วมให้ข้อมูลแต่ละท่านจะต้องตอบมีดังนี้

- 2.1 ผู้ที่ตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิตจะตอบคำถามในส่วนนี้จำนวน 13 ข้อ
- 2.2 ผู้ที่ปฏิเสธที่จะรับการรักษาเพื่อยืดชีวิตจะตอบคำถามในส่วนนี้จำนวน 17 ข้อ
- 2.3 ผู้ที่ขอให้แพทย์เป็นผู้ตัดสินใจจะตอบคำถามในส่วนนี้จำนวน 6 ข้อ
- 2.4 ผู้ที่ขอให้ครอบครัวเป็นผู้ตัดสินใจจะตอบคำถามในส่วนนี้จำนวน 7 ข้อ

ลักษณะคำถามในแบบสัมภาษณ์ทั้งสองส่วน เป็นคำถามปลายปิด และ ปลายเปิด คำถามทุกข้อไม่มีคำตอบใดถูกหรือผิดเพราะเป็นความคิดเห็นของแต่ละบุคคลจึงไม่จำเป็นต้องตอบเหมือนกัน แต่ละท่านอาจตอบเหมือนหรือต่างกันก็ได้ ขอให้ท่านตอบคำถามให้ตรงตามความคิดเห็น และความเชื่อของท่านให้มากที่สุด เพื่อบุคลากรในทีมสุขภาพจะได้มีความเข้าใจในความต้องการของผู้ใช้บริการเพิ่มมากขึ้นและเป็นประโยชน์ในการนำไปเป็นข้อมูลพื้นฐานในการพิทักษ์สิทธิของผู้ใช้บริการ ตลอดจนการปรับปรุง ส่งเสริม และ

พัฒนาการบริการพยาบาลในระยะสุดท้ายของชีวิตให้สอดคล้องกับความต้องการของ
ผู้ใช้บริการต่อไป คำตอบของท่านถือเป็นความลับ จะสรุปออกมาเป็นข้อคิดเห็นโดยรวม
ของคนไทยพุทธ ขอให้ท่านวางใจและตอบคำถามด้วยความสบายใจ ขอรับรองว่าจะไม่มี
การนำไปใช้ในทางที่ก่อให้เกิดผลกระทบใดๆต่อท่านแต่อย่างใดไม่ว่าทางตรงหรือทางอ้อม

ส่วนที่ 1 แบบบันทึกข้อมูลทั่วไปของคนไทยพุทธ

คำชี้แจงในการบันทึกข้อมูลจากการ สัมภาษณ์

โปรดใส่เครื่องหมาย ✓ ลงในช่อง () ตามความเป็นจริงและเติมข้อความลงใน
ช่องว่างให้สมบูรณ์

1. สถานภาพ

- () 1 ผู้ป่วย มาโรงพยาบาลด้วยโรค (ระบุ).....
- () 2 ญาติผู้ป่วยที่มีประสบการณ์ในการตัดสินใจในระยะสุดท้ายของชีวิตของญาติหรือ
ผู้อื่น ความสัมพันธ์กับผู้ป่วย (ระบุ).....
- () 3 ญาติผู้ป่วยที่ไม่มีประสบการณ์ในการตัดสินใจในระยะสุดท้ายของชีวิตของญาติ
หรือผู้อื่น ความสัมพันธ์กับผู้ป่วย (ระบุ).....

2. อายุปี

3. เพศ () 1 ชาย () 2 หญิง

4. สถานภาพสมรส

- () 1 โสด () 2 คู่ () 3 หม้าย () 4 หย่าร้าง

5. ระดับการศึกษา

- () 1 ไม่ได้รับการศึกษา () 2 ประถมศึกษา หรือเทียบเท่า
() 3 มัธยมศึกษา หรือเทียบเท่า () 4 อนุปริญญา หรือเทียบเท่า

- () 5 ปริญญาตรี หรือเทียบเท่า () 6 สูงกว่าปริญญาตรี (ระบุ).....
6. อาชีพ
- () 1 นักศึกษา (ระบุระดับ).....
- () 2 ค้าขาย (ระบุ).....
- () 3 รับจ้าง (ระบุ).....
- () 4 เกษตรกรรม (ระบุ).....
- () 5 รับราชการ/ รัฐวิสาหกิจ (ระบุ).....
- () 6 อื่นๆ (ระบุ).....
7. ที่อยู่: จังหวัด.....อำเภอ.....ตำบล.....
8. รายได้ (บาท/ เดือน)
- () 1 น้อยกว่า 5,000 () 2 รายได้ 5,000 - 10,000
- () 3 รายได้ 10,001 - 20,000 () 4 มากกว่า 20,000
9. ความเพียงพอของรายได้
- () 1 เพียงพอ
- () 2 ไม่เพียงพอ (ระบุสาเหตุ).....
10. บทบาทในครอบครัว
- () 1 หัวหน้าครอบครัว () 2 สมาชิกครอบครัว
11. จำนวนสมาชิกในครอบครัว (ระบุ).....คน
12. ภาวะสุขภาพ
- () 1 แข็งแรงดี
- () 2 ไม่แข็งแรง (ระบุโรคและระยะเวลาที่ป่วย).....
-
13. ประวัติการเข้ารับการรักษาในโรงพยาบาล
- () 1 ไม่เคย () 2 เคย (ระบุจำนวนครั้ง).....ครั้ง
14. ประสบการณ์ในการใช้เครื่องช่วยหายใจ เครื่องกระตุ้นหัวใจ การให้อาหารและน้ำทางสายยาง หรือ ยามาเชื้อโรคทางหลอดเลือดดำ

() 1 ไม่เคย

() 2 เคย (ระบุ

ชนิด).....

() 3 เคยเห็นผู้อื่นใช้ (ระบุชนิด).....

15. ประสบการณ์ในการตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิตในวาระสุดท้ายของชีวิตของสมาชิกในครอบครัว/ญาติ/ผู้อื่น

() 1 ไม่มี

() 2 มี (ระบุ).....

() 3 เคยเห็นผู้อื่นตัดสินใจ.....

16. กิจกรรมทางพุทธศาสนาที่ปฏิบัติในชีวิตประจำวัน (เลือกตอบได้มากกว่า 1 ข้อ)

กิจกรรมทางพุทธศาสนา	ปฏิบัติ สม่ำเสมอ (1)	ปฏิบัติ เป็นบางครั้ง (2)	ปฏิบัติ นานๆครั้ง (3)	ไม่ได้ ปฏิบัติ (4)
() 1 ทำบุญ ตักบาตร				
() 2 ไปวัด				
() 3 สวดมนต์				
() 4 รักษาศีล				
() 5 ถวาย สังฆทาน				
() 6 ปฏิบัติ สมาธิ				
() 7 อื่นๆ.....				

17. ความสำคัญของพระพุทธศาสนาต่อการตัดสินใจในชีวิตประจำวัน

- () 1 มีความสำคัญ () 2 ไม่มีความสำคัญ
() 3 อื่นๆ.....

18. หลักศาสนาที่ท่านนำมาใช้ในชีวิตประจำวัน หรือใช้เป็นเครื่องยึดเหนี่ยวจิตใจ

(เลือกตอบได้มากกว่า 1 ข้อ)

- () 1 เกิด แก่ เจ็บ ตาย เป็นเรื่องธรรมดา () 2 การเวียนว่ายตายเกิด
() 3 อนิจจัง ทุกขัง อนัตตา () 4 เกิดมาเพื่อชดใช้กรรม
() 5 การยึดมั่นถือมั่นเป็นเหตุแห่งทุกข์ () 6 บุญกรรม
() 7 ทางสายกลาง () 8 ศีล สมาธิ ปัญญา
() 9 อื่นๆ.....

19. จากข้อ 18 หลักศาสนาที่ท่านนำมาใช้ในชีวิตประจำวันที่สำคัญที่สุดคือ.....

ส่วนที่ 2 แบบสัมภาษณ์เกี่ยวกับคุณค่าที่ใช้ในการตัดสินใจในวาระสุดท้ายของชีวิต

คำชี้แจงในการบันทึกข้อมูลจากการ สัมภาษณ์

แบบสัมภาษณ์นี้ต้องการทราบเกี่ยวกับการตัดสินใจและคุณค่า หรือความเชื่อที่มีความสำคัญต่อการตัดสินใจของท่านเกี่ยวกับการรักษาเพื่อยืดชีวิต โดยแบบสัมภาษณ์จะอธิบายเกี่ยวกับความหมายของการรักษาเพื่อยืดชีวิตชนิดต่างๆและเรื่องราวของคนไข้ที่ป่วยหนักซึ่งไม่มีโอกาสรักษาให้หายได้ในวาระสุดท้ายของชีวิต โปรดฟังเนื้อหาต่างๆและเรื่องราวดังกล่าว รวมทั้งข้อความแต่ละข้อคำถาม แล้วเลือกคำตอบที่ตรงกับความคิดเห็นที่เป็นจริงของท่านเพียงคำตอบเดียว ขอให้ท่านตอบคำถามด้วยความสบายใจ ท่านสามารถซักถามข้อสงสัยได้ตลอดเวลาของการสัมภาษณ์และสามารถสงวนสิทธิ์ที่จะไม่ตอบคำถามที่ไม่สามารถตอบได้หรือไม่สบายใจที่จะตอบได้อย่างเป็นอิสระ สำหรับคำถามที่มีคำตอบ “ใช่” กับ “ไม่ใช่” เลือกตอบโดยมีเกณฑ์ในการพิจารณาดังนี้

ใช่ หมายถึง เมื่อท่านเห็นด้วยกับข้อความในคำถามนั้น

ไม่ใช่ หมายถึง เมื่อท่านไม่เห็นด้วยกับข้อความในคำถามนั้น

การรักษาเพื่อยืดชีวิต ประกอบด้วย

1. **การช่วยฟื้นคืนชีพ** หมายถึง การรักษาทางการแพทย์ที่ใช้ในการกระตุ้นให้หัวใจเริ่มกลับมามีการเต้นอีกในผู้ป่วยที่หัวใจหยุดเต้น ซึ่งประกอบด้วย การปั๊มหัวใจโดยการกดคลง บริเวณผนังทรวงอกเป็นจังหวะให้ผนังทรวงอกยุบลง 1-1.5 นิ้ว (ดังภาพที่ 1) การใส่ท่อเข้าไปในท่อหลอดลมคอเพื่อช่วยการระบายอากาศ (ดังภาพที่ 2) การช็อคด้วยไฟฟ้าเพื่อกระตุ้นการเต้นของหัวใจ (ดังภาพที่ 3) และการให้ยาหลายชนิดทางหลอดเลือดดำใหญ่เพื่อกระตุ้นการทำงานของระบบหัวใจและไหลเวียน (ดังภาพที่ 4)

2. **การใช้เครื่องช่วยหายใจ** หมายถึง การหายใจโดยใช้เครื่องช่วยหายใจซึ่งใช้กับผู้ป่วยที่ไม่สามารถหายใจด้วยตนเองได้อย่างเพียงพอ หรือหยุดหายใจ โดยผู้ป่วยจะได้รับการใส่ท่อซึ่งทำด้วยพลาสติกผ่านทางปากหรือจมูกลงไปในท่อหลอดลมคอ ส่วนอีกปลายหนึ่งของท่อจะต่อเข้ากับท่อของเครื่องช่วยหายใจ (ดังภาพที่ 5) ผู้ป่วยจะพูดไม่มีเสียง และไม่สามารถรับประทานอาหารและดื่มน้ำทางปากในขณะที่ใช้เครื่องช่วยหายใจดังกล่าว รวมทั้งจำเป็นต้องได้รับการดูแลผ่านทางท่อหลอดลมคอด้วยสายยางเป็นระยะๆ เมื่อมีเสมหะในทางเดินหายใจ

3. **การให้อาหารและน้ำด้วยวิธีการทางการแพทย์** หมายถึง การให้อาหารและน้ำโดยใส่สายยางให้อาหารทางปาก หรือจมูกผ่านคอ ลงสู่กระเพาะอาหารของผู้ป่วยโดยตรง (ดังภาพที่ 5) หรือโดยการผ่าตัดบริเวณผนังหน้าท้องเพื่อใส่สายยางลงไปในกระเพาะฯ หรือการให้อาหารและน้ำทางหลอดเลือดดำ การให้อาหารและน้ำโดยวิธีการเหล่านี้เป็นการรักษาเพื่อยืดชีวิตที่ใช้ในกรณีที่ผู้ป่วยไม่สามารถรับประทานอาหารและน้ำได้ด้วยตนเอง

4. **การรักษาด้วยยาต้านจุลชีพ** หมายถึง การรักษาด้วยการให้ยาฆ่าเชื้อโรคทางหลอดเลือดดำเพื่อยืดชีวิตแก่ผู้ป่วยในกรณีที่ผู้ป่วยในวาระสุดท้ายของชีวิตมีภาวะติดเชื้อแทรกซ้อน (ดังภาพที่ 5)

กรณีผู้ป่วย

นาย ก. (สำหรับผู้เข้าร่วมโครงการวิจัยที่เป็นเพศชาย) หรือนาง ข. (สำหรับผู้เข้าร่วมโครงการวิจัยที่เป็นเพศหญิง) เป็นผู้ป่วยระยะสุดท้ายซึ่งไม่สามารถเยียวยารักษาให้หายได้ นาย ก. หรือนาง ข. ได้รับความทุกข์ทรมานจากความเจ็บปวดมาตลอดหนึ่งปีที่ผ่านมา ต้องให้ยาเพื่อควบคุมอาการปวดในขนาดสูงๆอยู่เป็นประจำ และมีอาการหายใจหอบเหนื่อยร่วมด้วยในบางครั้ง อาการของนาย ก. หรือนาง ข. ทรุดลงเป็นลำดับ ไม่สามารถช่วยเหลือตนเองในการทำกิจวัตรประจำวันต่างๆได้ต้องนอนกับเตียงตลอดเวลา อาจจะต้องใส่สายยางผ่านผนังหน้าท้องเพื่อให้อาหาร และให้ยาต้านจุลชีพเมื่อมีการติดเชื้อแทรกซ้อนที่ปอดร่วมด้วย หากนาย ก. หรือนาง ข. หยุดหายใจและหัวใจหยุดเต้น แพทย์ก็จะทำการช่วยฟื้นคืนชีพ และใส่เครื่องช่วยหายใจ

หากท่านเป็นนาย ก. (สำหรับผู้ร่วมโครงการฯเพศชาย) หรือ นาง ข. (สำหรับผู้ร่วมโครงการฯเพศหญิง) ท่านจะตัดสินใจอย่างไรเกี่ยวกับการรักษาข้างต้น?

- () 1 รับการรักษาเพื่อยืดชีวิต (ตอบคำถามข้อ 1 - 13)
 () 2 ปฏิเสธ/ ยุติการรักษาเพื่อยืดชีวิต (ตอบคำถามข้อ 14 - 30)
 () 3 ขอให้แพทย์เป็นผู้ตัดสินใจ (ตอบคำถามข้อ 31 - 36)
 () 3 ขอให้ครอบครัวเป็นผู้ตัดสินใจ (ตอบคำถามข้อ 37 - 43)
 () 4 อื่นๆ โปรดระบุ.....

คำถามสำหรับท่านที่ตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต

1. ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิตด้วยวิธีการรักษาชนิดใดบ้าง?

(เลือกตอบได้มากกว่า 1 ข้อ)

- () 1 การช่วยฟื้นคืนชีพ () 2 การใช้เครื่องช่วยหายใจ
 () 3 การให้อาหารและน้ำทางสายยาง () 4 การรักษาด้วยยาต้านจุลชีพ

เพราะเหตุใด?.....

2. “ชีวิตเป็นสิ่งที่มีความสำคัญซึ่งต้องรักษาไว้ให้นานที่สุดเท่าที่จะทำได้” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

3. “ความตาย คือความทุกข์ทรมาน และการสูญเสีย” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญซึ่งทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

4. “ความรู้สึกกลัวความตาย /กลัวการพลัดพรากจากสิ่งที่เรารัก /กลัวการสูญเสีย” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญซึ่งทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

5. “มีความหวังว่าจะสามารถมีชีวิตรอดได้” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

6. “ความรับผิดชอบต่อครอบครัว หรือภาระหน้าที่การงาน” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

7. “ความรักความผูกพัน ความเอื้ออาทรที่มีต่อครอบครัวและ/ ญาติ” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

1 ใช่ 0 ไม่ใช่

เพราะเหตุใด?.....

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8. ท่านเชื่อในกฎแห่งกรรม “การมีชีวิตอยู่เพื่อสร้างบุญ” จึงเป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

 1 ใช่ 0 ไม่ใช่

เพราะเหตุใด?.....

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9. “การมีชีวิตอยู่เพื่อชดใช้กรรม” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

 1 ใช่ 0 ไม่ใช่

เพราะเหตุใด?.....

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10. “ยังตายไม่ได้เพราะยังไม่ได้ทดแทนบุญคุณพ่อแม่” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

 1 ใช่ 0 ไม่ใช่

เพราะเหตุใด?.....

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11. “สิ่งศักดิ์สิทธิ์ทำนายว่าชะตาจะไม่ถึงฆาต” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

 1 ใช่ 0 ไม่ใช่

เพราะเหตุใด?.....

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12. คุณค่าอื่นๆที่ทำให้ท่านตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต.....

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13. (จากข้อ 2 – 12) คุณค่าที่ท่านให้ความสำคัญที่สุดในการตัดสินใจที่จะรับการรักษาเพื่อยืดชีวิต คือ.....

.....

คำถามสำหรับท่านที่ตัดสินใจที่จะปฏิเสธ/ ยุติการรักษาเพื่อยืดชีวิต

14. “หากจะมีชีวิตอยู่ต่อไปก็ต้องเป็นชีวิตที่มีคุณภาพทั้งร่างกายและจิตใจ เป็นต้นว่า สามารถ มีชีวิตอยู่ในสังคมได้อย่างปกติสุข สามารถคิด และตัดสินใจได้ด้วยตนเอง และช่วยเหลือตัวเองในการทำกิจวัตรประจำวันได้” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

15. “หากจะต้องจาก โลกนี้ไปก็ต้องจากไปอย่างสงบ อบอุ่น ท่ามกลางบุคคลใกล้ชิด ตามวิถีทางแห่งธรรมชาติโดยปราศจากการผูกมัดหรือพันธนาการด้วยสายระโยงระยางของเครื่องมือทางการแพทย์” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

16. “การจากไปอย่างสมศักดิ์ศรีของความเป็นมนุษย์ เป็นต้นว่า ได้รับการเคารพในความเป็นบุคคล สิทธิขั้นพื้นฐาน การตัดสินใจ และความต้องการส่วนบุคคล ตลอดจนการรับรู้ข่าวสาร” เป็นสิ่งที่มีคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

17. “การใช้เครื่องมือทางการแพทย์ และการรักษาเพื่อยืดชีวิตทำให้เกิดความเจ็บปวด ทุกข์ทรมาน” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

18. “การที่ต้องมีชีวิตอยู่ในสภาพเดียวกับนาย ก. / นาง ข. เป็นภาระหนักในการดูแลของครอบครัว” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

1 ใช่

0 ไม่ใช่

เพราะเหตุใด?.....

19. “การรับการรักษาเพื่อยืดชีวิตต้องใช้จ่ายสูงมาก” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

1 ใช่

0 ไม่ใช่

เพราะเหตุใด?.....

20. “ถ้าต้องมีชีวิตอยู่ในสภาพร่างกายที่ไม่สามารถทำหน้าที่ต่อไปได้อีกแล้ว เช่นเดียวกับนาย ก. / นาง ข. การตายเพื่อที่จะไปเกิดในสภาวะใหม่ย่อมดีกว่า” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

1 ใช่

0 ไม่ใช่

เพราะเหตุใด?.....

21. “ทุกคนเกิดมาแล้วก็ต้องตาย ไม่มีใครหลีกเลี่ยงความตายไปได้” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

1 ใช่

0 ไม่ใช่

เพราะเหตุใด?.....

22. “สภาพร่างกายของนาย ก. / นาง ข. ในขณะนี้ล้วนเป็นทุกข์” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

1 ใช่

0 ไม่ใช่

เพราะเหตุใด?.....

23. “การชะลอความตาย โดยการทำให้ชีวิตยืนยาวออกไปในสภาพร่างกายที่ไม่สามารถทำหน้าที่ได้ดั้งเดิมเป็นสิ่งที่เป็นไปได้” คือคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

24. “การเข้าใจและยอมรับสภาวะความเป็นจริงที่ว่า การทำงานของส่วนต่างๆของร่างกายไม่สามารถเป็นไปตามธรรมชาติแล้ว” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

25. “เกิด แก่ เจ็บ ตาย เป็นไปตามบุญกรรมของแต่ละบุคคล หมคนบุญหมดกรรม” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

26. “การทำงานของอวัยวะต่างๆในกรณีของนาย ก. / นาง ข. อยู่ในสภาวะที่ไม่พอดีลงตัว ในสภาพปกติตามหลักกรรมของทางสายกลางต่อไปอีกแล้ว” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

27. “การยุติการรักษาเพื่อยืดชีวิตในกรณีนี้ไม่เป็นบาป เนื่องจากสังขารถึงวาระสุดท้ายของชีวิตแล้ว” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

28. “การใช้เครื่องมือทางการแพทย์เพื่อยืดชีวิตทำให้ขาดสติสัมปชัญญะ ทำให้ต้องจากโลกนี้ไปในท่ามกลางจิตที่ไม่สงบ ไม่เป็นสมาธิ และไม่สามารถระลึกถึงสิ่งที่ดีงาม” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

29. คุณค่าอื่นๆที่ทำให้ท่านตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต.....

30. (จากข้อ 14 - 29) คุณค่าที่ท่านให้ความสำคัญที่สุดในการตัดสินใจที่จะปฏิเสธการรักษาเพื่อยืดชีวิต คือ.....

คำถามสำหรับท่านที่จะให้แพทย์เป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต

31. “ความเคารพ หรือเชื่อมั่นใน ความรู้ความสามารถของแพทย์” คือคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้แพทย์เป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

32. “ความไว้วางใจ หรือเชื่อมั่นว่า แพทย์จะตัดสินใจโดยคำนึงถึงประโยชน์สูงสุดของผู้ป่วยเป็นที่ตั้ง” คือคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้แพทย์เป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

.....
 33. “ความตายคือ สิ่งที่น่ากลัว/ การสูญเสีย/ การพลัดพรากจากสิ่งที่เป็นที่รัก ทำให้ไม่
 มั่นใจ ไม่อยากตัดสินใจด้วยตนเอง” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่าน
 ตัดสินใจที่จะให้แพทย์เป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

.....
 34. “มีความหวังว่าอาจจะมีชีวิตรอดได้แต่ไม่มั่นใจ หรือไม่อยากตัดสินใจด้วยตนเอง” คือ
 คุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้แพทย์เป็นผู้ตัดสินใจ
 เกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

.....
 35. คุณค่าอื่นๆที่ทำให้ท่านตัดสินใจที่จะให้แพทย์เป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืด
 ชีวิต.....

.....
 36. (จากข้อ 31 - 35) คุณค่าที่ท่านให้ความสำคัญที่สุดในการตัดสินใจที่จะให้แพทย์เป็นผู้
 ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต คือ.....

.....
คำถามสำหรับท่านที่จะให้ครอบครัวเป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต

37. “ความไว้วางใจ หรือเชื่อมั่นว่าครอบครัวจะเลือกสิ่งที่ดีที่สุดให้ท่าน” เป็นคุณค่า
 (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้ครอบครัวเป็นผู้ตัดสินใจ
 เกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

38. “ความเชื่อมั่นในความรักและปรารถนาดีของครอบครัวที่มีต่อท่าน” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้ครอบครัวเป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

39. “ด้วยความรักและความผูกพันที่มีต่อครอบครัว ทำให้ต้องการให้ครอบครัวมีส่วนร่วมในการตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้ครอบครัวเป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

40. “ความตายคือ สิ่งที่น่ากลัว/ การสูญเสีย/ การพลัดพรากจากสิ่งที่เป็นที่รัก ทำให้ไม่มั่นใจ ไม่อยากตัดสินใจด้วยตนเอง” เป็นคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้ครอบครัวเป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

41. “มีความหวังว่าอาจจะมีชีวิตรอดได้แต่ไม่มั่นใจ หรือไม่อยากตัดสินใจด้วยตนเอง” คือคุณค่า (ค่านิยม) หรือความเชื่อที่สำคัญที่ทำให้ท่านตัดสินใจที่จะให้ครอบครัวเป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต ใช่หรือไม่?

() 1 ใช่

() 0 ไม่ใช่

เพราะเหตุใด?.....

42. คุณค่าอื่นๆที่ทำให้ท่านตัดสินใจที่จะให้ครอบครัวเป็นผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อยืดชีวิต.....

.....
43. (จากข้อ 37 - 42) คุณค่าที่ท่านให้ความสำคัญที่สุดในการตัดสินใจที่จะให้ครอบครัวเป็น
ผู้ตัดสินใจเกี่ยวกับการรักษาเพื่อชีวิต คือ.....
.....

ภาพแสดงการรักษาเพื่อยืดชีวิต*



ภาพที่ 1: การช่วยฟื้นคืนชีพ

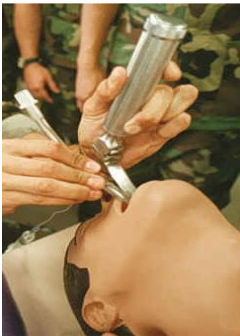


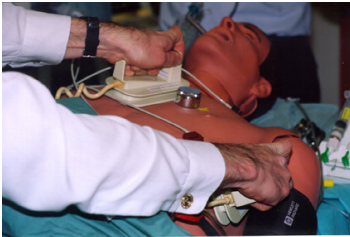
Figure 36: Ventilation through Endotracheal Tube

h. Bag-valve-mask attached directly to ET tube



SUSAN GILBERT

ภาพที่ 2: การใส่ท่อหลอดลมคอ



ภาพที่ 3: การกระตุ้นหัวใจ
ด้วยไฟฟ้า



ภาพที่ 4: การให้ยากระตุ้นหัวใจ
ทางหลอดเลือดดำ



ภาพที่ 5: การใช้เครื่องช่วยหายใจ การให้อาหารและน้ำทางสายยาง และการให้ยาฆ่าเชื้อโรคทางหลอดเลือดดำ

* ภาพย่อจากขนาดที่ใช้จริงในการวิจัย คือ ขนาดเอ 4 (21x 29.75 ซม.)

Research Instrument (English Version)

Interview form about the values used by

Thai Buddhists to make a decision at the end of their life

Explanation

This interview form is part of a research project for a Ph.D. program in Nursing, Faculty of Nursing, Prince of Songkla University about the values used by Thai Buddhists to make a decision whether to receive treatment to prolong their life or to stop receiving treatment at the end of their life. The interview form consists of two parts:

Part 1: The Demographic Data Form consists of 19 questions.

Part 2: The Values Underlying End of Life Decision Interview Form

This form consists of a vignette of end stage patient and 43 questions about the values used by respondents to make a decision whether to receive treatment to prolong their life or to stop receiving treatment at the end of their life, values that are important for making the decision, and the most important values used in making the decision. The numbers of questions that each respondent will answer are as follows:

2.1 Respondents who decide to receive treatment to prolong their life will answer 13 questions.

2.2 Respondents who refuse treatment will answer 17 questions.

2.3 Respondents who ask the doctor to make a decision will answer 6 questions.

2.4 Respondent who ask their family to make a decision will answer 7 questions.

The questions in both parts of the interview form are closed-ended and open-ended questions. There are not right or wrong answers to all the questions as they are

opinions of individuals and therefore, they do not need to be the same. Each respondent can have the same or different answers. Please give the opinions and beliefs that most correspond to those of your own. This is so that personnel in health teams will better understand the needs of their service recipients and will use them as basic data to protect their rights, improve, promote and develop nursing services for the service recipients' end-of-life to better suit the needs. Your answers will be kept confidential and will be summarized as overall opinions of Thai Buddhists. Please trust me and answer the questions freely. Your answers will not be used in a way that will affect you in any way whether directly or indirectly.

Part 1: The Demographic Data Form

Explanation for recording the data from the interview

Please check \surd in the parenthesis () according to the truth and fill in the blanks to complete each item.

1. Status:

() 1. A patient visiting the hospital with the disease (Please specify):

.....

() 2. A patient's relative with an experience in making a decision for the end-of-life for a relative or other people. Relationship with the patient (Please specify):

.....

() 3. A patient's relative without an experience in making a decision for the end-

of-life for a relative or other people. Relationship with the patient (Please specify):

.....

2. Age: years old.

3. Gender: () 1. Male () 2. Female

4. Marital status:

() 1. Single () 2. Married () 3. Widow/ Widower () 4. Divorced

5. Educational level:

() 1. No education /less than Primary education

() 2 Primary education or equivalent

() 3. Secondary education or equivalent

() 4. Associate degree or equivalent

() 5. Bachelor's degree or equivalent

() 6. Higher than bachelor's degree (Please specify)

6. Occupation:

() 1. Student (Please specify the level)

() 2. Seller/Vendor (Please specify)

() 3. Employee (Please specify)

() 4. Agriculturist (Please specify)

() 5. Government officer / State-enterprise employee (Please specify).....

.....

() 6. Other (Please specify)

7. Residence: ProvinceDistrict.....Sub-district.....

8. Income (Baht/month):

- () 1. Less than 5,000 () 2. 5,000 – 10,000
 () 3. 10,001 – 20,000 () 4. More than 20,000

9. Income sufficiency:

- () 1. Sufficient
 () 2. Insufficient (Please specify why)

10. Role in the family:

- () 1. Head of the family () 2. Member of the family

11. The number of family members (Please specify) persons

12. Health status:

- () 1. Healthy
 () 2. Unhealthy (Please specify the disease and the length of time that you have been sick)

13. History about admission in a hospital:

- () 1. Never
 () 2. Have been admitted (Please specify number of time) times

14. Experience in using life-sustaining treatment: a Ventilator, a defibrillator, receiving food and fluid through a tube, or receiving antibiotic intravenously.

- () 1. Never
 () 2. Yes (Please specify)
 () 3. Have seen others use them (Please specify)

15. Experience in making an end-of-life decision of a family member/ relative/

others:

- () 1. Never

() 2. Yes (Please specify)

() 3. Have seen others do it (Please specify)

16. Buddhist activities that you do in your daily life: (more than one answer is possible)

Buddhist activity	Regularly(1)	Sometimes(2)	Occasionally(3)	Never(4)
() 1. Offering food to a monk				
() 2. Going to a temple				
() 3. Praying				
() 4. Undertaking the precepts				
() 5. Making offerings to monks in general				
() 6. Meditating				
() 7. Others				
.....				
.....				
.....				

17. The importance of Buddhism to decision-making in your daily life:

() 1. It is important.

() 2. It is not important.

18. Buddhist doctrines that you use in your daily life or to hold on: (more than

one answer is possible)

- () 1. Being born, ageing, ailing and death are normal () 2. Rebirth
 () 3. Uncertainty, suffering, selfless () 4. Born for reparation
 () 5. Holding on to something is a cause of suffering () 6. Good and bad deeds
 () 7. The middle path
 () 8. Precepts, concentration, wisdom
 () 9. Others

19. From Question 18, the most important Buddhist doctrine that you use in your daily life is

Part 2: The Values Underlying End-of-Life Decision Interview Form

Explanation for recording data from an interview

This interview form is to find out about a decision-making and values or beliefs that are important to your decision-making about treatment to prolong life. The interview form will give meanings of types of treatment that prolongs life and stories about terminally-ill patients who have no chance of recovery at the end of their life. Please listen to the contents and stories as well as each of the questions. Then choose the one answer that corresponds with your opinion. Please feel free to choose the answer. You can always ask during the interview and you can reserve your rights not to answer any question that you cannot answer or feel uncomfortable answering. For those questions with “Yes” and “No” answers, you can choose the answer with the following criterion:

Yes means when you **agree** with the statement in that question.

No means when you do **not agree** with the statement in that question.

The life sustaining treatments consist of the following:

1. Cardiopulmonary resuscitation (CPR) refers to medical treatment by making the heart of a patient whose heart has stopped beating to beat again. This consists of pumping the heart by pressing on the chest up and down rhythmically about 1-1.5 inches (see Illustration 1); inserting a tube in the windpipe to help ventilate the air (see Illustration 2); electric shocking to make the heart beat (see Illustration 3); and administering various types of drugs intravenously to make the heart system work and to circulate the blood (see Illustration 4).

2. Using a respirator refers to breathing with the help of a respirator. This is used with patients who cannot breathe enough by themselves or those who stop breathing. A plastic tube is inserted through the mouth or nose into the windpipe; the other end of the tube is connected to a respirator (see Illustration 5). The patient will have no voice when speaking and cannot take food and drink orally while being connected to the respirator. Periodic suction through the tube is necessary when there is phlegm in the respiratory tract.

3. Giving food and fluid using a medical method refers to a way of giving food and water to the patient through a tube that is inserted in the mouth or nose through the throat directly into the stomach of the patient (see Illustration 5) or by cutting through the abdomen in order to insert the tube directly into the stomach; or giving food and water through a tube. These methods of giving food and water to the patient are treatment to prolong the life of a patient who cannot take food and water by him/herself.

4. Treatment using intravenous antibiotics refers to treatment by giving antibiotic through the vein to prolong the patient's life in the case of a terminally ill patient with complications (see Illustration 5).

Vignette

Mr. A (for a research project participant who is a male) or Ms. B (for a research project participant who is a female) is a terminally-ill patient whose illness cannot be cured. Mr. A or Ms. B has suffered pain over the past year and high doses of painkiller have been administered to the patient regularly. Sometimes it is difficult for him/her to breathe gasping for breath. The patient's condition becomes worse and he/she cannot help himself/herself in doing his/her daily routines and has to be bedridden. It may be necessary for a tube to be inserted through his/her stomach to give food to him/her. Antibiotic probably has to be administered for complications such as lung infection. If Mr. A or Ms. B stops breathing and his/her heart stops beating, the doctor will help making his/her heart beat again and the patient will have to be on a respirator.

If you were Mr. A (for a research project participant who is a male) or Ms. B (for a research project participant who is a female), how would you decide about the treatments described above?

- () 1. Receiving treatment to prolong your life (Answer Questions 1-13)
- () 2. Refusing/terminating treatment that prolongs life (Answer Questions 14-30)
- () 3. Asking the doctor to make a decision (Answer Questions 31-36)
- () 4. Asking your family to make a decision (Answer Questions 37-43)
- () 5. Others (Please specify)

Questions for those who would decide to receive treatment to prolong life.

1. What type/types of treatment would you receive to prolong your life? (More than one answers is possible)

1. Resuscitations 2. Using a respirator
 3. Giving food and fluid through a tube
 4. Treatment with intravenous antibiotic drug

Why/Why not?

2. "Life is something valuable that we need to keep as long as possible." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?

3. "Death is suffering and loss." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?

4. "Fearing death/parting from our beloved/fearing loss." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?

.....

5. "There is hope for survival." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

() 1. Yes. () 0. No.

Why/Why not?

.....

6. "Responsibility for family or burden and duty." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

() 1. Yes. () 0. No.

Why/Why not?

.....

7. "Love, tie, and care that you have for your family and/relatives." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

() 1. Yes. () 0. No.

Why/Why not?

.....

8. You believe in results of past deeds, so "Live to make merits". Is this an important value or belief that would make you decide to receive treatment to prolong your life?

() 1. Yes. () 0. No.

Why/Why not?

.....

9. "Living to make reparations of the past deeds." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

10. "You cannot die yet because you have not returned the favors your parents have done for you." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

11. "Sacred things have said that it is not high time I died yet." Is this an important value or belief that would make you decide to receive treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

12. Other value that would make you decides to receive treatment to prolong your life.

.....
.....

13. (From Questions 2-12) The value that you think most important for you to decide to receive treatment to prolong your life are

.....

Questions for those who would decide to refuse/terminate treatment to prolong life.

14. “If I go on living, my life should be with good quality both physically and mentally. For example, living in the society happily and normally, able to think and decide for myself and able to help myself in doing my routines.” Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?

15. “If I have to leave this world, I will leave it peacefully and warmly amidst my close family and relatives which is a natural way without holding on or being tied on to medical apparatus.” Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?

16. “Leaving with human dignity such as receiving respect as a person, basic rights, decision-making and personal needs, and information.” Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?

17. “Being on medical apparatus and treatment to prolong life cause pain and suffering.” Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

18. "Living in the same condition as Mr. A/Ms. B is a heavy burden for family." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

19. "Receiving treatment to prolong life incurs a lot of expenses." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

20. "If I had to live in such a condition that I could not carry on my duty as Mr. A/Ms. B, dying to be reborn in a new condition would be better." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

21. "Everyone has to die. No one can avoid death." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

22. "The physical condition of Mr. A/Ms. B at the moment is all suffering." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?
.....

23. "Slowing down death by prolonging life with a physical condition that cannot carry on duty as before is impossible." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?
.....

24. "Understanding and accepting the truth that different parts of your body can no longer function naturally." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?
.....

25. "Being born, aging, ailing, and death depend on the person's past deeds; the end of merits, the end of past deeds." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

26. "The functions of the organs, in the case of Mr. A/Ms. B, are no longer in a normal condition according to the Dharma principles of the middle path." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

27. "Terminating treatment that prolong life in this case is not a sin because the body has come to the end-of-life." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

28. "Using medical apparatus to prolong life is a lack of consciousness and common sense; you may depart from this world with an unrest mind, without concentration and unable to recall good things." Is this an important value or belief that would make you decide to refuse treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

29. Other value that would make you refuse treatment to prolong your life:

.....
.....

30. (From Questions 14-29) The value that you think most important for you to decide to refuse treatment to prolong your life are

.....

Questions of those who would ask the doctor to make a decision about life-sustaining treatment.

31. "Respect or trust in the doctor's knowledge and competence" Is this an important value or belief that would make you ask the doctor to make a decision about treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?
.....

32. "Trust or confidence that the doctor would make a decision based on highest benefit for the patient" Is this an important value or belief that would make you ask the doctor to make a decision about treatment to prolong your life?

1. Yes. 0. No.

Why/Why not?
.....

33. "Death is frightening/loss/parting from the beloved ones; this makes me lack confidence about making a decision for myself." Is this an important value or belief that would make you ask the doctor to make a decision about treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

34. "There is hope that I will survive but I am not confident and I don't want to make a decision by myself." Is this an important value or belief that would make you ask the doctor to make a decision about treatment to prolong your life?

() 1. Yes.

() 0. No.

Why/Why not?
.....

35. Other value that would make you ask the doctor to make a decision about treatment to prolong your life:

.....

36. (From Questions 31-35) The value that you think most important for you to ask the doctor to make a decision about treatment to prolong your life are

.....
.....

Questions for those who would ask their family to make a decision about life-sustaining treatment.

37. "Trust or confidence that your family will choose the best thing for you." Is this an important value or belief that would make you ask your family to make a decision about treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

38. "Confidence in the love and good wishes from your family to you." Is this an important value or belief that would make you ask your family to make a decision about treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

39. "With the love and tie you have for your family make you want your family to take part in making a decision about treatment to prolong your life." Is this an important value or belief that would make you ask the doctor to make a decision about treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

40. "Death is frightening/loss/parting from the beloved ones; this makes me lack confidence about making a decision for myself." Is this an important value or belief that would make you ask your family to make a decision about treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

41. “There is hope that I will survive but I am not confident and I don’t want to make a decision by myself.” Is this an important value or belief that would make you ask your family to make a decision about treatment to prolong your life?

1. Yes.

0. No.

Why/Why not?
.....

42. Other value that would make you ask your family to make a decision about treatment to prolong your life:

.....

43. (From Questions 37-42) The value that you think most important for you to ask your family to make a decision about treatment to prolong your life are

.....
.....

Life-sustaining treatment Pictures*



Illustration 1: Cardiopulmonary resuscitation



Figure 36: Ventilation through Endotracheal Tube



Illustration 2: Intubation and ventilation through endotracheal tube



Illustration 3: Defibrillation



Illustration 4: Intravenous drugs



Illustration 5: Ventilator, Artificial nutrition and hydration, and Intravenous antibiotic therapies

* These are the decreasing-size pictures. Its real size was A4 (21x 29.75 cm.).

APPENDIX D

ADDITIONAL TABLE OF DATA ANALYSIS

Additional Table of Data Analysis

Table 21

Reasons of Each Value Underlying the Decisions of Thai Buddhists Who Decided to Forgo the Treatment at the End-of-life

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Prolongation of death is a sin (Sila, n = 109)	1. Doing against nature	31	28.4
	2. Producing of suffering	29	26.6
	3. Suffering of body	25	22.9
	4. Suffering to self and family	7	6.42
	5. Non-peaceful death	5	4.89
	6. Prolonging of suffering	4	3.67
	7. Prolongation of reciprocity to kamma	2	1.83
	8. Forgoing LST treatment is not a sin and killing	1	0.92
	9. Producing a sin to family	1	0.92
	10. Do not give any reason	14	12.84
Quality of death (n = 104)	1. Need of natural death	54	51.9
	2. Need of peaceful death	48	46.2
	3. Need of comfort death	32	30.8
	4. Not being in pain	16	15.38
	5. It should not be survived.	12	11.54
	6. Need to die among close up Person	6	5.78
	7. Need to die at home	5	4.81
	8. Can say farewell with		

Table 21 (continued)

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
	Relatives	2	1.92
	9. Do not give any reason	2	1.92
Prolongation of death is impossible (Anattata, n = 101)	1. It's an end stage of life.	55	54.5
	2. Natural law	23	22.8
	3. Impossible	7	6.9
	4. Human Body is impermanent	6	5.9
	5. It is no improvement	3	2.97
	6. No miracle	3	2.97
	7. Do not give any reason	7	6.9
Death is inevitable (Aniccata/ Impermanence, n = 98)	1. Everyone was born and should die finally	34	34.7
	2. It's a time to go	29	29.6
	3. Natural law	18	18.4
	4. Time of life is over	9	9.18
	5. Death is a common thing	9	9.18
	6. Death is a truth	3	3.06
	7. Human Body is impermanent	2	2.04
	8. Death is permanent	1	1.02
	9. Birth, aging, illness, and death are life cycle	1	1.02
	10. Do not give any reason	8	8.16
Free from suffering (n = 95)	1. Fear of pain and suffering	47	49.5
	2. Need to free from suffering	46	48.9
	3. Everyone who on LST is suffer	2	2.11
	4. Death is better than living with suffering	1	1.05

Table 21 (*continued*)

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Family burden (n = 93)	1. Do not need to gain burden to family	68	73.1
	2. Fear to make family suffer	30	32.3
	3. Family concern	16	17.2
	4. Family should be suffer	4	4.3
	5. Do not give any reason	2	2.2
Merit and sin (Law of Kamma, n = 90)	1. End of kamma	67	74.4
	2. According to Law of Kamma	10	11.1
	3. My living should produce a fate and a sin to descendents	1	1.1
	4. Time is over	1	1.1
	5. Do not give any reason	13	14.4
Attachment is the cause of suffering (Patikkasamuppada, n = 83)	1. Acceptance truth of life	42	50.6
	2. Prolongation of suffering	13	15.7
	3. A person who attach with something should be occupied by excessive thought	1	1.2
	4. Do not give any reason	29	34.9
Quality of life (n = 63)	1. Need an independent living	25	39.7
	2. Do not need to live with suffering	24	38.1
	3. Do not need a futile living	17	26.9
	4. Do not need to be a family burden	4	6.4
	5. Impossible to turn to normal Life	2	3.2
	6. Need a complete life	1	1.6

Table 21 (continued)

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Economic burden (n = 44)	7. Do not give any reason	2	3.2
	1. Waste	20	45.5
	2. Concern about increasing economic burden to family	9	20.5
	3. High expense	7	15.9
	4. Futility	5	11.4
	5. Having economic problem	3	6.8
	6. Losing or no family income	2	4.6
	7. Do not use any LST in order to save money	1	2.3
Human dignity (n = 41)	8. Do not give any reason	2	4.6
	1. Unaccepted to connect with numerous tubes	15	36.6
	2. Integrity from birth to death	12	29.3
	3. Let it be as nature	10	24.4
	4. Should be calm and comfort or no suffering leaving	8	19.5
	5. Individuality and need of person should be respect	2	4.9
All of body is suffering (Dukkhatta, n = 24)	6. Do not give any reason	1	2.4
	1. Using life-sustaining treatment is more suffer	10	41.7
	2. Living is suffering	3	12.5
	3. Do not need to gain body Suffering	2	8.3
	4. Using LST is a sin and a fate	1	4.1
	5. Do not give any reason	9	37.5

Table 21 (*continued*)

Values underlying End-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Death with consciousness (Samadhi, n = 12)	1. Peaceful death	5	41.7
	2. Can think of merit	4	33.3
	3. Meditative mind	3	25.0
	4. Do not have any obstruction to an conscious accumulation	2	16.8
	5. Enable to go to good future existence	2	16.8
	6. Do not give any reason	2	16.8
Rebirth (Panca-khandha, n = 6)	1. Living is suffering	3	50.0
	2. Rebirth is better	2	33.3
	3. Do not give any reason	2	33.3
The Middle Path (Majjhima-patipada, n = 3)	1. Four elements of a body is degeneration.	1	33.3
	2. Do not give any reason	2	66.7
Do not specify other values	-	-	-

Table 22

Reasons of each Value Underlying the Decisions of Thai Buddhists Who Decided to Continue the Treatment at the End-of-life

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Hope (n = 41)	1. May be possibly to survive	28	68.3
	2. Still need to live	6	14.6
	3. Hope to have a miracle	4	9.8
	4. Had experience about surviving patient by a doctor	4	9.8
	5. Do not give any reason	1	2.4
Life is valuable (n = 38)	1. Need to survive as long as possible	23	60.5
	2. Need to do the most benefit	2	5.3
	3. Life is the most important	2	5.3
	4. Life loving	1	2.6
	5. An adult children want me to live with them so long	1	2.6
	6. Do not give any reason	9	30.0
Family concern (n = 31)	1. Worried about his or her descendant	17	54.8
	2. To be in love with family	16	51.6
	3. Wait for seeing a success of his or her descendant	5	16.1
	4. Still need to live with family	4	12.9
	5. Give a chance for family mind preparation	2	6.5
	6. Do not give any reason	1	3.2
Responsibility (n = 23)	1. Family burden responsibility	23	100

Table 22 (continued)

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Fear of death or loss from death (n = 21)	1. To be separated from lover and significant others	12	57.1
	2. Don't need to die	6	28.6
	3. Worried about his or her descendant	5	23.8
	4. Fear of suffering	2	9.5
	5. It's a nature	1	4.8
	6. Self loving	1	4.8
Gratitude and reciprocity (n = 8)	1. Need to live for parent care	5	62.5
	2. Never live with the parent	1	12.5
	3. No opportunity to help the parent formerly	1	12.5
	4. Do not give any reason	2	25.0
Belief in supernatural power (n = 7)	1. Believe it	4	57.2
	2. Possibly to survive	2	28.6
	3. Had experience about it	1	14.3
	4. Do not give any reason	1	14.3
Doing good receiving good (n = 6)	1. Need to live for making merit	3	50.0
	2. Making merit in the past was not enough	2	33.3
	3. Do not give any reason	1	16.7

Table 22 (*continued*)

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Reciprocity to kamma (n = 1)	1. Believe about Law of Kamma	1	100.0
Don't specify other values	-	-	-

Table 23

Reasons of each Value Underlying the Decisions of Thai Buddhists Who Allowed a Physician to Make the Decisions for Them

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Respect for physician (n = 38)	1. Trust in the physician's knowledge and competence	33	86.8
	2. Confide that the physician would help a patient with his all competence	22	57.9
	3. Trust in the physician's experience	4	10.5
	4. Had experience about surviving patient by a doctor	2	5.3
Hope (n = 34)	1. Hope to survive	28	82.4
	2. Hope to have a miracle	2	5.9
	3. Hope to survive accidentally	1	2.9
	4. Do not give any reason	3	8.9
Death is loss (n = 9)	1. Fear to die	4	44.4

Table 23 (continued)

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
	2. Do not know where we go after death	2	22.2
	3. No confidence for self end-of-life decision	2	22.2
	4. Death is terrible	1	11.1
	5. Do not give any reason	1	11.1
Do not specify other values	-	-	-

Table 24

Reasons of Each Value Underlying the Decisions of Thai Buddhists Who Allowed Their Family to Make the Decisions for Them

Values underlying end-of-life decision	Reasons of the value underlying the decisions	Frequency	Percentage
Respect for family (n = 22)	1. Confide in the family's decision	12	54.6
	2. The family know what we need	7	31.8
	3. The family love and has a good wish for us	7	31.8
	4. I and my family love each other	2	9.1
	5. Do not give any reason	2	9.1
Family concern (n = 21)	1. Close up more than others	8	38.1
	2. Love and attachment with the family	8	38.1
	3. Care for family's feeling	5	23.8
	4. Family has all right because of their nurture to me	2	9.5
	5. Do not give any reason	2	9.5
Hope (n = 8)	1. Hope to survive	7	87.5
	2. Do not give any reason	1	12.5
Death is loss (n = 6)	1. Separation from loved ones is terrible.	4	66.7
	2. Do not need to think of or meet a death.	1	16.7
	3. Do not give any reason	1	16.7
Do not specify other values	-	-	-

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Manasurakarn, J. (2003). *Values underlying end of life decisions in Thai Buddhists: scale development and psychometric evaluation*. Proceeding of the Twelfth Nursing Academic National Congress, The Nurses' Association of Thailand, Bangkok, Thailand.

Thaniwattananon, P., Herunchunha, S., & Manasurakarn, J. (2002). *Alternative health care methods used by family and patients with head or spinal cord injuries*. Proceedings of the Fifth Nursing Academic International Congress, Faculty of Nursing, Khon Kaen University, Khon Kaen, Thailand.