# Life Journey of Death Acceptance in Thai Buddhist Older Persons with Advanced Chronic Organ Failure

**Tusanee Khaw**

**A Thesis Submitted in Partial Fulfillment of the Requirements for the Degree of**

**Doctor of Philosophy in Nursing (International Program)**

**Prince of Songkla University**

**2019**

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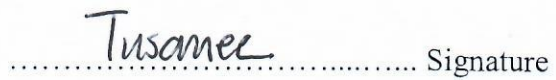

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| **ชื่อวิทยานิพนธ์** | การเดินทางไปสู่การยอมรับการตายในผู้สูงอายุไทยพุทธที่เจ็บป่วยด้วยโรคอวัยวะล้มเหลวแบบเรื้อรังในระยะก้าวหน้า |
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## บทคัดย่อ


การวิจัยครั้งนี้มีวัตถุประสงค์ในการค้นหากระบวนการเดินทางไปสู่การยอมรับการตายในผู้สูงอายุไทยพุทธที่เจ็บป่วยด้วยโรคอวัยวะล้มเหลวแบบเรื้อรังในระยะก้าวหน้าโดยใช้วิธีการวิจัยแบบการสร้างทฤษฎีรากฐานจากผู้ให้ข้อมูลที่เป็นผู้ป่วยนอกในภาคใต้ จำนวน 16 ราย โดยมีเกณฑ์ในการเลือกผู้ให้ข้อมูล ดังนี้ 1) ผู้สูงอายุที่นับถือศาสนาพุทธที่มีอายุมากกว่า 60 ปีขึ้นไป 2) ได้รับการวินิจฉัยด้วยโรคอวัยวะล้มเหลวแบบเรื้อรังในระยะก้าวหน้า ประกอบด้วย โรคหัวใจวายที่มีระดับการทำงานของหัวใจในระดับ 3 และ 4 โรคไตวายเรื้อรังระยะที่ 5 หรือไตวายระยะสุดท้าย และปอดอุดกั้นเรื้อรังที่มีความจำเป็นต้องเข้าโรงพยาบาลซ้ำจากอาการกำเริบของโรคมากกว่า 3 ครั้ง/ปี 3) มีระดับความรู้สึกตัวอยู่ในระดับดี 4) มีความพร้อมและอารมณ์ทางบวกในการพูดคุยเรื่องความตายได้ 5) เป็นผู้ที่ไม่ได้รับการรับประทานยาคลายวิตกกังวลหรือซึมเศร้า และ 6) รับรู้ว่าตนเองสามารถยอมรับความตายของตนเองได้ โดยเก็บรวบรวมข้อมูลและวิเคราะห์ข้อมูลตามขั้นตอนของสทรอลและคูบินส่งเสริมความน่าเชื่อถือของผลการศึกษาด้วยวิธีการของลินคอนและคูบา

ผลการวิจัยพบว่าการกระบวนการเดินทางไปสู่การยอมรับการตายในผู้สูงอายุไทยพุทธที่เจ็บป่วยด้วยโรคอวัยวะล้มเหลวแบบเรื้อรังในระยะก้าวหน้าประกอบด้วย 4 แนวคิด คือ 1) การต่อรองความตาย ประกอบไปด้วย 3 แนวคิดย่อย คือ 1.1) นึกถึงความตายของตนเองแต่ไม่พร้อมที่จะตาย 1.2) ทำกิจกรรมเพื่อคงไว้ซึ่งสุขภาพของตนเอง และ 1.3) หวังเพื่อให้ตนเองมีชีวิตยืนยาว 2) การขจัดความกลัวตาย ประกอบด้วย 3 แนวคิดย่อย 2.1) ตระหนักว่าความตายเป็นเรื่องหลีกเลี่ยง

ไม่ได้ 2.2) ทำใจ: สะท้อนให้ประจักษ์ถึงความตายของตัวเอง และ 2.3) ยอมรับความเป็นจริงของชีวิตและความตายโดยทั่วไป 3) การทำให้ตนเองสามารถอยู่กับความตายของตนเองที่กำลังจะเกิดขึ้น ประกอบ 3 แนวคิดย่อย 3.1) ทำความเข้าใจความตายของตนเองตามความเชื่อของศาสนาพุทธ 3.2) นำความเชื่อพุทธศาสนาที่เกี่ยวข้องกับความตายมาใช้ปฏิบัติในชีวิตประจำวัน และ 3.3) ยอมรับความตายของตนเองได้ และ 4) การก้าวผ่านไปสู่การยอมรับการตายตนเองที่จะเกิดขึ้น ประกอบด้วย 3 แนวคิดย่อย 4.1) อยู่อย่างมีสติและจิตใจสงบ 4.2) การเตรียมเพื่อไปสู่การความตายอย่างสงบ และ 4.3) อยู่อย่างสมดุลอยู่อย่างมีคุณภาพชีวิตและการตายที่ดี

ผลการวิจัยแสดงให้เห็นความสัมพันธ์ของ ปัจจัยที่ทำให้เกิดการยอมรับความตาย วิธีการเดินทางไปสู่การยอมรับการตายด้วยศาสนาพุทธ และผลลัพธ์ของการยอมรับการตาย ซึ่งบุคลากรทางสุขภาพโดยเฉพาะพยาบาลสามารถนำองค์ความรู้ดังกล่าวไปใช้ในการส่งเสริมให้ผู้สูงอายุไทยพุทธที่อยู่ด้วยโรคอวัยวะล้มเหลวแบบเรื้อรังในระยะก้าวหน้าสามารถยอมรับการตายของตนเอง โดยอาศัยวิธีการทางพุทธศาสนา เพื่อส่งเสริมให้ผู้สูงอายุตายอย่างสงบต่อไป โดยเฉพาะผู้สูงไทยพุทธที่อยู่ด้วยโรคอวัยวะล้มเหลวแบบเรื้อรังในระยะก้าวหน้า ผลการศึกษาดังกล่าวสามารถนำไปทดสอบกระบวนการ รูปแบบการยอมรับการตาย และพัฒนาทฤษฎีจากองค์ความรู้ดังกล่าวต่อไป

**Thesis Title** Life Journey of Death Acceptance in Thai Buddhist Older Persons with Advanced Chronic Organ Failure

**Author** Miss Tusanee Khaw

**Major Program** Nursing (International Program)

**Academic Year** 2018

## ABSTRACT

This study purposed to discover the process of death acceptance in Thai Buddhist older persons with advanced chronic organ failure. Grounded theory was used as a method of the study. Sixteen Thai Buddhist older persons with advanced chronic organ failure in out-patients in the South of Thailand were the participants. Inclusion criteria included 1) Aged more than 60 years old and belief in Buddhism religion; 2) Diagnosed with advanced chronic organ failure such as congestive heart failure functional class III/IV, end stage of renal disease, and chronic obstructive pulmonary disease and readmitted to the hospital more than three times per year due to exacerbation; 3) Have normal levels of consciousness and not taking anxiety and depression medications; 4) Ready to talk about death by showing positive emotions when hearing about death and confirmed the accepting of own death. Data were analyzed and systematized using Strauss and Corbin's approach. Trustworthiness of the study was established following Lincoln and Guba's criteria.

This study discovered that the process of death acceptance in Thai Buddhist older persons with advanced chronic organ failure consisted of four stages: 1)

Negotiating of their own death, included 3 sub-categories*; recognizing their own death but not ready to die; taking actions to maintain health; hoping for longer life.*; 2) Neutralizing fear of death, consisted of 3 sub-categories; *realizing that death is inevitable, tamjai: reflecting their own death, and accept the truth of life and death.*; 3) Affirming their impending death, consisted of 3 sub-categories of *mobilizing Buddhist faith, engaging in religious practices, and accepting their own death.*; and 4) transcending of death acceptance, consisted of 3 sub-categories: *having mindfulness and being in a peace of mind, preparing a peaceful death*, *and living-well and dying-well.*

The findings of this study showed the relationship components of the conditions, actions, and the consequences of death acceptance. Healthcare providers can implicate the process of death acceptance to develop a program to enhance death acceptance based on Buddha's teaching to promoting a peaceful death for patients especially in the older persons with advanced chronic organ failure. Future study should be a testing of this process or model of death acceptance to develop a formal theory.

## ACKNOWLEDGMENTS

I would like to express my grateful to all those who have supported me for my life journey to successful in PhD program. These people could be great assistance and encouragements for my completion in thesis writing task.

First of all, I would like to express my deep gratitude to my major advisor and co-advisor, Associate Professor Dr.Kittikorn Nilmanat, Assistance Professor Dr. Pleonpit Taniwattananon, and Associate Professor Dr.Waraporn Kongsuwan whose encouragement, guidance and support from the initial to the final level enabled me to develop an understanding of the subject and successful. I would like to express my very great appreciation to for their valuable and constructive suggestions during the process of analyzing and development writing the result. Their willingness to give their time so generously has been very much appreciated.

I am particularly grateful Professors Wilfred McSherry, Department of Nursing School of Health and Social Care, Faculty of Health Sciences, Staffordshire University, who give offering to be supervised for me to undertake a period of supervision at an overseas university. He was a good guidance for me to exchange experience in grounded methodology. He provided available time and gives numerous consultations for my experience between being in oversea.

I would like to acknowledge the dissertation examining committee members, Assoc. Prof. Dr. Aranya Chaowalit, Prof. Dr.Rozzano C.Locsin, and Assoc. Prof. Dr. Karnsunaphat Balthip for their comments, guidance, and suggestions.

I would like to thank my Faculty of Nursing and Prince of Songkla University for the opportunity to study in the Ph.D. program and providing funding support for my study. I also greatly appreciate funding support from the Graduate school, Prince of Songkla University.

I wish to thank patient who were my participants this study, for their help in giving the data in collecting the data process and they could help me to fulfillment the result of the study.

I am indebted to my colleagues, friends, and others academic staff in my faculty have made valuable cheerful during the leaning process which gave me an inspiration to improve my thesis.

Importantly, the completion of this dissertation would not have been possible without the encouragement and support of my family, my lovely parents, my brother, my sister, my daughter, my husband, and my relatives for their assistance, and their supports, throughout my study. They have been source of strength and support during Ph.D. journey. Lastly, I offer my regards and blessings to all of those who supported me in any respect during the completion of the project.

Tusanee Khaw

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# CHAPTER 1

# INTRODUCTION

## Background and Significance of the problem

Improving the medical care and successful promotion and prevention has resulted in a vast increase in the life expectancy of the population in the previous years. Nowadays, the percentage of elder people aged 60 years or over has increased from 9.2 percent in 1990 to 11.7 percent in 2013 and will continue to grow as a proportion of the world population, reaching 21.1 percent by 2050. Increasing longer life expectancy in the older persons is associated with the prevalence of an increasing rate of chronic illnesses as the major cause of disability and most common cause of death worldwide (United Nations, 2013). In Thailand, it is stated that the number of older persons over 60 years old has been increasing every year (Bureau of Heath Policy and Strategy, 2014). In the next twenty years Thailand is expected to be engaging in an aged society (Office of the National Economic and Social Development Board, 2015). It is interesting to note that heart diseases, chronic lung diseases, and renal disease not only are the top ten major causes of chronic illnesses but also are the cause of death in the Thai older populations (Bureau of Heath Policy and Strategy, 2014).

Murray, Kendall, Boyd, and Sheikh (2005) mentioned that congestive heart failure (CHF), chronic renal failure (CRF), and chronic obstructive diseases (COPD) are grouped in chronic organ failure trajectory. The characteristic of patients in this

trajectory usually remain uncertain from fluctuations of the disease for many months or years and they will confront occasional acute, often severe phases, and exacerbation that can lead to death at any time than other trajectories (Cortis & Williams, 2007; Leary, Murphy, Loughlin, Tiernan, & McDonald, 2009). Trajectory illness and trajectory phases in patients will be different in terms of the physical and psychological problems, conditions, and goal of care. Significantly, changes in the trajectory phase of illnesses relate to changes in both the perception of death and the death acceptance in the older persons with chronic organ failure (Corbin & Strauss, 1991; Murtagh, Murphy, & Sheerin, 2008). After the older persons had been diagnosed with advanced chronic organ failure the majority of patients had initial an emotional response such as shocked and uncertainty from their disease (Schell, Patel, Steinhauser, Ammarell, & Tulsky, 2012). Throughout the treatment processes the elderly with chronic organ failure have to confront active treatments, and co-morbidities, these can lead them to psychological burdens (Douglas, 2014) such as anxiety, depression, and a poorer quality of life than that of cancer trajectory (Leary et al., 2009), and physical burdens (Janssen, Spruit, Wouter, & Schols, 2008; Howlett, 2011). The experience of a high symptom burden in both mental and physical will impact negatively with their spiritual well-being and quality of life (Davison & Jhangri, 2010; Douglas, 2014; Strada, Homel, Tennstedt, Billings, & Portenoy, 2013). Patients had a fear of dying as the cause of stress (Yodchai, Dunning, Hutchison, Oumtanee, & Savage, 2011). In addition, the influence on their overall quality of life led many older persons to consider suicide (Molzahn, Sheilds, Bruce, Stajduhar, Makaroff, Beuthin, & Shermak, 2012). Characteristic of thoughts on death in this phase are looked on as a relief from the symptom distress in older persons (Stromberg

& Jaarma, 2008; Yodchai, et al., 2011; Molzahn et al., 2012). Moreover, the transition from advanced chronic organ failure and a worsening condition of their disease to end of life stage in these patients can be a confusing and traumatic time not only in the older persons but also on their caregivers (Seymour, Kumar, & Froggatt, 2010; Grant, Cavanagh, & Yorke, 2012).

Furthermore, when elderly patients have been withdrawn from treatment due to the progression of their condition, to symptoms gradually getting worse, and to the progressive deterioration of their bodies, these patients had confronted the different thoughts on death and dying (Axelsson, Randers, Hagelin, Jacobson, & Klang, 2012; John & Thomas, 2013; Nguyen, Chamber-Evans, Joubert, Drouin, & Ouellet, 2013; Stajduhar & Makaroff, 2012). Molzahn et al. (2012) conducted a study focused on perceptions regarding death and dying of individuals with chronic kidney disease, they found that there were older persons both living with the fear of dying and accepting death as a very real consequence of renal failure. In addition, when the elderly with heart failure had advanced stages of the disease, they thought about death fearfully, death as a relief from symptoms, and death as a natural part of life (Strombege & Jaarsma, 2008). In addition, some older persons had been aware that his/her death is near and courage to accept their own death (Axelsson et al., 2012; Nguyen et al., 2013).

A current study found that some older persons would like to be informed of their prognosis and to discuss death and dying whenever patients' illnesses became life threatening. However, some older persons with advanced chronic organ failure were alone with their thoughts on death because they had been difficult to talk about death with their families and healthcare providers (Axelson et al., 2012). Similarity,

Thai older persons wound like to discuss their living will and decision to treat in their end of life by themselves (Sriyodchat & Hutterat, 2014). Thai elderly was reported that they need to be well prepared for their death because they wish to die with dignity and die in peace (Rodpal, Kespichayawattana, & Wisesrith, 2007). There are also reported decisions by family members and doctors that may not be related to the wishes of older persons (Chatkeaw, 2013; Suwanil, 2012). Although, in Thailand there is an implication of policies related to the right to die at the end of life in the Thai National Health Act legislation in B. E. 2007. Section 12 of the Act for decrease the suffering in Thai patients (The National Health Commission Office, 2007), Thai older persons are treated by life sustaining treatment because they are close to be out of knowing their diagnosis (Tongprateep, 2014). Furthermore, a literature published both in Europe and in Asia about palliative care for the elderly, have founded that palliative care was provided for only in the older persons with advanced stages of cancer (Cheng, Lo, & Woo, 2010; Matsui, 2010). Most of palliative care interventions had been highlighted both physical and emotional burden (Tamura & Cohen, 2010). There are also few studies that had related with the meaning and factor of death acceptance but it was not specific to the older persons with advanced chronic organ failure (Upasen & Thanasilp, 2018; Krapo, Thanasilp, & Chimluang 2018). Moreover, it has been reported that late referral palliative care is not beneficial for older persons because those older persons cannot discuss an advance directive care plan, there are limits in providing comfortable care (Auer, 2008), an inadequacy to alter the quality of their life (Harris et al., 2011), and an increase in the cost of treatment due to the failure to treat (Colla, Morden, Skinner, Hoverman, & Meara, 2012).

Death acceptance is an important factor contributing to communication about older person's wishes and death between healthcare providers and older persons (Axelson et al., 2012), and it facilitates psychological preparedness, and a peaceful death in the dying stage (Lokker, Carin, & Heide, 2012; Zimmerman, 2012). Moreover, there are reports that death acceptance is an important factor to starting point for the discussion, an advance directive care plan in older persons with chronic organ failure (Nguyen et al., 2013). It can be decreased being alone with existential on death in older persons from difficult to talk about death with their families and healthcare providers (Axelson et al., 2012). In addition, at least two studies reported that patients who lived with the denial of death or the fear of death were a major barrier in the discussion of an advanced care plan (Curtis, 2008; Glass & Nahapetyan, 2008). The death acceptance is imminent and will increase awareness and prepare them for dying in the end of life stage, led to a readiness for death (Lokker et al., 2012; McLeod-Sordjan, 2013), contribute to dying according to the patients wish (Detering, Hancock, Reade, & Silvester, 2010; Pautex & Zulian, 2011), and enhance dying with dignity and autonomy (McLeod-Sordjan, 2013; Zimmerman, 2012). In addition, another report said that the older persons who could accept that their death is imminent would prepare them for their death (Taniwattananon, Isaramalai, & Naka, 2015).

However, accepting death mostly depends on cultural and religious beliefs (Conner et al., 2010; Wong, Recker, & Gresser, 1988). In Thailand, 93.5% of population is Buddhist (National Statistical Office, 2018), so thoughts on death in Thai society in general are based on the Buddhist doctrine. Buddhist beliefs have positive effects in death acceptance in Thai older persons (Krapo et al., 2018).

Buddhist philosophy views birth, ageing, sickness, and death as both the reality of nature life and impermanence of life (Dhammananda, 1987; Payutto, 1995). All patients need to confront the experience of death because death is certain for everyone and an integral part of life. Buddhist principles can lead older persons to gain an understanding of the nature of life, of non-attachment or a peaceful mind, acceptance of death, and a peaceful death in the dying stage (Kongsuwan, Keller, Touhy, & Schoenhofer, 2010; Somanusorn, 2009). In addition, families usually tie their anticipated grief into their belief of karma and they are aware of the impermanence of life (Nilmanat & Street, 2007). Thai older persons who understand that death is a natural part of life usually do not want to follow aggressive treatment, and want to plan an advanced directive by themselves (Sriyodchat & Hutterat, 2014). Thai older persons will prepare for their death by reading the religious books related to their beliefs to prepare their mind to accept their death and that death is imminent and it is not uncertain (Rodpal et al., 2007). Moreover, Thai Buddhist older persons who decided to forgo life sustaining treatment decided this because they believed that birth, aging, pain, and dying are a normal part of life. It is useless to prolong life, and they needed peaceful death (Rukchart, Chawalit, Suttharungsee, & Parker, 2014). Similarly, in a study with older Singaporeans who perceived that Buddhism is an important component to advocate for understanding the natural death, being spiritually prepared for death, and helped them to denial to be on life support at the end of their life (Malhotra, Chan, Kyung, Malhotra, & Goh, 2012). Although, the situations of death can lead to suffering for all humans, suffering from a death sentence can be realised by following the Buddhist principle to consider that death is a natural part of life (Masel, Schur, & Watzke, 2012). Significantly, all of the studies

did not explore the process how older persons went onto accepting their death through Buddhist ways both in older persons with cancer and anvanced chronic organ failure.

This study used grounded theory to describe the process of the death acceptance in Thai Buddhist older persons with advanced chronic organ failure. Symbolic interactionism was underpinning the method of grounded theory to understand the patient's exhibition of some specific behaviors and interaction with other persons. Discovering the death acceptance process have various use for the older persons with advanced chronic organ failure such as to prepare them for dying in the end of life stage, contribute to dying according to the patients wish, enhance dying with dignity and autonomy, and to die in peace. In addition, death acceptance process has result in enhance the confidence of health care provider to communicate about death with older persons and their families. In addition, knowing the death acceptance process will contribute to the health care palliative policy in Thailand in part of movement advanced directive care plan and enhance peaceful death in older persons.

**Objective of the Research**

To describe the process of death acceptance among Thai Buddhist older persons with advanced chronic organ failure.

**Research Questions**

The main research question in this study was how was the process of death acceptance experienced by Thai Buddhist older persons with advanced chronic organ failure.

**Framework of the study**

The framework of this study was based on Buddhist philosophy related to death acceptance as following details;

**Buddhist philosophy**

Buddhism highlights that the human being will not suffer if humans can understand the nature of the reality of life and death. Understand about the truth of human life which can decrease the illusion of a permanent self, and the attachment to any mental or material state in a person (Dhammnanda, 1987). Understanding about the reality of human life consists of the four noble truths, the law of *kamma* or Karma, the nature of existence or *tri-lukkhana*, and the five aggregates of life (Dhammananda, 1987; Payutto, 1995).

The four noble truths are the core essence to emphasize the true nature of life in Buddhism. The suffering (*Duhkha*); the suffering will be occurred throughout 1.1) corporeality (*rupa-dhamma*) consist of body and behavior of the body, 1.2) feeling and sensation (*vedana*), 1.3) perception (*sanna*) such as emotion or mood, 1.4) mental formations (*sankhara*) are psychological compositions that the mind making is good, bad, and neutral, and 5) consciousness (*vinnana*) is being aware of sensation via the six senses such as seeing, hearing, smelling, tasting, physical touching, and mental touching. The five aggregates are the sensation of the human body and are the essential elements of life (Payutto, 1995) or we can call being (*satta*). Whenever, the five aggregates have the objects of attachment, human beings will have *dukkha* or suffering. The cause of suffering (*Samudaya*) can begin from ignorance, anger, and attachment. There are eight kinds of causes of suffering common to all human life or

human beings such as birth, aging, illness, death, separation from love ones, being with people we dislike, desiring things we cannot have, and mental irritation (Dhammananda, 1987; Payutto, 1995). The cessation of suffering (Nirodha: Nirvana) is eliminating the root of suffering by non-attachment or to understand and realize the truth of life, and it a state of being free from all delusions, defilements, and suffering. The path for the cessation of suffering (*Marga*); the noble eightfold path is the ways to achieving freedom from suffering based on three elements cover 4.1) morality (*shila*) consists of right speech, right action, and right livelihood, 4.2) concentration (*Samadhi*) or meditation consists of right effort, right mindfulness, and right concentration, and 4.3) wisdom (*panna*) consists of right view or right understanding, and right thought or right aspiration (Dhammnanda, 1987; Masel et al., 2012).

In addition, Buddhism states that human being is related to *Kamma*. Buddhism believes that everything is a result of acts in previous lives. *Kamma* refers to acting or doing and if whoever is acting in a good way, the consequence will result in a good outcome. In addition, in the language of science belief says that *kamma* is the law of cause and effect. *Kamma* is the result of our action as one of the factors which is responsible for the success and the failure of our life and next life (Dhammananda, 1987). Moreover, Buddhists' views about life after death are that the state of mind at the time of dying can allow patients to go on to have a good rebirth (Khadro, 2013; Willkins, Mailoo, & Kularate, 2010). At the time of death, the mind must be alert so as to allow humans to be continuously reborn (Chan, Poon, & Hegney, 2011).

For Nature of existence, nature of existence is born from the integration of many elements and all things exist in a constant flow or flux. The Buddha has explained the three characteristic of existence as the universal characteristic of all

things and consists of 1) *aniccata* means impermanence, instability, and uncertainty. All things can occur and can extinguish 2) *dukkhata* is a state of suffering, the cause of *dukkha* for the persons are to desire things with attachment, 3) *anatta* means all phenomena are not the self, no real essence (*anatta*) (Payutto, 1995). Death is viewed as the impermanence of life, which is undeniable, inescapable, unavoidable, and a natural part of life. Teaching about impermanence of life is important in Buddhist Philosophy (Chan et al., 2011; Masel et al., 2012; Shubha, 2007). All humans will certainly die because death is a natural part of existence but the time of death is not certain (Khadro, 2013; Willkins, Mailoo, & Kularate, 2010).

Preparation of death by Buddhist practice is a central feature in Buddhism because it is an important factor for understanding physical, perception, and metal phenomena leading to a peaceful mind and alertness in the dying state (Chan et al., 2011). Thai older persons who have perception and understanding related to Buddhism will easily accept death in regards to both their own death and their loved one's death. From the literature review, it was found that the teachings of the four noble truths lead patients to have an understanding of what the true problems that people face are, and then, to be in the present, to always be aware and conscious of death, as no one can live forever (Chiaranai, 2014). Patients with advanced cancer perceived that Buddhism could help them to understand the reality around them and transcend the stresses and suffering in their life (Miccinesi, Bianchi, Brunelli, & Borreani, 2012). In addition, understanding the natural existence can influence both the death acceptance and decisions in the end of life in patients with chronic illnesses. Thai Buddhists with chronic illnesses who make the decision to forgo life sustaining treatment when their illnesses are diagnosed to be terminal find that the Buddhist

teachings can emphasize for them an understanding that death is a natural part of life, and prolonging death is impossible (Manasurakarn et al., 2008; Rukchart et al., 2014).

The majority of patients had expressed the Buddhist way by depending on their religious beliefs to confront their illnesses and their death. Buddhism has vital factors for decision making in daily life in the patients with chronic illnesses such as making merit or *Thum-boon*, going to the temple, following the middle path, offering food to the monks, praying, following *sila* and good moral conduct and practicing meditation (Manasurakarn et al., 2008). Meditation practice can enhance the balancing agent of the body and mind, promote self-healing, and help patients to develop the wisdom to understand the reality of life in cancer patients (Baehr, 2009; Sungsing, Hatthakit, & Aphichato, 2007). Thai Buddhist patients perceived that religious practice can release distressing symptoms and calm the mind, release stress, and help in managing body control (Supoken, Chaisrisawatsuk, & Chumworathayi, 2009; Temtap & Nilmanat, 2011).

From the application of Buddhist beliefs in nursing practice such as performing good acts and thoughts (Kongsuwan & Locsin, 2009), caring with merit, caring based on the belief of *kamma*, being caring for *Sati* or consciousness, and being spiritual and faithful in the *Dharma* for patients in the end of life stage can enhance those patients to non-attachment, to find peace of mind, feel that they are going to go to a good place, and have a peaceful death (Kongsuwan & Locsin, 2009; Somanusorn, 2015). Moreover, the application of Buddhist religion through religious activities made them feel more peaceful and they came to accept the truth that death is universal (Kwankhao & Boonmongkol, 2013). Although Thai patients with end stage renal failure had depression, stress, and suicidal thoughts as dominant psychological

problems between the hemodialysis processes, Buddhist beliefs helped them to understand the value of life and to reflect that suicide is not the right path in their life (Yodchai et al., 2011). Accepting death as the life process of a patient's life can be a useful time for learning and gaining insight into the true nature surrounding us. Importantly, accepting death will enable us to be free from suffering, have a peaceful state of mind, and go onto have good rebirths (Dhammananda, 1987; Payutto, 1995).

## Definition of Key Terms

### Older persons with advanced chronic organ failure

Older persons with advanced chronic organ failure refers to the patients aged more than 60 years old and have been diagnosed with in an advanced stage of illness and they had confronted with their near death experienced. These older persons have lived with long term limitations with intermittent bouts of serious illnesses that consist of congestive heart failure (CHF) stage III-IV, chronic renal disease (CRF) stage V or end stage of disease (ESRD), and chronic obstructive pulmonary disease (COPD) and who need to be readmitted to hospital more than three time per year from exacerbations.

### Life journey to death acceptance

Life journey to death acceptance refers to the ongoing process of death acceptance among Thai Buddhist older persons with advanced chronic organ failure. The process covered the domains of conditions to enhance accepting their death, strategies to confront with their impending death until they can overcome to death

acceptance and the consequences after among Thai Buddhist older persons with advanced chronic organ could accept their death.

**Significance of the Study**

Understanding the process of death acceptance in Thai Buddhist older persons with advanced chronic organ failure will contribute to both new knowledge development in nursing, and to the provision of high quality end of life care in the elderly with advanced chronic illnesses.

New knowledge from this study can fill the gap of knowledge in the empirical science of nursing. Although there have been reports of Buddhist teachings/Buddhist beliefs positively relating to death acceptance among Thai patients, most of the reports have not demonstrated the process of death acceptance through Buddhism. This result can extend the knowledge base to the group of patients with advanced chronic organ failure because the past of studies were mostly reported in cancer patients. Moreover, the process of the death acceptance in the context of Thai Buddhist older persons with advanced chronic organ failure can show the relationship of the conditions, actions, and consequences of the death acceptance. Therefore, the results of this study can be knowledge based to test the hypothesis in future research and develop a formal theory of death acceptance.

Moreover, the result will be useful for healthcare providers to develop palliative care programs to enhance death acceptance for both older persons and their families based on Buddhist practices to decrease feelings of uncertainty and suffering, to increase well-being or quality of life, and to allow the patient to have a peaceful death in the end of life stage. In addition, the study can promote a peaceful death for

older persons because being able to accept their impending death will result in both preparing for their death and managing final arrangements. Having the chance to discuss advanced directive care plans can result in reduced grief and the feeling of loss in families because death acceptance encourages patients and their families to plan for death preferences in regards to management of care.

For the provision of high quality end of life care, the results can be the ideas for nurses by using the attributes of accepting death to assess the competency of death acceptance in patients before starting any discussion about a patient's death and his/her wishes at the end of his/her life. The usefulness of the study will promote the success of living wills or the Patient Self Determination Act (PSDA). It can provide an advanced care plan or living will for Thai older persons while they have the capacity to do so. In addition, the result will be useful for extending the ethic principle of respecting autonomy and dying with dignity because patients who accept their death will die with their wishes fulfilled. Moreover, the conflicts in regards to the preferences of others both from families and healthcare providers will be decreased when older persons can die according to their wishes. Importantly, if older persons accept their death this will result in decreases hospital costs for patients' families and the government insurance companies because older persons who had been preparing for their death mostly select to forgo sustaining treatments in the end of life stage.

# CHAPTER 2

# LITERATURE REVIEW

This chapter is presented in four main parts consisting of 1) older persons with advanced chronic organ failure, 2) acceptance of death, 3) life and death in Buddhists' views, and 4) grounded theory.

**1) Older persons with advanced chronic organ failure**

1.1 Older persons with advanced chronic organ failure trajectory

1.2 Health impact in older persons with chronic organ failure trajectory

1.3 Care needed for older persons with advance chronic organ failure

**2) Acceptance of Death**

2.1 Significance of death acceptance

2.2 Attributes of death acceptance

2.3 Influencing factor of death acceptance

2.4 Consequences of death acceptance

**3) Life and Death in Buddhists' Views**

3.1 Buddhists' views on life

3.2 Buddhists' views on death

3.3 Buddhist philosophy influencing the acceptance of death

**4) Grounded Theory**

4.1 Philosophical background of grounded theory

4.2 Ontology of grounded theory

4.3 Epistemology of grounded theory

## 1. Older Persons with Advanced Chronic Organ Failure

### 1.1 Older persons with advanced chronic organ failure trajectory

Chronic organ failure trajectory consists of heart failure (CHF), chronic renal failure (CRF) and chronic obstructive pulmonary disease (COPD), these are grouped in long term intermittent serious illness trajectory. It was mentioned in two researches that specific characteristics covering CHF, CRF, and COPD trajectory are usually uncertain due to the fluctuations of the disease and other complications that may lead to death at any time (Lunney, Lynn, Foley, Lipson, & Guralnik, 2003; Murray, Kendall, Boyd, & Sheikh, 2005). Patients with organ failure need to cope with the uncertainties of the diseases. Onset and progression of the illness may be gradual, slowly eroding body functions, and often punctuated by crises from exacerbations of the underlying disease or by some accompanying acute illness (Ballentine, 2018). In addition, most of the older persons within the organ failure group usually differ from cancer and motor neuron diseases group because in most cases, organ failure group suffer from many complications, and severe limitation in activity until the final stage of the illness including coping with treatments and acute relapse of disease (Murtagh, Preston, & Higginson, 2004). Moreover, it was found that older persons in organ failure group have more co-morbidities, emotional distress, anxiety and depression, burdens, and poor quality of life than older persons with cancer (Leary et al., 2009).

The New York Heart Association (NYHA) older persons with CHF into four classes: Class I, older persons in this class do not have limitations in physical activities; Class II, older persons in this class have slight limitations in physical activities. The older persons are comfortable at rest, but regular physical activity

results in heart failure symptoms; Class III, older persons in this class have marked limitations in physical activities. The older persons are comfortable at rest, but less than usual activity causes symptoms of heart failure; and Class IV, older persons are unable to carry on any physical activity without heart failure symptoms or have symptoms when at rest (Inamdar & Inamdar, 2016). In class I and II, the older persons have stable symptoms and can be managed by routine care. While class III and IV involves a decline in the older persons' condition. Despite having maximal treatment, complications may still occur such as renal impairment, hypotension, persistent edema, fatigue, and anorexia (Howlett, 2011; Jaarma, 2009).

For older persons with CRF, the disease can be separated into five stages based on the degree of renal dysfunction, as measured by the estimated glomerular filtration rate (eGFR) derived from creatinine serum using standard estimating equations. The five stages ranges from G1 to G5: G1 normal level eGFR ≥ 90 mL/min/1.73 m2; G2 eGFR higher than 60-89 mL/min/1.73 m2; G3 is divided into two G3a with eGFR 30-59 mL/min/1.73 m2 and G3b with eGFR level < 60 mL/min/1.73 m2 which is at a greater risk; G4 is severely decreased levels of eGFR 15-29 mL/min/1.73 m2; and G5 eGFR level ≤ 15 mL/min/1.73 m2 which indicates kidney failure (Fraser & Blakeman, 2016; Janssen et al., 2008). A patient with CRF stage V (eGFR<15 ml/min) will have functional trajectories similar to the end stage of cardiac and respiratory disease. Older persons with renal dysfunctions need urgent dialysis for specific acute episodes from cardiovascular events, infective episodes, and problems with fluid overload (Tumura & Cohen, 2010).

Meanwhile evaluating the severity of lung function in older persons with COPD can be classified depending on various conditions. Firstly, post-bronchodilator

forced expiratory volume in one second (FEV1)/ forced vital capacity (FVC) ratio that can be classified in to four grades; GOLD 1: Mild symptoms in patients with a level of FEV1 level ≥80%. GOLD 2, moderate symptoms in patients with FEV1 level <80% to ≥50%, GOLD 3, severe symptoms in older persons with FEV1 level <50% to ≥30%, and GOLD 4, older persons have very severe symptoms with FEV1 level <30% predicted. (Escarrabill, Cataluna, Hernandez, & Servera, 2009; Viviers & Zyl-Smit, 2015). Older persons in an advanced stage of disease have a vital capacity < 60%, and transfer factor < 40% and meets the criteria for long term oxygen therapy ($PaO_2$<7.3. The criteria include breathless at rest or on minimal exertion between exacerbations, persistent severe symptoms despite optimal tolerated therapy, symptomatic heart failure, and a body mass index <21 (Boyd & Murray, 2010), body mass index less than 20 kg/m2 (Goodridge et al., 2009), oxygen dependent, and increased emergency admissions, one or more hospital admissions in the previous year from acute exacerbation (Curtis, 2008; Escarrabill et al., 2009). The characteristics of advanced stages of three chronic organ failure diseases can summary in table 1 as followed;

**Table 1** *The characteristics of advanced stages of three chronic organ failure diseases*

| **Diseases** | **Stage of diseases** | **Characteristics of older persons** | **Mark** |
|---|---|---|---|
| Congestive Heart Failure (CHF) | Class I | - does not cause limitations in physical activities | - has stable symptoms |
| | Class II | - causes slight limitations in physical activities | |

| Diseases | Stage of diseases | Characteristics of older persons | Mark |
|---|---|---|---|
| | | - comfortable at rest, but regular physical activity results in heart failure symptoms | |
| | Class III | - causes certain limitations in physical activities<br>- comfortable at rest, but less than usual activity causes symptoms of heart failure | -includes renal impairment, hypotension, persistent edema, fatigue, and anorexia. |
| | Class IV | - unable to perform any physical activity without heart failure symptoms<br>- has symptoms when at rest. | |
| Chronic Renal Failure (CRF) | G1 | - has normal level of eGFR ≥90 mL/min/1.73 m2. | - considered a low risk |
| | G2 | - eGFR higher 60-89 mL/min/1.73 m2. | |
| | G3 | - G3a eGFR 30-59 mL/min/1.73 m2 and G3b eGFR < 60 mL/min/1.73 m2 | - considered greater risk. |
| | G4 | - eGFR 15-29 mL/min/1.73 m2. | - considered high risk. |
| | G5 | - eGFR level ≤ 15 mL/min/1.73 m2.<br>- needs urgent dialysis for specific acute episodes from cardiovascular events, infective episodes, and problems with fluid overload | |
| Chronic Obstructive Pulmonary Disease (COPD) | GOLD 1 | - Has mild symptoms<br>- FEV1 ≥80% | |
| | GOLD 2 | - Moderate symptoms<br>- FEV1 <80% to ≥50% | |
| | GOLD 3 | - Severe symptoms<br>- FEV1 <50% to ≥30% | - Advanced stage of disease with a vital |
| | GOLD 4 | - Very severe symptoms | |

| Diseases | Stage of diseases | Characteristics of older persons | Mark |
|---|---|---|---|
| | | - FEV1 <30%<br>- Meets the criteria for long term oxygen therapy ($PaO_2<7.3$) or oxygen dependent. | capacity < 60%. |

**1.2 Health impact in older persons with chronic organ failure**

Older persons who are diagnosed with advanced chronic organ failure experience many problems in physical, psychosocial, and spiritual aspects. For the physical aspect, from the experiences of the older persons who have been living with congestive heart failure stage II-IV, many have suffered from several symptoms from dyspnea or breathlessness, falls, anorexia, insomnia, edema, pain and fatigue (Cortis & Williams, 2007; Howlett, 2011). In addition, from the study on the prevalence of daily symptoms burden in the older persons with end stage of chronic organ failure involving CHF, COPD, and CRF by Janssen et al. (2008), it was found that fatigue was the most common symptom and dyspnea, insomnia, and pain are frequent symptoms that are reported in all three diseases.

For the psychosocial aspect, older persons with end stage renal disease had emotional burdens such as shock after knowing the seriousness of their diagnosis (Douglas, 2014; Schell et al., 2012), and increased levels of uncertainty because they did not know the progression of the disease (Schell et al., 2012). Nevertheless, confronting the symptoms of burden and loss of independence in performing activities daily life care leads to the psychosocial distress, both anxiety and depression, of the older persons with chronic organ failure (Cortis & Williams, 2007; Howlett, 2011).

Between treatment and dialysis, it was found that the older persons with advanced chronic renal failure (CRF) stage IV-V needed to confront the burden from anxiety and depression (Douglas, 2014). Increasing levels of disability and the progression of the disease can involve both a decrease in the quality of life and an increase in the level of anxiety and depression in older persons with COPD (Cutis, 2008).

Moreover, it has been reported that the older persons with chronic organ failure having to cope with active treatment, and co-morbidities can lead these patient to experience higher levels of psychological burdens such as anxiety, depression, and a poorer quality of life than that of older persons with cancer (Leary et al., 2009). The progression of the disease can also decrease the sense of self and spiritual well-being of the older persons with congestive heart failure (Bekelman, Dy, Becker, Wittstein, Hendricks, & Gottlieb, 2009). Symptoms of distress and physical impairment negatively correlated with spiritual well-being and quality of life in older persons with advanced CHF and COPD (Strada et al., 2013). The patient's low level of quality of life and severe or worsening disease symptoms will relate to the prevalence rate of psychosocial distress such as depression and stress in caregivers (Grant, Cavanagh, & Yorke, 2012).

It is interesting to note that both illness trajectories and trajectory phases in older persons will be different in terms of the physical and psychological problems, conditions, and goal of care (Corbin & Strauss, 1991; Murtagh, Murphy, & Sheerin, 2008). Corbin & Strauss (1991) classified the trajectories of chronic illnesses model into eight stages: 1) pre-trajectory phase or prevention phase, occurs before any signs and symptoms are present; 2) trajectory onset phase, occurs with the first onset of signs and symptoms and includes the diagnostic period; 3) crisis phase or emergency

critical care, when a potentially life-threatening situation arises; 4) acute phase from complications, follows the crisis phase and refers to the period when the patient's symptoms can be controlled by a prescribed regimen; 5) stable phase, this phase starts once symptoms are controlled by regimen; 6) unstable phase, when the patient's symptoms are uncontrolled by the previously adopted regimen; 7) downward phase, characterized by progressive deterioration in mental and physical status; and 8) dying phase, refers to a period of weeks, days, or hours preceding death.

Changes in the trajectory phase of illnesses relate to changes in both the perception of illnesses and the perception of death in older persons with chronic organ failure (Corbin & Strauss, 1991). After having been diagnosed with advanced chronic organ failure the majority of older persons had an emotional response such as shocked by their diagnosis or after knowing the seriousness of their diagnosis (Schell et al., 2012). Throughout the treatment processes, it has been found that older persons had confronted with the uncertainty of their disease (Schell et al., 2012), suffered from confronting both psychosocial (Douglas, 2014) and physical burdens (Janssen et al., 2008; Howlett, 2011). The experience of a high symptom burden both mentally and physically will impact on the patient's quality of life (Davison & Jhangri, 2010). Increasing uncertainty from the deterioration of their conditions were factors contributing to these older persons having an awareness of their diagnosis. A patient tries to find out more information which is important in managing the uncertainty of the future (Warterworth & Jorgensen, 2010).

In an acute phase from complications, older persons talked more about physical needs and practical problems in their daily lives and feeling isolated and unsupported are spiritual distresses that concerned older persons. Older persons felt

worthless and useless, nothing but a burden to others and many expressed a wish for death (Murray, Kendall, Boyd, Worth, Benton, 2004). In symptoms controlled by regimen, it was found that older persons had experience a high symptom burden, impacting on their quality of life both mentally and physically (Davison & Jhangri, 2010; Douglas, 2014), and older persons had a fear of dying as the cause of stress (Yodchai et al., 2011). In addition, the influence on their overall quality of life in older persons led many older persons to consider suicide (Molzahn et al., 2012). Characteristic of thoughts on death in this phase are looked on as a relief from the symptom distress in older persons (Stromberg & Jaarma, 2008).

Moreover, both in the unstable phase and downward phase, when the patient's symptoms are uncontrolled by the previously adopted regimen results in symptoms gradually getting worse which leads to the progressive deterioration of the patient's body. Older persons with advanced chronic organ failure experience different thoughts and responses on death (Axelsson et al., 2012; John & Thomas, 2013; Nguyen et al., 2013; Cortis & Williams, 2007; Stajduhar & Makaroff, 2012) such as perceiving that death will approach (Molzahn et al., 2012), and they had awareness of the certainty of death (Buranaruch, 2013). Some older persons perceived that death and dying is a real life moment situation for them (Axelson et al., 2012) and they will prepare both for their death and final arrangements (Stajaduhar & Makaroff, 2012).This means that deterioration in disease and worsening generic health status is a facilitating factor in the acceptance of death of older persons because they had a change in the level of their fear of dying to accepting, death is not fearful, they had adapted to their condition, had made a will and planned their funeral (Stromberg & Jaarsma, 2008), increasing probability to change from preferring to refusing life

sustaining treatments (Janssen, Spruit, Schols, Cox, Nawrot, Curtis, & Wouters, 2012), and adaptation to the nearing of death by looking at or thinking of death as natural for the old and ill (Axelsson et al., 2012; Nguyen et al., 2013). When the older persons approach end of life, older persons were aware of their approaching death, and lived with the uncertainty about death happening (Axelsson et al., 2012).

### 1.3 Care needed for older persons with advanced chronic organ failure

Palliative care is a specific care for older person with advanced chronic organ failure group. The care consists of 3 stages: Stage one, starting from the diagnosis of any serious or advance chronic illness. In this stage, physical and psychological functions are still good as well as self-management with their conditions of illnesses.; Stage two, active and supportive palliative care, in this stage needs patients need caregivers to help and support them due to the decrease of functional ability; and lastly, stage three, terminal care and bereavement support, involves specific professional (Murray et al., 2005). Palliative care for older persons with advanced chronic organ failure group need to understand the transition of health and illness trajectories consisting the transition from treatment under long-term conditions care to palliative care, and transition from palliative care to terminal care (Boyd & Murray, 2010).

Whenever an older person's illness became life threatening it was found that older persons would like to receive the prognosis and talk about their impending death because they will prepare both for their death and final arrangements (Stajaduhar & Makaroff, 2012). There are older persons with advanced chronic renal failure would like to discuss death and dying because death and dying was a real life moment

situation for them (Axelson et al., 2012). Knowing about impending death for some older persons can promote a patient's fight to prevent exacerbation which can create a new normality for the patient by adapting to his/her illnesses and the symptoms that go with the illness (Lowey, Norton, & Quill, 2013). In the same time there are reported Thai older persons wound like to discuss living will and decision to treatment in their end of life by themselves (Sriyodchat & Hutterat, 2014). The older persons wish to die with dignity or without any life supporting systems, and well-prepared were highlight of good dead from Thai Buddhist older person's perspectives (Rodpal et al., 2007).

Although, an advanced care plan is an increasing recognition for palliative care for the older persons, it has been extended in western countries (Payne, Chan, Davies, Poon, Connor, & Goh, 2012). An advanced care plan is of concern only in the older persons with an advanced stage of cancer because being diagnosed with cancer equals death at that time and it is easy to estimate the prognosis (Cortis & Williams, 2007; Leary et al., 2009). Meanwhile providing an advanced care plan in older persons with chronic organ failure is not yet in place (Tamura & Cohen, 2010). However, there are reports that older persons with advanced chronic organ failure felt lonely with existential thoughts about death because they found it difficult to talk about their thoughts and feelings concerning death and dying with their families and healthcare providers (Axelson et al., 2012). Older persons' families also pushed away from them when they want to talk about death because their families are afraid. Health care providers may not be comfortable discussing (Stajaduhar & Makaroff, 2012), they also may lose confidence, and avoid discussing the topic of death with older persons (Axelson et al., 2012).

In practice, starting a discussion about an advance directive care plan, the healthcare provider needs to be concerned with religions and beliefs of the patient because the differences in religious beliefs may effect the thoughts on death and decisions in the end of life stage (Manasurakarn et al., 2008; Nijinikaree, Chaowalit, & Hatthakit, 2008). In addition, it was suggested that the advance directive care plan should be completed when the older persons still have the capacity to do it. Providing advanced directive care plans need to concern with the competency to communicate of older persons (Sataporn, 2014). Enhancing good death throughout the death acceptance and discussions about an advanced care plan for the older persons with chronic organ failure in Thailand should be extended.

**2. Acceptance of death**

The acceptance of death in older persons is important for healthcare providers to provide palliative care especially in enhancing the discussion of advanced care planning in advanced stages of illness. It has been reported that accepting their death is the first priority of older persons before the initial discussion about an advance directive care plan (Nguyen et al., 2013). Death acceptance is a key factor for preparing well for the death of the older persons. It has been reported that health professionals can guide patients' symptoms and psychological condition to provide better death. Older persons who can accept death easier than those older persons living in denial of death (Black, 2011). Accepting and acknowledging death will produce awareness of the imminence of death, valuing of life, open communication about death, and peaceful death in the dying process (Zimmermann, 2012). Existing literature showed that the older persons with advanced chronic organ failure who can

accept their impending death or death as a natural part of life will result in many positive outcomes for them such as increased competence to cope, living with value, having readiness for death, awareness of dying, preparing for their death, advanced care plan discussion, and an acceptance of dying in the end of life stage (Lokker et al., 2012; McLeod-Sordjan, 2013). In addition, the older persons who had accepted their death will die according to their wishes and will be able to die with dignity and autonomy because they had previously discussed an advanced care plan (Detering, Hancock, Reade, & Silvester, 2010; Pautex & Zulian, 2011), (McLeod-Sordjan, 2013; Zimmerman, 2012). At the same time there are reports that Thai adults and older persons who have an understanding that death and dying is a natural part of life and their death is inevitable prefer to discuss living wills and the decision of treatment in the end of their life phase by themselves (Manasurakarn et al., 2008; Rukchart et al., 2014; Sriyodchat & Hutterat, 2014). From Thai older persons' perspective, preparedness in mind will lead them to die with dignity and die in peace (Rodpal et al., 2007).

### 2.1 Attributes of death acceptance

Literature review showed that the death acceptance, death preparation, understanding about death, and awareness of dying are attributes that are closely related (Black, 2011; Lokker et al. 2012; McLeod-Sordjan, 2013). Death acceptance is a unique life experience for each individual and it is a dynamic event that cannot be fixed in time (McLeod-Sordjan, 2013). Death acceptance is viewed in different ways.

Death acceptance is viewed as a life process or a successful outcome of coping with traumatic events or death in human beings. Like an older person with cancers

being aware that their lives would come to a close in the near future although they did not know exactly when. Although they did not want to depart from their love relatives, they could not avoid it. Older persons indicated that they had to accept their illness, and death was part of their life process. They stated that birth, ageing, sickness, and death were the processes of life. Acceptance was passion of the person to liberty, and to conscious positive choices. Acceptance of their illness helped older persons to let go of things they could not control and to set priorities that were within their reach. In addition, death acceptance is a process in life leading to harmony with self and nature, letting go, finding meaning in life, receiving and giving love in relationships and connectedness, having faith in God/higher power, being a good person, having a sense of peace (Mok, Wong, & Wong, 2009). Death is seen as a process rather that an event. From the study that explored the perception of a good death in 66 older persons with cancer in the palliative phase in Sweden, older persons viewed death as a process because they need to confront their death by discussing issues such as decision making at the end of life, preparing for their death or good death related to older persons' activity such as saying good bye to their love one, completing unfinished task, and involvement in end of life decision at the end of life. Older persons would like to die comfortably by dying quickly, with independence, with minimized suffering and with social relations intact. They had decided on the treatments they would receive to avoid suffering during the process of dying (Kastbom, Milberg, & Karlsson, 2017).

In addition, death acceptance is the final stage of grief and loss which a person who has accepted death can understand the inevitability of death, being peaceful and calm, and this is opposite in the person who has a denial of death. Kubler-Ross (1969)

stated five stages of grief: 1) Denial, in this stage people's life in this stage becomes meaningless and overwhelming. People are in a state of shock and denial. However, both feelings help people to cope and make survival possible. This stage people tried to accept the reality of the loss and start to ask themselves questions, beginning the healing process, becoming stronger, and the denial is beginning to fade (Kessler, 2019); 2) Anger, the individual recognizes that denial cannot continue. It is natural to feel abandoned and not in control. Anger is strength and it can be an anchor, giving temporary structure to the nothingness of loss. This is a common stage to think "why me?" and "life's not fair!" People might blame others for the cause of their grief and also may redirect their anger to others persons such as close friends, god, doctor, and family; 3) Bargaining, the third stage involves the hope that the individual can somehow postpone or delay death. Usually, the negotiation for an extended life is made with a higher power in exchange for a reformed lifestyle. Psychologically, the individual is saying, "I understand I will die, but if I could just have more time..."; 4) Depression, in this stage a dying person begins to understand the certainty of death, the individual may become silent, refuse visitors and spend much of their time crying and grieving. "I'm so sad, why bother with anything?"; "I'm going to die... What's the point?"; "I miss my loved one, why go on?". This process causes the dying person to disconnect oneself from things of love and affection. It is not recommended to attempt to cheer up an individual who is in this stage. It is an important time for grieving that must be processed; and 5) Acceptance, in this last stage, the individual begins to come to terms with their mortality. "It's going to be okay."; "I can't fight it, I may as well prepare for it.". At this stage the older person is now able to prepare for death (Kessler, 2019; Kubler-Ross, 1969).

However, Kubler-Ross (1969) claimed these steps do not necessarily come in the order noted above, all steps experienced were not the general step for all older persons, though she stated a person will always experience at least two. Often, people will experience several stages in a "roller coaster" effect-switching between two or more stages, returning to one or more several times before working through it. Significantly, people experiencing the stages should not force the process. The grief process is highly personal and should not be quick, nor extended, on the basis of an individual's forced time frame or opinion. One should merely be aware that the stages will work through and the ultimate stage of "Acceptance" will be reached (Kubler-Ross, 1969).

In the research by Kyota and Kanda (2019), it was found that when terminally ill older persons with cancer who were receiving symptom-relieving treatment at home or in palliative care units had been facing with death they have to accept that they have developed cancer, development of cancer disease, and having worsening symptoms. They need to accept the undeniable approach of their own death and have to accept this as their destiny and an outcome of their life. Older persons felt that their symptoms were worsening and their physical power was deteriorating. Although, they were afraid of death and the process of death and earnestly desired to live but felt that death was imminent, they need to accept this situation because they felt that they would not change the situation, and they tried to accept their situation.

Moreover, Gesser, and Reker (1988) view the acceptance of death in three distinct definitions: 1) “neutral death acceptance” as a decision to face death because of the belief that death is unchangeable or inevitable in the end of every life such as death is simply a part of the process of life, death is a natural aspect of life, death

should be viewed as natural, undesirable, and unavoidable event, death is neither good nor bad, and one should neither fear death nor welcome it; 2) “approach acceptance” as accepting death as a gateway to a better or happier afterlife such as death brings a promise of a new and glorious life, one sees death as a passage to an eternal and blessed place, death is a union with God and eternal bliss, the individual looks forward to a reunion with his/her loved ones after he/she dies. One thing that gives the individual comfort in facing death is his/her belief in the afterlife, he/she believes that he/she will be in heaven after he/she dies, he/she looks forward to a life after death, death is an entrance to a place of ultimate satisfaction, he/she believes that heaven will be a much better place than this world, and death offers a wonderful release of the soul; and 3) “escape acceptance” as choosing death as a better option to a painful existence such he/she sees death as a relief from the burden of life, he/she views death as a relief from earthly suffering. There are reports that older persons who accept the dying process and understand that death is one part of nature expresses less fear of dying. It means that a neutral acceptance has a significant relationship with fear of death and anxiety (Neimeyer, Wittkowski, & Moser, 2004).

In regards to the characteristics of death acceptance in older persons with chronic organ failure such as older persons with end stage renal failure who can accept death, they have thoughts on death as the inevitable part of everybody’s life, it is natural for the old and ill, and knowing that death is imminent (Axelsson et al., 2012). Older persons with advanced congestive heart failure had accepted death and will think of death as certain, or a sure thing that it will happen in their life. However, they perceived that time for death is not certain nor the time it will occur (Stromberg & Jaarsma, 2008). On the other hand, characteristic of death acceptance in some older

persons mentioned that they accept death and wish to die a quick death during sleep because they would like to release their suffering and symptoms such as pain, shortness of breath, and lose of functioning ability (Stromberg & Taarsma, 2008). In relation to the study by Axelson et al. (2012) about thoughts on death and dying when living with hemodialysis and approaching end of life. The study found that older persons hoped for a sudden death or quick death because they wished to escape from the progressing losses and suffering from loss of control, and complications.

### 2.2 Influencing factor of death acceptance

The death acceptance in older persons relies on different factors which can be explained as follows;

#### *2.2.1 Cultural and religious beliefs*

The individual's culture will influence how he/she makes sense of his/her illness and death (Michell & Mitchell, 2009). Moreover, views about death are different between western and eastern cultures. Death from a western viewpoint is a medical failure and for many older persons there is an endeavor to avoid it for as long as possible (Shubha, 2007) while in the eastern culture views about death is that it is inevitable and there is a belief that the state of mind at the time of dying will influence a good rebirth (Wilkins, Mailoo, & Kularatne, 2010). Whenever conventional curative therapies fail older persons in eastern countries people usually turn to alternative therapies such as Siddha medicine or herbal medicine for healing powers (Mudigonda & Mudigonda P, 2010).

In terms of religious beliefs, these will lead older persons to different decisions in the circumstance of death such as choosing die, decisions in dying, place of death, loss and approach to treatments (Connor et al., 2010). The differences in religions can influence beliefs about life, death, and suffering and have an effect on the perception on death and attitudes toward end of life decisions. In Islam the belief is that life, death, and suffering are connected with a God or Allah. The Qur'an states that a patient's death does not happen if Allah does not give permission or only Allah can make decisions on life and death (Sachedina, 2005; Steinberg, 2011). Acceptance of death can occur in the first instance of diagnosis because illnesses, life, death, and end of life depend on Allah or originate from Allah (Islamic Center of Blacksburg for Islamic Information and Education, 1995). Islamists will not accept a decision to forgo treatments to endure pain and suffering, and developing spiritually (Roswell Park Cancer Institute, 2015), they mostly decide to continue treatments because they believe that when they perceive the illnesses, they need to retrieve treatments, and refusing the treatment is a demerit and has an effect on the next life (Nijinikaree et al., 2008).

While death in Christians is eternal life, and death as the way or transition to another life. Christian's belief that the spirit continues to live, and that dying is a passage from this world to the resurrection (Cheraghi, Payne, & Salsali, 2005). Eternal life in Christianity is accepted if a person has a fullness of the knowledge of God. Sacrament of the sick with serious illnesses and a dying person is a sign of God's presence, and as a source of grace and strength (Puchalski & O'Donnell, 2005). Christian older persons who have a strong faith in God and the afterlife associated with God are able to come to an accepting attitude toward death (Parker, 2013).

Having faith in God and hope for an eternal life are helpers in the death acceptance because faith and spirituality emphasize that death is not only an ending to life on earth but a new beginning in heaven with God and his son Jesus (Jianbin & Mehta, 2003).

Buddhism on the other hand teaches about the impermanence of life, death, and life after death. All older persons need to confront the experience of death because death is certain for everyone and an integral part of life. Although, the situations of death can lead to suffering for all humans, suffering from a death sentence can be released by following the principle of the middle way to considering that death is a natural part of life (Masel, Schur, & Watzke, 2012). The literature shows that Buddhist principles can lead older persons to gain an understanding of the nature of life, of non-attachment, acceptance of death, a peaceful death in the dying stage (Kongsuwan, Keller, Touhy, & Schoenhofer, 2010; Somanusorn, 2009). Buddhism is used for trying to understand that no living thing can escape from death and provides reflection to help one prepare for impeding death (Nguyen et al., 2013).

Furthermore, it was found that older persons with cancer with high religiosity had a higher acceptance of death (Lehto & Therrien, 2010; Pinquart, Frohlich, Silbereisen, & Wedding, 2006). Older persons had religion and spirituality that will relate to a higher purpose to life, and higher behavior of prayer and meditation (Lehto & Therrien, 2010). Moreover, older persons with a strong religious belief in an afterlife had a negative relationship with fear of death, death anxiety and a positive relationship with death acceptance, and level of personal meaning and well-being (Wong, Recker, & Gresser, 1988). The study by Glass and Nahapetyan (2008) about discussions of elders and adult children about end of life preparation and preferences

found that the older persons who had religious faith and spirituality as important factors to facilitate their preparedness led to an acceptance of their death. This is supported by findings from another study in which older persons that had high experience in religious coping and spirituality, both through themselves and through spiritual support by chaplain services will result in experienced less aggressive treatment, reduced medical care, and high intent to hospice care in end of life and at near death (Balbini et al., 2013).

*2.2.2 Health problems*

It is interesting to note that, both thoughts on death and the acceptance of death mostly occurred when older persons were in advance stages of illness treatment. The study by Strombege and Jaarsma (2008) about thoughts about death and the perceived health status in older persons with heart failure, found that when older persons had an advanced stage CHF class II–IV they thought about death in different ways such as death is a natural part of life, death is fearful, and death is a relief from symptoms. Thoughts on death related to a study about older persons' experiences with chronic organ failure by Joen, Kraus, Jowsey and Glasgow (2010), found that when the diseases advance, older persons had to recognize they were visiting death's door, and had worries about dying while asleep. Older persons with end stage chronic renal failure had different definitions of death depending on their condition. Whenever they were living with maintenance hemodialysis, were severely ill, had a deteriorating body, and worsening conditions, the older persons had an awareness that death may be near, and adapted to their approaching death by looking

upon death as natural, preparing to face death, hoping for a quick death and repressing thoughts of death and dying (Axelsson et al., 2012).

Whenever the older persons had a progression of conditions, symptoms, and they gradually got worse, some older persons with congestive heart failure had to suddenly recognize that their death was imminent (Cortis & Williams, 2007). This includes older persons with advanced congestive heart failure withdrawing from treatment and having to face their thoughts on death and dying (John & Thomas, 2013). In addition, a progressive deterioration of a patient's body, strong impairments in ADL, and worsening condition and prognosis due to an advanced of disease will affect the mental and emotional health of the older persons in having to be aware that his/her death is near and strong to accept their own death (Axelsson et al., 2012; Nguyen et al., 2013).

*2.2.3 Demographic data and individualized nature*

Death acceptance in people relates to the development of their ego integrity (Parker, 2013; Stromberg & Jaarsma, 2008). A person who has high achieved ego integrity is satisfied with life and can accept both the successes and failures of his/her life, and can accept his/her life' as life in compasses past and present (Zimmerman, 2012). The older persons had developed both integrity and accept death more than younger adults (Parker, 2013). In addition, Ericson (1963) mentioned that the older persons had ego integrity and develop their task in coping with many situations higher than younger people. The older persons in general are easy to accept death than younger persons in general. According to Erikson (1963), the eight steps of psychosocial development about ego integrity and despair that the

person who has achieved ego integrity is satisfied with life and accepts responsibility for its successes and failures. Achieving ego integrity will allow a person to face death without fear or accept his/her impending death. The study on the thought of death in older persons with congestive heart failure by Stromberg and Jaarsma (2008) found that very younger aged people had always been afraid of dying both of their own death and their loved ones also.

Acceptance of death is easy for the older persons because they have already lived a long life yet a younger person has not had that same chance for long life goals. Getting older in older person’s perspective means that death is nearer to them, and had less maintenance of long life goals. As found by Pinqart, Frohlich, Silbereisen and Wedding (2006) that younger older persons have difficulty in coping with death because they are more distressed on how being diagnosed with cancer interfere to their future goal and unfinished life tasks. They found that older adults showed higher levels of death acceptance than younger adults. It can be inferred that as a person gets older and death grows nearer, the individual may become increasingly accepting of its necessity and increasing incorporate it into their planning for the remainder of their lives.

Furthermore, older people can accept death more than younger people because the older person are living with religious belief more than younger people (Harding, Flannelly, Weaver, & Costa, 2005). The on administering of the Death Attitude Profile-Revised (DAP-R) of Wong et al. (1988) in age groups such as the young, middle-aged, and older females found that the older persons had a greater belief in the afterlife than the younger and middle-aged groups. Rodpan et al. (2007) found that older persons have thoughts on death as a natural part of life or death as certain,

acceptance of their own death, do not fear about death, being aware of death, learn how to deal with death, and preparing for death.

Moreover, there are reports that gender is associated with attitudes toward death, for example, females had higher level of death anxiety and psychological distress than male older persons (Pinquart, Frohlich, Silbereisen, & Wedding, 2006). From studies about thoughts about death in the older persons with heart failure, it was found that women older persons were afraid of death for a long time in six months deterioration of disease while men older persons had a decline in being afraid of death in six months deterioration of disease (Stromberg & Jaarsma, 2008)

*2.2.4 Past experiences on confronting death*

Witnessing others dealing with end of life situations can emphasize to older persons to accept their own death because seeing other older persons pass away encourages those older persons to reflect or think about a plan for themselves (Nguyen et al., 2013). Older persons' experiences when confronted with periods of grief several times are a contributing factor to the acceptance of death as a natural part of life (Glass & Nahapetyan, 2008). Stromberg and Jaarsma (2008) found that older persons with advanced chronic organ failure can accept death as a natural part of life because they had experiences of being confronted with death during periods of grief several times from friends and family members who had already died.

From the study conducted by Parker (2013), it was found that the ability to accept the past is a significant predictor of the attitude toward death in the older person's population. The ability to accept the past was a significant factor of the fear of death, death avoidance, and neutral acceptance. The result indicated that the greater

one's ability to accept his/her past lived experiences in life as necessary and meaningful despite the failure and regrets leads to an acceptance of death. There are reports from the older persons living with hemodialysis in foreign countries, that they had already experienced what death is like, and that they did not fear the moments of death.

*2.2.5 Negative emotions*

Negative emotion such as fear, anxiety, depression, and denial are factors that negatively correlate with the acceptance of death. Older persons have a higher level of depression and anxiety that positively correlates with fear of death both in the start of deterioration of disease and six months after deterioration of disease. Due to the older persons having negative emotions and thoughts about death which were difficult to control especially when the older persons suffered pain from their disease they usually thought about death and fear was associated with those thoughts (Stromberg & Jaarsma, 2008). The older persons believed that denying rather than confronting dying or thinking about dying all the time made life more manageable on a daily level (Nguyen et al., 2013).

Death anxiety will increase in middle-aged adults but decreases in level in old-aged persons. The study conducted by Beydag (2012) found that death anxiety levels of older persons with cancer ranging from 17-30 years of age were higher. This study explained that younger older persons did not have enough energy to cope with the things in the process of the disease. From the study conducted by Stromberg and Jaarsma (2008), it showed that thoughts on death as fearful or fear of dying are more evident in the adult and young adult age group. Adults who had feared death both

their own death and the death of loved ones had changed attitudes on death between the initial study and six months follow-up. In addition, there was a study that reported that high death anxiety was associated with less preparation for end of life, more generalized anxiety, and more depressive symptom severity (Krause, Rydall, Sarah, Rodin, & Lo., 2014).

*2.2.6 Concerns with loss, their loved one and meaning of life*

Older persons had higher concern about death because of the recognition of personal death associated with grief and impending losses. Some older persons' readiness to die was because they were living with multiple losses such as loss of their relationship and social networks, loss of friends and hobbies. While some older persons were not ready to die because they had things to wanted to do (Waterworth & Jorgensen, 2012), and had considered the negative consequence to loved one such as leaving families, not seeing their grandchildren grow, and the effect their death may have on their families. Moreover, thinking about loved ones can contribute to those older persons wanting to extend their life, having a plan for death, and having hope for their loved ones before death will come upon them. Some older persons try to improve their health by changing their life style, adhering to treatments, and increasing self-care activities because they hope they can extended their life to see their grandchildren grow up, and to support their families (Lehto & Therrien, 2010; Stromberg & Taarsma, 2008).

Thai adult have concerns or worries about their families and having to prepare their families for after their death more than older persons (Kunsongkeit, 2011). From the experiences of adult persons on ventilators, they perceived that confronting

endotracheal tubes indicate a critical illness and near death. Some older persons have thoughts on the fear of death and their future. They wish to recover from their illness and get well because they have worries about their children, their families, and business responsibilities (Chaiweradet, Ua-Kit, & Oumtanee, 2013). In Manasurakarn et al. (2008) research where in most of the participants were middle aged adults, 19.5% of the Thai Buddhists participants decided to continue the treatments because they needed to survive for various reasons or because life was important for them.

The meaning of life and attitude toward life are both significant to a person's perceptions towards death. Although people feel that they have difficulty in their life, the meaning of their life experiences can contribute to their attitude when they are faced with the reality of death. In the same way if people cannot find meaning in their life, they are unable to accept death and it will cause them to be full of fear (Wong, 2000; Erickson, 1982; Parker, 2013). In addition, older persons with feelings of hopelessness because they were going to die had a lower level of acceptance of death but higher thoughts that they could escape from dying or escape death acceptance (Gresser, Wong, & Reker, 1988). However, finding meaning in their life will increase psychosocial development which is commonly seen among the older age group who had built their ego integrity. Therefore, people with high levels of ego integrity will put a lot of thought into the meaning of their life and can face their impending death better than those people with less ego integrity (Parker, 2013). In addition, if people have less ability to accept their own past lived experiences in life or feel that their life is not meaningful, those older persons will have high levels of fear or avoidant attitudes to their impending death (Parker, 2013).

*2.2.7 Desire to escape from suffering symptoms*

Some older persons can accept death and wish to die a quick death during sleep because they would like to be relieved from their suffering and symptoms such as pain, shortness of breath, and loss of functioning ability. Those older persons would like to die when they sleep because they believe that death will be peaceful for them (Stromberg & Taarsma, 2008). A study by Axelson et al. (2012) about thoughts on death and dying when living with hemodialysis and approaching end of life found that older persons hoped for a sudden death or quick death because they wished to escape from the progressive losses and suffering from loss of control, complications, sense of self and dignity.

**2.3 Consequences of death acceptance**

Death acceptance has many effects to patients with progressive diseases. Death acceptance may cause patients to prepare for their death and for an advance care plan, fight their diseases, being psychologically prepared and had the competence to discuss death, and dying with dignity and autonomy in older persons.

*2.3.1 Preparing for their death and an advance care plan*

Majority of older persons who can accept their death will prepare for their death and for an advance care plan. Older persons with heart failure who had accepted their death had prepared for a living will, financial issues, and planning for their funeral, their partner and children (Lehto & Therrien, 2010; Waterworth & Jorgensen, 2012; Stromberg & Taarsma, 2008). From the study by Glass and Nahapetyan (2008) about the discussions by elders and their adult children about end of life preparation and preferences, they found that older persons who have an

acceptance of death or awareness about death will most likely prepare for their death. In some situations, older persons witnissing others in end of life care causes them to plan ahead for themselves (Stajduhar & Makaroff, 2012). In addition, from the concept analysis about death preparedness of McLeod-Sordjan (2014) found that older persons who had readiness for death and an understanding of the consequences of death usually have incomplete advanced care planning because they wished to die at home.

*2.3.2 Fighting their diseases*

The older persons who acknowledges death as a natural part of life or death is certainly, have no fear for death, have a better understanding on how to deal with death, and have prepared for death (Rodpal et al., 2007). Similarly, older persons with heart failure who had accepted their death they had confronted death by trying everything to extend life, and learn how to deal with death along the process (Lehto & Therrien, 2010; Waterworth & Jorgensen, 2012; Stromberg & Taarsma, 2008). This also included older persons living with hemodialysis who had reflected on what will cause their death, they are aware of themselves, living with the awareness that death may be near, and adapting to their approaching death. Older persons would read obituaries for handling any uncertainty of thoughts on death (Axelsson et al., 2012). Knowing and accepting impending death for some older persons can promote a patient’s fight to prevent exacerbation which can create a new normality for the patient by adapting to his/her illnesses and the symptoms that go with the illness (Lowey, Norton, & Quill, 2013).

*2.3.3 Being psychologically prepared*

For being psychologically prepared, older persons with advanced-stage cancer, who understand that death is imminent and cannot change it, can accept all of the suffering from their illness, be in peace, and harmony with self and nature (Mok et al., 2009). Acceptance of death can improve the quality of life for older persons (Curtis, 2008).

*2.3.4 Ability to discuss death*

Older persons who can accept death will most likely to be more open to discuss about death. In cases where the older persons suffer from advanced chronic organ failure and can accept their death would like to talk about their death with their families and healthcare providers (Axelson et al., 2012; Stajaduhar & Makaroff, 2012). From the study about awareness of dying of Lokker et al. (2012) and the study about the acceptance of dying: a discourse analysis of palliative care literature by Zimmerman (2012), they found that older persons who had been living with no awareness of death did not openly communicate about their wishes in the dying stage.

*2.3.5 Dying with dignity and autonomy*

Death acceptance can provide death with dignity and autonomy, reduce stress and burden, and improve the quality of death such as having a good death (Lokker et al., 2012; McLeod-Sordjan, 2013; Zimmerman, 2012). Thai older persons who understand that death is a natural part of life usually do not want to follow aggressive treatment, and want to plan an advanced directive by themselves (Sriyodchat & Hutterat, 2014). Thai Buddhist older persons with chronic illness

believing that birth, aging, pain, and dying are a normal part of life usually chooses to forgo life sustaining treatment (Manasurakarn et al., 2008; Rukchart et al., 2014). Older persons who can understand the nature of life, non-attachment, and acceptance of death achieves a peace of mind, readiness to die, reduction in suffering, and an enhanced peaceful death in the dying stage (Kongsuwan et al., 2010; Somanusorn, 2009).

## 3. Buddhists' views on life and death

### 3.1 Buddhist's views on life

Buddhists believe that life or the self was the combination of mind (Nama) and matter (Rupa). Life is a temporary combination of matter and mind. Matter consists of the combination of the four elements solidity, fluidity, motion, and heat. Mind consists of the combination of sensations, perceptions, mental formation, and consciousness (Dhammnanda, 1987). Therefore, there was no real self (essence) in all things or all things are an integrated from both physical (rupa-dhamma) and mental aspects (nama-dramma). Buddhist teachings about understanding the reality of human life can decrease the illusion of a permanent self, attachment to any mental or material state in a person (Dhammnanda, 1987)

### 3.2 Buddhists' views on death

Buddhist philosophy views birth, ageing, sickness, and death as both the reality of life, and a natural part of life (Dhammananda, 1987; Payutto, 1995). Buddhism stresses that all things in the world cannot remain and can pass away, searching for permanence in the Buddhist view is argued (Prayut, 1995; Khado,

2003). Teaching about impermanence of life was important in Buddhist Philosophy. All humans will certainly die because death is a natural part of existence but time of death is not certain. Life was the co-existence of the physical body and mind that are related in which two things will only separate when the person dies (Dhammnanda, 1987; Masel, 2012). In addition, death and the dying period are important in the life process that relate to a good death will be dying with consciousness, be sensible and will not forget, have a peaceful mind, with no regrets in their mind. Buddhists believe living with the understanding that death is the reality of life, the impermanence of life, and acceptance of death are important teachings in Buddhism because these can lead to a good death (Kunaporn, 2011).

Moreover, Buddhists believe in life after death that the events of dying in human life are opportunities of preparing and training the mind and death can be the opportunities to be free from all suffering both in mind and body, and a peaceful mind in the dying state can lead to a good rebirth (Khadro, 2013). Buddhist’s view the attribute of death acceptance is understanding that death is a natural part of life, to which one should not have attachment to, and it is a method to release the suffering (Keown, 2005). According to Thai Buddhist older persons with chronic illness who can accept death, their view of death is that it is natural, death is part of human life, and prolonging death is impossible (Rukchart, Chaowalit, Suttharangsee, Parker, 2014). Moreover, the older persons who could accept their death recognize that death is a natural part of life or death is certain, they do not fear death, are aware of death, learn how to deal with death, and prepare for death (Rodpal et al., 2007).

### 3.3 Influences of Buddhist philosophy on death acceptance

Buddhism was strongly influenced by traditional beliefs regarding the faith Thai people have in Buddha and in following his teachings. Buddhism places emphasis on human beings needing to understand about the reality of human life which can decrease the illusion of a permanent self, and the attachment to any mental or material state in a person (Dhammnanda, 1987). Understanding about the reality of human life consists of the four noble truths, the law of kamma or Karma, the nature of existence or tri-lukkhana, and the five aggregates of life (Dhammananda, 1987; Payutto, 1995). Understanding the reality of life and death or accepting death as the life process of a patient's life can be a useful time for learning and gaining insight into the true nature surrounding us. Furthermore, accepting death will enable us to be free from suffering, have a peaceful state of mind, and go onto have good rebirths.

#### *3.3.1. Mind (Nama) and matter (Rupa)*

Among older persons with cancer who can accept both their sickness and their death because they had presence of mind and body. They were able to cope with the illness with their religious practices which gave them consciousness and consideration on the truth of life and death. A patient's awareness of emotional suffering and stress will have an effect on the body and illness. If a patient perceive that if he/she has positive emotions, then he/she will have better health during his/her chronic illness (Khaw, Thaniwattananon, & Chinnawong, 2013).

#### *3.3.2. The reality of human life*

Buddhism place emphasis on human beings needs to understand the

reality of human life which consists of the four noble truths, law of kamma or Karma, nature of life or nature of existence, and five aggregates of life.

*3.3.2.1 Four noble truths.*

The four noble truths (ariyasacca) are Buddha's basic teachings to enhance the understanding of the reality of human life which consists of suffering, cause of suffering, cessation of suffering or nirvana, and path to the cessation of suffering (Dhammananda, 1987; Payutto, 1995).

In the Buddhist perspective, *suffering* is believed to be *corporeality (rupa-dhamma)*, the elements of the whole and consist of body and behavior of the body. *Feeling and sensation (vedana)* are the impression of *happiness (happiness of the body and mind), sukha (physical or mental distress),* and *upekkha (nether-pleasant and nor-unpleasant)* that occur by contact with the world through the five senses. *Perception (sanna)* is the establishment of known or characteristics of the various features of an object such as emotion or mood. *Mental formations (sankhara)* are psychological compositions of the mind with *intention (cetana)* as a guide. Those things good and bad thoughts are *confidence (saddha), mindfulness (sati), compassion (karuna), loving-kindness (metta), joy (mudita), equanimity (upekkha), wisdom (panna), delusion (moha), and ill-will (dosa). Consciousness (vinnana)* is being aware of sensation using the six senses seeing, hearing, smelling, tasting, physically touching, and mentally touching. Five aggregates are the sensation of the human body and are the essential elements of life or we can call being (satta) (Payutto, 1995). Whenever, the five aggregates have objects of attachment, human beings will have dukkha or suffering.

The cause of suffering (Samudaya) can begin from ignorance, anger, and attachment. There are eight kinds of causes of suffering common to all human life or human beings birth, aging, illness, death, separation from love ones, being with people we dislike, desiring things we cannot have, and mental irritation. All people will have experience to confront the eight causes of suffering during the period of life. These causes are all impermanent states and will pass away when the condition changes (Dhammananda, 1987; Payutto, 1995). Buddha had strong beliefs in a relationship between impermanence or *anitya* and suffering. Nothing in nature is fixed, everything is always in a state of flux, and can come and go. Therefore, if we are ignorant of the cause, we will not refuse suffering. Understanding about the cause of suffering can lead to the elimination of suffering.

Cessation of suffering or end of suffering (Nirodha) is eliminating the root of suffering. Suffering comes from several Kleshas which consist of incorrect views, greed, anger, ignorance, pleasure, and doubt. In order to end suffering, its cause must be eradicated. Nirvana is the cessation of suffering that means to understand and realize the truth of life. Therefore, nirvana is a state of being free or the extinction of suffering Kleshas. Being free from all delusions, defilements, and suffering are nirvana or cessation.

The pathway to the cessation of suffering (Marga) is the way to achieve freedom from suffering which is called the noble eightfold path. The noble eightfold path can be separated into three categories; moral conduct, concentration, and wisdom. Persons who can achieve the release of suffering will follow these elements. Firstly, moral conduct (shila) or morality consists of right speech, right action, and right livelihood. Secondly, concentration (Samadhi) or meditation consists of right

effort, right mindfulness, and right concentration. Lastly, wisdom (panna) consists of right view or right understanding, and right thought or right aspiration (Dhammnanda, 1987; Masel, 2012).

From the literature reviewed, it was found that there are older persons with heart failure who have used the four noble truths of the Buddha to understand their conditioned reality throughout reading Dharma books which help them to realize and understand the reality of their sickness. The teaching of the four noble truths lead older persons to have an understanding of what the true problems that people face are, and then what the true causes of those problems are, and thus this had helped older persons to see the way to stop any problems leading to the ending of all problems. Moreover, Buddha teaches older persons to be in the present, to always be aware and conscious of death, as no one can live forever (Chiaranai, 2014).

In addition, there were older persons who had expressed religious beliefs through Buddhist ways to prepare spiritually for their death. From a study by Miccinesi et al. (2012) on the end-of-life preferences in older persons with advanced cancer, the older persons perceived that Buddhism could help them to understand the reality around them, and transcend the stresses and suffering in their life. They were willing to discuss issues surrounding their terminal condition because religion can help older persons to find meaning at the end of life and to accept the end of their lives. Moreover, from the perceptions of Thai older persons with heart disease, it has been shown that initially the older persons perceived treatment as a terrifying and life-threatening experience for them. Older persons had spent more time and effort in religious activities, such as reading books on the Dharma, merit-making, offering food to the monks in the morning, visiting temples or listening to sermons, and they

believed that these activities would be rewarded in their next life. The Buddhist religion made them feel more peaceful and they came to accept the truth that death is universal (Kwankhao & Boonmongkol, 2013).

Meditation practice can enhance the balancing agent of the body and mind, promote self-healing, and help older persons to develop the wisdom to understand the reality of life in older persons with cancer (Baehr, 2009; Sungsing, Hatthakit, & Aphichato, 2007). Moreover, Thai older persons reported that the psychosocial and spiritual intervention was highlighted to manage and control symptoms distress and to relieve suffering. Thai Buddhist older persons perceived that religious practice can release distressing symptoms and calm the mind, release stress, and help in managing body control (Supoken et al., 2009; Temtap & Nilmanat, 2011). Older persons in advanced stages of cancer have settled their consciousness and considered the truth of life to overcome suffering for an acceptance of their illness and death through Buddhist practice such as praying, listening to chanting, and meditating (Khaw et al., 2013).

In addition, Buddhist beliefs may be important for older persons with serious chronic illnesses for approaching death or the dying stage, and decision making in the end of life. Thai older persons with end stage renal failure had depression, stress, and suicidal ideas as dominant psychological problems between the hemodialysis processes. They had fear of dying as the cause of stress. Buddhist beliefs helped them to understand the value of life and to reflect that suicide is not the right path in their life. Older persons with end stage renal failure can deal with their death by following Buddhist practices such as praying, making merit, doing good deeds, and meditating (Yodchai et al., 2011).

*3.3.2.2 Nature of existence*

Buddhists believe that nature of life or nature of existence is born of the integration of many elements and all things exist in a constant flow or flux. The Buddha has explained the three characteristic of existence as the universal characteristic of all things. First, *aniccata* means impermanence, instability, and uncertainty. All things can occur and can extinguish such as person can be born and can die. Second, *dukkhata* is a state of suffering, condition of pressure. Causing of dukkha for the persons are desiring things with attachment. And third, *anattata* means all phenomena are not the self, no real essence (anatta) (Payutto, 1995).

Understanding the natural existence can influence both the acceptance of death and decisions in the end of life in older persons with chronic illnesses. Thai Buddhists with chronic illnesses who make the decision to forgo life sustaining treatment when their illnesses are diagnosed to be terminal they find the Buddhist teachings able to emphasize to them an understanding that death is a natural part of life, and prolonging the occurence of death is impossible (Rukchart et al., 2014). A majority of Thai Buddhist older persons and their families' decision to forgo life sustaining treatments depends on their understanding that the prolongation of the occurance of death is impossible (Manasurakarn et al., 2008).

In addition, the preliminary finding from interviewing bed-bound older persons needing palliative care and their caregivers found that perceptions on death and understanding about death in the Buddhist caregivers are related with Buddhist teachings. The caregivers perceived that death, ageing, sickness, and death are the reality of life, and all human life needs to confront death. These perceptions on death in the caregivers were related to the acceptance towards the death of the older

persons. Moreover, their caregivers understood that death is a natural part of human life and planned to forgo sustaining treatments for the older persons in the end of life stage because they wished for the patient's death to be without suffering (Pleonpit, Sanarun, & Kanitha, 2015).

*3.2.2.3 Kamma or Karma*

Lastly, Buddhism emphasizes that the human being is related to Kamma or Karma. Buddhism believes that do good and good will come to you, now and here after and do bad and bad will come to you, now, and here after. In addition, in the language of science belief that kamma is the law of cause and effect. Kamma is stated in the Anguttara Nikaya. Everything is a result of acts in previous lives. Kamma refers to acting or doing and if whoever is acting in a good way, the consequence will result in a good outcome. The Buddha says that 'there is no place to hide in order to escape from kammic result' Therefore, kamma is the result of our action as one of the factors which is responsible for the success and the failure of our life (Dhammananda, 1987).

The principle of karma can help persons to accept their death. Whenever human illness cannot be cured by the healthcare provider, the patient's families usually express spiritual concern through Buddhist practice because the spiritual approach might help older persons to cope with the suffering at the end of their life. From the application of Buddhist beliefs in nursing practice such as performing good acts and thoughts (Kongsuwan & Locsin, 2009), caring with merit, caring based on the belief of kamma, being caring for Sati or consciousness, and being spiritual and faithful in the Dharma for older persons in the end of life stage can enhance those

older persons to non-attachment, to find peace of mind, feel that they are going to go to a good place, and have a peaceful death (Kongsuwan & Locsin, 2009; Somanusorn, 2015). Buddhism has vital factors for decision making in daily life in the older persons with chronic illnesses such as making merit or boon kama, going to the temple, following the middle path, offering food to the monks, praying, following *sila* and good moral conduct and practicing meditation (Manasurakarn et al., 2008).

Buddhism influences many aspects of Thai culture and not only plays an important role in the ways of thinking and living for Thai people but also plays an important role in shaping many aspects of perception on health, illnesses, and death. Buddhism plays a major role in the perceptions and understanding about death in Thai Buddhists. Understanding the reality of life and death or accepting death as the life process of a patient's life can be useful for learning and gaining insight into the true nature surrounding us. Accepting death will enable older persons to be free from suffering, have a peaceful state of mind, and go onto have good rebirth. Therefore, perceptions and understanding death in Thai Buddhists will relate to teachings and beliefs on death in Buddhism. The majority of older persons had expressed the Buddhist way by depending on their religious beliefs to confront their illnesses and their death. Thai older persons who have perception and understanding related to Buddhism will easily accept death in regards to both their own death and their loved one's death. However, these studies have not shown the processes that one goes through to accept death through Buddhist ways. Therefore, grounded theory is an important method for gathering information on the process of accepting death through Buddhist ways in Thai Buddhists with advanced chronic organ failure in this study.

## 4. Grounded Theory

### 4.1 Philosophical background of grounded theory

The grounded theory was developed in 1967 from data gathered from social research by Barney Glaser and Anselm Strauss who are sociologists at the University of California, San Francisco (Annell, 1996; Tavakol, Torabi & Zeinaloo, 2006). Symbolic interactionism is the root of the philosophy of grounded theory that is concerned with the meaning of events to people and the symbols that people use to convey those meanings (Baker, Wuest, & Stem, 1992). Symbolic interaction demonstrates the interaction in individuals or groups to do something and to communicate their objectives or some meaning with other persons (Becker, 1993; Bower, 1989; Levers, 2013; Streubert & Carpenter, 2003). Grounded theory is an inductive study that does not begin with an existing theory but rather generates the theory from the data from the specified substantive area (Chen & Boore, 2009; Hearth, & Cowley, 2004). The goal of grounded theory is appropriated to discover a theory that explains a basic social process that is understandable to those involved in the process from the substantive theory (Levers, 2013).

Grounded theory generates a concept or theoretical construction through systemically collecting and analyzing data. In addition, substantive theory or the relationships of concepts are developed through constant comparative which is the outcome of grounded theory (Baker et al., 1992; Tavakol et al., 2006). Therefore, the grounded theory approach is used for seeking new points of knowledge for the fulfillment of existing knowledge specific to the phenomenon under the study (Strauss & Corbin, 1998). However, there are three differences of philosophical paradigm of

grounded theory and these consist of postpositivist paradigm of Glasser and Struass in 1967, interpretivist paradigm of Corbin and Struass in 1998 and revised in 2008, and constructivist paradigm of Charmaz's in 2006 (Annell, 1996; Levers, 2014).

The grounded theory approach in health care research mostly relies on two different philosophical views consisting of the objectivist grounded theory of Glaserian which is rooted in postpositivist paradigm or based on an etic position (researcher is separate and looks at social realities) and subjectivist grounded theory which is the root of interpretive paradigm of Strauss and Corbin or is based on an emic position (researcher constructs the data through adopting a position of mutuality and partnership between the researcher and the participant and creates the theory of social process using their own perspectives, values, privileges, interaction, and understanding of the social realities (Taghipour, 2014).

**4.2 Ontology of grounded theory**

Relativist ontology believes that the construction of the multiple realities comes from the multiple interpretations of the different subjective experiences (Levers, 2013). People in the social world usually have specific symbols such as style of dress, language, verbal and nonverbal expressions for many situations through the interaction of behavior in their lives. In addition, the reality from relativist ontology is concerned with the conditional matrix of people in social interaction and their context such as historical, temporal, cultural, and subjective. The reality is constructed relatively to people, time, place, and their interaction. The reality cannot actually be known but is always interpreted from the perspective of individual thought, meaning

of human action and social processes under a specific context (Bikes, Chapman, & Francis, 2006).

While the grounded theory according to Glaser is based on a critical realist ontology and postpositivistic paradigm which places belief in a single reality or true reality that is comprehendible from a partial fragment in direct experience (Levers, 2013), a participant's main problem, and how he/she resolves it emerges objectively from the data (Marky, Tilki, & Taylor, 2014). The purpose of critical realist ontology is to identify and develop agreement regarding the description of the whole from previews or partial fragments, it is searching for the true meaning or the reality that exists in the data concerning only the individual in society, the relationship of the individual perspective, the objective of investigation (Levers, 2013), which is to discover a theory from unbiased observer data (Targhipour, 2014). Critical realist ontology does not consider the existence of reality in social phenomena, the epistemology, and the observations (Annell, 1997; Levers, 2013). The true reality needs to be identified without the researcher's experience, belief, view, perception (Annell, 1997; Marky et al., 2014), and human mind (Levers, 2013).

### 4.3 Epistemology of grounded theory

Epistemology refers to the way of understanding and explaining how knowledge is developed, and the relationship between the inquirers and who are inquired. This study will rely on the grounded theory of Strauss and Corbin (1998) or subjectivist epistemology (Bikes et al., 2006; Lervers, 2013). The reality is subjectively perceived which is able to be fully understood or reconstructed by a researcher (Lervers, 2013). The researcher needs to be involved with the method in

the research process such as collecting data, analyzing data, and theoretical sampling (Annells, 1996). The researcher is internal to the process of emergence by participating as a constituent element in the creation of emergence. In addition, subjectivism has a belief that knowledge is always filtered thought the lenses of language, gender, race, social class, and ethnicity (Lervers, 2013).

While Glaser and Strauss in regards to objectivist epistemology, believe that the truth resides within an object and is independent of human subjectivity and human mind. The researcher is external to the process, there is no researcher involvement in interpreting the data, and the researcher is the observer rather than a creator or participant. The researcher remains open to what is actually happening without forcing the data (constituent parts) to fit the theory (emergent theory). Removing the human bias or the independence of the researcher and having a separate existence will lead to the discovery of knowledge (Lervers, 2013). Finally, the research approach must be based on philosophical background because it will guide the research process and methodology of research (Backman & Kyngas, 1999; Birks et al., 2006). The difference of paradigmatic dimension will lead to differences of formulation of research question, analysis procedure, usage of literature, sampling procedures, and the procedure for validating the results of the study.

**5. Summary of the literature review**

The increasing older population relates to the increase of older persons with advanced chronic illnesses which are the top five causes of death in the older persons. Advanced chronic organ failure is a life threatening illness in the older persons due to its effects to physical, psychological, social, and spiritual aspects. In addition, it does

not only affect the older persons but also their caregivers. When the older persons with chronic organ failure had advanced stages of illness, worsening of their disease and treatment withdrawal, they had to recognize or think about death in different ways depending on their condition. The older persons with advanced chronic organ failure can accept death as inevitable and not that far away in terms of their life, they have a desire to discuss an advanced care plan to prepare for their death. Acceptance of death is first priority of older persons before discussing an advanced care plan related with death preparedness, death awareness, sharing decision making, and communicating their wishes in their life. Acceptance can lead to a peaceful death and dying with dignity at the end of life in older persons.

In the Thai context, life and death are viewed based on Buddhism where in human life relies on the nature of the reality of life, the four noble truths, the law of kamma, the nature of life existence or trilukkana, and the five aggregates. Buddhist's view on death is the impermanence of life, preparing for death at any time, and the peace of mind that can lead to a good rebirth. Buddhism is a way for Thai patients to accept death, enhancing non-attachments, releasing the suffering, creating a peaceful mind and peaceful death. However, the literature does not show any study about the process of accepting death especially in the older persons with advanced chronic organ failure. Therefore, the grounded theory of Strauss and Corbin (1998) is a vital method to discover the acceptance of the process of death for older persons with advanced chronic organ failure. The results of this study will be useful for healthcare providers to improve their communication skills about death with the older persons with advanced chronic organ failure and their families, as well as enhance the palliative care movement in Thailand in part of advanced care plans

# CHAPTER 3

# RESEARCH METHODOLOGY

This chapter describes the research design, setting, participants, instrumentation, data collection, data analysis, ethics of the study, and the establishment of the trustworthiness used to conduct the study. For each detail, the researcher had explained as follows;

## Research design

Grounded theory approach developed by Strauss and Corbin (1998) was used because the journey to death acceptance among Thai Buddhists older persons with advanced chronic organ failure contained specific actions, symbols, meaning, and objectives. Research methodological refers to how the researcher or inquirer goes about finding the reality. This study discovered the new points of knowledge of the process of death acceptance in Thai Buddhist older persons with advanced chronic organ failure for the fulfillment of existing knowledge throughout the process of systemically collecting and analyzing data. The researcher had constructed the ontology of death acceptance components throughout the interpretation of the symbolic interaction of the older persons with advanced chronic organ failure in covering how they had processed death acceptance, and how they had interacted/communicated about death between nurses, the physician, and their family members. All the processes of this research depended on grounded theory that was a systematic method because analyzing data, and generating a theory occurred simultaneously while collecting the data. At the same time the researcher tried to

concern with theoretical sampling, constant comparatives methods when analyzing data, and tried to write memos during the process of the study (Baker et al., 1992). Importantly, the methodology of this research was based on previous knowledge, previous researcher's experience, and literature reviews. Strauss and Corbin (1998) state that it can enhance theoretical sensitivity and can contribute to starting the research process, helping the researcher to select the appropriate first participants, and theoretical sampling helps to find the next participants, to develop, create or cut research questions. Moreover, throughout the data collection process the researcher has to verify the similarities or differences through constant comparative in the course of the research project, memo writing, and theory construct at the same time.

**Setting and context**

This study was conducted in older persons in the community who had been living in the Southern part of Thailand. However, the majority of the sixteen participants in this study had experienced follow up appointments, admissions, and referrals to Songklanakarind Hospital, Songkhla, and Hatyai Hospital because they were in advanced stages of diseases and had confronted near death experiences. The participants had experienced requiring advance medical treatments from three hospitals which were tertiary hospitals that are advanced in the use of medical technology.

## Participants

### Selection of the participants

Sampling in grounded theory consisting of purposive sampling and theoretical sampling. Selecting sampling of participants is defined in the first time and theoretical sampling occurs between data collection and analysis after several observation visits to the site, the researcher will know who the participants of the study are or who fits with the purpose of the study such as age, gender, status, and role or function (Coyne, 1997).

Firstly, selecting or purposive sampling is the process that makes decisions for the researcher for the recruitment participants by defining purposive sampling from literature reviews. In this study, firstly the participants were selected by purposive sampling by following the inclusion criteria which consists of: 1) age more than 60 years old, 2) Thai Buddhist older persons having been diagnosed with advanced chronic organ failure consisting of 2.1) congestive heart failure (CHF) functional class III or IV, 2.2) chronic renal failure (CKD) in end stage of disease or stage V, or end stage of renal disease (ESRD), and 2.3) chronic obstructive pulmonary disease (COPD) having had been readmitted to the hospital more than three times per year due to exacerbation of the disease, 3) having normal levels of consciousness, 4) willing to be interviewed or participate in the study, and, 5) had near death experienced and perceive his/herself as accepting his/her coming death or that his/her death is imminent and they do not fear death. In addition, this study has an exclusion criterion for older persons who have been diagnosed with anxiety and depression that are taking medication for the treatment of anxiety and depression symptoms because

there were studies that have shown that the level of anxiety and depression are negative factors to predict fear of death in older persons (Stromberg & Jaarsma, 2008).

Secondly, theoretical sampling or theoretical sample is a rigorous method for generating substantive theory in the process of the collecting and analyzing the data. Theoretical sampling had happened between the collection process for generating the theory which collects codes, analyses the data, and decision in regards to the data to collect next and where to find to it in order to develop the theory that emerges simultaneously. Theoretical sampling strategies controlled the process of the collection of the data and the emerging theory by based on the decision of researcher who will be the sample next by relying on the collection guide underpinning the coding of the categories, analyzing, and comparing (Coyne, 1997). Theoretical sampling is the process for sampling the event more than specific to a person. The process of theoretical sampling believes that if differences in persons exist, the meaning will be different (Birks et al., 2006). The researcher could conduct theoretical sampling by checking the development of the categories, filling out categories and the properties, and decision making as to what is the data that needs to be connected next, and who is the next appropriated sample until theoretical saturation has been reached. Saturation is reached when no new data emerges that is relevant to particular categories and subcategories (Becker et al., 1992; Bower, 1989; Coyne, 1997). Moreover, theoretical sampling has an effect to change the interview questions by cutting or adding questions. The process of theoretical sampling believes that if differences in persons exist, the meaning will be different (Birks et al., 2006). The researcher needs to return to the participants according to the aim of study

research until the properties of categories are defined, and the categories to be saturated or nothing new emerges from the participants (Birks et al., 2006).

For the next participants in this study were selected by theoretically sampling. Some inclusions criteria were added to, depending on several observation visits to the site because the researcher got to know who were the suitable participants of the study or who fits with the purpose of the study. Selecting further participants on the basis of the information gathered from the early interviews. In this study, after interviewing and analyzing the data from the first participants, the researcher found that the characteristics of the older persons who could accept their death had inclusion criteria more than purposive inclusion criteria. In the next step, the researcher needed to add to the inclusion criteria depending on the data from the first participants for finding the next participants who would meet new inclusion criteria. For example, the data from first participants' analysis found that the participants who had been in the stage of death acceptance had prepared for their impending death by donating their body to the hospital. The researcher had used this criteria to find the next the participants who could accept death and had prepared for their death in ways such as donating their body. In addition, based on the results from second interviews, the researcher found that the participants who had confronted near death experiences was an important condition that led to the participants accepting their impending death. In the next step, the researcher needed to find the participants who had near death experiences as the next participants. In addition, the researcher knew what data needed to be explored and considered those who would be the next appropriate participants until no new data emerged. In addition, with regards to the results from the first participants, the researcher needed to constantly compare or test the hypothesis due to the participants

who had near death experiences as to whether they had accepted their death or not. Moreover, if the researcher had found any new data in the next participants, the researcher would have had to return to the first participants or add some new questions for the next participants to fulfill the aim of the study until the properties of the categories were defined, and the categories from the participants were saturated or nothing new emerged. The number of participants in this study cannot be determined as it depended on the data generated and the saturation of the data until no new information was generated from the process of data analysis and theoretical sampling (Birks et al., 2006). For the issues Theoretical sampling in this study can show in Appendix E.

**Participant recruitments**

Talking on death issue is difficult because it may be a sensitive issue for the participants. In this study, the researcher had prepared the guideline consisted of three steps for recruiting the participants to participate in the study. Firstly, the researcher had approached Thai Buddhist older persons with advanced chronic organ failure who had met the inclusion criteria from the suggestions of gatekeepers or the nurses in the community hospitals. The nurses had suggested patients who met the inclusion criteria to gain the participant's diagnosis, age, religion, name, address, telephone number and their key family member, respectively. Secondly, the researcher had contacted the key family members to ensure that the participants could accept their death by asking about the patient's feelings and thoughts about death through the key family member. The key family members confirm that the older persons could talk on death issues or have positive emotion when they heard about death issue both death of

others and their own death. Lastly, understanding and perception about a patient's own death would be reconfirmed by the researcher's screening. In this step the researcher confirmed the older persons about their feeling or thought on death, if the older persons have positive thought on death or look at death as inevitable, and prolonging death is impossible, understand that birth, aging, sickness, and death is a natural part of life, accepting the reality of life that everyone dies (including the older persons) and perceive him/herself as accepting his/her coming death or that his/her death is imminent, they were recruited to be the participants in this study.

**Research instruments**

The instruments for collecting the data are consisted of the researcher, the instrument for collecting demographic data, and open-ended questions for in-depth interviews. These can be explained as follows;

The researcher was the key instrument for the investigation process in this study of the death acceptance in Thai Buddhist older persons with advanced chronic organ failure. The majority of the roles of the researcher was interviewer, analyzing the data, comparing the data, memo writing, and developing theoretical sampling. In addition, the researcher used observations, made tape recordings, and taken field notes together. In during the data collection process the researcher had analyzed the data, compared the data under the conditions, action, and consequences of death acceptance with the knowledge from the literature review, between the participants, write memos in regards to the process of death acceptance in Thai Buddhist older persons with chronic organ failure, as well as produce research questions, and recruit participants to fulfill the substantive theory.

The instrument for collecting demographic data consists of age, gender, marital status, level of education, occupational status, type of diseases and stage of disease, time period of having been diagnosed with advanced chronic organ failure, and type of treatments were appeared in Appendix A. In addition, an open-ended question was developed by the researcher for in-depth interviews in the process of death acceptance in Thai Buddhist older persons with advanced chronic organ failure were appeared in Appendix D.

**Ethical considerations**

Before starting to collect the data, the researcher had approached the Ethics Committee of the Faculty of Nursing, Prince of Songkla University, Thailand. Afterwards, the researcher obtained ethical approval from the IRB (No. 521.1.05/2684) and received permission from the Head of the Public Health Department of Songkhla province to approach the participants through the nurses in community. Consent was also provided for the protection of the participants who met all of the inclusion criteria and who were willing to join this study.

Significantly, before the participants were asked for consent and started interviewing, they received all the information related to this study such as the objectives of the study, and examples of the questions. The researcher concerned the beneficence to the older persons because this study was talking about death which is a sensitive issue for them. The researcher gave the information that if some questions will make them uncomfortable or will have a negative effect to them, the researcher will stop the interview, provide support for their feeling, and follow up at least one time if the participants need. In addition, if the participants do not appreciate to join

with the study, they can withdraw in any time of the study and will not have any effect to their nursing service or medical treatment in the future. Finally, the researcher ensured the confidentiality of the older persons that all information presented was in number and informal name. All of the data were kept in confidential and all of personal data will be destroyed after completing the analyzes of the data process.

**Data Collection Method**

The data collection in the grounded theory approach needs to combine many sources to enhance creditability including observations, in-depth interviews transcripts of documents, diaries or written documents for social structure, and field notes throughout the research process (Birks et al., 2006). In this study the researcher had collected the data by a combination of various techniques that is shown as followed;

**In-depth interview**

Interviews with individual participants are the most commonly used methods for data collection in grounded study. Both unstructured and semi-structured can be suitable in grounded study. However, semi-structured is most important in grounded study because the key issues emerge to facilitate the development of the theory (Bluff, 2005). The duration of time for the interviews in grounded study around 1 hour can be considerable varying to every individual participant's health and other circumstances. Audio-recording and transcribing are usually done between the

interviews. The interview process requires good listening skills, and sharp observation of the researcher (Foley & Timonen, 2015).

In this study, in- depth interview was used to discover the life journey and death acceptance process of Thai Buddhist older persons with advanced chronic organ failure. In the initial interview process the participants were asked by a semi-constructed interview and all participants were asked some key open-ended questions following the interview guide that the researcher had developed from the literature reviews. The researcher spent time to interview and audio-record for around one hour with concern to the readiness of participants.

**Observations**

Observation is a rigorous method in grounded study because it is important to pay attention to nonverbal signs in different contexts all throughout the interview. In addition, observation is the ability to perceive the reaction and sensitively of participants to some research questions (Foley & Timonen, 2015). The researcher needs to concern with the ethical issues of observations (Bluff, 2005).

In this study, observations were used to perceive the interaction between the participants and their family members, other patients, and health care providers especially nurses. The researcher prevented the occurrence of ethical issues by keenly observing the reaction of the participants when talking about death knowing that death is a sensitive issue for them. Observing the action of the participants is also useful in explaining their reactions in terms of accepting their death like facial expressions and gestures.

### Writing field notes and reflective thinking

Field notes are writing the researcher's observations during the data collection covering the aspects of context of the study, facial expressions and signs that cannot be recorded on the tape (Bluff, 2005). Writing field notes is very important in grounded theory. Field notes in grounded study are essential because they contain some early analytical notes. Field note also includes more information during the preparation from the first draft, during coding and to memo writing. It is useful because it guides the researcher to read further literature to expand the researcher's ideas. Writing field note is also used to describe the interview setting and record observations such as tone, mood, and reaction of the participants after the interview. Field note is described as the researcher's memory in studies (Foley & Timonen, 2015).

In this study, after each interviews the researcher had a written summary that was transcribed from the audio-recorded, writing reflective thinking on the result of interview, and taking field note if some of the content that are needed for further interview. Writing the field note and reflective thinking is useful for researcher in the initial process and when deciding for the theoretical sampling such as deciding of the next question, need to be explored and the next participants. An example of writing field note and reflective thinking can be seen in Appendix D.

## Data Collecting Process

The data in this study was collected following these steps:

1) After approaching both the Ethics Committee of the Faculty of Nursing,

Prince of Songkla University, Thailand, and gaining permission from the Head of the Public Health Department of Songkhla province for approaching the participants, the researcher recruited participants through the suggestions of the nurses in the community hospitals to access the prospective participants who met all the inclusion criteria and used snowball technique by relying on the inclusion criteria.

2) The researcher needed to know the background information of the illnesses of the participants, and key family members that have close relationships with the participants. Before the participants were informed and asked consent for the study, the researcher applied some guidelines for approaching this difficult conversation about death from the Help Guide's Harvard Collaboration, 2015. Initially, the researcher needed to ensure that the participants could accept their death. Which the researcher had assessed the competency of the participants in accepting their death through the key family members who have a good relationship with the participants through these questions such as ‘how are the participant’s reactions or feelings when he/she hears about his/her death sentence’?, ‘What is the understanding of death by the participant’?, and ‘what are the participant’s feelings on confronting the death experience of a loved one or other older persons’?

3) After the key family members who have a good relationship with the participant had confirmed that the participant could accept his/her death, the researcher confirmed again the competency of the patient to accept his/her death. In the first contact session, the researcher developed a relationship between the researcher and the participant over time for facilitating the discussion of this sensitive and complex topic. The researcher required to have adequate time to develop the relationship by starting to talk about general issues until the older persons with

advanced chronic organ failure was familiar with the researcher, and they were comfortable to talk about issues such as how sick are you?, what do you worry about?, how can I help?, and is there anything you want to talk about?, this might have helped instead of asking specific questions. After that, the researcher had reconfirmed the participant's acceptance of their death by asking the participant about his/her experience in confronting death such as the death of a loved one, or experience in confronting a situation about the death of other older persons. The following question explored what do you feel/think about it? to open the door for the patient who was ready to talk about death. The answers of the patient could reflect that he/she could accept his/her death or what his/her attitude was towards death. If the participants mentioned death/looking on death was a natural part of life, death was inevitable, and prolonging death was impossible, and birth, aging, sickness, and death as inevitable, the researcher then decided how to proceed with a more in-depth interview.

4) After the participants had met all of the inclusion criteria and agreed to be a part of the study, the participants were provided with information about the purpose of this study, the potential benefits or results to nursing practices, and informed consent was gained form them.

5) The researcher collected the data following the interview guide. While collecting the data the researcher performed comparative sampling data concerning the differences of diagnoses, gender, and stage of illnesses, and compared previous study reviews between the participants in terms of perceptions on death, perceptions of death acceptance, strategies for death acceptance, conditions, and the consequences of death acceptance. In addition, during the process of collecting the data and

analyzing the data the researcher generated some questions to test some of the hypothesis to enhance the completeness of the constructed model. At the same time the researcher wrote memos for the operation theory and theoretical sampling in relation to how the participants reach death acceptance through the model based on the Buddhist way. The time for the collection of the data until the saturation of the conceptual information was achieved meant no new codes emerged, and no new data was produced to explain the situation further (Baker et al., 1992).

6) Between the interview processes, the researcher screened the participants' emotions after the interviews as well as any time during and before the interviews. If the questions led to develop the physical and emotional distress for the participants, the researcher will stop, provided an opportunity for the older persons with advanced chronic organ failure to withdraw from the study at any time. If the patient needed counseling and support, the researcher provides time to follow up by telephone call and home visit. However, the researcher has prepared the ethical guideline through data collection process both recruitment stage and collecting data stage are shown in figure 1 as follows;

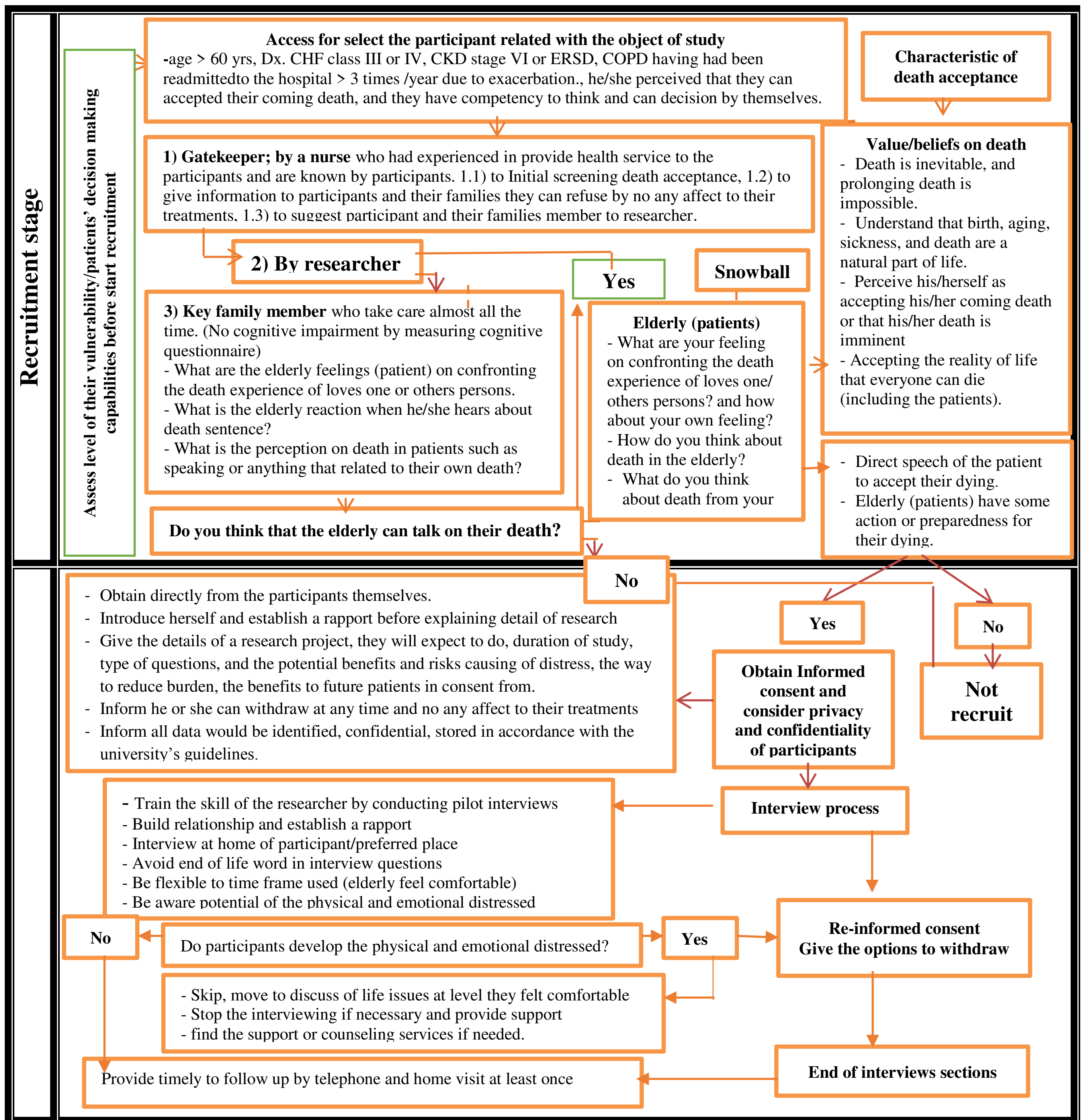



**Figure 1** *Collecting process covered recruitments stage, the data collecting stage, and ethical guideline*

**Data Analysis**

The demographic data consists of age, gender, marital status, education level, occupational status, type of diagnosis, time period of diagnosis, and type of treatments by using descriptive statistics such as mean and percentage. The data from the interviews were analyzed following the three steps coding procedure of Strauss and Corbin (1998); open coding, axial coding and selective coding are outlined as follows;

Firstly, open coding is the first phase of the analysis of the data that is breaking the raw data into units of meaning. This phase is trying to develop an in vivo code to the concrete description by labeling the single word, and decoding line-by-line the data to describe the essence of the experience. However, concrete descriptions may overlap and thus need to be modified and deleted in the process of data analysis (Birks et al., 2006). In this step, the researcher split the raw data into units of meaning that were concerned with the objectives of the study and research questions that occurred every time during data collection. After splitting the raw data into units of meaning, the researcher looked at the conditions of unit meaning, the actions, and the consequence of death acceptance in Thai Buddhist older persons with advanced chronic organ failure.

Secondly, axial coding is reforming the data from open coding into categories. A category is classified as a concept through the process of constant comparative method that is controlled by the theoretical sampling (Devadas, Silong, & Ismail, 2011). The constant comparative method is specifically used in the axial coding analysis stage. Constant comparative is comparing the units of data for comparing the incidents applicable to each category, integrating the categories, delimiting the theory, and writing the theory. Constant comparative has the objective for comparing codes

or substantive theory with others such as similarities and differences between participants, and between previous literatures reviews (Coyne, 1997). This stage is comparing the data with the data, case with case, event with event, and code with code for understanding the variables in the study. Constant comparative is based on 6C paradigm model such as context, cause of some actions, consequences, conditions, covariance, and contingents (Strauss & Corbin, 1998). Importantly, the constant comparative of data continues until the theory is fully developed or the theory has sufficient detail and it can be explained (Baker et al., 1992; Birks et al., 2006).Therefore, this phase is used to identify the conditions, actions, or interactions, and the consequences to guide the properties in grouping the categories and the relationships between the categories (Birks et al., 2006). After performing the constant comparative this can lead to flexibility and open-ended questions may change (Baker et al., 1992).

In this phase the researcher applied axial code to the categories by concerning the interrelationship of all the categories. Connections are made between the categories and the subcategories which involved putting the data together, leading the categories to the core phenomena or core categories. The researcher had concerns with the core phenomena that need to consist of causal conditions (what factors caused the core phenomena), strategies (actions taken in response to the core phenomena), contextual or intervening conditions (broad and specific situational factors that influence the strategies), and consequences (outcomes from using strategies). In addition, while categories are classified, the hypotheses must be verified at the same time through the constant comparatives process or seeking the similarities and differences in meaning between the participants and previous

literature reviews. Therefore, during the process of data analysis and data collecting, researcher had compared the similarities and differences of conditions, actions, and consequences of death acceptance between the participants, and between previous literature reviews by constant comparative similarities and differences of antecedence to thoughts on death, the attributes of death acceptance, conditions that influence the death acceptance, and the consequence of death acceptance in Thai Buddhist older persons with advanced chronic organ failure. Moreover, the researcher had compared the process in death acceptance in the differences between the contexts of diseases such CHF, ESRD, and COPD, the stage of disease, the context of treatments, gender both males and females, age range or level of ages, and interactions between family members/doctors/nurses. For example, from the pilot preliminary study it was found that the participants needed hospitalization from worsening progressions of their disease and this was an antecedence to recognizing on death in the first being the older persons in the preliminary study. The researcher needed to compare what is an antecedence to recognizing on death for the other participants to cover CHF and COPD older persons. For the issues constant comparative in this study can show in Appendix E.

Importantly, theoretical sensitivity is important for successful development of substantive theories. Theoretical sensitivity refers to the competency of the researchers to have insight into the meaning of the data, understand and to separate both relevant and irrelevant data. The source of theoretical sensitivity of Straussian grounded theory comes from professional experience, personal experience, literature reviews and the analysis process (Annells, 1997). The literature should be reviewed because it can enhance the process of analysis, enhance theoretical sensitivity, direct

theoretical sampling, and comparison the concept (Strauss & Corbin, 1998). Although prior knowledge and experiences are useful for the sensitivity of the researcher to develop the theory, this needs to be done without preconceived concepts into the data analysis process. In this study the researcher started with literature review and had used some conditions from literature reviewed to make constant comparative with the process of death acceptance in Thai Buddhist older persons with advanced chronic organ failure such as literature reviews found that no one need to concern in positive condition that could contribute the older persons to accept their death. The researcher had tested the hypothesis by comparing these issues from the participants in this study.

Finally, selective coding developed the conceptual model into the theory. Selecting coding is the process that links all categories and sub-categories to the core category. In this phase the researcher integrated the core categories, identifying the relationship or overreaching of a category, and the ability to explain the propositional statements or hypothesis relationships between the categories. (Strauss & Corbin, 1998). Straussian mentioned that selecting coding is to be done since this generates the core categories. In addition, memos writing coded notes, and theoretical notes or operational notes during the research process were important issues in this stage. Memos are formed or integrated throughout the structure of the diagram in the process of selective coding (Birks et al., 2006). The researcher needs to write memos as it is a crucial method in theory development and occurs throughout the process of data collection and analysis. Memo writing is the direction for emerging theoretical construction from the researcher's thinking by exploring provisional hypotheses from coding, categories, and the relationship of the categories. While integrating the model,

the researcher needs to be concerned with frequent occurrence, good connections to other categories, existing literature or other data, and filling in the categories for completeness. For the method open coding, axial coding, selective coding and memos writing were appeared in Appendix D.

It is most important to validate the result of grounded theory. Validating the relationship between a core category and other categories that require further refinement and development will also be carried out by the researcher. The result of grounded theory is a substantive theory that consists of concepts that are related to others and can be explained by the relationship of those concepts. The result of grounded theory approach must be to present the quality and the credibility of the data, must be well integrated, easy to understand, relevant to the empirical world, and can explain the process of the phenomenon of the study. Theory must be fit, grab, and work. By fit means as the categories are generated that is indicated by the data or is fitted with the area. Theory is general and easy to understand for the application to the substantive area. Grab means the data must be relevant to the participant's group and to the practice groups. Lastly, work means the theory should explain what is happening, predict, and interpret the outcome (Beker et al., 1992). Strauss and Corbin, (1990) use many techniques to cover validity, reliability, credibility, and plausibility and the value of theory, adequacy or research process, and the empirical grounding of the research process (Devadas, Silong, & Ismail, 2011). Constant comparative in the verification of Strauss will occur in any stage of the research process. Some ideas or hypotheses generated will be dropped if their importance fails to appear in the data (Hearth & Cowley, 2004).

## Establishment of Trustworthiness

In qualitative research, errors can occur from the process of data collection and analysis. Therefore, the rigors of research process are important to reflect the quality of the research study. The trustworthiness is important in evaluating the worthiness of the research study. Especially, grounded theory is constructed theory from the data so the researcher needs to design the way to increase the rigor of study by establishing and following the strategies of credibility, transferability, dependability and conformability of Lincoln and Guba (1985). Which the criteria of these strategies can be explained as follows:

### Credibility

Credibility refers to the confidence that the researcher can present the truth of the findings of the study and is confident that the information is sufficiently accurate or correct (Sikolia, Biros, Mason, & Weiser, 2013). Credibility in qualitative research can compare the internal validity in quantitative research. There are several techniques to enhance credibility that are explained as follows:

#### *Prolonged engagemen*

Prolonged engagement refers to period of time spent with the informant to enhance the research findings through intimate familiarity and increased rapport. The true data of qualitative research relies on the closeness of the relationship between the researcher and the informants (Morrow, 2005). Informants will become accustomed to the researcher which can lead to the discovery of hidden facts,

misinformation and the repetition of some questions to confirm the information through numerous interviews and observation periods (Bitsch, 2005).

*Triangulation*

Triangulation refers to the use of multiple techniques for collecting data to minimize distortion from single data sources or a biased researcher. In addition, triangulation can be generated through three methods 2.1) triangulation of data methods or getting data from a combine many sources such as observations, in-depth interviews, transcripts of documents, and field notes throughout the research process (Sikolia, Biros, Mason, & Weiser, 2013), 2.2) triangulation of data source by relying on a variety of times such as time of day, week, and seasons, variety of persons, age, gender, and variety of settings. Using triangulation of data sources because of the belief that differences of environments or natural situations can affect the perception of participants and results, theoretical triangulation means ideas from various theories are considered when interpreting the data, and 2.3) investigator triangulation means using a research team or more than one person to investigate the data (Bitsch, 2005).

*Member checking*

Member checking refers to continually testing the researcher's data with the informants between collecting the data and the final check for ensuring that the researcher has accurately translated the informant's viewpoint into the data. Selecting the terminal member check needs to be concerned with ethical aspects such

as the participant must be conscious of the information because it may trouble them (Bitsch, 2005; Sikolia et al., 2013).

*Peer debriefing or peer checking*

Peer checking refers to using a panel of experts who have had experience with those issues or the researcher's colleagues to discuss the research process, the findings, and to check the categories that are constructed. Therefore, the availability of the informant's verbatim or transcripts of interview accounts are helpful for examiners to assess the interpretations from direct quotes (Morrow, 2005). For others such as the interviewing process, the credibility can be enhanced by the process of reframing questions, repetition of questions, and expansion of questions on different occasions. Structural coherence is the consistency between the data and its interpretation or it integrates the research report into a logical or holistic picture (Bitsch, 2005; Sikolia et al., 2013).

The credibility in this study is when the researcher enhanced the correctness of the findings to the phenomena under study through prolonged engagement, triangulation, peer review, and member checking techniques**.** Before the initial interview process the researcher tried to gain more understanding about methodology and analyzing data through the preliminary study were appeared in Appendix D. The research established the trust in patient throughout starting with general perception in their illnesses before asking about death acceptance. For triangulation the researcher used a triangulation of data methods for collecting data such as observations, in-depth interviews, taking field notes, reflective thinking, and memos writing. Lastly, both during the interview and after analyzing the data, all of the results were checked by

some participants by re-interviewing in some part for prevent mistake information, enhance understanding, and confirm interpretation.

**Transferability**

Transferability refers to findings that can be applied to other contexts and settings that are not relevant to qualitative study because a unique phenomenon is being described. The results are general in relation to other contexts, situations, and populations. The findings fit into other contexts that are determined by the degree of similarity or goodness of fit between the two contexts. Therefore, enhancing the transferability in the original by thick description mean that the researcher needs to present sufficient descriptive data both information of research contexts or setting and demographic information of participants. Moreover, transferability can be enhanced through clear description of the research, the participant's diverse perspective and experiences, methodology. It is useful for the reader in comparative studies and decisions for application to other contexts (Bitsch, 2005; Morrow, 2005 Sikolia et al., 2013). Transferability in this study, the researcher explained characteristics of sixteen participants through the inclusion criteria such as varies stage of illnesses, variety of diagnosed, varieties both males and females. In addition, in the result researcher tried to present the context of study through explanation about demographic information of participants in the study. It is useful reader decision to apply the result to others group or similar setting.

### Dependability

The dependability criterion relates to the consistency of findings across time, researcher, and analysis technique (Sikolia et al, 2013). Between methods such as the focus group and individual interviews. Therefore, exact data gathering, analysis, and interpretation must be described. In regards to the techniques for enhancing dependability, there are many methods such as peer researchers (stepwise replication by two researchers between student and major advisor), code-recode procedure by repeat code after a distance of at least two weeks, and triangulation between method and experts. Audit trial by other experts is useful for any decisions of the researcher in the study and can enhance both the dependability and conformability of the project (Morrow, 2005). For dependability in this study, the researcher clearly defined the process of the research methodology. The researcher had sufficiently supported the raw data or statements and explained clearly the categories, properties, and relationships between the core categories.

### Conformability

External audit is a major technique for establishing conformability in qualitative study. An external auditor will consider the process of the research as well as the product, data, findings, interpretation, and recommendations. Auditing trial provides the necessary material for confirming research (Sikolia et al, 2013). Therefore, the researcher needs to prepare six categories recoded for auditor reconstruction and analysis product (thematic categories, interpretation, inference), cover raw data (field notes or audio recordings), data reduction and analysis production (condensed notes), process notes (data procedure, design strategies,

trustworthiness notes), materials related to intentions (study proposal and field notes), and instrument development information (pilot forms, survey format, schedules). In addition, the auditing process uses a team of researchers familiar with qualitative methods rather than single researchers, triangulation of multiple methods, data sources, and theoretical perspectives (Shenton, 2004). In regards to confirmability in this study, the researcher kept all documents or original data for the auditor (advisor) such as pilot data, raw data, and verbatim transcript for confirmability. Enhancing trustworthiness was applied in this study can be show in the table 2:

**Table 2** *Trustworthiness was applied in this study*

| Trustworthiness | Strategies | Methods applied in the study |
|---|---|---|
| Creditability | Prolonged engagement | • Establishing trust, intimate familiarity, and increased rapport throughout starting with general perception of their illnesses about 30-45 minutes before asking about accepting death. |
| | Triangulation of data sources | • Using a variety of triangulation methods for collecting data such as observations, in-depth interviews, reflective thinking, and taking field notes. |
| | Peer debriefing | • Using the major and co-advisors check on the research process and check preliminary findings and interpretations against the raw data. |
| | | • Using a panel of experts (major advisor and co-advisor) to discuss the research process, the findings, and to check the categories that were constructed between the collecting and analyzing the data process. |

| Trustworthiness | Strategies | Methods applied in the study |
|---|---|---|
| | Member checking | • Confirming all of the results by the participants both during the interview and after analyzing the data.<br>• Re-interviewing in some parts to check for any mistakes in the information, enhance understanding, and confirm interpretation. |
| **Transferability** | Thick descriptions | • Trying to describe the methodology, interpretation of results and demographics of participants through all details of inclusion criteria such as various stages of illnesses, diagnoses, ages, and gender both males and females. |
| | | • Trying to present the context, and setting of the study in the results of study. |
| **Dependability** | Audit Trails | • Supporting sufficiently the raw data or statements and explanations clear for the categories, properties, and relationships between core categories for auditing. |
| | Code-recode procedure | • Repeating and rewriting the sub-categories, categories, and concepts until the results could explain the phenomena by researcher and major advisor, and co-advisors. |
| **Confirmability** | Audit trial | • Keeping all documents or original data such as pilot data, raw data, and transcript verbatim for auditing by major advisors and co-advisors.<br>• Trying to mention the reasonable for selecting the theoretical, methodological, and analytical choices throughout the entire study. |

# CHAPTER 4

# FINDINGS AND DISCUSSIONS

The objective of this study was to discover the process of death acceptance and constructed the ontology of death acceptance components among Thai Buddhist older persons with advanced chronic organ failure. The study attempts to answer the main research question using the grounded theory of Strauss and Corbin (1998). This chapter presents all of the results covering the characteristics of Thai Buddhist older persons with advanced chronic organ failure, the processes used among the Thai Buddhist older persons in confronting overcoming fears and accepting associated with their death. In addition, the acceptance of death among Thai Buddhist older persons with advanced chronic organ failure also covers the conditions, action or interactions and the consequences. This chapter includes explanations and discussion about the relationship between the core-categories, categories, sub-categories and the concept of death acceptance in Thai Buddhist older persons with advanced chronic organ failure.

## Characteristics of the Participants

The participants in this study were sixteen Thai Buddhist older persons with advanced chronic organ failure consisting of nine males and seven females. Their ages ranged from 60 to 81 years old. The mean age was 63.56 years old. Most of the participants had an educational level at elementary school level. Eight participants were married, six participants were widows, and two participants were divorced. Eight participants were diagnosed with end stage renal disease (ESRD), five

participants were diagnosed with congestive heart failure (CHF) with functional class III/IV, and three participants were diagnosed with chronic obstructive pulmonary disease (COPD). Eight participants had been diagnosed from ten to twenty years, six of them less than five years, and two persons had been diagnosed for more than twenty years. The average length of time having been diagnosed was 11.81 years. The most common type of treatments are medications, hemodialysis (H/D), and continuous ambulatory peritoneal dialysis (CAPD), respectively. The demographic characteristics of the participants are shown in table 3.

**Table 3** *Demographic characteristics of the participants (N=16)*

| Characteristics | Frequency |
|---|---|
| **Gender** | |
| Male | 9 |
| Female | 7 |
| **Age** | |
| 60-65 yrs. | 9 |
| 66-70 yrs. | 3 |
| 71-80 yrs. | 1 |
| 81+ yrs. | 3 |
| **Education level** | |
| Elementary school | 10 |
| Secondary school | 1 |
| High school | 5 |

| Characteristics | Frequency |
|---|---|
| **Relationship** | |
| Married | 10 |
| Widow | 4 |
| Divorced | 2 |
| **Diagnosis** | |
| CHF | 5 |
| COPD | 3 |
| ESRD | 8 |
| **Length of time diagnosed** | |
| <5 yrs. | 5 |
| 5- 9 yrs. | 3 |
| 10-20 yrs. | 6 |
| >20 yrs. | 2 |
| **Type of treatments** | |
| CAPD | 1 |
| H/D | 7 |
| Medications | 8 |

The details of the demographic background of each participants are explained in the following;

**Participant 1**

Reon is 73 years old. He graduated from high school. He was a retired government officer. His status was married. He has been diagnosed with COPD for

over 30 years.When he was about 50 years old, he began to realize that death was common and he saw himself as an old man because he started thinking about his old issues when his children graduated and started to their careers. About 6-7 years ago, he experienced severe symptoms of asthma and he could not breathe. After his admission to a hospital, his stay caused him to think about death and dying. Although he will die, he was not worried about his children who he would leave behind. Because all of his children had their own roles and responsibilities to continue on with. Some of his children were already married.He travelled and experienced many places and talked with religious leaders such as the monk until he perceived that when people die, they become useless like a piece of decayed wood. About 4-5 years before his retirement, he decided to donate his body to the hospital because he believe this would be a good thing.

In addition, because he lived near a temple he often experienced death due to the number of funerals held there. It was a factor that helped him to overcome his fear of dying. Living so near the temple always helped him to see the real life cycle of people from birth to death. He believes in Buddhism and he understands about death and that being born, being old, sickness, and death are common things for people. In addition, he always and often speaks and repeats this to his grandchildren because he would like them to understand that death is normal. If someone passes away, they can have regret but don't cry.

**Participant 2**

To is 62 years old. His status was married. He graduated from high school. He was a government retiree. He had two children, one girl and one boy. He had been diagnosed with ESRD about 15 years ago. The first time when the doctor told him that he had end stage of renal disease, he could not believe it and he refused treatment because he did not understand about it. It was not until he got worse that accepted hemodialysis treatment. At the time he could not accept his illness, and he thought that the information he given was not necessary. He believes that reading about his condition is important as it makes it easier for him to understand and believe his doctor as well as accept his condition. When the doctor told him that if he stayed like this without treatment he would not live for more than 6 months. He felt disheartened because he believed that he would certainly die within the next 6 months. He decided to go on hemodialysis because he could not die because he is the head of the family. Between receiving treatments, encouraging words from his nurses motivated him to keep continuing on with his treatment. Both his wife and his children give him the spirit and will to keep living. Society and socializing in the community is important as it allows us to release tension. Friends encourage him to be strong and to keep going on.

After being on hemodialysis for about 8 years, he experienced heart arrhythmia symptoms. It made him think about death again. But the feelings and the thoughts about death were less intense the second time. His fear of death decreased because sleeping in the hemodialysis room makes him often see other older persons die. In addition, he believes in rebirth and this decreases his level of fear in regards to death and dying. From his experience of reading and reciting the Dhamma, his

religious beliefs, and religious practice, he does not have a fear of death anymore. He thinks that everyone has to confront death. It would make him free from worries. The first when he heard about death, death is cause of the suffering for him. Sometimes, he thinks death can be compared to a needle because death is our relief from the suffering.

**Participant 3**

Jaruk is 67 years old. He graduated from primary school. His status was married. He was a tuk-tuk driver. He has 3 daughters. The oldest one is 41 years old, she is a teacher. The middle one is 40 years old, she is working in the media field, and the youngest is 38 years old, and she works in Bangkok. Nobody has their own family. He was diagnosed with heart failure when he was 50 years old. He had treatment in PSU Hospital. He has experienced unconsciousness twice (in 2011, 2016) because he had forgotten to take his medicine, and his symptoms were severe enough that he nearly died. The first time this happened, he got up at midnight and he could not breathe, and there was discomfort in his chest. The second time was when he was asleep one night and he became unconscious. If no one had found him and sent him to hospital, he would have died. He began to think about death in 2011 because at that time he wanted to die. He had been unconscious for around 12 nights. He thought that when the body stops working, we die. He looks at death as a natural thing from the experience of seeing. He had an idea that when people died or passed away it was like dead timber and ashes which are useless. According to his near death experience,

sometimes his children are afraid for him. But he thinks that we cannnot teach others about death and dying as this depends on their thinking and their learning.

He always jokes around with his wife and his children. He thinks that talking about death and preparing for death is not a curse. He doesn't think that it is a curse and there is nothing wrong about this preparation. He thinks that the acceptance of death is not to be afraid of death. He looks at everything as a part of nature, it will die, like trees, banana trees after they produce the banana fruit will die. An old man is like a banana tree, when it gets older, it has to die. He thinks that the important thing, which makes him think that death is natural, depends on his perception and experience of his learning. Having directly experienced it, he thinks that there is no need to study as he can practice by self-studying from experience. This makes him have the ideas. He thinks that if his children haven't finished their degrees yet, he thinks that he can solve this the problem by preparing for them. He thinks that this preparation and creative ideas can help him be ready for an uncertain future more than others. He thinks that fear of death causes mental health problems. If mental health is a problem, the physical health of such a person will be problematic as well. This is because the two things are linked together. If we live without fear of death, we will live with no stress. Finally, we can feel comfortable, and it will have a good impact on the physical body.

**Participant 4**

Paw is 65 years old. She graduated from primary school. She is a vegetable grower and pig farmer. She is a widow because her husband died while her daughter was studying in primary school. She has five children, 4 males and 1 female. She has been diagnosed with HT, and diabetes for over 20 years. She has had these diseases since her youngest daughter was just 3 years old. Now, her daughter is 30 years old. After her daughter graduated about 10 years ago, she was diagnosed with ESRD. The doctor told her that if she does not go through dialysis treatment, she will die. At that time, she didn’t think about death. She postponed receiving hemodialysis from the doctor for about 3-5 years. She was wondering about dialysis, there was a nurse who told her that she needed to sell all the properties she has because she needs to pay for dialysis treatment which costs several thousand baht per week. So, she decided not to receive dialysis treatment. At that time, she was stressful for a long time. Then one day, she needed to be admitted to the hospital because she had severe symptoms. She was very tired, couldn't eat, was drooling, and nausea had and vomiting until nothing was coming out. Experiencing these severe symptoms made her wonder whether she would die and that this was the end for her. She finally underwent dialysis. Now, she has had dialysis treatment for about 5 years.

When her daughter was still single, she felt stressful. All of her children are already married and have settled down. Although, she will die at this time, she can die because she has nothing to be concerned about. She thinks that dialysis treatment will help her as well as prevent her symptoms from becoming worse as well as stabilize

them. It helps her to live for her children. She would like to see them around. From the beginning to now, she is better reassured about death. The length of time can help her see things more clearly and this has led to her modifying her perception and understanding. She admitted that when she thinks about her death now that she feels comfortable, happy, and is not worried. She reads Dhamma books when she has free time. In talking about death, she still feels okay, she is not be stressed about it because she understands that all people must die. In addition, she wishes to die without suffering. Now, she was diagnosed with heart disease and needs to take heart medicine. She did not fear about her death because she thinks that it is a normal.

**Participant 5**

Nuan is 60 years old. She has a primary school education level (grade 4). Her status was widow because her husband passed away 5 years ago. She lives with her two daughters, who now have their own families. She started having dizzy symptoms and hypertension 6 years ago. She was diagnosed with ESRD (End Stage Renal Disease) about 4 years ago, in 2013. After being told of the diagnosis, the doctor told her that she needed to have a shunt. When the doctor told her that for the first time, she was in the end stage of renal disease. She did not panic, and she not confused or stressed. She thought that other people had been diagnosed with ESRD. She knew people could be well and then suddenly die. She never felt terrified about death because she has had the experience of taking care of a close person until he died. Confrontation with the death of her husband made her think about her own death. She thinks that taking care of him could help her to accept her own death more easily. She thinks that all people must confront death.

Currently, she goes on hemodialysis every Monday and Thursday. She expects that it is temporary treatment. She already knows that this disease cannot be cured. Treatment is only to support her symptoms. If she was not on hemodialysis at this time, she would have already died. She thinks death is natural. She accepted her own death after her children grew up. At the beginning, she couldn't accept it because her children were very young; they have had no pillars in their lives, and they were studying. When she was young, her thoughts about death were different. She didn't want to die because her children were not grown up yet. She was concerned about her children. Now, her children already have their own families. All of them are well. They have good jobs and high salaries. So they can move on. She can die any time because she isn't worried about it. Now she has no worries, and no stress. She believes in Buddhism and follows the Buddhist doctrine. She believes that if she does a lot of merit making during this year, when she has her next life she will not get this disease again. Now she can sleep well, and she is not worried.

**Participant 6**

Supa is 66 years old, and she studied in a primary school. Her status was divorced. She has two daughters. The oldest one was 46 years old, and the younger one was 44 years old. Both of them are already married. She worked in a textile factory and she lived alone. She was diagnosed with a hyperthyroid disease when her old age was more than 20 years old. She had CHF after she had a hyperthyroid disease when she was nearly 30 years old. After surgery, she had both low immunity and low blood calcium. She had experienced syncope and had been unconscious twice (7-8

years ago, and 3 years ago) because she did not take her medications. After 4-5 years after the surgery on her thyroid, she was involved in a car accident which resulted in a ruptured bladder as well as bleeding, and she was unconscious for about 4 days. At that time, she thought that if she died, her mind would be still dark because her eldest child was 7 years old and the younger one was 5 years old. She did not want to die because she was more concerned about her children. She could not walk after the accident. Everything she had needed to be sold.She prayed that if she could walk again, she will be ordained. After that 1 year, she could walk so she decided to be ordained to be a nun. She has been a nun since she was 33 years old. Overall, she has been a nun for 29 years. Her children are her heart. She had worried that if she died, how would my children live. They were just 6 and 7 years old. She has been in many various bad situations, but this is okay and she has accepted the death.

Although she has been ordained for about 29 years, her dharma practice did not develop because she still living with past issues. However, nowadays she feels better and has been able to release the things that have happened in her life in only the last 2-3 years. Now, talking about death does not affect her. Religion is like the bright side, it helps her to see the light and to find a new world and to see the truth of the problem. Nothing is obscuring this and this makes her see everything clearer. She can see the truth and can accept the reality of many things. She is not afraid to die. She is ready to die. She already has prepared for her death. In 1986 she donated her body because she thinks that she has no knowledge, no education, and her life is nothing.

She has only her body, donating her body is the last bit of good merit that she can do. She decided to donate her body to the hospital as this will be helpful to others. Since she has no one who is concerned about her, it becomes an important factor for her to decide to donate her body. She could accept death before studying religion. However, religion only helps her to understand clearer.

**Participant 7**

Wang is a driver, and 81 years old. He graduated from primary school. His status is married and he has five children. Now, he lives with his youngest daughters. He was diagnosed with chronic obstructive pulmonary disease about 19 years ago. When he was 79 years old, he had to go the emergency room because he had dyspnea and unconscious symptoms. He thinks these were his most severe symptoms. At that time, he reassured himself that all people need to confront being born, then getting old, then sick and then dying. Even the Buddha and the King of Thailand are dead, it makes him acknowledge that he must certainly die too. Religion teaches us to accept death after demonstrating to us that to be born, then to get old, then to get sick, and die are things we cannot escape from. There are the religious teachings about the impermanence of things is wisdom. The impermanence is our body, but the permanence is death.

Between the time when he had been diagnosed with the disease and nowadays he has been able to accept death more today than in the past because of often being confronted with difficult symptoms to deal with, he has become more familiar with it so he can accept more easily the perspective of his own death. In addition, going to the funeral of a friend, it makes him think that he cannot escape from death. He

started thinking about death when he was hospitalized for the first time. He was 72 years old. When he had a physical checkup it was found that he had many diseases. It made him start thinking about death and it made it easier for him to accept his own death. He mentioned that people who can accept death are people who do not fear death and death acceptance is admitting the right thing, and it is the acceptance of natural things. Acceptance of death has a good moral effect of being with no worries.

**Participant 8**

Pra is 65-year-old. He graduated from primary school. He had two children who are already working and are married. He lost his wife about 5 years before he was ordained. He has been ordained as a monk for 8 years. He was diagnosed with CHF 10 years ago. It started with chest pain symptoms, and lipidemia. 5 years after he was diagnosed with heart disease, he was diagnosed with COPD. His health got worse, with dyspnea, and from there he needed to be in hospital. At that time, he thought that he would not survive because he couldn't breathe.

By going to so many funerals, he started to have more and more thoughts on his own death. Death is normal. It is just a step in a cycle. All animals in the world die. All forms of life in the world must die even the trees. Now, he does not fear his own death. And he accepts death and that death must happen to him sooner or later. Even the Buddha did not escape from death. In addition, because of the principles of Anicca (impermanence), Dukkha (unsatisfactory) and Anatta (not self) he is not attached to anything. It helps him to see the truth in reality, and that death is the truth of everyone; do not suffer with it.

Now, he prepares to die by talking with his children, he tells them that they need to eagerly work because he will not be with them forever. He always talks with them. He expects that they will be prepared when he passes away. He had planned to donate his body to the Songkla hospital but the hospital did not accept his offer and suggested that he donate to the hospital near his hometown. He thought that the donation of his body would be of benefit for others and of merit for him. He mentioned that the acceptance of death is contemplating the truth or the reality of life, the truth of birth, and suffering, and death, which are the parts of life. Death acceptance is letting go about death or not being worried about death, it makes him feel peaceful, and he doesn't worry about it.

**Participant 9**

Somchai is 62 years old. He graduated at primary school level. He has two children who are already married and working. He was diagnosed with ERSD about 14 years ago. He is a truck driver. His illness started with HT.  At that time the doctor said that his illness was severe and that 5 years or less he would need to start dialysis. On the first day of having hemodialysis, he walked back because he was afraid. However, he saw a girl older persons who was not afraid, so he had to be brave. He had hemodialysis 3 times a week.

Between being with illnesses, he has experienced near death three times. Every time he was admitted to the hospital he had intense thoughts on death, he was afraid of death. He doesn't want to die at this point in time, he wants to live. He would like to see his children be successful, and have confidence on their work. Now, all of his children are married, but he still would like to be around to see his grand-children

growing up. Now, he reassures himself about death. He mentioned that sometimes, fear of death is useful, it makes him take better care of himself.

Now, he acknowledges that he can die whenever because he has seen so many friends who were diagnosed the same illness as him who have passed away. He tries to reassure himself about my own death since everyone needs to confront it at the end. Even the King of Thailand has to die. He understands that at some point all people must die. He has faith in Buddhism. He knows that all people have to die. The religion helps him to understand the natural cycle of life: it talks about being born, growing old, getting sick and dying. Talking about death, he feels apathy (no facial expression of any sadness while talking about death). Now that he has had dialysis for about 5 years, he is less afraid of death than at the beginning. Hemodialysis has become more and more familiar in the long run. Also he has confronted severe situations many times, so he feels nothing.

## Participant 10

Jang is 81 years old. She graduated at primary school level. She was a widow because her husband died from asthmatic attack. She was diagnosed with HT when she was nearly 50 years old. She needs to take medicine all the time. In the past, she did not think of her death because she had only concerned in her worked that she was a farmer. When she was 69 years old, she had nausea and vomiting, was always dizzy, and had fatigue until she could not do anything. This was like a shock for her. The doctors told her that she had renal failure. She doesn't worry about her children because of they are already grown. If her children were not grown up, she would think about death differently because she would be concerned about her child having food

to eat, and money for bills. She got sick after all of her children had graduated and were working, and they already had their own properties. So she is not afraid to die, and it is easy for her to accept her death. When her own children were very little, if she heard other children talking about death, she would complain and ask why they talked about this because at that time, she would like to grow up and get a job.

She has received hemodialysis for about 12 years. She feels strong, but all the time she still thinks about her death and that to die is to die. Especially when she is suffering, has extreme fatigue, cannot eat, and is very weak, this makes it easier for her to accept her death. The pain from the marks of needle injections causes her to accept her death as an escape from her suffering. She talked with her children about 12 years ago about death. She always speaks to her children, until her children complain that she only talks about death. Since, she has been diagnosed with ERSD, she always jokes often, and is preparing for her funeral with her children.

The acceptance of death is being not afraid of death, despite whatever happens. The acceptance of death is admitting death (Thum-jai), and accepting the truth that death will certainly happen, no one can escape from death. The acceptance of death brings her comfort, she can sleep better, and she is not stressed. When she heard her friends talking about death, she could talk about it all day with them. Making merit is a good thing as it provides her with comfort and calmness. While she is at the temple, her mind is so calm, and she feels without Dukka, she does not think about her illness. Going to the temple and practicing and following the religion, provides her with comfort. It gives her strength. Now, she wants to survive because she wants to enjoy life and go to the temple. If she is without suffering, she wants to continue living.

**Participant 11**

Kumpet is 84 years old. She graduated from primary school. She is a widow because her husband died from lung cancer when he was 71 years old. She was diagnosed with HT about 20 years ago and end stage renal failure about 9 years ago. When she was diagnosed with hypertension, she did not think about death. She thought that taking medicine can resolve her symptoms and make her better. But the doctor said that if she did not come to the hospital, maybe she would not survive. When she heard the doctor say this, she was fearful of death because she was concerned about her youngest daughter. She wishes to be with her. It was an event that she was not prepared for her impending death.

Over about 4-5 years, she came to accept her death. Now, if she will experiences any repeat symptoms or critical symptoms, she does not fear death. Because she does not want to worry her daughter, all of her children already have their own families and are working. She has seen many similar older persons like her go through death. After her husband's death 3 years, her mother-in-law died, and her mother died at home. After seeing the death of others, she have become familiar with death and does not fear death. She thinks that one day she must die. Every time when she met the death of her friends, she does not fear death and she accepts that she must die like this.  Since she has had dialysis, she always prays. She thought that praying is forgiveness, and believes that if she makes merit in this world, in the next world she will not have this disease.

Now, if she must die, she is ready to die. But it is possible, she also doesn't want to die, she wants to see her grandchild become a doctor. She wants to see the success of her youngest grandchild because she has always lived with her. She is

closer to her more than her other grandchildren. Now, she is starting preparations, and she has already collected money for her funeral. Having someone to talk about death with her, she was still merely feeling because she already does not fear death.

**Participant 12**

Sit is 61 years old. His status was government retiree from teaching and he was married. He has two children. He had heart arrhythmia 15 years ago and HT 2 years before he was diagnosed with end stage renal failure. After the doctor told him that his kidneys were damaged, he felt stress because of his two children and that is was one year before they would graduate. He worried that his wife could not take care of their children if he did not survive. Then he experienced an infection in the blood stream twice during hemodialysis. He has also been diagnosed with a coronary disease and a stent was put in about 3 years ago. Because of repeat admissions to the hospital, he is able to accept death more.

He had talked with his friends who have been diagnosed with the same disease. Talking with his friends provides comfort and cheers up him. He hopes that he may survive another 4-5 years. In the last 11 years to the present, both of his children have already graduated. He has prepared money for them. Now, he admitted and putted down on death. He is ready to die. This feeling just came to his mind and he accepted it about 1 year ago. After my children graduated. He begins to prepare for my death. Acceptance of death is let go the death and ready to go. Although, he has anything need to concern, cannot hold on to these things. Acceptance of death is let go the things that it is not ours. He would like to die as like a sleeping. For other things, he had prepared only one in my mind. He wishes to write in the document to

their family for do not prolong life his life. About one year, he has idea to donate my body to the hospital.

## Participant 13

Tew was 66 years old. She graduated in high school. She was a retile electrical government. Her status got married. She has one daughters. At the end of 2016, she had diagnosed with HT, DM, and CHF. She had donated her body to the hospital because she thinks about 5 years ago. At that time her children have their working, and already got married. She does not worry that how she being after she die away. But if her daughter still did not graduate and did not married, she had more worry because she being alone no brothers.

After she had retired she went to pray. In the script has the lesson of speculating about the body of people. The detail of script talking about born, older, sickness, and dies. After she had performed praying about one year, makes her understand about life. She thinks about my deaths that one day she need to face death. She does not afraid of death. She wishes to die with a calm, and not agitated. She already told her daughter and I already prepared some reminder for using in her funeral. Her preparing because she doesn't want to worry before she will die. If she doesn't prepare anything, she worries that my daughter doesn't know where anything is. She thinks that people behind will difficult to manage. She thought that preparing is doing do not miscalculate because we don't know that when whatever will be happened.

Death based on her idea is the thing she already defined that we were losing our Kamma. Life after our death, we must go to wherever in new worlds will depend

on the shit with karma. Nobody can live forever. She thinks that she goes to the temple every day until she died. It is the charitable support and can take us go to good place. Be compassionate to who died away. It makes us have not attached everything and more comfortable at all. Sometimes make me concentrate on acoustic prayer until to forget my illness because her mind cannot be distracted.

Religion helps her apply to practice and see the truth of life. The religion taught her be being with conscious, and mental calm. Acceptance of death is accepting the destiny that acting before (Boon and Kamma). Acceptance of death is put down about born, older, sickness, and dies, that one day we must confront this point, and we don't have to worry. She familiar and put down about death. Talking about death is not makes her feel stress or worry, she still merely.

**Participant 14**

Changnoi was 65 years old. He graduated in primary school. He was radio sound controner in the temple. He had diagnosed with DM, HT and CHF about 4 years. He was window because his wife dies away about 10 years ago from renal failure. He usually has syncope, in this years he had syncope total 12 times. He had experienced intubated endotracheal tube, and was helped by CPR from unconscious. He could remember that it is severe suffering. He had experienced being in the temple, it makes him to see the death situation of people and all kinds of animals. From seeing that everything must be eliminated. Listening, seeing, and reading a lot of the Buddhism since he was a child. The experience makes him occur learning and absorbing before. In addition, confronting with the death situation of close person such as losing of his parents, and his wife makes him understand that born, old, sick,

and death are common things for people. He always thought that one day the death will come to him.

Buddhist teaching need to understand about death. If only seeing or knowing, it is not shallow. He usually has conscious, do not be distracted, and don't be anxious whatever will be happened. He mentioned that being with mindfulness, not being with anxious makes me not distract, being not worry and be being with confidence. He can Thum-jai on their own death. It makes him being life a normal, no worries, can sleep, being no anxious, and comfortable. He feels good while someone has talking about death with him because he thinks that everyone is not interested in death. He thinks that if people come to think of death, people will die at the right time. Now, he can accept death and does not fear on their own death. However, he wants to live longer because he wishes to look at grandchild grow up and successful of his children.

**Participant 15**

Charon is 60 years old. She graduated in primary school. He was housewife. Her status got married and she has three children. She never worries about my children because all of my children already graduated and already had worked. She doesn't worry about my death because she already prepare everything for them. She thought that all of my children can survive. She diagnosed with DM about 22 years ago. When she perceived that she had diagnosed with diabetes, she thought that it is normal. Because it is a genetic, his parents and his sister had diagnosed with disease. She was diagnosed with ESRD in 3 years ago (2014), When the doctor told her that she got ESRD, she thought that it is the rule of Kamma. About 15 days before she had shocked from sepsis, she had the severe symptom, chill, and semi-unconscious.

According to she had diagnosed with more illnesses, she thinks that our body is uncertain. We can come, and we can pass way. Someone died since they were a baby. In addition, having experience of confronting with my parent's death, neighbor, and other older persons, it makes her easy to accept my death. Seeing people more confronted with death, make her see the truth of life. All people were born to die, it is natural. Everyone must die, but do not know that what is the date of their die. She thought that born, older, sickness, and dies easily to happen. She need to accept it because we cannot define anything. She could accept at that time because others people are hundreds of people that need to hemodialysis. In her mind thought that even the highest of Thailand still die, he could not buy his life. Even people who got rich must die, she like the little ants that had not competency to buy exceptional medicine.

She already prepared the money for her funeral because she knows that all people need to die. She often talking both the children and her husband that where is the money for my funeral after she die away. Every time when she had mind discomfort, she will practice meditation and sometimes she prays. It makes her can put down. She has not thought a lot, and make me comforting. In addition, she believes that hearing the sound of prayer, it a good way to dies with peaceful, and not agitation before her death. She does not want to CPR, and tracheostomy tube because she wants to pass away with peaceful, and without suffering. She frequently talking about death together because everyone can accept it. Having someone to talk about death, she thinks it is natural. Talking about death in her home will happen every day. All of my children ready to talk about death. Including, she always talks about death with her husband, let's talk about how to manage the funeral if someone died before.

She thinks that it is natural, and it is preparing. However, she thinks to receive treatment until it die with her. Hemodialysis helps to support her symptom. She tries to better take care her selves for still being with my grandchildren. She usually making merit about 10 years, when she got illnesses not more often than the past. After her doing this, it makes her mind comfortable and like us receive blessing.

**Participant 16**

Preecha is 64 years old. He graduated at high school level. He was an electrical government officer. His status is married and there are two children from the marriage. Both of them have already graduated and are working. But if they had not graduated, he would be stressed, it certainly caused him stress because he needed to earn more money and to send to them for their study. He was diagnosed with hypertension when he was 19 years old. When he was working, he had dyspnea symptoms. He went for a checkup, and he was diagnosed with congestive heart failure with MR about 6 years ago. Before he retired about 5 years, he was diagnosed with diabetes, he thinks that it is normal because his parents got this disease together. He retired in 2013 when he was 56 years old. After his known diagnosis he was not shocked because he had already prepared his mind in that the machines deteriorate after a long time of use like the human body - it's normal. When he had both hypertension, and diabetes mellitus. He already knows that heart disease will follow. It is generally common because everyone knows about this.

His house is near a temple and he has often experienced attending funerals at the temple. He had experienced seeing his parent die over 20 years ago, and his sister died 2 years ago, it made him think that all people have to pass away. His colleague

who he had studied with and was very close to died. After seeing a lot of people die, he realized that he can't escape from being born, getting older, experiencing sickness, and death. His beliefs about death of people depend on karma. If people act well, they will die well, if people acting badly, people will die badly. In addition, being of an older age helps him to accept his death more as well as his experience of seeing many deathful situations. When he was younger, he only thought about his work and his children. He never thought about his death. The thought of death immediately came when he got severely sick. But diabetes and hypertension are common diseases and a majority of people suffer with these diseases. Acceptance of death is understanding and accepting the reality of life and admitting that all people are born, get older, suffer sickness, and then die. When the people arrive at the end of life, all people need to die. The acceptance of death is being without attachment to death, or an understanding about birth, aging, sickness, and death.

**The death acceptance journey in Thai Buddhist older persons with advanced chronic organ failure**

The results show that the journey of death acceptance in Thai Buddhist older persons with advanced chronic organ failure consist of four categories: 1) negotiating of their own death, 2) neutralizing fear of death, 3) affirming impending death, and 4) transcending of death acceptance.

**“Negotiating of their own death”** was identified as the initial category of the journey to death acceptance in Thai Buddhist older persons with advanced chronic organ failure. This category consisted of 3 sub-categories*; recognizing their own*

*death but not ready to die; taking actions to maintain health; hoping for a longer life.* This category reflected that when the participants encountered the life threatening situations as informed by their medical doctors that their disease reached the end stage and was not reversible. In addition, they experienced life threatening situations with worsening symptoms such as weight loss, feeling very tired and suffering fatigue, not being able to eat, nausea and severe vomiting, and facing near death experiences. All these situations made the participants aware of their own death and they had recognized their life time was limited.

This situation led them to feel fear of their own death because they were not ready to die. Most of them stated that they were not ready to let go life because most of participants were more concerned that if they died, who would take care of their families and their children as they were concerned about their family. Actions, they tried to maintain their health as much as possible because they hoped to live as long as possible. The participants took action to maintain their health by adhering to medical treatments as long as possible, modifying health behaviors or trying to do everything to get better, learning more about their illnesses by searching for health information and reading books regarding how to manage their illnesses because they believed these actions could help to maintain their life so they could be with their families as long as possible. In addition, seeking emotional support and spirit support from others were important in supporting them and cheering them on to live life longer.

**"Neutralizing the fear of death"** was the realization that death is inevitable. This category consisted of 3 sub-categories; *realizing that death is inevitable, "Thum-jai": reflecting on their own death, and accepting the truth of life and death.* In

conjunction with living with their disease, the participants had confronted various difficult symptoms to deal with as well as experienced seeing death scenes of others. The health of the participants gradually deteriorated due to the progression of their disease and getting older. They repeatedly faced life-threatening situations from time to time and were hospitalized due to acute exacerbated symptoms and some participants had repeated experiences of near death. These conditions led the participants to realize that their time was relatively short and that death was inevitable, therefore, the participants could more acceptance of their own death. These experiences desensitized and lessened their fear of death and they became aware that their life was getting closer to the end and death was evitable. The participants in this category tried to 'Thum-jai' to anticipate death by reflecting on the death of other persons such as the significant persons in their families, the highest leader in the country/ in their religion, even the child, and other older persons who had similar diseases. Having experienced exposure to a death situation helped the participants 'Thum-jai'. After the participants had tried to 'Thum-jai' on their death from seeing the situation of the deaths of others and from reflecting on their own death in different ways. It desensitized their fear of death and they were more able to accept the truth of life and death. Having confronted the situation of the deaths of others helped the participants to become more accepting of their own death, as well as reducing their fear of death and becoming more accepting of the truth of life compared to when the participants were first diagnosed.

**"Affirming impending death"** was the transitional category between trying to 'Thum-jai' and accepting their impending death. This category consists of 3 sub-categories: *mobilizing Buddhist faith, engaging in religious practices, and accepting their own death.* After the participants had realized that death was inescapable for them, they now had meaning on their death through mobilizing religious resources from their previous experiences of the Buddhist teachings. Understanding the law of nature and Buddhist truths drove the participants to engage in religious teachings and practices in daily living until they had a clear picture of their impending death and accepted their death. In this category, the participants had to mobilize their Buddhist faith to make sense of their life and death situation. Three main Buddhist teachings were usually mentioned by the participants which had beneficial effects on their understanding about death and dying. These three teachings consisted of the principle of natural law (birth, aging, sickness, and death which are normal for human life), the concept of anatta which helped the participants to see that death was certain, and the principle of rebirth and the law of karma in that the participants believed that if they performed good acts, they will receive good things in return, but if they performed bad acts, they will then receive bad things later. The belief in rebirth and the law of karma could decrease their fear of death. The Buddhist teachings helped the participants to understand life and death.

The participants, however, stated that reflecting on learning about death was not enough to enhance their understanding of their death. Considering or contemplating was an important step for gaining understanding clearly about death. After the participants had an understanding on the law of nature and the Buddhist truths, the participants engaged in religious practices such as merit making, mediation,

chanting or praying which they performed in their daily practice. The participants mentioned that the benefit of these activities aimed not only to gain insight on death and dying, but also to calm and comfort their minds. The application of the participants' understanding on death into their daily practice was not only an important process for clearly understanding their impending death but also for accepting their own death as the consequence of this category.

After the participants engaged in religious practices, they gained insight into the truth of life and death and had a clearer picture of their own death. Engaging in religious practices and contemplating Buddhist teachings led to a true understanding of the truth of life and acceptance of the reality of death. Death acceptance was the consequence of mobilizing religious beliefs and engaging in religious practices consisting of understanding the truth of life 'Thum-jai' that one day the death will come, living with no fear of death, and letting go of their death/ let it go with the death.

**"Transcending of death acceptance"** was the final process in the journey of death acceptance. This category consists of 4 sub-categories covering; *having mindfulness and being in a peaceful state of mind, preparing a peaceful death covered preparing self* (Making a treatment plan to die peacefully), *and others* (Talking over death issues with family members?) and managing business tasks, funeral and death rituals), *and living-well and dying-well.* In this category the participants focused their mind on the present moment which was having mindfulness. Under the condition of being in a peaceful state of mind, the participants had prepared or managed living and

dying in the end stage of life in order to have a peaceful death. This was two processes: 1) preparing self and 2) preparing others.

Preparing self is a process of managing the participants' living and dying. The participants had prepared their self by two actions - making merit and making a treatment plan to die peacefully. Regarding Buddhism beliefs on collecting good-*Kamma* or *Boon* in the present for the next life or next category, the participants desired to do good things before passing. Doing good things were reflected in the practices of helping and donating. The donation of the participants' dead body organs was viewed as a last making of merit in the present life for themselves as they would like to do something that is useful for others before they die. In regards to making a treatment plan to die peacefully, even though the participants accepted their death, they were still fearful of dying with suffering. They perceived that getting some treatment and extending life by receiving aggressive treatments such as treatments that included many needle punctures, intubating an endotracheal tube, putting in a stent, CPR (Cardio Pulmonary Resuscitation), having their body hooked up to medical machines and dying from an accident caused them suffering. At the end of life, they wished to die without suffering, like going to sleep. This condition led to the idea of making a plan to die without aggressive treatments. They had informed a family members about the treatments in the end-of-life stage that they wished not to extend their lives by any aggressive treatments. Some participants had the idea of not prolonging life when their symptoms got worse by writing a living will and informing their family to let them die without prolonging their life.

Preparing others, according to the wish to die without burdening family members, the participants had prepared others by often talking about death issues to

their family members, and managing business tasks and their funeral and death rituals. The participants had been talking about their death with their family because they wished their family members to familiar with their death situation. This could prepare the family members to accept the loss. The participants always joked about their death with children because they hoped to see them can accept and prepare their mind to confronting with his death happening. After the participants died away, they hoped that their family members would be strong being by themselves and not mourn. In addition, the participants had managed business tasks, their funeral and death rituals aimed to reduce their family's burden due to their death. The participants had prepared many things such as number of rituals, money for their rituals, and some extra money. They thought that preparing in advance was not wrong, it was not only being with readiness but also without putting any burden on their families after they passed away. In addition, preparing could settle their mind and reduce their worrying especially about their children.

Transcending of death acceptance has the consequences of the participants' preparing themselves and others contributed to their living-well and dying-well or the quality of living and dying at the end stage of life. The participants were living-well by they could be living with harmonious body and mind, had a purpose in life, and a desire to continuous living while being ready to die any moment. Participants perceived that body-mind were connected. Being in positive felling could affect to physical functions such as sleeping and eating well. If he had the positive emotion from death in term of be happy, feel comfortable, no worries, no stress, not anxious, and not afraid, the physical would be in healthy in term of being able to eat and sleep well. In addition, living with purpose and desiring to continuous living was also a sign

of living-well. The participants engaged more activities that made them be in happiness. They still had hope to see growing up of grandchild and successful of their children. Finally, participants in this category could result in dying-well which can be inferred as being ready to die at any moment and being able to communicate about death as normal and not auspicious. The participants had positive emotion when they heard on death issues and they were interesting in communication on death. After the participants could accept their death, they did not fear and worry on their own death. They were ready to die in this moment. The details of each categories are described in the figure 2 as following;

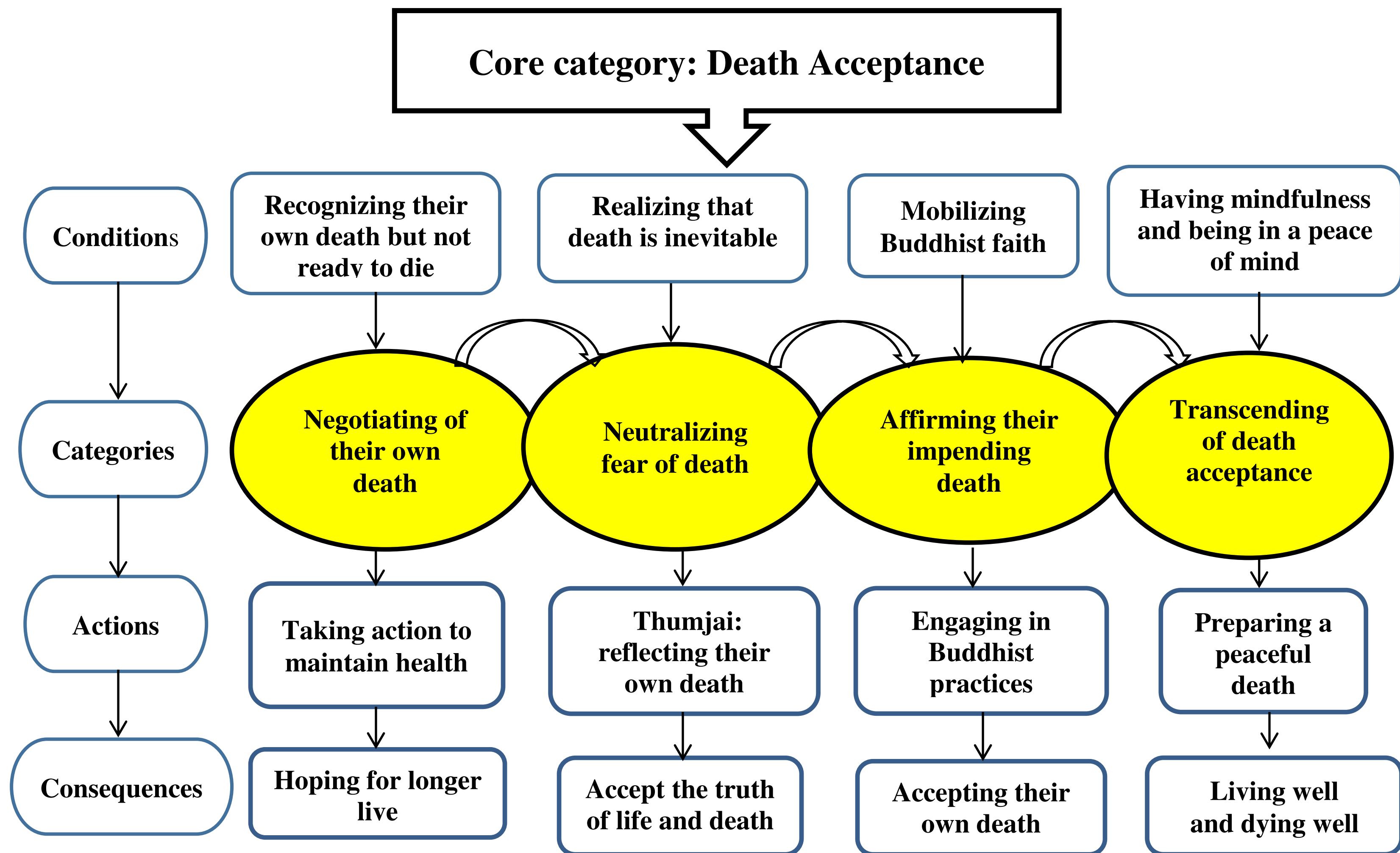
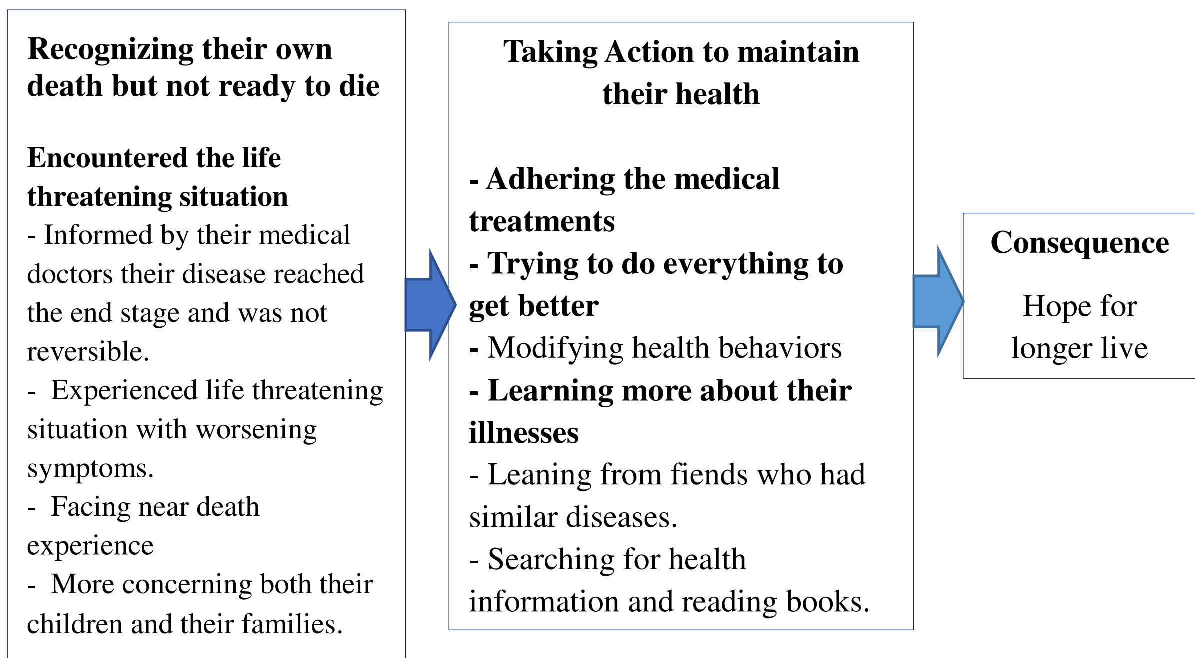



**Figure 2.** The death acceptance journey in Thai Buddhist older persons with advanced chronic organ failure

**Category 1: Negotiating of their own death**




*Negotiating of their own death* was identified as the initial of death acceptance process. This category consisted of 3 sub-categories; recognizing their own death but not ready to die; taking actions to maintain health; hoping for longer life. It reflected that when participants encountered the life threatening situations where they had recognized their life time became limited. This situation led them to feel fear of their own death. Participants did not accept the truth that they were going to die soon. Most of them stated that they were not ready to let go life because there were many things in their life wait for them to accomplish. They were concerned about their family. Consequently, they had action attempted to do their best to maintain their health well with the hope to live longer.

## Conditions

### Recognizing their life time is limited but not ready

Participants have been sick with chronic conditions for several years. As the disease progressed, they were informed by their medical doctors that their disease reached the end stage and was not reversible. Apart from that, they experienced with life threatening situations with worsening symptoms from time to time. Some participants reported their near death experiences. All these conditions made them aware of their own death. Their life time became relatively short and limited. It can show as followed;

*Informing by medical doctors that their illness reached the end stage and was not reversible*

Kumpet (P11) recalled her experiences when being informed by her doctor that she was in terminal stage of kidney disease and the current medications could not cure. She had to receive renal replacement therapy. It was the first time that she recognized her own death and that her life time was limited. She stated that;

> "The doctor told me that I needed urgent hemodialysis. He said that I had a very severe renal failure that even medicines cannot help and cure it. At that time, I thought of my own death and feared for my life. I never thought about death before. When I was diagnosed with hypertension, I did not think about death. But with this diagnosis, I feel my life was threatened. The doctor said that if I came to the hospital late, I would not stand a chance to survive." (P11)

Similarly to Sit (P12) who instantly thought that he could not live longer when he was told by the doctor that his disease could not be cured. He described that;

> "When the doctor told me that my kidney did not function, I knew that renal disease could be not cured. At that time, I was shocked for a while. I felt stress and fear because I thought I could not live longer. I felt nervous" (P12)

*Experiencing life threatening situation with worsening symptoms*

In addition, participant with Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure (CHF) experienced worsening distressful symptoms such as very tired and fatigue. They couldn't eat although they want to eat. Some participants suffered from nausea and severe vomiting. They had loss their weight and too tired to do things. These participants perceived that they had severe symptoms. The participants thought that if theses symptom could not have relieved, it can be the cause of death for them.

Roen (P1) shared his experiences of acute exacerbation from asthmatic attack. Due to the severity of symptoms, he was hospitalized. This situation led him to recognize his own death. He said;

> "I had been diagnosed with chronic lung disease for 30 years. That was about 6-7 years ago, I did not take any bronchodilators for a month, so, I developed severe symptoms of asthma. I could not breathe. My son took me to the hospital to receive oxygen therapy. At that time, I thought about death. To me, those who were hospitalized was about 50/50 chance to life and death. So I thought if I was hospitalized, it

> would mean that my health become worsen… meaning that I have more chance to die" (P1)

*Facing near death experience*

Another illness situation that triggered some participants to recognize their own death was when facing near death experience. Due to serious illness, participants developed unconscious and stopped breathing.

Pra (P8) mentioned that admission to the hospital due to worsening of symptom such as short of breathing led him to think about the possible death. He thought that if he could not breathe, he could not survive. He said;

> "When I was diagnosed with congestive heart failure, it started with chest pain symptoms and I had high fat in my blood. I got a heart disease and was diagnosed with chronic lung disease five years ago. It went worse, with dyspnea, which made me go to the hospital from time to time. At that time, I thought that I would not survive because I couldn't breathe." (P8)

*More concerning both their children and their families*

Experiencing life threatening situations led participants to know that their life was to the end. Fear of their own death was commonly reported by participants. However, they did not prepare to face that end yet. Most of participants had more concerned that if they died, who will be take care for their families and their children because they were head of the family. The participants were afraid that their children might not be able to complete their studies. It can show as followed;

To (P2) accepted that he was fear of death and not ready to die because he was the head of the family. He afraid that if he died, his family's member could not go on living, especially their children could not the chance to study. He states that;

> "At that time, I was still working. I felt stressed and feared because I thought that I could not live any longer. I felt stress because of my two children were studying and did not graduate yet. I was a breadwinner of the family. I was worried that my wife alone cannot support my children. An income from rubber plantation was not enough to support our children to complete their studies. I felt stress that if I died, they would not graduate, and they would have no future. I didn't want to die at that time" (P2)

Similarly, Supa (P6) said that when she had near death experience, she was not ready to die. She felt afraid of death because she was very concerned about her children. She was concerned that if she died at that time, her children could not live. She stated that;

> "At that time, I was afraid that I would die and I did not want to die yet because I was very concerned about my children. They are my heart. I had been worried how my children could live if I died,. They were just 6 and 7 years old" (P6.)

Similarity with P2, he decided to continuous hemodialysis because he could not die. The treatments could help them both get better and prolong their life as long as possible. He perceived that he was a head of his families. He states that;

> "After I knew I would probably live not longer than 6 months. I decided to have a hemodialysis because I couldn't afford to die. I have a responsibility. I am a head of family" (P2)

**Actions**

**Taking actions to maintain health**

Fear of death and not ready to die motivated participants to take actions to extend their lifetimes and delay death. The participants took action to maintain their health by adhering to medical treatments as long as possible, modifying health behaviors or trying to do everything to get better, learning more about their illnesses by searching for health information and reading books regarding how to manage their illnesses They tried to maintain their health as much as possible because they hoped to live as long as possible as followed;

*Adhering to medical treatment*

Participants understood that if they had withdrawn their treatments, they would have die. The participant decided to continue their treatment because it could help them for get better and enhance their live longer.

Like a P14, even he known that the treatments could not cured his disease, he still continuous his treatments. In addition, he tried to do everything for being with his disease because he hopes to survive. He states that;

> "I think that if I have an illness, I need to be cured. I think everyone needs a treatment that could cure their illnesses and recovers from their illnesses. I tried to do everything to cure my illness." (P14)

Like a P11, she already knows that her treatments could not cure her disease. However, she still has received her treatments as long as possible because she believed that getting her treatments could prevent both relapse of symptom and severe of symptoms. She states that;

> "I knew that it (my disease) cannot be cured but I always go for the hemodialysis because it prevents me from having worsening symptoms. The doctor already told me since the start that it could not be cured." (P11)

Similarity with a P3, he states that although he known that the treatments could not cure his disease, he still had gotten his treatments. He known that if he had stooped treatment, he will die as soon as. He states that;

> "I don't think whether it could be cured or not. What I know is that if I got sick, I should take medicines. If I stopped taking them for only two days, I would die." (P3)

Like a P5, she perceived that whenever she had stopped to receive her treatments, she will suddenly die. She states that;

> "Currently, I go on hemodialysis every Monday and Thursday. I hope that it is temporary treatment. I already know that this disease cannot

be cured. Treatment is only to alleviate my symptom. If I was not on hemodialysis at that time, I would have died already." (P5)

*Trying to do everything to get better*

Participants had tried to do everything that would help them live longer. The participants perceived that complying to treatments together with modified their behaviors was important keys for their longer life.

*Modifying health behaviors*

Like a P2, He mentioned that he need to do something to make him strong. He believes that if he was healthy, he would have live longer. He states that;

> "I believed that someone who is weak will die, while the stronger one will survive. I thought that I had to do everything to make me strong. I started walking and then running. Anything that helps make me strong, I do it all." (P2)

Like P9, he thought that being in feared state, it is important factor that contribute him to take better care himself. He states that;

> "I think that complying with the treatments and strictly following the medical professional's suggestion will help me to survive. Sometimes, fear of death is useful, it makes me take better care of myself." (P9)

Similarity with P15, she mentioned that she tried to take care herself because she would like to live life longer for see her grandchild growing up. She states that;

"I try to take care myself well. I want to see my grandchildren grow up." (P15)

*Learning more about their illnesses*

The participants had learning about their illnesses and their treatment from their primary doctor and nurses and other older persons who had same diseases. They also searched health information and read books regarding how to manage their illness.

*Leaning from fiends who had similar diseases*

A P4 described that she had learned about ESRD and its treatments from friends who had the same disease. The participants mentioned that having the chance to talk with older persons with ESRD made her decide to receive the renal replacement therapy, CAPD. This treatment was her hope to live longer and well. It can show as followed;

"My neighbors both male and female also had end-stage kidney disease. Initially, they refused dialysis treatment. They said that they preferred to die, but finally they turned to the dialysis treatment. They visited me and advised me to receive dialysis. They said if I didn't accept this treatments, I would go west. I also saw my sister-in-law who was also diagnosed with the end-stage kidney disease. She has been doing well with dialysis for a long time. She looks just like a healthy person. I then decided to receive treatment." (P4)

*Searching for health information and reading books*

In addition, some participants, particularly older persons with ESRD had searched health information regarding medical treatments. This health information helps them make a decision on their treatments. They would like to live as long as possible. A P2, He mentioned that information from his reading could confirm the information that he got from the healthcare provider. He states that;

> "I looked for books related to my diseases to read. I have learned a lot from reading. Since starting receiving dialysis, I read many books about my illness, reading about every medication that I take, drug names, and side effects. Firstly, I could not follow what the doctors and nurses told or explained to me. I thought that the information was too complicated and not important. …I think reading is important because it is easier to understand and helps me understand what the doctor said to me previously. It has helped me accept my health conditions." (P2)

**Consequence**

**Hope for living longer**

Stories of hope for living longer were frequently told by participants. It was the main reason to make decisions to receive treatments which one they refused. Participants also modified their life style in order to restore their health as they felt fear of death and not ready to die. They wish to continue their life for being with their families as long as possible.

Like P4, she tried to go to continuing receive hemodialysis because she hoped that the hemodialysis could be maintaining her life. She hopes to survive each year because she would like to be with her children. She states that;

> "I was getting confident no matter how long I can live. I decided to do continuous abdominal peritoneal dialysis. I think that it will help me prevent and relieve my symptoms. I try to go for dialysis as it can give me a better life for another year. It makes me live with my children. I would like to see them around. Now, I have had dialysis treatment for about 5 years." (P5)"

Like a P15, she hopes to live longer for looking her grandchild. She mentioned that she still continuous her treatment and tried to do everything to her getting better.

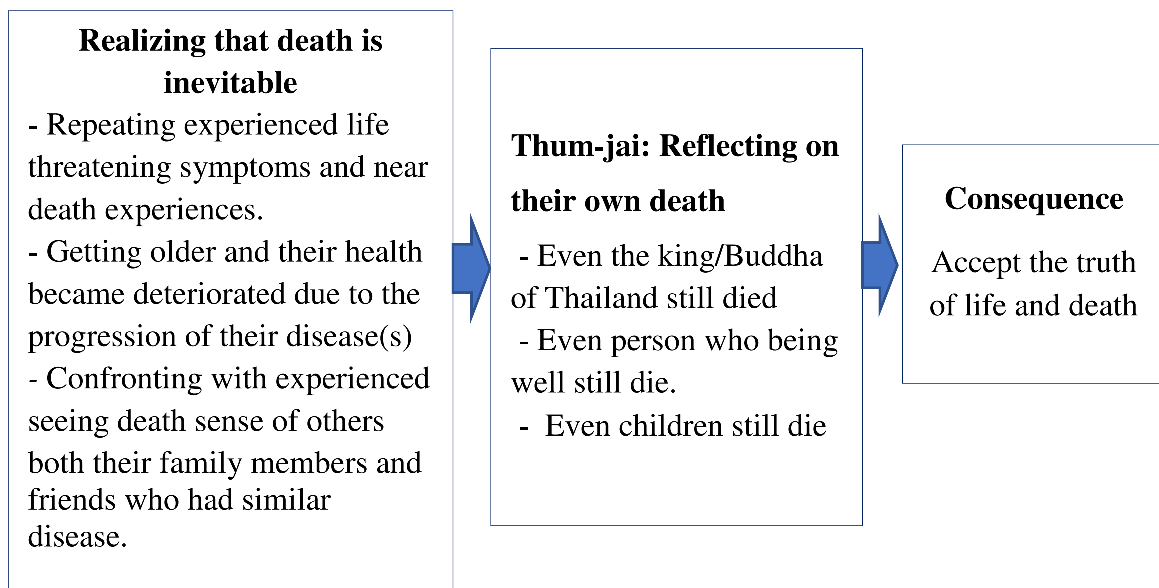
> "I came to hemodialysis 3 days a week. I think I will receive treatment until the disease die with me. I try to take better care of myself to still live. I hoped to live longer to look after my grandchild" (P15)

Similarity with P12, he mentioned that exchanging experience with older persons who had similar disease could lead him to know that he could not die in years. Knowing that he did not die as soon, it could support his mind comfortable because he did not ready and afraid to die. In addition, talking with friends could support and cheer up him. He states that;

> "I had a chance to talk with those who had the same disease as me. They have been on dialysis for several years. Some said that they can survive 5 years, the others can survive about 7 years. After I heard

from them, I hope that I too can live longer for another 4-5 years. I feel happy." (P12)

**Category 2: Neutralizing fear of death**




*Neutralizing fear of death,* this category reflected times when participants got older and their health became deteriorated due to the progression of their disease(s). They experienced life-threatening situations and had been hospitalized several times. These conditions led them to realize that their time is relatively short and death is inevitable. Participants tried to Thum-jai to anticipated death by reflecting on the death of others person. Having experience to expose with death situation both death of friends with similar disease and of their relatives or significant persons help participants Thum-jai, reduce the fear of their own death and accept the truth of life.

## Condition

### Realizing that death is inevitable

Although participants have attempted to stay healthy and keep restoring their health as well as possible, their health gradually deteriorated due to the progression of their disease and older age. They repeatedly life-threatening situations from time to time and were hospitalized due to the acute exacerbate symptoms. Some participants experienced near death experiences. These experiences desensitized and lessen their fear of death and became aware that their life was getting closer to the end and death was evitable.

*Repeating experienced life threatening symptoms and near death experiences*

Like the P2 and P12, they mentioned that between they living with their disease from 8 to 12 years, they had been confronted with repeated life threatening symptom until they had repeating both admit to the hospital and need the emergency room. Having experiences of both life-threatening and being hospitalized for several times reduced the feeling fear of death.

> "After being on hemodialysis for about 8 years, I have had heart arrhythmia symptom. When I knew that I had heart arrhythmia, it made me think about death again. I often experienced of being sent to emergency room with heart arrhythmia symptom. The feelings when I knew I was in the end stage of renal disease and when I was diagnosed with heart-arrhythmias were similar. But the feelings fear of death were less intense at the second time" (P2)

Another participant with …..also shared his experiences.

> "Then I had infection in the blood stream during hemodialysis twice. I thought that I would certainly die." (P12)

Similarity with P7, and P6, they mentioned that they could more accept their death than the first diagnosed. They mentioned that being with their disease could lead them to confronting with many various difficult symptoms to deal with. It could lead him both more familiar and more easily accept his own death. It can show as follow;

> "Being often confronted with difficult exacerbating symptoms made me more familiar with and accepting of my own death. (P7)

> "As I have encountered with various bad health situations, these situations make me okay and accept the death" (P6)

*Getting older*

Furthermore, getting older led participant's idea of getting closer to the end of their lives. To them, older age was associated with experience of physical deterioration.

Like a P3 and a P2, they perceived that life of human like a life of plants. It can show as follow;

> "In my opinion, old people will die. The elders are like banana trees…when it grows older, it will die. Like all human being, if their

> physical body stop functioning, people will finally die. Even our soul cannot hold our body to survive because the body is not real anymore. Our life can still belong as long as the body still function. If the body can still work properly, our life still keeps being. If our body stop working, we will die" (P3.)

> "I think that an old man is more ready to die because his body gradually deteriorates. Older age makes me think of death without being afraid of it" (P2)

Similarity with P7, He thought that getting older could lead him to be in illness stage due to the body decline and could not hold functioning. He explained;

> "When we are 40 or 50 years old, we must deal with illnesses. I grow older, my body function is declining. I was 60 years old when I was diagnosed with chronic lung disease. At that time, I was well. I didn't suffer from any illness, so I was still able to take care of myself. Now I am 70 years old and my deteriorated condition makes me think my own death. The body of older people will break sooner or later." (P7)

*Confronting with experienced seeing death sense of others*

Not only their own experiences of being in life-threatening situation, but also witnessing death scenes of other persons such as relatives or older persons with same diseases brought participants to be familiar with the death and dying situation. This made them reduce level of fearing on death realize that the death will be happened to them sooner or later.

*Experienced to confront death of family's member*

Like a P11 and a P14, they mentioned that whenever they had experienced to confront death of family's member such as their husband, their housewife, their sister or brother, their parents, and grandparents, these situations of death will lead them to recognize that one day the death will come to them like this. Every time the participants had confronting with death situation is always made the participant saw the real life that all people need to confronting with death include them. It made the participant both had more familiar and had more easy to accept their death. It can show as follow;

> "My husband died from lung cancer when he was 71 years old. Three years later, my mother-in-law died. I thought about my death too. When my mother got sick, I took her to live with me. After that, my mother died at home. Seeing the death of others makes me familiar with the death and did not fear death. I think that one day I will die too." (P11)

> "Every time I saw another person dying like grandparents, I always think about my death. When my father died, and my wife died, I thought that at the end of my life, I will be like this." (P14)

*Death of others older persons who had similar diseases*

In addition, some participants stated that seeing death of others older persons who had similar diseases and joining the funerals of others person reminded them that one day they would face with their death. The participants perceived that they could not escape from their own death.

Like a P2 and P12, they mentioned that when they had having often seeing situation death of others led them more easy to accept and decrease the level fear on their death. If can show as follow;

> “My fear of death decreased because in a hemodialysis room, I often see other older persons die” (P2.)

> “Almost 10 years that my health got better. This made me think that I could have a longer life. Later, I saw a friend who underwent hemodialysis like myself died. From this experience, I think that death just came close to me. Seeing someone die makes me think that one day, it must be ours. Seeing a death of a friend makes me accept my death easier.” (P12)

In the same way a P8, he mentioned that often seeing people died away from joining the funerals, it made him thought on his death every time. It can show as followed;

> “I went to many funerals. I saw many people pass away. Going to so many funerals, I started to have more and more thoughts on my own death.” (P8)

**Action**

**Thum-jai: Reflecting on their own death**

After the participants had experienced witnessing the death situation of others, the participants had been trying to Thum-jai to accept their own death. The strategies to Thum-jai included reflecting on the death of others such as the significant persons.

These reflections made the participants accept their inevitably death and live without fearing on their death.

*Even the king of Thailand and Buddha of Thailand*

Like a P15, she perceived that even the king of Thailand who had the chance to buy exceptional medicine and to be cured himself. It was differences from her who is not rich which she need to confront with death only. It can show as follow;

> "In my mind thought that even the highest of Thailand still die, he could not buy his life. When he walked, all people in Thailand will see him. He still got illnesses too. Even rich people die. I am like a little ant and I cannot afford to buy expensive medicines" (P15)

Similarity with P7, he thought that even Buddha of Thailand who highest leader in the religion still died. Therefore, he thought that all organisms need to confront with death even he could not escape from death too. It can show as follow;

> "Humans are living things. Even the Buddha died. As even the king of Thailand is dead, it makes realize that I will definitely die, too" (P7)

*Even who had been being well still die*

In addition, some participants tried to make up their mind to accept the truth of life. They reminded themselves that death can be occurred for everyone even who had been being well.

Like a P5 and P4, they perceived that they had been being with end stage of their illnesses that they having the chance to die more than people who being well. It can show as follow;

> "I was at the ending stage of renal disease. I was not panic, not confused, and not stressed. I knew people could be well and then suddenly died."(P5)

> "I think death is natural. Either healthy or sick people must prepare to die." (P4)

Similarity with a P7, seeing situation of people die even people being in sleep stage, it could lead him had firming that death is certainly for him. While he had more the chance to die because he had been being in illnesses stage.

> "While I am getting treatments, some people may die in their sleep. Even the people who are better than us die before us. This is because (the time of) death is uncertain" (P7)

*Even children still die*

In addition, seeing death of children situation is important factor that contribute the participants easy to Thum-jai their death. The participants thought that they had more the chance to die than children because they were older.

Like a P10 and a P4, seeing the situation death of children were important factor led the participants both did not suffer and did not worries on their death. They thought that even the child still died while they were older that had more the chance to die than children. It can show as follow;

> "Recently, a very young child died during hemodialysis. The nurse told me that the child already died. I think that even the kid still died. While I get older, I do not suffer from death because I will certainly die." (P10)

> "I had a direct experience about my grandson. He is still young but he has also got diagnosed with end-stage kidney disease. At the hospital, I saw many children waiting in a row for follow-up visits. It makes me think that I was not the only person diagnosed with the disease. I get sick when I get older. I think I am not nervous about death."(P4)

**Consequence**

**Accept the truth of life and death**

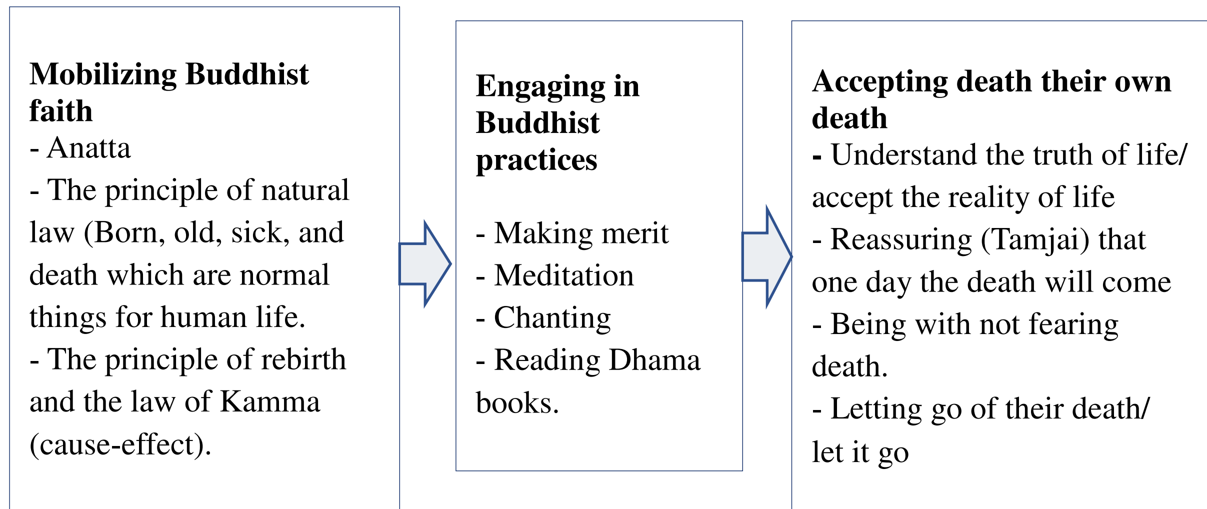
After the participants had tried to Thum-jai on their death from seeing situation of others death and reflecting their own death in difference ways. It desensitized their fear of death and accept the truth of life.

A P15 and a P10, they mentioned that confronting with situation of others death, it made them both more acceptable their own death and more decrease fear of their own death because it made them to see the truth of life. It can show as follow;

> "Seeing more people confronting with death makes me see the truth of life. All people were born to die, it is natural. Everyone must one day die." (P15)

> "Seeing a friend die makes me more accepting and not afraid, and not nervous with my death" (P10)

**Category 3: Affirming impending death**




*Affirming impending death* was the transitional category between trying to Thum-jai and accepting their impending death. In this category consist of 3 sub-categories consist of *mobilizing Buddhist faith, engaging in religious practices, and accepting their own death.* After the participants had realizing, that death was inescapable for them. They had made meaning on their death through mobilizing religion resources from their previous experience exposing to Buddhist teaching. Understanding on law of nature and Buddhist truths drove them to engage in religious teaching and practices in daily living until they get a clear picture of their impending death and accept death.

## Conditions

### Mobilizing Buddhist faith

Buddhist faith plays a key role as a condition to help participants move forward to accepting death. Participants mobilized their faith in Buddhist teachings to make sense of their life and death situation. Several participants stated that these Buddhist teachings help them understand life and death.

Like a p13 and P6, both of them mentioned that they did not known about death before until she met the religion. It could show as follows;

> "Initially, I never paid attention to the Dharma. After retirement, I perform the Buddhist chanting every day. The Buddhist prayer and script is about considering a body of human being. The details of script teach about birth, ageing, ailment, and death. After praying and chanting for one year, I thought of my death and realized that one day I would face death. The Buddhist lesson makes me understand life, and put down about life." (P13)

> "Studying about religious teaching makes me understanding about death and understands the life." (P6)

However, the participants reflecting that learning about death did not enough to enhancing their understanding on their death. Considering or contemplating was an important step for gaining understanding clearly about death. It could show as follows;

"People need to consider the truth of life by studying and considering it by themselves. Like a death, if we don't understand about our impermanent body and we did not study, we may not accept it (death). Although we had scientific knowledge about death, we do not accept about Anitata, Dukkata, Anattata, and still think that death is not real. In this case, it means you still do not understand the truth of death." (P1)

"Buddhist teaching is about understanding about life and death. If only seeing or knowing, it is not enough. We need to have wisdom, in order to gain insight into the reality of dying and death" (P14)

"The religion helps me to let go of the death. I was about to die several times. If I can let it go, it will not makes me suffer any more. Religion makes me to see the light …to find a new world… to see the truth of the problem, nothing obscuring. This makes me see everything clearer. I can see the Truth and can accept the reality of many things. The religious teachings by Buddha taught us to know about death before we will die. When we see the death in its reality, we will not be afraid to die. The religion taught everyone from birth to death. Some people don't understand the religion, and never think of the death that one day their death will come true." (P6)

"Religion helps me to cope with death, and allows me to accept death more easily. Religion can help a lot. The principles of Anitata, Dukkata, and Anatta make me not holding on. They make me see the truth in reality, like a death is the truth of everyone, do not go unbowed" (P8)

"Religion or Buddha taught me about uncertainty of our body. Everyone will go through a cycle of birth, ageing, ailment, and death. The religion makes me not fear of death and I can accept death easily" (P1)

It was appeared that three main Buddhist teaching were usually mentioned by participants.

*The natural law*

Participants commonly mentioned the natural law. The principle of natural law is that born, aging, sick, and death is normal for human life. This principle led the participants to realize that no one can escaped from death. As a P9 said,

> "From my experience of Dhamma reading and reciting the Dhamma religion belief, I have come to have no fear of death anymore. I believe in Buddha. I understand that at some point all people must die. I'm a Buddhist, I have faith in Buddhism. I know that all people will die. The religion helps me to understand the natural cycle of life, it is to say being born, growing old, getting sick and dying" (P9.)

The principle of natural law demonstrates that death was one-step in the natural cycle of their life. It was explained by one participant as follows;

> "To be born, then old, then sick, and die is common. One day or another, all people have to confront with death, and no one can escape from it. Even younger and older people cannot escape from death. Humans are organisms. The body of people will break down sooner or later. Birth, ageing, sickness, and death are simply steps in the natural cycle of life." (P7)

*Anatta*

The concept of Anatta is another Buddhist teaching that participants applied to make sense of their life situation. It helps them realize the uncertainty in life. Like a P1, he mentioned that the principle of Anatta make him had seen that death was certain. It could show as follow;

> "Religion or Buddha taught me about uncertainty of our body. Everyone will have to go through a natural life cycle of birth, ageing, illness, and death. In religious term of Anatta, it means that birth, ageing, illness, and death are common things for everyone. Everybody must eventually die. Because death is natural. We should sit or sleep well because we will certainly die" (P1)

*Rebirth and the law of karma*

Some participants mentioned the principle of rebirth or their belief in the next life which will depend on the law of karma. The law of karma reflects the law of cause and effects. Participants explained that if they conduct good acts, they will receive good things in return, but if they conduct bad acts, they will then receive bad things later. The belief in rebirth and the law of karma decreases their fear of death.

> "I believe that after death we will be born again. What will happen after people die depends on cause and effect, good acts will receive good things, and bad acts will receive bad things" (P7)

> "I believe that after our death, we can be born again. And since we can be born again, I am not afraid to die. In the past I believed that after death, there was nothing. So it was the cause of my fear of death. (P2)

Another participant shared her belief in boon - or good deeds or good karma - and the consequences. She said that

> "I thought that it is the law of Karma. Whatever will be, will be. We need to accept it. We need to let go of everything. I can accept everything that will happen because we cannot defy everything. We need to accept it. I thought that if I still have boon (good karma) I will not die but if I have no boon, I will die. Living or dying depends on Karma." (P15)

Like a P6, she believed in the next life. She explained if they do bad things, they will receive bad things in return. The participants believed that if they do good things, they will be born in a good place in the next life. This is shown in the following;

> "I think that death of all creatures depends on their Kamma. If we have done good acts or deeds, we will not suffer like this and we may go to a better peaceful place for the next life. I believe that if I act well and spread good karma, this karma will be accumulated or driving good force for me. If I do not accumulate goodness or I have no good driving force or power of good merit, Kamma will choose the way how my spirit goes during dying. Where and how the spirit will go to the next state depends on Kamma. Boon and Karmma that we commit will be the driving force to push our mind or our soul to be born in a good place in next life." (P6)

### Actions

### Engaging religious practices

The firm faith in Buddha's teachings had beneficial effects on the participants' understanding about death and dying. It motivated the participants to engage more in religious practices. Several religious practices or activities such as merit making, mediation, chanting or praying were performed. These activities aimed not only to gain insight on death and dying, but also to calm and comfort their minds.

> "Buddhist teaching helps me consider what's good or bad and apply it to the daily practice. … The religious ritual is to learn, to understand, and leads to daily practice." (P1)

> "I think that every religion teaches about death, like Buddhism. Buddhism teaches us to apply knowledge from Buddha to practice." (P15)

> "Religion helps me to think about my death, makes me see the truth of life. Religion guides my practice. When we see someone close to death, we can guide them in the right way instead of regretting it." (P13)

Like a P3 and P7, both of them mentioned that applying their understand on death into daily practicing had important process for clearly understanding on their death. It can show as followed;

> 'The most important thing which makes me think that death is a nature is the experience from my own learning. When we directly experience it, it makes me understand. If we do not practice it, it is useless although we know a lot by studying." (P3)

> "Although I had knowledge about death because I had experience leaning about this, this knowing was still unclear because it did not occur from my real insight. Knowing from remembering cannot much help me understand the reality. There are various kinds of knowing - knowing from memory or knowing what dead people look like. Knowing from the real practice will make me clearly understand about death" (P7)

Several religious practices were performed to accumulate good deeds and to comfort the participants' minds.

*Making merit*

Merit making was a common religious practice that most of the participants performed. They mentioned that merit making practices provided comfort for their mind. Participants stated that it had mental effect. It settled and calmed their minds. It could be shown as in the following;

> "I believe that making merit makes us mentally comfortable." (P3)

> "I always make merit, and prepare food for the monks in the morning. I have been making merit for about 10 years. After doing this, our mind is settled as if we have received a blessing". (P15)

> "I always go to the temple. Going to the temple and practicing and following the religious teachings comforts us. Gain strength. Making merit is a good thing, it makes me feel calm and settled. After coming back from the temple, I fall asleep easily. While I am in the temple, my mind is so settled, and the feeling is without Dukka (suffering), I do not think about my illness" (P10)

One participant believed that making merit could compensate for bad deeds.

> "I go to the temple on weekdays. I offer food for the monks every morning. I think that there is nothing much about human life. I think that going to the temple and performing good acts is enough. I believe that making merit makes me settled. I do not think too much, and I can accept this truth (about my own death). Beside that, making merit for whoever has already passed away can devote to the past nemesis. After I make this merit, it provides me with comfort." (P4)

Moreover, making merit could have an effect on their next life. For example, P5 and P11 believed that making more merit in the present could have an influence on their next life (rebirth). They tried to do good things because they believed that this will have a good effect on them. They hoped that by making more merit in the present this would help them not suffer with illnesses in next life or in their rebirth they will not get disease like this. This is illustrated by the following;

> "I respect Buddha, and I believe in Buddhism. …. I believe that if I do more merit making during this life,….I will not get this disease again in the next life (laugh)." (P5)

> "I do more merit making, I always go to the temple for making merit. I hope that by making merit in this world, we will not have a disease like this in the new world, we will have comfort and not experience difficulty from my illnesses. I believe that if I make merit in this world, in the next world I will not have this disease." (P11)

*Meditation*

Practicing the meditation could help the participants being mindful, living in the present, and seeing the real situation of their death. Mentally comfort was another effect of meditation practice. Like a P15, and P6, both of them mentioned that meditation could help them being with both mind comfort, being in the present and seeing the real situation. It could show as follows;

> "I practice the meditation since I got illnesses. Every time when I cannot sleep and when my mind was unrest, I always practice defining my breathing. It stops me from thinking about other matters; it stops me from getting distressed and makes me comfortable." (P15)

> "Meditate until your mind is still, I can know the present truth and see the actual truth wisdom. Most people just hold on with something until do not see what the real truth is. Seeing the real with your intellect is the understanding throughout our soul. Understanding with my wisdom enlighten me from the inside. Knowledge and understanding were the result from wisdom. It will hold on to us forever without learning new ones" (P6)

*Chanting*

Chanting was aimed at forgiveness. This could help the participants being peaceful in mind, considering and put down on their death, and enhancing peaceful mind in dying Category. It can show as followed;

> "Every time when I feel unrest, I pray. I did not fear what will happen. It makes me let go of things. Not a lot of things was in my mind and this makes me peaceful" (P15)

"I sometimes concentrate on acoustic prayer until I forget my illness because my mind cannot be distracted" (P13)

"Since I had dialysis, I have prayed a chapter of Iitipiso every night. On the day, if I have free time I always pray. I thought that it is for forgiveness" (P11).

In addition, participants believed that listening chanting or praying would lead to the peaceful mind and peaceful death later. As one participant shared,

"When my mother was about dying, I went to pick up my mom from the hospital back to home. I opened prayer by telephone to her all night. I believe that the sound of the prayer would guide her to the good direction, not the bad way. About 2 nights, she suddenly passed away peacefully with no restlessness before her death. I think that she passed away peacefully, and did not suffer. I believe that she went with a peaceful death." (P15)

*Reading Dhamma books*

Reading Dharma books helps participants understand and accept more about their own death. It expelled their fear of death away and comfort their mind. Similarity with a P12 and P4, they stated that reading the dharma could help them understand on their death, could put down on their death, and be in mind comfortable. It can show as follows;

"I started reading the Dharma books since I was diagnosed with the disease. I never read them before. Reading the Dharma books helps me let go of things. …and If I die, I will live without worry about anything. When we learn to

understand the truth of life, it lead to acceptance. When we bring the knowledge to practice, it made us know how to let go" (P12)

"I will pick up the Dhama book to read when I have time. It makes me comfortable. I do not think too much, and I can accept this truth." (P4)

"From the knowledge I have got by studying Buddhist religion, I know that before people die… the Dhama words need to be recited near their ears or listen to Dhamma talk. It can help them go to peaceful death." (P2)

**Consequence**

**Accepting their own death**

Accepting their own death was a consequence of this phase. After the participants engaged in religious practices, they gained insight into the truth of life and death and get clearer picture on their own death.

*Understanding the truth of life*

Engaging in religious practices and contemplating Buddhist teaching led to understand truly the truth of life and accept the reality of life. Like a P14, and P16, both of them stated that accepting death need to understand about death that born, older, sickness, and dies as the natural law of human life. Whenever they saw the people birth, they could already know that they need to confront with death. It can show as follow;

> "Death acceptance means understanding that all things rely on the rule of natural law of birthing and passing. Just only knowing not enough to accept death, acceptance death needs understanding" (P14)

> "Death acceptance is living with not attachments with death. Someone only knows about this, but cannot accept it. Many people only know about this but do not put down about death." (P16)

Similarity with a P6 mentioned that accepting death as accepting the reality of life that all people need to confront with born, older, sickness, and dies. The participants stated that acceptance death as accept the natural thing. It can show as followed;

> "In the past, I didn't understand about death, I felt the same as others people that I don't want to talk about death because it is not a good thing to talk about. Now, I can accept that death is the truth. I can accept the truth of life that this is real. Acceptance of death is an acceptance of the reality of life. People are born, and will die. We need to let go quickly on what is nonsense or useless. Don't keep it like trash." (P6)

*Thum-jai that one day the death will come*

In addition, accepting death is an ability to Thum-jai that one day the death will come to them. Like a P9, and P10, both of them mentioned acceptance death as trying to Thum-jai or reassuring that everyone need to confront with death situation. Thum-jai is admitting that death will be happened certainly. It can show as follow;

> "Now, I can reassure myself about death. I acknowledge that I can die whenever because I saw so many friends who were diagnosed the same illness who passed away. I try to reassure myself about my own death, since every one need to confront it at the end." (P9)

> "I could reassure myself that all people need to face with being born, then old, then sick and then dead. To be born, then old, then sick, and to die is common. One day or another, all people have to face with death, and cannot escape from it. Even younger and older people cannot escape from death. Death is the only certainty we have." (P7)

Similarity with a P10, and P11, respectively, they mentioned acceptance death Thum-jai to accepting that death will be happened for all human. They stated that;

> "Acceptance of death is Thum-jai about death that death will happen certainly, no one cannot escape from death" (P10)

> "Acceptance of death is (Thum-jai) or accepting that everyone will die" (P11)

*Living with no fear of death*

Moreover, accepting death is being with not fear of death. People who could accepting their death, they will not fear whatever will be happened. Like a P7, a P10, P3, and P8, they mentioned accepting death was being with not afraid of death. Which people who being with not fearing of death, they can have more activity that related to death will be happened such as driving trucking road, have dominated their body, and not get frightened when they being lonely. They perceived that people who

could accept death will be being with happiness and without worries about their death that will be happed. It can show as follow;

> "People who can accept death are people who do not fear death. I have seen people who are afraid of death. When their children go away, they get frightened. Their children need to rotate for taking care of them." (P7)

> "Acceptance of death is being with not afraid of death, and do not be afraid whatever will happen" (P10)

> "I think that the acceptance of death is not afraid of death. I am not fearful of death, and I look at death as natural, everything is natural. I think that people who are afraid of death are those who cannot think or have no idea. They remind me of the people who stopped me from preparing for the funeral for my parents" (P3)

> "Now, I do not fear of my own death. And I accept death that death must happen to me sooner or later." (P8)

*Letting go with their death/ let it go*

Moreover, accepting death is let it go the death and being with ready to die. The participants mentioned that accepting death is admitting or let go that we will die and must to die. Let it go with the death is being with not attachments with their own death. Like a P6, P4, and a P12, they stated that accepting death in term of let it go was not hold on their life and every people need to confront and could not escape from death. It can show as followed;

"The religion helps me to let go the death. I was about to die several times, and experienced syncope several times. I can let it go if this situation like this will happen again. It makes me free from suffering." (P6)

"If I die, I can admit that one day the death will come to me. Acceptance of death is admitting it. Admitting is to let go that we will die and must die" (P4)

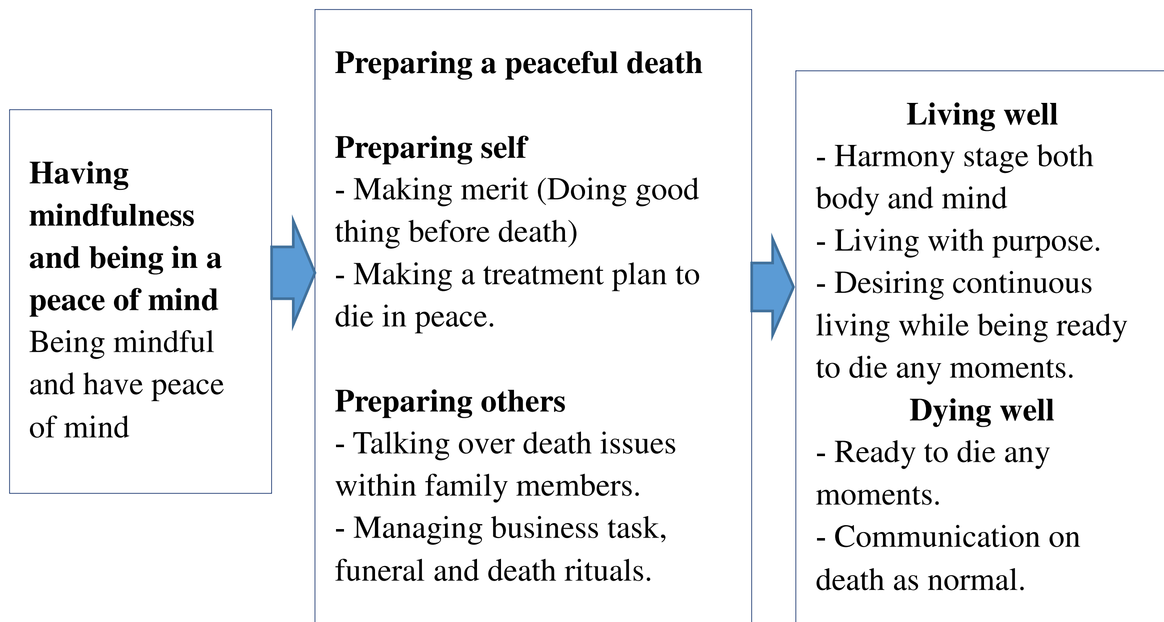
"Acceptance of death is to let go the death and ready to go. Although, I have something of concern, we cannot hold on to these things. Acceptance of death is let go the things that it is not ours" (P12)

Similarity with two participants consist of P16, and P13, both of them mentioned that let it go on death was non–attachments or put down that one day people need to confront with on their death. It can show as followed;

"Acceptance of death is being with not attachments with death, or must understand about the cycle of birth, ageing, sickness, and death. Someone only knows about this, but cannot accept it. Many people only know about this but do not let go of death. Like a retirement we need to let go at the beginning, someone knew that they would retire but when that time arrived, they could not admit it" (P16)

"Acceptance of death is letting go of birth, ageing, sickness and death, that one day we must come to this point, we don't have to worry. If we have prepared, it makes us free from worrying" (P13)

**Category 4: Transcending of death acceptance**




*Transcending of death acceptance* is a major process in the journey of death acceptance. This process consists of 4 sub-categories covering; *having mindfulness and being in a peaceful state of mind, preparing a peaceful death covered preparing self* (Making a treatment plan to die peacefully), *and others* (Talking over death issues with family members) and managing business tasks, funeral and death rituals), *and living-well and dying-well.*

**Condition**

**Having mindfulness and being in a peaceful state of mind**

This category is about the self-actualization and the management of living and dying in the end stage of life in order to have a peaceful death. After the participants realized that they could not escape from the reality of their own death and discovered

the meanings of death and death acceptance, they transformed their mind from fear and anxiety into a peaceful mind. The participants focused the mind with the present moment which was being mindfulness. This stage of mind made them to have more potential and encourage for genuine living and dying.

Like a P8, and P14, both of the participants stated that having mindfulness could help them being without fear and worries about their own death. Having mindfulness enhanced them have consciousness.

> "…I thought that death is common because I had mindfulness. It made me never fear about death." (P8)

Another participant explained,

> "I didn't panic, and not stress. I am usually mindful, not distracted, and not anxious about whatever will happen. Being mindful and not being anxious makes me not distract, and not worry. Anxiety will diminish feelings, make me afraid and be without confidence" (P14)

**Actions**

**Preparing a peaceful death**

Under the condition of being in a peace of mind, the participants had prepared a peaceful death which included of two processes: 1) preparing self and 2) preparing others.

*Preparing self*

Preparing self is a process of managing the participants' living and dying. The participants were aware their deaths happening in doubt time. Hence, they prepared self with two actions-making merits and making treatment plan to die peacefully.

*Making merits*.

Regarding Buddhism belief on collecting good-*Kamma* or *Boon* in the present for the next life or next stage, the participants desired in doing good things before passing. Doing good things were reflected in the practices of helping and donating.

For example, a P6, she understood that her life was defined by *Kamma* that would accumulate her next life. She wished to do good things until she died away because she had planning her next life that if she had good action, it might result in rebirth in good place.

> "Before this, I have pursued to do good things. I believed that if I act well, I will have good karma. This karma will be accumulated or driving good force to me. Our soul will fall in good way after I died. After I have a clear understanding about death, the only thing I can do is to make only good merits. I have only my body and my life. If I still have the value, donating my body is the last good merit that I can do. I decided to donate my body to the hospital which will be helpful to others" (P6)

Another example affirmed,

P13, she hoped to go to the temple until she died away. She needed to do

something for increasing her goodness in next stage.

> "I think that I go to the temple every day until I died. At the time my friend died, a friend helped arrange her funeral. I think that I have come the right way. If one day I die, I hope my friends will help arrange a funeral like this. I think that we must have connection with their temple because it is easy to contact when we need to organize the funeral" (P13)

Donation of the participants' dead body organ was viewed as a last merit in the present life for themselves and the others' lives. Some participants had decided to donate their body to the hospitals. For example, a P1 would like to do something that useful for others before he dies. He had been preparing for donating his body to the hospital.

> "I have travelled to many places and I like to talk with leaders of religion such as *Pra (the monk)* or the leaders of other religions. They expressed that when people died, they become useless like a piece of decayed wooden log. After that, I always thought that if I can do something useful, it will be good. I thought if I died, I can donate my body for medical students to study, and become useful for their future treatment to take care other people. I think that it is good if we have a chance to help others like that. 4-5 years ago, I thought that before retirement, I will donate my body to be useful for others. Then, I decided to donate my body because I thought and believed that this is a merit making and a good thing. In turn, the good thing will come to me without praying for anything." (P1)

While a P8 having idea to dominate his body to the hospital. He concerned about both making useful for others and doing the merit for himself.

> "I thought that the donation of my body would be a benefit for others and a merit for myself" (P8)

*Making treatment plan to die peacefully.*

Valuing on death without sufferings was employed in preparing self for a peaceful death. Even though, the participants accepted their death, they were still fear dying with suffering. They perceived that getting some treatments such as puncturing the needle, intubating endotracheal tube, putting the stent and dying from accident were the causes of pain for them. At the end of life, they wished to die without suffering, like sleeping. This condition led to the idea of making plan to die without aggressive treatments.

Like a P1 and a P10, they had been having order to family's member about the treatments in end-of-life stage that they wished not to extend their lives by any aggressive treatments. They perceived that extending life by receiving aggressive treatments such as CPR (Cardio Pulmonary Resuscitation) and intubating endotracheal tube caused them suffering.

> "Now if I am dying, I want to tell my doctor to let me die. I think that having an airway tube in cannot make me become like a normal person again. For me, I think that there is no need. My children should go to consult with a monk and prepare my funeral. I think that the life of people depends on *Kamma.* Our life is not that long. If we get sick and we will die, we should not extend by any aggressive treatments. I

> always order the children that if I have severe illnesses and I have low percentage to survive, do not extend my life, and should not insert the breathing tube. I thought that it will cause me more suffering than curing me" (P1)

Another excerpt supported,

> "About 6 last years, I was put on a breathing tube because I was comatose from the infection of my shunt. At that time, I never thought about death, I had only feeling of pain at my throat. I thought I could recover. If I did not recover, I would just die. The tube made me suffer a lot. If I got worse again, I did not want the breathing tube anymore because I could not eat, and my mouth cannot move. I already talked with my daughter and told her that I do not want it even if it is needed it again. Although I will die, I do not worry. I only wish to be free from suffering. Because after they pulled out the tube, I continued to suffer about 2-3 days" (P10)

Some participants had not discussed about the treatments with their families' members but they had had the idea of not prolonging life when their symptoms got worsening.

For example, P12, he experienced of witnessing the other older persons receiving intubated endotracheal, CPR, and put full equipment into body. This led him understanding that it caused suffering. He planned to write a living will and inform his family to let him die without prolonging life.

> "I have prepared only one in my mind. I wish to have it written in the document for them to explain my feeling. I witnessed other older persons being put on full equipment. I just could not accept it. If I had

worsening of my symptoms again, I don’t want to deal with any more stress. I do not fear of death but I fear to die with suffering. I ask for comfort during my passing, and not wailing. If already know that I have a zero chance to survive, don’t prolong my life, and just let me go. I want to tell my wife as well. I plan to have this happen within a year” (P12)

*Preparing others*

According to the wish to die without burdening family members, the participants had preparing others by often talking death issues to their family members, and managing business task and their funeral and death rituals.

*Talking death issues with family members*

The participants had been talking on their death with family because they wished their family’s member to familiar with their death situation. This could prepare the family member’s mind to accept the loss. After the participants died away, they hoped that their family members were strong being by themselves and not mourning.

For example, a P10, she always talked about her own death with her children. She thought that it was useful for preparing the mind of their children and their funeral.

“I always talk about my funeral plans. When I die, all of you don't cry. I talk with my children about this 12 years ago. I always speak with my children, until my children complain that I only talk about

> death. I always joke, and prepare for the funeral with my children." (P10)

Similarly, a P8 mentioned that he always jokes talking on his death with children because he hoped to see them can accept and prepare their mind to confronting with his death happening.

> "Now, I prepare to die by talking with my children. I tell them to work hard because I will not forever be with them. I always talk with them, I expect that they will be prepared when I pass away" (P8)

*Managing business task, funeral and death rituals*

This process aimed to reduce family's burden from the participants' death. The participants perceived that everyone need to confront and manage own death. They had concerned that if they died while not preparing everything, it would be burdened for their families who left behind. This can effect to the participants' readiness to die and their peaceful death. The participants had prepared many things such as number of ritual, money for their ritual, and some reminder.

Like a P3, and P12, they thought that preparing had nothing wrong but it was not only being with readiness but also being without burden to their families after they pass away. In addition, preparing could enhance their mind without worrying especially about their children.

> "Like my father and mother, I have already prepared everything such as a funeral, the coffin, cloth-bound car, and maps to the funeral place. When that day comes, just give them a call. Within seconds, my funeral ceremony will be ready. I used to experience that no one is ready for this ceremony and family was so busy organizing it. So, I decided to prepare for all for my father. I don't think that it is a curse and there is nothing wrong about this preparation. It was a good thing that everything was already prepared" (P3)

Another quote,

> "I have already prepared for the money and insurance for them (children). At that time, I prepared money for them after I had retired. Now, I prepared the expenses for them. Although, I had to die in this time, I do not fear death, and no stress. Now, I am ready to die." (P12)

**Consequence**

Transcending of accepting death by preparing self and others was an anticipating for a peaceful death, which is an optimal wish for all Thai Buddhists. However, the consequences of the participants' preparing self and others contributed to their living-well and dying-well or the quality of living and dying at the end stage of life.

**Living-well**

The participants were living with harmonious body and mind. They had a purpose in life and a desire to continuous living while being ready to die any moment. They took care of both physical and mental under their understanding of body-mind were connected. Being in positive felling could affect to physical functions such as sleeping and eating well. Like a P1 perceived that his body and mind was related. If he had the positive emotion from death in term of be happy, feel comfortable, no worries, no stress, not anxious, and not afraid, the physical would be in healthy in term of being able to eat and sleep well.

> "Thinking that death is natural and we will eventually die helps clear my mind, and I live with no worries. I think that worries affect my health. If our mind is well prepared, our physical health will be good too. If we have a good mind, we can eat. When we want to sleep, we can sleep. I think that mental health is more important to live longer" (P1)

*Living with purpose and desiring to continuous living*

Living with purpose and desiring to continuous living was also a sign of living- well. The participants engaged more activities that made them be in happiness. They still had hope to see growing up of grandchild and successful of their children.

> "Now, I can reassure myself about death. I acknowledge that I can die whenever because I saw so many friends who were diagnosed the same illness who passed away. If I could choose I'd rather not to. I would like to see my children's success and having job security. Now, all of my children already got married, but I still would like to be around to see my grandchildren growing up" (P12)

**Dying-well**

This consequence can be inferred as being ready to die at any moment and being able to communicate about death as normal and not auspicious. After the participants could accept their death, they did not fear and worry on their own death. They were ready to die in this moment. As a participant said,

> "Even if I have to die now, I do not fear death, and not stressed. I admit and let go of death. Now, I am ready to die. I am always ready to die. This feeling just came to my mind and I just accepted about 1 year ago." (P12)

In addition, it will result in attitude to communicate on death. The participants had positive emotion when they heard on death issues and they were interesting in communication on death.

> "Now, talking about death, it does not affect me. Someone came to talk about death. I felt calm because it is a normal part of life. It did not make me suffer, and not cause me stress. I think that I already accepted my death. Before that, though, thinking about death made me feel stress. I still don't want anyone to talk about death to me. People in general get upset after hearing about the

death. Some people don't want to talk about death because of feeling discomfort. Some don’t want to talk about it because it is not a good thing to talk about.” (P6)

“In my family, we experienced and witnessed the death of two older people. One of our elder is now over 100 years old. Talking about death in my home will happen every day. All of my children are comfortable talking about death. I always talk about death with my husband. We talk about how to manage the funeral if one dies before the other. Everyone in my family can let go about death, and they can talk about death. We frequently talk about death together.” (P15)

**Discussion**

The results show that the death acceptance journey in Thai Buddhist older persons with advanced chronic organ failure consist of four categories; 1) the negotiating of their own death,2) neutralizing the fear of death, 3) affirming impending death, and 4) transcending of death acceptance. Each category can be explained as follows;

**Category 1: negotiating of their own death** was identified as the initial category of the journey to death acceptance in Thai Buddhist older persons with advanced chronic organ failure. This category consisted of 3 sub-categories; *recognizing their own death but not ready to die; taking actions to maintain their health, and hoping for a longer life.*

Recognizing their own death but not ready to die, this category reflected the psychosocial process when participants encountered the life threatening situations from when they were informed by their medical doctors that their disease had reached

the end stage and was not reversible, had experienced life threatening situations with worsening symptoms, and these conditions led the participants to recognize that their life time was limited because their disease would be the cause of death for them. This result supports that when an older person's symptoms were uncontrolled by a previously adopted regimen this resulted in symptoms gradually getting worse which led to the progressive deterioration of the older person’s body. Older persons with advanced chronic organ failure had thoughts and responses on death that death is approaching (Axelsson et al., 2012; John & Thomas, 2013; Nguyen et al., 2013; Molzahn et al., 2012). This result is congruent with the older persons in advanced stage of congestive heart failure when they had been withdrawn from treatment and they had to face their thoughts on death and dying (John & Thomas, 2013).

In addition, the results show that some participants recognized their own death when facing near death experience due to becoming unconscious and having stopped breathing because of the severity of their illnesses. Experiencing life threatening situations led the participants to know that their life was close to the end and this made them aware of their own death. In addition, the result is congruent with the study about older persons’ experiences with chronic organ failure by Joen, Kraus, Jowsey and Glasgow (2010), which found that when older person’s diseases were in an advance stage this led the older persons to recognize they were visiting death’s door, and they had worries about dying while asleep.

Concern for both their children and their families, Because of the awareness and fear of their own impending death due to the aforementioned situations, the participants recognized that their life time was limited and this added to their feeling of the fear of their own death because they were not ready to die. Most of them stated

that they were not ready to let go of life because most of the participants were more concerned about their family when they died as to who would take care of their families and their children because the participants were the head of the family. This result could support that when having experienced a high symptom burden, older persons had a fear of dying as the cause of stress because they were concerned with loss, their loved ones and meaning in life (Yodchai et al., 2011). In addition, the older persons had higher concern about death because of the recognition of personal death associated with grief and impending losses. This result is congruent with the older persons with advanced congestive heart failure who were not ready to die because they had some things they still needed to do, and they had considered the negative consequences on loved ones such as leaving families, not seeing grandchildren grow up, and the effect their death may have on their families (Waterworth & Jorgensen, 2010). Moreover, the result could support that unfinished tasks was a significant factor that was negatively related to death acceptance of advanced cancer older persons While some older persons who had a readiness to die because they could accept living with multiple losses such as the loss of their relationships and social networks, loss of friends and hobbies. (Krapo et al., 2018).

Taking actions to maintain their health, and hoping for a longer life, the results showed that not being ready to die led the participants to try to take actions to maintain their health and their life and this covered learning about their illnesses and treatments from their primary doctor and nurses and other older persons who had the same diseases. Some participants learned more about their illnesses by searching for health information and reading books regarding how to manage their illness and to help them make decisions on treatments which they hopes could help them live longer

and well. Moreover, some participants had taken action to maintain their health by adhering to medical treatments, trying to do everything to get better, and keeping up their spirits and seeking support from others. Although the participants already knew that their treatments could not cure their diseases, they still received treatment as long as possible because they believed that this could prevent both a relapse of their symptoms and less severe symptoms. Being in a feared state was an important factor that contributed to the participants taking better care of themselves. However, the participants had keeping up their spirits and sought emotional support from others for support and motivation to live life longer. Talking with friends, and their family members provided support and motivated them to fight to live. The results showed that the participants believed the actions outlined above could help them to maintaining their life for being with their families as long as possible. They hoped to survive each year because they would like to live life longer to see their grandchildren grow up.

The results are congruent with knowing about impending death for older persons living with advanced heart failure and COPD which can promote an older person's fight to prevent exacerbation which can create a new normality for the older persons by adapting to his/her illnesses and the symptoms that go with the illness (Lowey, Norton, & Quill, 2013). Thinking about loved ones can contribute to those older persons wanting to extend their life, having a plan for death, and having hope for their loved ones before death will come upon them. This result can be supported by the experiences of adult older persons on ventilators, they perceived that confronting endotracheal tubes indicate a critical illness and as near death experience for them. Although some adult older persons had thoughts on the fear of death and

their future, they wished to recover from their illness and get well because they have worries about their children, their families, and business tasks (Chaiweradet, Ua-Kit, & Oumtanee, 2013). This result is related to the study conducted by Manasurakarn et al. (2008) about the underlying end-of-life decision of Thai Buddhist older persons and their families which reported that most of the participants were middle aged adults and 19.5% of the Thai Buddhists decided to continue the treatments because they needed to survive for various reasons or because life was important for them. This result is related with to the studies on thoughts about death in older persons with congestive heart failure of Stromberg and Jaarsma (2008). They found that younger aged people had always been afraid of dying both of their own death and of their loved ones. Concern for their loved ones was an important reason for them. The result is similar to older persons in advanced stage of congestive heart failure and cancer older persons as they tried to improve their health by changing their life style, adhering to treatments, and increasing self-care activities because they hope they can extend their life to see their grandchildren grow up, and to support their families (Lehto & Therrien, 2010; Stromberg & Taarsma, 2008).

**Category 2: neutralizing the fear of death,** this category consisted of 3 sub-categories; 1) realizing that death is inevitable, 2) Thum-jai: reflecting on their own death, and 3) accepting the truth of life and death. This category reflected times when participants got older and their health deteriorated due to the progression of their disease(s). They experienced life-threatening situations and had been hospitalized several times. Although the participants have attempted to stay healthy and tried to restore their health as well as possible, their health gradually deteriorated due to the

progression of their disease. While they living with their disease, the participants were confronted with many difficult symptoms that they had to deal with. They had been confronted with repeated life threatening symptoms until they had to be admitted to the hospital or the emergency room due to acute exacerbate symptoms. In addition, some participants had repeated of near death experiences. These conditions led to the participant realizing that their time was relatively short and death was inevitable and this contributed to the participants accepting more their own death.

This result could be supported by older persons who were living with maintenance hemodialysis whenever they were severely ill as their bodies were deteriorating body, and their conditions were worsening conditions. These older persons had an awareness that death may be near, and as they prepared to face death, they thoughts of death and dying (Axelsson, Randers, Hagelin, Jacobson and Klang, 2012). Moreover, this result is related with the study about awareness of dying: it needs words of Lokker et al. (2012), they found that symptoms most prevalent during the last 3 days of life were related to lack of energy (need for rest, fatigue, and weakness), lack of appetite, and difficulty concentrating and shortness of breath. Older persons who were aware of dying more often experienced a lack of appetite and less often experienced tenseness compared to older persons not aware of dying. Importantly when symptoms gradually get worse this leads to the progressive deterioration of the older person’s body. They have an awareness of the certainty of death (Buranaruch, 2013).

In addition, having both life-threatening experiences and being hospitalized for several times reduced the feeling fear of death. The participants could more accept their death than when first diagnosed. It is interesting to note that deterioration in

disease and a worsening generic health status is a facilitating factor in the acceptance of death in these older persons because the older persons had a change in the level of their fear of dying to accepting, death is not fearful, they had adapted to their condition, had made a will and planned their funeral (Stromberg & Jaarsma, 2008). When the older persons approached end of life, older persons were aware of their approaching death, and lived with the uncertainty about death happening. Increasing uncertainty from the deterioration of their conditions were factors contributing to these older persons having an awareness of their diagnosis. An older persons tries to find out more information which is important in managing the uncertainty of the future (Warterworth & Jorgensen, 2010).

Furthermore, older persons getting older and their health gradually deteriorating due to the progression of their disease and older age could lead them to becoming both more familiar with and more easily accepting of their own death. Getting older led to the participants' realization of getting closer to the end of their lives. Older age was associated with the experience of physical deterioration. Participants had perceived that the life of a human was like the life of plants. Getting older could lead result in an illness stage due to the decline of the body and not being able to function properly. The result can be supported by the awareness of death or death acceptance in people which was related to demographic data, individualized nature and the development of their ego integrity (Parker, 2013; Stromberg, & Jaarsma, 2008). This result can be supported by the study to determine the relationship of perception of aging, and a group of demographic factors, with death anxiety in the older persons living in Gonabad which found that the perception of aging perfects by age and there is a more realistic view of the acceptance of aging

conditions. The older persons who are aware of the natural aging process and have accepted their physical and mental status at this category of life reported less anxiety even though they had poor physical and mental conditions. In addition, the perception of aging can contribute to improving the older person's satisfaction with aging and their adaptation to age-related changes (Mohammadpour, Sadeghmoghadam, Shareinia, Jahani, & Amiri, 2018). In addition, this result congruently matched with the older persons who had a progressive deterioration of their body, strong impairments in ADL, and worsening conditions and prognosis due to an advanced stage of disease, all of which resulted in the mental and emotional health of the older persons in having to be aware that his/her death is near and to strongly accept their own death (Axelsson et al., 2012; Nguyen et al., 2013).

These experiences desensitized and lessened their fear of death as they became aware that their life was getting closer to the end and death was evitable. Participants in this category tried to Thum-jai to anticipate their own death by reflecting on the death of other persons. Between the participants living with their disease, the participants had experiences of being confronted with or seeing the deaths of others. Some participants stated that watching the death of other older persons who had similar diseases and going to the funerals of other persons reminded them that one day they would face their death. They also had experience in confronting the deaths of family members such as their husband, their wife, their sister or brother, their parents, and grandparents, these situations of death will lead them to recognize that one day death will come to them like this and they could not escape from their own death.

After the participants had experienced witnessing the deaths of others, some participants tried to make up their mind to accept the truth of life. Whenever they had

witnessed the death of others this led them to more easily accept and decrease the level of their fear of their own death. Every time the participants had confronted a death situation, it always made the participants see the reality of life in that all people need to confront death including them. This made the participants both be more familiar with and more easily accept their own death. This result related to a study conducted by Parker (2013) who found that the ability to accept the past experience was a significant predictor of the attitude toward death in the older person's population. The ability to accept the past experience was a significant factor of the fear of death, death avoidance, and neutral acceptance while acceptance in the past was not a significant predictor of approaching acceptance or escaping acceptance. The result indicated that the greater one's ability to accept his/her past lived experience in life as being a necessary and meaningfully whole despite the failure and regrets. While the older persons who have been able to accept the fact of their life, they will also accept the fact of their impending death rather than feeling fear and anxiety about their death. This result is congruent with exploring the advance care planning needs of moderately to severely ill people with COPD by Nguyen et al. (2013), they found that having experiences confronting a death situation, witnessing others dealing with end of life situations can emphasize to older persons to accept their own death because seeing other older persons pass away encourages those older persons to reflect or think about a plan for themselves. In addition, the result can support that older persons' experiences when confronted with periods of grief several times are a contributing factor to accept death as a natural part of life (Glass & Nahapetyan, 2008). From conducted thoughts on death in advanced heart failure older persons of Stromberg and Jaarsma (2008), they found that the older persons with advanced

chronic organ failure can accept death as a natural part of life because they had experiences of being confronted with death during periods of grief several times from friends and family members who had already died.

Having experience of being exposed to the death of both friends with similar diseases and of their relatives or significant persons help the participants Thum-jai, reduce the fear of their own death and accept the truth of life. Seeing the situation of people die could lead to confirming that death is certainly for them. All organisms need to confront death. Witnessing the death of others is an important factor that led the participants both to not suffer and to not worry about their impending death. This result was related with the concept analysis to explore the usage of the term Thum-jai in research studies and clarify its conceptual meaning of Mills, Anuchit, and Poogpan (2017) found that Thum-jai is a coping strategy embedded in the culture of Thailand and used by people when facing an adverse situation or circumstance for which there seems to be no escape. Which the attributes of Thum-jai are accepting and letting go of the negative situation, forgetting the bad feeling, calming or steadying the mind, and developing patience and understanding. Thum-jai may be understood within either the Buddhist religious context. It is typically practiced during the life cycle of birth, aging, sickness, and death. The religious/spiritual context produces a sense of obligation to respond in a manner consistent with the teachings of faith and personal integrity. Moreover, this result can be supported by the study to explore how terminal cancer older persons who have not clearly expressed a depressed mood or intense grief manage their feelings associated with anxiety and depression. Kyota and Kanda (2019) found that the terminally ill older persons with cancer tried to accept their situation by having to accept that they have developed cancer, the development of the

cancer disease, having worsening symptoms, and accepting the undeniable approach of their own death because they thought that they could not change their situation. Even though they felt that their symptoms were worsening and their physical power was deteriorating, they were afraid of death and the process of death and earnestly desired to live but they had to accept what was happening because they already knew that death was imminent.

After the participants had tried to Thum-jai on their death from witnessing the death of others and reflecting on their own death in different ways, it desensitized their fear of death and helped them to accept the truth of life and death. Confronting the situation of the death of others made them both more acceptable their own death, reduced the feeling of the fear of death and become more accepting of the truth of life than the first diagnosis because it made them to see the truth of life. Their own experiences of being in life-threatening situations, and also witnessing the death of other persons such as relatives or older persons with the same diseases helped the participants to be familiar with the death and dying situation. This reduced the participants' level of fear on death and helped them to realize that death will happen to them sooner or later. This result is also related with the consequence of the concept analysis to explore the usage of the term Thum-jai in research studies and clarify its conceptual meaning of Mills et al. (2017) found that the consequences of Thum-jai were peace of mind, emotional stability, positive thoughts, and productive change.

**Category 3: affirming impending death** was the transitional category between trying to Thum-jai and accepting their impending death. This category consists of 3 sub-categories consisting of *mobilizing Buddhist faith, engaging in*

*religious practices, and accepting their own death.* After the participants had realized that death was inescapable for them, they made meaning on their death through mobilizing religious resources from their previous experiences exposed to Buddhist teachings. In this category, the participants had mobilized their Buddhist faith, which played a key role as a condition to help the participants move forward to death acceptance. Participants mobilized their faith in Buddhist teachings to make sense of their life and the situation of death. Buddhist teachings helped the participants understand life and death. Previous experience exposed to Buddhist teachings helped the participants to clearly understand that all animals must to die and one day their own death will come. The participants had leant about death by learning or approaching religion by themselves. Wanting to learn and know about death from religious beliefs or Buddhist teachings on death could help the participants to see the truth of life and death.

This result is congruent with the study on the discussions of elders and adult children about end of life preparation and preferences by Glass and Nahapetyan (2008). They found that the older persons who had religious faith and spirituality were important factors to facilitate their preparedness leading to an acceptance of their death. The study related to the administering of the Death Attitude Profile-Revised (DAP-R) of Wong et al. (1988) in age groups such as the young, middle-aged, and older females which found that the older persons had positive attitude on death related with the religious beliefs or a greater belief in the afterlife than the younger and middle-aged groups. In addition, the older persons have positive attitude on death related to approaching death acceptance more than other groups. In addition, this is supported by the findings from another study in which older persons that had a lot of

experience in religious coping and spirituality, both through themselves and through spiritual support by chaplain services resulted in accepting their own death in terms of experienced less aggressive treatment, reduced medical care, and high intent to hospice care in end of life and at near death (Balbini et al., 2013). This is similar to the investigation on the factors related to the death acceptance of Thai advanced cancer older persons, which found that Buddhist beliefs about death were significantly positive correlated with death acceptance of advanced cancer older persons (Krapo et al., 2018). Moreover, older persons had been willing to discuss issues surrounding their terminal condition because their religion could help them to find meaning at the end of life and to accept the end of their lives. The application of the Buddhist religion through religious activities made them feel more peaceful and they came to accept the truth that death is universal (Kwankhao & Boonmongkol, 2013).

Moreover, the result found that three main Buddhist teachings were usually mentioned by participants consisting of the principle of natural law, the concept of anatta, and the principle of rebirth and the law of karma. The principle of natural law is that birth, aging, sickness, and death are normal for human life and this demonstrates that death was one-step in the natural cycle of their life. This principle led the participants to realize that no one can escape from death. This result can be supported by Buddha's teaching about the truth regarding life and death that everyone is born, then gets old, sick, and finally dies, which is a natural law of life (Dhammananda, 1987; Payutto, 1995). All people need to confront the experience of death because death is certain for everyone and is an integral part of life. This result can be supported by the Buddhist teachings in terms of the four noble truths that led the older persons to have an understanding of what the true problems that people face

are, and then, to be in the present, to always be aware and conscious of death, as no one can live forever (Chiaranai, 2014). Although, the situations of death can lead to suffering for all humans, suffering from a death sentence can be released by following the Buddhist principle in considering that death is a natural part of life (Masel et al., 2012). A relevant study in Thai Buddhist older persons with chronic illness who can accept death also viewed death as natural and a part of human life (Rukchart et al., 2014). Congruently, a study in older persons with end stage renal failure who can accept death had thoughts on death as the inevitable part of everybody's life, which is natural for the old and ill (Axelsson et al., 2012).

Next, the concept of anatta is another Buddhist teaching that participants applied to make sense of their life situation. It helped them to realize the uncertainty in life. The principle of anatta helped the participants to see that death was certain. This result can be supported by the nature of existence in Buddhism which views all things exist in a constant flow or flux. The Buddha has explained the three characteristics of existence as the universal characteristic of all things and consists of 1) aniccata means impermanence, instability, and uncertainty. All things can occur and can be extinguished, 2) dukkhata is a state of suffering, the cause of dukkha for persons are desiring things with attachment, 3) anattata (anatta) means all phenomena are not the self, no real essence (Payutto, 1995). Buddhism states that all things in the world cannot remain and can pass away, searching for permanence in the Buddhist view is argued (Prayut, 1995; Khado, 2003). Teaching about impermanence of life is important in Buddhist Philosophy (Chan et al., 2011; Masel et al., 2012). Death is viewed as the impermanence of life, which is undeniable, inescapable, unavoidable, and a natural part of life. All humans will certainly die because death is a natural part

of existence but time of death is not certain (Dhammnanda, 1987; Masel, 2012). Buddhism teach about understanding the reality of human life can decrease the illusion of a permanent self, attachment to any mental or material state in a person (Dhammnanda, 1987). This result could support that understanding the natural existence can influence both the acceptance of death and decisions in the end of life in older persons with chronic illnesses. Thai Buddhists with chronic illnesses who made the decision to forgo life sustaining treatment when their illnesses are diagnosed to be terminal find the Buddhist teachings can emphasize for them that prolonging death is impossible (Manasurakarn et al., 2008; Rukchart et al., 2014).

Moreover, the principle of rebirth and the law of karma reflects the law of cause and effects. Participants explained that if they conduct good acts, they will receive good things in return, but if they conduct bad acts, they will then receive bad things later. The result can be supported by the Buddhism principle which states that a human being is related to kamma. Buddhism believes that everything is a result of acts in previous lives. Kamma refers to acting or doing and if whoever is acting in a good way, the consequence will result in a good outcome (*Boon*). In addition, in the language of science, the belief is that kamma is the law of cause and effect. Kamma is the result of our action as one of the factors which is responsible for the success and the failure of our life (Dhammananda, 1987). The participants also believed that the effects of *'Boon'* and *'Kamma'* in the past and present will result after death or in the next life. Participants believed that after our dying, we could be born again and this depends on cause and effect. The participants believed that if they have performed good things, they will be born in a good place in next life. This result can support the belief in rebirth and the law of karma to decrease the fear of death for the participants.

Buddhists also believe in life after death which will guide Buddhists to prepare a good death in order to have a good rebirth (Khadro, 2013). This knowledge can influence the participants' perception on death and they viewed death as a passage of *'Boon'* and '*Kamma'* to the next life." The Buddhist perspective on karma provides the hope that even when facing death, one still has the opportunity to make positive, benevolent causes through one's words and actions for a better future (Choudhury, 2017). In addition, Buddhists believe in rebirth and that they will be reborn again and a person's state of mind as they die is very important so they can find a happy state of rebirth when they pass away. In addition, death and the dying period are important in the life process that relate to a good death which will be dying with consciousness, being sensible and not forgetting, and having a peaceful mind with no regrets. At the time of dying the mind must be alert so as to allow humans to be continuously reborn (Chan et al., 2011). Having a peaceful mind and the acceptance of death can lead to a good death. Buddhists believe living with the understanding that death is the reality of life, the impermanence of life, and acceptance of death are important teachings in Buddhism because these can lead to a good death (Kunaporn, 2011).

The result is congruent with the application of Buddhist beliefs in nursing practice such as performing good acts and thoughts (Kongsuwan & Locsin, 2009), caring with merit, caring based on the belief of kamma, being caring for sati or consciousness, and being spiritual and faithful in the Dharma for older persons in the end of life stage can enhance those older persons to non-attachment, to find peace of mind, feel that they are going to go to a good place, and have a peaceful death (Kongsuwan & Locsin, 2009; Somanusorn, 2015). In addition, the result related with Thai older persons, they believed that dying without worry and attachment will lead

them to die in peace and to have a good rebirth (Rodpal et al., 2007). Moreover, older persons with a strong religious belief in an afterlife and had a negative relationship with fear of death, death anxiety and a positive relationship with death acceptance, and level of personal meaning and well-being (Wong et al., 1988). Similarly with older persons who had high religiosity had positive correlations with death acceptance because these older persons were religiously serviced and believed in a happy afterlife (Lehto & Therrien, 2010; Pinquart, Frohlich, Silbereisen, & Wedding, 2006).

However, the participants reflected that learning about death was not enough to enhance their understanding of their death. Considering or contemplating was an important step for gaining understanding clearly about death. The participants mentioned that having a clear understanding about death needed to be arrived at through a process of critical thinking, and consideration. This result was related with the highlights of Buddhism that the human being will not suffer if humans can understand the nature of the reality of life and death. Understanding about the reality of human life can decrease the illusion of a permanent self, and the attachment to any mental or material state in a person (Dhammnanda, 1987). The understanding about the reality of human life and death in Buddhism consists of the four noble truths, the law of kamma or Karma, the nature of existence or tri-lukkhana, and the five aggregates of life (Dhammananda, 1987; Payutto, 1995). The four noble truths are the core essence to emphasize the true nature of life in Buddhism which consists of; 1) suffering (Duhkha), 2) the cause of suffering (Samudaya) can begin from ignorance, anger, and attachment., 3) the cessation of suffering (Nirodha:Nirvana), is eliminating the root of suffering by non-attachment or to understand and realize the truth of life, and it a state of being free from all delusions, defilements, and suffering, and lastly, 4)

the path way to the cessation of suffering (Marga) is the ways to achieving freedom from suffering which is called the noble eightfold path. (Dhammananda, 1987; Payutto, 1995). The noble eightfold path can be separated into three categories; moral conduct, concentration, and wisdom. Persons who can achieve the release of suffering will follow these elements. Firstly, moral conduct (shila) or morality consists of right speech, right action, and right livelihood. Secondly, concentration (Samadhi) or meditation consists of right effort, right mindfulness, and right concentration. Lastly, wisdom (panna) consists of right view or right understanding, and right thought or right aspiration (Dhammnanda, 1987; Masel, 2012).

The result can support that understanding the reality of life and death or accepting death as the life process of an older person's life can be a useful time for learning and gaining insight into the true nature surrounding us. Buddhism is strongly influenced by traditional beliefs regarding the faith Thai people have in Buddha and in following his teachings. Buddhism influences many aspects of Thai culture and not only plays an important role in the ways of thinking and living for Thai people but also plays an important role in shaping many aspects of perception on health, illnesses, and death. The literature shows that Buddhism is used for trying to understand that no living thing can escape from death and provides reflection to help one prepare for impeding death (Nguyen et al., 2013). Buddhist principles can lead older persons to gain an understanding of the nature of life, of non-attachment, acceptance of death, a peaceful death in the dying stage (Kongsuwan et al., 2010; Somanusorn, 2009). In older persons with advanced cancer, the older persons perceived that Buddhism could help them to understand the reality around them, and transcend the stresses and suffering in their life (Miccinesi et al., 2012). This was

similar with Thai older person's older persons who usually do not want to follow aggressive treatments, and want to plan an advanced directive or make a living will by themselves because the older persons understand that death is a natural part of life (Sriyodchat & Hutterat, 2014). Thai Buddhists with chronic illnesses who make the decision to forgo life sustaining treatment when their illnesses are diagnosed to be terminal find the Buddhist teachings can emphasize for them an understanding that death is a natural part of life, and prolonging death is impossible (Manasurakarn et al., 2008; Rukchart et al., 2014).

Engaging in religious practices, the firm faith in Buddha's teaching had beneficial effects on the participants' understanding about death and dying. It led the participants to engage more in religious practices. The participants had mentioned that applying their understanding on death into daily practice was an important process for clearly understanding their death. Several religious practices or activities such as merit making, mediation, chanting or praying were performed. These activities aimed not only to gain insight on death and dying, but also to calm and comfort their minds. Several religious practices were performed to accumulate good deeds and to comfort their minds. The majority of older persons had expressed the Buddhist way by depending on their religious beliefs to confront their illnesses and their death. This result can support that Buddhism has vital factors for decision making in daily life in Thai older persons with chronic illnesses such as making merit or boon kama, going to the temple, following the middle path, offering food to the monks, praying, following sila and good moral conduct and practicing meditation (Manasurakarn et al., 2008). Thai Buddhist older persons perceived that religious practice can release distressing symptoms and calm the mind, release stress, and help in managing body

control (Supoken et al., 2009; Temtap & Nilmanat, 2011). From the application of Buddhist beliefs in nursing practice such as performing good acts and thoughts (Kongsuwan & Locsin, 2009), caring with merit, caring based on the belief of kamma, being caring for Sati or consciousness, and being spiritual and faithful in the Dharma for older persons in the end of life stage can enhance those older persons to non-attachment, to find peace of mind, feel that they are going to go to a good place, and have a peaceful death (Kongsuwan & Locsin, 2009; Somanusorn, 2015). This result related to the study about defining a good death (successful dying): a literature review and a call for research and public dialogue of Meier, Gallegos, Montross-Thomas, Depp, Irwin, and Jeste (2016), they found that nearly two-thirds of older persons (65%) in the articles reviewed expressed a desire to have religious or spiritual practices fulfilled as a theme of a good death. Indicating that the role of religiosity/spirituality is important for result in the good death of the older persons concerned.

The result found that merit making was common religious practices that most of participants performed. They mentioned that this merit making practice comforted their mind and they felt calm. Moreover, making merit could have an effect on their next life. The participants had believed that making more merit in the present could have an influence on their next life (rebirth). They tried to do good things because they believed that they will receive the good effect. They hoped that making more merit in the present would help them to not have illnesses in the next life or in their rebirth they will not get diseases like these. This result congruently fits with the application of Buddhist beliefs in nursing practice such as performing good acts and thoughts (Kongsuwan & Locsin, 2009), caring with merit, caring based on the belief

of kamma, and for older persons in the end of life stage this can enhance those older persons to non-attachment, to find peace of mind, feel that they are going to go to a good place, and have a peaceful death (Kongsuwan & Locsin 2009; Somanusorn, 2015). Moreover, the result is similar with Thai older persons with heart disease which showed that initially the older persons perceived treatment as a terrifying and life-threatening experience for them. Older persons had spent more time and effort in religious activities such as merit-making, offering food to the monks in the morning, visiting temples because they believed that these activities would be rewarded in their next life. (Kwankhao & Boonmongkol, 2013).

In addition, meditation practice could help the participants to be mindful, live in the present, and see the real situation of their death. Mental comfort was another effect of meditation practice. The result can support that meditation practice can enhance the balancing agent of the body and mind, promote self-healing, and help older persons to develop the wisdom to understand the reality of life in cancer older persons (Baehr, 2009; Sungsing, Hatthakit, & Aphichato, 2007). Older persons in advanced stage of cancer have settled their consciousness and considered the truth of life to overcome suffering for an acceptance of their illness and death through meditating practice (Khaw et al., 2013). From the application of Buddhist beliefs in nursing practice such as being caring for Sati or consciousness, and being spiritual and faithful in the Dharma for older persons in the end of life stage can enhance those older persons to non-attachment, to find peace of mind (Kongsuwan & Locsin, 2009; Somanusorn, 2015). In addition, the result congruently fitted with Thai older persons with end stage renal failure in that they could deal with their living by following Buddhist practices by meditating. They mentioned that initially they had depression,

stress, and suicidal ideas as dominant psychological problems between the hemodialysis processes. They had a fear of dying as the cause of stress. The application of Buddhist beliefs by meditating practice could help them to understand the value of life and to reflect that suicide is not the right path in their life. (Yodchai et al., 2011).

Chanting was aimed at forgiveness. This could help the participants be peaceful in mind, consider and on their death, and enhance a peaceful mind in the dying stage. In addition, participants believed that listening to chanting or praying would lead to a peaceful mind and a peaceful death later. Finally, reading Dhamma books could help them understand their death, on their death, and be in a comfortable frame of mind. The result can support that Thai older persons had prepared for their death by reading religious books related to their beliefs for preparing their mind to accept their death, that death was imminent and it was not uncertain (Rodpal et al., 2007). Similarly in the older persons with heart failure, they used the four noble truths of the Buddha to understand their conditioned reality throughout reading Dharma books. Reading Dhamma books could help them to realize and understand the reality of their sickness.

It is interesting to note that accepting their own death was a consequence of this phase. After the participants had an understanding on the law of nature, the Buddhist truths drove them to engage in religious teachings and practices in daily living until they got a clear picture of their impending death and accepted their death. Moreover, the result showed that the participants who accepted their death had demonstrated accepting death that covered understanding the truth of life or an acceptance of the reality of life, reassurance (Thum-jai) that one day death will come

to them, were not fearing death, and had let go/resigned to death/let it go. The result from this was similar with the preliminary study to deeply understand death acceptance among older persons with terminal cancer of Upasen and Thanasilp (2018), they found that there were six major themes of death acceptance consisting of perceiving death as a natural part of life, thinking that death can come up at any time, letting everything go before dying, designing an advance care plan before dying, and perceiving that death cannot be controlled.

For understanding the truth of life, the participants stated that for death acceptance, one needed to understand about death that being born, getting older, sickness, and death were the natural law of human life. The participants stated that the acceptance of death was both accepting the natural things and as accepting the reality of life that all people need to confront birth, getting older, sickness, and death. Buddhism views that all humans will certainly die because death is a natural part of existence but the time of death is not certain (Khadro, 2013; Willkins, Mailoo, & Kularate, 2010). The teaching of the four noble truths lead older persons to have an understanding of what the true problems that people face are, and then, to be in the present, to always be aware and conscious of death, as no one can live forever (Chiaranai, 2014).

This result congruently fits with older persons with advanced cancer who perceived that Buddhism could help them to understand the reality around them (Miccinesi et al., 2012). Thai Buddhist older persons with chronic illness who could accept their own death viewed death as a natural part of life, death is part of human life, and prolonging death is impossible. Similarly with the study about focusing on end-of-life decisions among Thai Buddhist adults with chronic illness of Rukchart et

al. (2014), they found that in most Thai Buddhist adults who had made the decision to forgo life sustaining treatment was because they believed that birth, aging, pain, and dying are a normal part of life. It is useless to prolong life. Similarly, Thai older persons older persons usually do not want to follow aggressive treatments because they understand that death is a natural part of life (Sriyodchat & Hutterat, 2014).Thai Buddhists with chronic illnesses who make the decision to forgo life sustaining treatment when their illnesses are diagnosed to be terminal find the Buddhist teachings can emphasize for them an understanding that death is a natural part of life, and prolonging death is impossible (Manasurakarn et al., 2008; Rukchart et al., 2014).

In addition, the Buddhist’s view the attribute of accepting death is understanding that death as a natural part of life, to which one should not have attachment to (Keown, 2005). In addition, Gesser and Reker (1988) view one characteristic of acceptance of death in terms of neutral death acceptance as a decision to face death because of the belief that death is unchangeable or inevitable in the end of every life such as death is simply a part of the process of life, death is a natural aspect of life, death should be viewed as a natural, undesirable, and unavoidable event, death is neither good nor bad, and one should neither fear death nor welcome it. Buddhism is used for trying to understand that no living thing can escape from death and provides reflection to help one prepare for impeding death (Nguyen et al., 2013).

In addition, accepting death is an ability to Thum-jai that one day the death will come to them. The participants mentioned acceptance of death as trying to Thum-jai or reassuring that everyone needs to confront the death situation. Thum-jai is admitting that death will happen certainly for all humans. Older persons views Thum-jai which is similar to reassuring as setting aside negative feelings and making up

their minds to accept the hardships. This result can support that Thum-jai is a cognitive and emotional system from drawing psychological strength when confronted with an adverse, verifiable truth experiential or evidential that they cannot change (Mills et al., 2017). In regards to the characteristics of acceptance of death in older persons with end stage renal failure who can accept death, they have thoughts on death as the inevitable part of everybody's life, it is natural for the old and ill, and a knowing that death is imminent (Axelsson et al., 2012). Like cancer older persons who were receiving symptom-relieving treatment in Japan, although, they were afraid of death and the process of death and earnestly desired to live when they were facing death, they had feelings to accept the undeniable approach of their own death because they perceived that death was imminent (Kyota & Kanda, 2019). Similarity with the older persons with advanced congestive heart failure who have an acceptance of death and having thoughts on death is a certainty, more of a reality, or a sure thing that it will happen in their life. However, they perceived that the time for death is not a certainty or they do not know when death will occur (Stromberg & Jaarsma, 2008).

Moreover, accepting death is being without the fear of death. People who can accept their death will not fear whatever will happen. People who without the fear of death, all time they can have activities that related to death situations. The participants perceived that people who could accept death will be with happiness and without worries about when their death will happen. The teachings about the four noble truths led the older persons to have an understanding of what the true problems that people face are, and then, to be in the present, to always be aware and conscious of death, as no one can live forever (Chiaranai, 2014). The application of the Buddhist religion through religious activities made them feel more peaceful and they came to accept the

truth that death is universal (Kwankhao & Boonmongkol, 2013). Kubler-Ross (1969) mentioned that acceptance of death is the final Category of grief and loss which a person who has accepted death can understand in inevitable death, being peaceful and calm, and this is opposite to the person who has a denial of death. Acceptance of death is viewed as a successful outcome of coping with traumatic events or death in human beings. This result could support that older persons who accept the dying process and understand that death is one part of nature in their life will express less fear of dying. It means that a neutral acceptance has a significant relationship with death fear and anxiety (Neimeyer, Wittkowski, & Moser, 2004). Similarity with older persons with a strong religious belief in an afterlife and had a negative relationship with fear of death, death anxiety and a positive relationship with death acceptance (Wong et al., 1988). Moreover, the older persons who hold the view of accepting death not only perceived that death is a natural part of life, certainly they perceived that acceptance of death is not fearing death and being aware of death (Rodpal et al., 2007). For some older persons who decide to forgo life sustaining treatments it is because they did not fear their own death (Rukchart et al., 2014).

Finally, the participants mentioned that death acceptance is letting go of death and being ready to die. Letting go of death is being without attachments to their own death or that one day people need to confront their own death. Accepting death in terms of letting it go was not holding on to their life and every person needs to confront that as they cannot escape from death. The Buddha has explained the three characteristics of existence as the universal characteristics of all things and this consists of 1) aniccata which means impermanence, instability, and uncertainty. All things can occur and can be extinguished, 2) dukkhata is a state of suffering, cause of

dukkha for persons are desiring things with attachment, 3) anattata means all phenomena are not the self, no real essence (anatta) (Payutto, 1995). All humans will certainly die because death is a natural part of existence but time of death is not certain (Khadro, 2013; Willkins et al., 2010). Buddhism views death as the impermanence of life, which is undeniable, inescapable, unavoidable, and a natural part of life (Chan et al, 2011; Masel et al., 2012; Shubha, 2007). The key principles of impermanence of all things in Buddhism are the interdependence of all phenomena, an understanding of these principles assists Buddhists on their spiritual path. Impermanence refers to the process of change or anything created must eventually dissolve, including this body and mind (Futen & Wangmo, 2014). Buddhism can lead older persons to gain an understanding of the nature of life, of non-attachment, and acceptance of death in the dying stage (Kongsuwan et al., 2010; Somanusorn, 2009). Letting go is like a Thum-jai which is responses on negative situations. Letting go is forgetting the bad feelings, calming or steadying the mind, and developing patience and understanding. The consequences of letting go or Thum-jai are peace of mind, emotional stability, positive thoughts, and productive change (Mills et al., 2017). This result congruently fits with the study that explored the phenomenon of spirituality and spiritual care among 15 terminally ill Chinese by Mok et al. (2010), they found that the participants had mentioned that letting go is one dimension of the acceptance of death which leads to serenity and peace of mind. The attribute of letting go is similar with having to accept it as the illness cannot be cured, and not thinking so much. The older persons stated that it is useless to think too much because the outcome is still the same. In addition, the older persons who had accepted death and that death is imminent and it is not uncertain, they made the decision to forgo life sustaining

treatment for a natural death because they thought that they could not avoid death (Rodpal et al., 2007).

**Category 4: transcending of death acceptance** is the final process in the journey of death acceptance. This process is about the self-actualization and the management of living and dying in the end stage of life in order to have a peaceful death. This process consists of 3 sub-categories covering 1) having mindfulness and being in a peaceful state of mind, 2) preparing for a peaceful death covered preparing self and others, and 3) living-well and dying-well.

Being in a peaceful state of mind, after the participants realized that they could not escape from the reality of their own death and had accepted their own death, they transformed their mind from fear and anxiety to a peaceful state of mind. The participants focused their mind with the present moment which is having mindfulness. Having mindfulness enhanced their consciousness. Similarly with the study about the application of the Buddhist religion through religious activities made Thai older persons feel more peaceful and they came to accept the truth that death is universal (Kwankhao & Boonmongkol, 2013). This result can support that death acceptance was the final stage of grief and loss which a person who has accepted death can understand in inevitable death, being peaceful and calm, and this is opposite to the person who has a denial of death (Kubler-Ross, 1969). In addition, this result can support that death acceptance in Buddhism principle stated that death acceptance can enable people to be free from the suffering, and have a peaceful state of mind (Dhammananda, 1987; Payutto, 1995). In addition, this result related with the older persons with advanced stage cancers who had concerned and understood that death is

imminent and cannot change it, they could be in peace, leading to serenity, and harmony with self and nature (Mok et al., 2009).

Under the condition of being in a peace of mind, the participants had preparing or management of living and dying in the end stage of life in order to have a peaceful death both preparing self and preparing others. This result could support that death acceptance, death preparation, understanding about death, and awareness of dying were attributes that are closely related (Black, 2011; Lokker et al., 2012; McLeod-Sordjan, 2013). The result is congruent with accepting that death is imminent could increase awareness and prepare them for dying in the end of life stage, and led to a readiness for death (Lokker et al., 2012; McLeod-Sordjan, 2013). The result is congruent with a previous study that found that the older persons who accepted death or had recognized that death is a natural part of life or death is certain did not fear death, were aware of death, learned how to deal with death, and prepared for their death (Rodpal et al., 2007). This is similar with the study about discussions by elders and adult children about end of life preparation and preferences by Glass and Nahapetyan (2008), they found that older persons who have an acceptance of death or awareness about death will relate to preparing for their death. In the same way older persons could accept death from what they have seen of other older persons dying around them, they usually have a plan or prepared for their death (Stajduhar & Makaroff, 2012).

The result found that the participants who had preparing self-used two actions consisting of making merit and making a treatment plan to die peacefully. Regarding Buddhism beliefs on collecting good-*Kamma* or *Boon* in the present for the next stage of life, the participants desired in doing good things before passing. Doing good

things were reflected in the practices of helping and donating. The donation of the participants' dead body organs was viewed as a last merit in the present life for themselves and they would like to do something that was useful for others before they died. The result related to how older persons people living in the community perceived issues around death, dying, and the end of life, and the results showed that some of the participants wished to donate their body after they died. They thought of the importance of being able to give something back even after they had gone (Lloyd-Williams, Kennedy, & Sixsmith, 2007).

Furthermore, the result show that the participants prepared their selves by making a treatment plan to die peacefully. Even though, the participants accepted their death, they were still fearful of dying with suffering. They perceived that getting some treatments and extending their life by receiving aggressive treatments such as many needle punctures, intubating endotracheal tube, putting in a stent, CPR (Cardio Pulmonary Resuscitation), put full equipment into body, and dying from an accident could cause them suffering. At the end of life, they wished to die without suffering, like going to sleep. This condition led to the idea of making a plan to die without aggressive treatments by had informed a family members about the treatments in the end-of-life stage that they wished not to extend their, had the idea of not prolonging life that when their symptoms got worsen and they wished not to extend their lives by any aggressive treatments and of informing the family to let them die without prolonging life. This result was related to Thai adults and older persons who have an understanding that death and dying is a natural part of life and their death is inevitable, they usually decide to forgo life-sustaining treatments and their decision depended on the important value that was freedom from suffering (Manasurakarn et

al., 2008; Rukchart et al., 2014). This result is congruent with a previous study that stated that Thai older persons who understand that death is a natural part of life usually do not want to follow aggressive treatment because it causes suffering for them (Sriyodchat & Hutterat, 2014). Similarly, Thai older persons wish to die with dignity or without any life supporting systems, and be well-prepared which were the highlights of a good death from Thai Buddhist older person's perspectives *(*Rodpal et al., 2007). In addition, from the concept analysis about death preparedness of McLeod-Sordjan (2014), they found that the older persons who are ready for death and have an understanding have an incomplete care plan.

In addition, the result shows that the participants had prepared others. According to the wish to die without burdening family members, the participants had prepared others by often talking about death issues to their family members, managing business task and their funeral and death rituals. The participants always joked when talking about their death with children because they hoped to see them accept and prepare their minds to confront death. They wished their family members to be familiar with their death situation. This could prepare the family members' minds to accept the loss. Moreover, the participants had to manage business task-unfinished business funeral and death rituals aimed to reduce their family's burden as a result of their death. They thought that preparing was not wrong but was only being with readiness and also without creating burden for their families after they passed away. In addition, preparing could enhance their mind without worry especially about their children. The result related to exploring how older persons people living in the community perceive issues around death, dying, and the end of life, and the results show that the participants were wanting to prepare for and have a choice with regard

to where and when they die, and issues relating to assisted dying because the older persons were afraid that their death will have a burden impact on their families. They had been preparing for their death because they would like to minimize the burden on their families in the event of their death such as making a will, funeral arrangements, and sorting out belongings (Lloyd-Williams et al., 2007). Like the older persons with heart failure who had accept their death and had prepared for death cover with a living will, financial issues, and planning for their funeral, their partner and children because these older person were concerned about their loved ones (Lehto & Therrien, 2010; Waterworth & Jorgensen, 2012; Stromberg & Taarsma, 2008).

Living-well, transcending of death acceptance has the consequences of the participants preparing their selves and others which contributed to their living-well and dying-well or the quality of living and dying at the end stage of life. The participants were living-well by living with harmonious body and mind, they had a purpose in life, and a desire to continuously live while being ready to die at any moment. Participants perceived that the body-mind were connected. Being in a positive frame of mind from death in terms of being happy, feeling comfortable, having no worries, no stress, not feeling anxious, and not being afraid, meant that physically the participants would be in healthy state in terms of being able to eat and sleep well. This result can explained Buddhists believing that life is temporarily combined of matter and mind. Life is the co-existence of the physical body and mind that are related in which two things will only separate when the person dies (Dhammnanda, 1987; Masel, 2012). Like a review found that death acceptance not only improved dying with dignity and autonomy but also reduced stress and burden (Lokker et al., 2012; McLeod-Sordjan, 2013; Zimmerman, 2012). It has been reported

among cancer older personss who could accept both their sickness and their death they had been fighting to balance their body and mind, and to have presence of mind and body. An older person's awareness of emotional suffering and stress will have an effect on their body and illness. If an older persons perceived that if he/she has positive emotions, then he/she will have better health during his/her chronic illness (Khaw et al., 2013). This result related with study about defining a good death (successful dying): literature review and a call for research and the public dialogue of Meier et al. (2016) which indicates that majority of older persons had viewed emotional well-being as a critical component of a successful death for them.

In addition, living purposefully and desiring to continuously live was also a sign of living-well. The participants engaged more in activities that made them happy. They still had hope to see their grandchildren grow up and to see the success of their children. The result, related to how older people living in the community perceive issues around death, dying, and the end of life, showed that some participants wished to continue their life because they had great joy in life even before they knew that death was not far away from them (Lloyd-Williams et al.,2007). This result is congruent with finding meaning in their life which is related to levels of psychosocial development, if people have less ability to accept their own past lived experiences in life or feel that their life is not meaningful, those older persons will have high levels of fear or avoidant attitudes to their impending death (Parker, 2013). Meaning of life and attitude toward life was significantly related to a person's attitudes on death. If people cannot find meaning in their life, they unable to accept and death will cause them to be full of fear (Wong, 2000; Erickson, 1982; Parker, 2013). The result can support the older persons' feelings of hopelessness because they were going to die

negatively correlated with the level of acceptance of death but positively correlated with the thought that they could escape from dying or escape death acceptance (Gresser et al., 1988). Like the existing literature awareness of dying of Lokker et al. (2012) they found that older persons who were aware of the imminence of death were more often in peace with dying and felt more often that life had been worth living compared to older persons who were not aware. This is similar with the benefits for older persons who have accepted their death which results in awareness of the imminence of death, and living life with value (Zimmermann, 2012). In addition, this result is similar with the study that describes death attitudes and the associated factors in institutionalized older persons in North Eastern Delta, Egypt which found that the older persons who had been perceived of having satisfaction and meaning in their life were able to confront the reality of their death without extreme anxiety and fear. The older persons who had the ability to find meaning of life and accept the past life, had less amount of avoidant and fearful attitudes toward death (Fadila, Ebeid, & El-Gilany, 2018).

Dying-well, finally the result of the participants in this category was dying-well which can be inferred as being ready to die at any moment and being able to communicate about death as normal. After the participants could accept their death, they did not have fear and worry of their own death and they were ready to die in this moment. Existing literature showed that the older persons with advanced chronic organ failure who can accept their impending death or death as a natural part of life will result in many positive outcomes for them not only an awareness of dying, preparing for their death, advanced care plan discussion but also having a readiness for death, increased competence to cope, and an acceptance of dying in the end of life

stage (Lokker et al., 2012; McLeod-Sordjan, 2013). In addition, death acceptance could improve the quality of death such as having a good death by dying with dignity and autonomy, and reduce stress and burden (Lokker et al., 2012; McLeod-Sordjan, 2013; Zimmerman, 2012).

In addition, death acceptance will result in an attitude to communicate on death. The participants had positive emotions when they heard about any death issues and they were interested in communication on death. This is congruent with the literature found that showed the benefits for older persons who have accepted their death will result in older persons being able to communicate about death (Zimmermann, 2012). Moreover, at least two studies reported that older persons who lived with the denial of death or the fear of death were a major barrier in the discussion of an advanced care plan (Curtis, 2008; Glass & Nahapetyan, 2008).There are reports that the acceptance of death is an important factor for the starting point for the discussion of an advance directive care plan in older persons with chronic organ failure (Nguyen et al., 2013). Furthermore, older persons who can accept death will have the competence to communicate on death issues. There are reports that older persons with advanced chronic organ failure who can accept their death would like to talk about their death with their families and healthcare providers (Axelson et al., 2012; Stajaduhar & Makaroff, 2012). From the study about awareness of dying by Lokker et al. (2012) and the study about the acceptance of dying: a discourse analysis of palliative care literature by Zimmerman (2012), they found older persons who had been living with no awareness of death and did not openly communicate about their wishes in the dying stage. This is similar with existing literature that showed that the older persons with advanced chronic organ failure who can accept their impending

death will result in many positive outcomes for them including increased opened advanced care plan communication (McLeod-Sordjan, 2013). Furthermore, this result relayed to a study on the end-of-life preferences in older persons with advanced cancer by Miccinesi et al. (2012), they found that the older persons perceived that Buddhism could help them to understand the reality around them and to accept the end of their lives, they were willing to discuss issues surrounding their terminal condition.

However, four categories death acceptance theory from Thai Buddhist older persons with advanced chronic organ failure there were both the similar and the difference with five stage of grief of Kubler-Ross (1969). Firstly, the negotiating of their own death was first categories of death acceptance theory in Thai Buddhist older persons with advanced chronic organ failure similar with denial stage of grief model. In this category stated that after older persons encountered the life threatening situations from were informed by their medical doctors, they experienced with life threatening situations with worsening symptoms, and had facing near death experiences. All these situations made older persons aware of their own death and they had recognized their life time was limited. Older persons with advanced chronic organ failure had psychosocial response such as shock, denial, and feel fear of their own death because they had concerning grief form their families and their children. Like a denial stage of grief that people in this stage being with shock and denial. They were become meaningless and overwhelming. However, both of feeling help people to cope and make survival possible. People try to handle with grief, tried to accept the reality of the loss and beginning to the healing process, becoming stronger (Kessler, 2019).

Moreover, negotiating of their own death in the initial of the journey to death acceptance in Thai Buddhist older persons with advanced chronic organ failure similar with the third stage of grief model is bargaining that involves the hope that the individual had postpone or delay death. People had showed the negotiation for an extended life is made with a higher power in exchange for a reformed lifestyle. The individual is saying, "I understand I will die, but if I could just have more time..". Like a first category of death acceptance in Thai older persons, after they tried to make understanding until they could accept their illnesses situation. Older persons had handle with their illnesses situation in differences way to maintain their health by adhering to medical treatments as long as possible, modifying health behaviors or tried to do everything to get better, learning more about their illnesses because they believed these actions could help to maintain their life for being with their families as long as possible.

Furthermore, the third category of death acceptance is affirming their impending death was the transitional between trying to Thum-jai and accepting their impending death. In this stage older persons being understanding the truth of life, Thum-jai that one day death will come, living with no fear of death, and letting go of their death/ let it go with the death. Including the fourth category is transcending of death acceptance that was the final category in the journey of death acceptance in Thai Buddhist older persons with advanced chronic organ failure. Under the condition of having peace of mind, the participants had prepared or managed living and dying in the end stage of life in order to have a peaceful death both preparing self and

preparing others. Both third and fourth categories of death acceptance in Thai Buddhist older persons are similar with the final stage of grief model state that the individual begins to come to terms with their mortality. "It's going to be okay."; "I can't fight it, I may as well prepare for it.". The characteristic of older persons in this stage being with preparing (Kessler, 2019; Kubler-Ross, 1969). Kubler-Ross claimed that the reached stage of grief is acceptance.

However, death acceptance theory that covering from Thai Buddhist older persons with advanced chronic organ failure is difference from grief model. In the second stage of grief people will have anger. This is a common in this stage to think that “why me?” and “life’s not fair!” .People had response on grief by redirect their anger to others persons such as close friends, god, doctor, and family. Including the fourth stage of grief is depression , in this stage dying person begins to understand the certainty of death, the individual may become silent, refuse visitors and spend much of the time crying and grieving. This process allows the dying person to disconnect oneself from things of love and affection. It is not recommended to attempt to cheer up an individual who is in this stage. It is an important time for grieving that must be processed. However, both anger and depression are not appeared in death acceptance theory of Thai Buddhist older persons with advanced chronic organ failure.

In addition, the second category of death acceptance theory is neutralizing fear of death is action led the older person in this category tried to Thum-jai to anticipate death by reflecting on the death of other persons. From having repeated life-threatening situations from time to time and were hospitalized due to the acute exacerbate symptoms, and some older persons had repeated experiences of near death

and having experienced seeing others die while they were living with their disease led the participants to realize that their time was relatively short and death was inevitable and this contributed to the participants accepting more their own death. These experiences desensitized their fear of death and they were able to accept more the truth of life and death. The characteristic of Thum-jai is specified for Thai older persons, it was not show in grief model.

Finally, Kubler-Ross claimed the five steps of grief do not necessarily come in the order noted above, all steps experienced were not the general step for all persons, though she stated a person will always experience at least two by switching between two or more stages, returning to one or more several times before working through it (Kubler-Ross, 1969). While death acceptance theory in Thai Buddhist older persons is direct stage by starting from first category to completing death acceptance and did not returning or backward. The final outcome of death acceptance led the participants were living-well in that they were living with a harmonious body and mind, had a purpose in life, and a desire to continuously live while being ready to die any moment and dying-well which can be inferred as being ready to die at any moment and being able to communicate about death as normal.

# CHAPTER 5

# CONCLUSION AND RECOMMENDATIONS

In this chapter, the study findings are concluded. Then the recommendations for nursing practice, nursing education, further research, and improving the healthcare policy are presented.

## Conclusions of the study

A qualitative grounded theory was conducted to discover the process of death acceptance among Thai Buddhist older persons with advanced chronic organ failure. The research questions that were covered in this study are; 1) what are the conditions related to death acceptance, 2) how the Thai older persons with advanced chronic organ failure confronted their death/overcome fear to accept their death, and 3) what are the consequences of their life after accepting death among Thai Buddhist older persons with advanced chronic organ failure. Researchers have constructed the death acceptance theory through the multiple interpretations of the meanings of symbolic interactions of among Thai Buddhist older persons with advanced chronic organ failure or investigation on how among Thai Buddhist older persons interact from the context of being with advanced chronic organ failure. Therefore, this chapter shows the conclusions. The death acceptance process have been outlined in chapter 4 showed the theory of death acceptance among Thai Buddhist older persons with advanced chronic organ failure and the symbolic interaction under the study between

the older persons, health care provider, and their family members which were contained in these results.

The study findings show that the core category of death acceptance theory in Thai Buddhist older persons with advanced chronic organ failure consists of four categories which are 1) negotiating of their own death, 2) neutralizing the fear of death, 3) affirming their impending death, and 4) transcending the acceptance of death. This can be summarized as follows;

**Category 1: negotiating of their own death** was identified as the initial of the journey to death acceptance in Thai Buddhist older persons with advanced chronic organ failure and consisted of 3 sub-categories*; recognizing their own death but not ready to die; taking actions to maintain their health; hoping for a longer life.* This category reflected that when participants encountered the life threatening situations from were informed by their medical doctors, they experienced with life threatening situations with worsening symptoms, and had facing near death experiences. All these situations made the participants aware of their own death and they had recognized their life time was limited. This situation led them to feel fear of their own death because they did not ready to die. Most of them stated that they were not ready to let go life because most of participants had more concerned that if they died, who will be take care for their families and their children they were concerned about their family. Consequently, they tried to maintain their health as much as possible because they hope to live as long as possible. The participants had taking action to maintain their health by adhering to medical treatments as long as possible, modifying health behaviors or tried to do everything to get better, learning more about their illnesses

because they believed these actions could help to maintain their life for being with their families as long as possible. This also included seeking the emotional support from others were important for supporting and motivating them to live life longer.

**Category 2: neutralizing fear of death,** this category consisted of 3 sub-categories; *realizing that death is inevitable, Thum-jai: reflecting on their own death, and accepting the truth of life and death.* Because of the older persons' health gradually deteriorating due to the progression of their disease and older age they repeatedly faced life-threatening situations from time to time and were hospitalized due to the acute exacerbate symptoms, and some older persons had repeated experiences of near death. Being confronted with various difficult symptoms to deal with and having experienced seeing others die while they were living with their disease led the participants to realize that their time was relatively short and death was inevitable and this contributed to the participants accepting more their own death. Participants in this category tried to Thum-jai to anticipate death by reflecting on the death of other persons such as the significant persons in their families, the highest leader in country/ the religion, even the death of children, and others older person who had similar diseases. These experiences desensitized and lessen their fear of death and they became aware that their life was getting closer to the end and death was evitable. It desensitized their fear of death and they were able to accept more the truth of life and death.

**Category 3 affirming impending death** was the transitional between trying to Thum-jai and accepting their impending death and this consisted of the *3 sub-categories of mobilizing Buddhist faith, engaging in religious practices, and accepting their own death.* After the participants had realized that death was inescapable for them, they made meaning of their death through mobilizing religious resources from their previous experiences of being exposed to Buddhist teachings. The result shows that three main Buddhist teachings were usually mentioned by the participants that had beneficial effects on their understanding about death and dying. These consisted of the principle of natural law (birth, aging, sickness, and death which are normal for human life), the concept of anatta, and the principle of rebirth and the law of karma. However, the participants reflected that learning about death was not enough to enhance their understanding of their death. Considering or contemplating was an important step for gaining understanding clearly about death. After the participants had an understanding on the law of nature and Buddhist truths, the participants had engaged in religious practices such as merit making, mediation, chanting or praying which were performed in their daily practices. The participants mentioned that the benefit of these activities not only gave them an insight on death and dying, but also calmed and comforted their minds. After the participants had engaged in religious practices and contemplation of the Buddhist teachings, this led to understand truly the truth of life and accepting the reality of death. Death acceptance was the consequence of mobilizing religious beliefs and engaging in religious practices consisting of understanding the truth of life, Thum-jai that one day death will come, living with no fear of death, and letting go of their death/ let it go with the death.

**Category 4: transcending of death acceptance** was the final category in the journey of death acceptance and consists of 3 sub-categories covering; *having mindfulness and having peace of mind, preparing for a peaceful death covered preparing self and others*, *and living-well and dying-well.* In this category the participants focused their mind on the present moment which was having mindfulness. Under the condition of having peace of mind, the participants had prepared or managed living and dying in the end stage of life in order to have a peaceful death. This consisted of two processes: 1) preparing self with two actions-making merit and making a treatment plan to die peacefully. Even though, the participants accepted their death, they were still fearful of dying with suffering. They perceived that getting some treatments and extending their life by receiving aggressive treatments such as many needle punctures, intubating an endotracheal tube, putting in a stent, CPR (Cardio Pulmonary Resuscitation), having their body hooked up to medical machines and dying from an accident caused them suffering. At the end of life, they wished to die without suffering, like sleeping. This condition led to the idea of making a plan to die without aggressive treatments. They had told family members of their wishes about the treatment in the end-of-life stage and that they did not want to extend their lives by any aggressive treatments, and 2) preparing others, according to the wish to die without burdening family members, the participants had prepared others by often talking about issues surrounding death with their family members, the participants had prepared others by often talking about death issues to their family members, and managing business tasks and their funeral and death rituals. The consequences of transcending the acceptance of death for the participants led to preparing self and others to contribute to their living-well and dying-well or the

quality of living and dying at the end stage of life. The participants were living-well in that they were living with a harmonious body and mind, had a purpose in life, and a desire to continuously live while being ready to die any moment. Finally, the result for the participants in this category was dying-well which can be inferred as being ready to die at any moment and being able to communicate about death as normal.

## Recommendations of the Study

The results of the study have highlighted the following recommendations for nursing practices, nursing education, nursing research, and the health policy. The study recommendations are as follows;

### Nursing practice

The result can be useful both for older persons, their family members, and health care providers especially nurses as demonstrated in the following;

The conditions of first category shows the situations the participants were in which were; being informed by the doctors that they were facing life threatening situations and that their disease had reached the end stage and was not reversible, the older persons had been experiencing life threatening situations with worsening symptoms, and the older persons had faced near death experiences. These situations made the older persons aware of their own death and they had recognized their life time was limited. This category showed that providing information at this category is not important because older persons would like to learn about their illnesses and about their death by themselves. Moreover, talking and sharing between older persons who

had similar diseases was important for their understanding and for their acceptance of their illnesses. In addition, having emotional support from other persons such as friends, family members, nurses, and doctors was important for supporting and cheering up the older persons in this category and for continuing their life as best as they could.

However, after older persons had make their understanding until they could accept their illnesses most of older persons hope for longer life is the consequence in the first category. They had tried to maintain their health by seriously taking action to maintain their health by adhering to medical treatments, modifying their health behaviors, and doing anything to aid their recovery. This included learning more about their illnesses by searching for health information and reading books regarding how to manage their illness. Therefore, healthcare providers especially nurses can provide information that is appropriate in self-care for the older persons.

The results show that the attributes of older persons who accepted their death consisted of having prepared for a peaceful death which covered preparing self (making treatment plan to die peacefully and making more merit or doing good thing such as donate their body because they hope to useful for others after they died away), and preparing others (talking about death issues with family members and managing business tasks, their funeral and death rituals), living-well by living a live harmonious with their body and mind, having a purpose in life, and a desire to continuously live while being ready to die at any moment, and being positive about death in terms of being happy, feeling comfortable, having no worries, no stress, not feeling anxious, and not being afraid, being ready to die at any moment, being able to communicate about death as a normal part of life, having positive emotions when they heard about

death issues, interest in communicating about death, and being physical healthy in terms of being able to eat and sleep well. Usefulness of the attributes of older persons who could accept their impending death were mentioned above can be a guideline for nurses to know the appropriate time for discussion on older person's death. Death acceptance attribute useful for nurses to assess the readiness to death acceptance in older persons with advanced chronic organ failure before starting any discuss about an older person's death. Moreover, the results are useful in that they can be a step or provide ideas for health care providers in approaching older persons for discussing the topic of death.

Furthermore, the results also show that the participants' health gradually deteriorated due to the progression of their disease and older age. The deterioration included repeated life-threatening situations from time to time and hospitalization due to the acute exacerbate symptoms and repeated near death experiences in some. These conditions led the participants to realize that their time is relatively short and death is inevitable and this contributed to the participants better accepting their own death. Importantly, the results show that after the older persons had recognized their own death they were not ready to die because most of the older persons were more concerned about their family and their unfinished tasks. The older persons who did not have family to be concerned about and who had no unfinished business in their life had a high chance of recognizing that death was imminent and were open to discussions about their impending death. Therefore, having no one need to be concerned about is a vital turning point to death acceptance for the older persons. Therefore, in a health care provider's initial discussion of an advanced care plan with an older persons, the healthcare provider needs to concern ascertain whether the older

persons is what they have prepared such as they has prepared his/her children in regards to his/her death' or 'has made preparations for his/her children. Knowing about the death trajectory in older persons with chronic organ failure leads to knowing the appropriate time for any discussion on death.

The results can explain how older persons reach the stage of death acceptance under the conditions of Buddhism methodology or depends on the principles of the Buddhist teachings. There were three main Buddhist teachings that were usually mentioned by the participants as having beneficial effects on their understanding about death and dying consisted of the principle of natural law (birth, aging, sickness, and death are normal for human life), the concept of anatta which helps participants to see that death was certain, and the principle of rebirth and the law of karma. Buddhist teachings helped the participants understand life and death. In addition, after the older persons had mobilized their religious beliefs and had been engaging in religious teaching practices such as merit making, mediation, chanting or praying in their daily practice, this led older persons to understand truly the truth of life and accept the reality of death. Including older persons had mentioned that consideration or contemplation was an important step for gaining a clear understanding about death. Therefore, training their mind was important for older persons to be with their impending death, Meditation should be applied in a nursing program because it allows the older persons to have a peaceful in mind and as a way have to a peaceful death in the end of life stage. Therefore, the results will be useful for healthcare providers to develop palliative care programs to enhance death acceptance for both older persons and their families based on Buddhist teachings. Importantly, the result useful to develop a culturally sensitive care intervention.

**Nursing education**

The results from this study can be a guideline for assessment and communicate on death issues with older persons and families for nurses and nursing students. In addition, the benefits from this study can be knowledge based for training palliative care for nurses and nursing students.

**Nursing research**

New knowledge from this study can fill the gap of knowledge in the part of the death acceptance process depending on Buddhist teaching especially in the older persons group. Moreover, the process of the acceptance of death in the context of the Thai Buddhist older persons with advanced chronic organ failure can show the relationship of conditions, actions, and the consequences of death acceptance. Including the attribute of death and death acceptance from clearing understanding their own death in Thai older persons. The conditions of death acceptance consist of being informed by their medical doctors that their disease had reached the end stage and was not reversible, older persons had experienced life threatening situations with worsening symptoms, and had facing near death experiences, and their health was gradually deteriorating due to the progression of their disease and older age. This also included repeated life-threatening situations from time to time and hospitalization due to acute exacerbate symptoms as well as repeated near death experiences in some. The action of this study consisting of taking action to maintain health, Thum-jai: reflecting on their own death, engaging in religious practice, and preparing a peaceful death. For the attributes of death acceptance in terms of understanding the truth of life, this consisted of Thum-jai that one day death will come, living with no fear of death, and

letting go of their death/ let it go with the death. In addition, conditions that contributed to death acceptance consisted of concern for loved ones, Buddhist teachings, and witnessing the death of others. The consequences of death acceptance consisted of living well (living with a harmonious body and mind, having a purpose in life, and a desire to continuously live while being ready to die at any moment, and dying-well (being ready to die at any moment and being able to communicate about death as normal). Therefore, the results of this study can be knowledge based to test the hypothesis, test relationships among concept, and develop instruments for screening death acceptance in Thai older persons in the future.

**Health policy**

The results from the study show that older persons who transcending to accept their death could be being ready to die at any moment and being able to communicate about death as normal. In addition, older persons had the idea of not prolonging life when their symptoms got worsen by writing a living will and informing their family to let them die without prolonging their life. The participants had positive emotions when they heard on death communication. And they were interested in communication on death. The result will be a useful contribution to the health care palliative policy in Thailand in the part of the movement of discussion of advanced directive care plans as well as enhancing a peaceful death in older persons. This study use to promote the success of living wills or promote the older persons Self Determination Act (PSDA) while older persons have the capacity to communicate in regards to their values and religious beliefs. To assist the dying older persons in

fulfilling their wishes at the end of their life and to decrease the conflicts in regards to the preferences of others when families and doctors make decisions for them.

The results show that older persons who could accept their death had been preparing themselves by making a treatment plan to die peacefully. Older persons perceived that getting some treatments and extending life by receiving aggressive treatments such as many needle punctures, intubating endotracheal tubes, putting in a stent, CPR (Cardio Pulmonary Resuscitation), being put onto machines to be kept alive and dying from an accident caused them suffering. Older persons had a verbal plan in place with their family members that they wished not to extend their lives by any aggressive treatments by avoiding aggressive treatments using modern medical technology to extend their life. In the future, preparing oneself to die peacefully can result in decreased costs in regards to hospital stays for older person's families and the government insurance companies from the sustaining treatment selected part of preparing oneself to die peacefully.

**Limitation of the study**

The limitation of the study lack of variation of the participants, most of them were end stage renal disease (ESRD) and only one participants received continuous ambulatory peritoneal dialysis (CAPD). Further research should be extended to varies illnesses and others illnesses trajectories. In addition, the results present only the process of death acceptance in Thai Buddhist older persons. They cannot be generalized to the other age groups and older persons who had other religions. In future research discovering knowledge of death acceptance process should be gathered from Muslims and Christians.

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# APPENDIX A

# DEMOGRAPHIC DATA AND HEALTH HISTORY FORM

1) Name …………….……………Name quotation…………………...………….
2) Age……………………………………………………………….………
3) Gender………………………………………………………….……………
4) Marital status ……………………………………………………………...
5) Education level…………………………………………………………….
6) Occupational status………………………………………………………...
7) Type of diagnosis and stage of diagnosis ………………………………………
8) Time period of diagnosed with advanced stage of diseases………………........
9) Type of treatments……………………………………………........................
10) Date of participant recruitment……………………………………….……

# APPENDIX B

# INTERVIEW GUIDE

These interview guides are designed to gather the process of accepting death in Thai Buddhist elderly with chronic organ failure patients after providing informed consent.

**Research questions**

The interview guide before exploring beliefs and ideas about death as follows;

- How do you feel about your illness such as the stage of your disease, treatments and goal of treatments?
- How do you know you are in the end stage of your disease?
- How do you feel when you know you are in the end stage of your disease?
- How do you deal with your feelings?

For the main questions about perception about life and death;

1.1) Have you thought about death, for example?

- When you think about death?
- What are the factors that lead you to think about death?
- How do feel when you heard about your given death sentence at the first time, from whom?
- What is the meaning of death in your perception?

1.2) What is your meaning of accepting death?

- How do you feel about accepting death?

1.3) How do you confront with their death/overcome to accept your death?

- What is the way that you use to accept death?,
- Why do you choose that way in preparing to accept your death?
- How are you preparing for your death?
- Have you discussed your death with any other persons?, who?
- How have you discussed your death?

1.4) What are the factors that influence you to accept their death?

- What are the barriers that make you feel the difficult to accept the death?

1.5) What are consequences of your life after you can accept death?

- How does the acceptance of death affect your life?

# APPENDIX C

# INFORMED CONSENT FORM

**Research Title: Life Journey to Death Acceptance in Thai Buddhist Older Persons with Advanced Chronic Organ Failure**

Dear Participants

My name is Tusanee Khaw. I am a Ph.D. student in Doctor of Philosophy in the Nursing Programm, Faculty of Nursing, Prince of Songkla University, Hatyai, Thailand. I am conducting a research study titled "Life Journey to Accept Death in Thai Buddhist Elderly with Chronic Organ Failure"

The objectives of this study are to discover the process of accepting death in Thai Buddhist elderly patients with advanced chronic organ failure. You are an important person who has experienced the journey to accepting death through Buddhism ways. Although the participants do not directly benefit for these results, they are useful to health care providers to assess in accepting death, to guide methodology for discussion about advanced care plans, and to provide programs to enhance accepting death to other elderly patients who are in advanced stages of their illnesses to improve quality of life, enhance dignity, and die in their wish in the future.

In this study the researcher will ask you about you attitude to death, methods for accepting your death, the process of accepting your death, factors that influence accepting death, and the outcomes after you accept death by using open-ended questions to interview. The interview will spend about 45-60 minutes at least two times. Importantly, if some questions upset you or negative effect to you, the

researcher will support for your felling. In addition, if you do not appreciate to join with study, any time of this study you can withdraw by it has not any result to your nursing service or medical treatment.

All data will be analyzed and used in only academic reports. Your personal information will be kept confidential by the use of coded numbers. If you have any questions or suggestions about this study, you can directly contact the researcher on my mobile phone 088-7827073 and major advisor on her mobile phone 088-7336006. Finally, if you agree to participate in this research study please sign your name on the consent form.

I agree to participate in the study.

Signature………………………………………………Date…………………..

Thank you for your kind cooperation

(Miss Tusanee Khaw)

Researcher

(Assoc.Prof.Dr.Kittikorn Nilmanat)

Major advisor

# APPENDIX D

# OPEN CODING, FIELD NOTES, REFLECTIVE THINKING, AND MEMO WRITING

## เคสที่ 1 ลุงโต ESRD อายุ 62 ปี

| Statements | Open coding | Field note / Reflective thinking | Others |
|---|---|---|---|
| **ข้อมูลส่วนบุคคล**<br>- *ลุงโต ESRD อายุ 62 ปี เป็นโรคมาประมาณ 15 ปี ยังรักษาการฟอกเลือด*รับรู้ว่าเป็นไตวายเรื้อรังแต่ประกอบไปด้วยความดัน นิ่วนำมาสู่ไต *เป็นไตเรื้อรังระดับ 5 บางคนก็เป็นไตวายแบบเฉียบพลัน ฟอกเลือดสักทีก็หายแต่ถ้าการเป็นเรื้อรังนี้ต้องฟอกเลือดตลอดชีวิต* เริ่มเป็นมีอาการก่อนปี 43 สัก 3-4 ปี ตั้งแต่ก่อนปี 43 ลาออกจากงานปี 43 *ตอนนั้นเริ่มด้วยปัสสาวะออกเลือดเพราะมันครูดกับก้อนนิ้วเป็นอยู่นาน (มีการนำก้อนนิ่วที่เป็นในกรวยไตมาโชว์ให้ดู) หมอผ่าตัดนิ่วข้างขวาได้เดือน 2-3 เดือน ข้างซ้ายยิงสลายก้อนนิ่วแล้วไม่ดีขึ้นก็ต้องผ่าตัดด้านซ้ายอีกข้างซ้ายข้างขวาผ่าหมด หลังจากผ่าตัดนิ่ว 2 เดือน อาการทรุด ของเสียขับไม่ได้ กินอะไรไม่ได้ จากนั้นผอมจากสบายดี 86 กิโลกรัม ลดลงมาถึง 50 กิโลกรัม ภาวะตอนนั้นรู้สึกน่าว่าจะตาย และตอนนั้นกินไม่ได้ นึกว่าจะกินอะไรก็กินไม่ได้ และทรุด ใครมาแลตอนนั้นก็นึกว่าตายแล้ว กลับมานอนอยู่ห้องพระ เพราะห้องนั้นมันสบาย (ไม่ได้มีความเชื่ออะไร) แต่ตอนนี้น้ำหนัก 64.8 ปี ถึงตายก็รู้สึกกลัวบ้างไม่กลัวบ้าง แต่คิดว่าไม่กลัวเพราะเราใกล้ๆๆๆ ตายมาหลายครั้ง* | - นึกถึงความตายเมื่อมีอาการที่ทรุดลงหรือแย่ลง กินไม่ได้ น้ำหนักลด(antecedence)<br>- กลัวตายบ้างไม่กลัวบ้างแต่คิดว่าสิ่งที่ทำให้ไม่กลัวเพราะผ่านประสบการณใกล้ตายมาหลายครั้ง (factor) | - ผู้ให้ข้อมูลอยู่กับภรรยา 2 คน ลักษณะบ้านเป็นทาวเฮาส์บรรยากาศสบาย ผนังบ้านเต็มไปด้วยรูปถ่ายพ่อแม่ รูปลูกรับปริญญา ให้การต้อนรับเป็นอย่างดี สอบถามวัตถุประสงค์การไปพูดคุย และให้ความร่วมมือเป็นอย่างดี สามารถตอบคำถามได้ทุกคำถาม ระหว่างตอบคำถามสามารถเล่าได้อย่างไม่รู้สึกอึดอัด<br>- ผู้ให้ข้อมูลดูสภาพร่างกายภายนอแข็งแรง เหมือนคนไม่ได้เจ็บป่วย ช่วยเหลือตนเองในการทำกิจวัตรประจำวันได้หมดทุกอย่างรับรู้ว่าเป็นไตวายระสุดท้ายเมื่ออายุ 52 ปีหรือไตวายระดับ 5 มา 15 ปี รับรู้ว่าตนเองต้องฟอกเลือดตลอดชีวิต ผู้ให้ข้อมูลเล่าว่าเริ่มต้นโรคด้วยการเป็นนิ่วที่ไต รักษาด้วยการผ่าตัด หลังผ่าตัดนิ่ว ผู้ให้ข้อมูลมีอาการทรุดลง ของเสียคั่ง กินอะไรไม่ได้ น้ำหนักตัวลดลงจาก 86 กิโลกรัม เหลือ 50 กิโลกรัม ตอนนั้นผู้ให้ข้อมูลคิดถึง | **Constant comparative**<br>- จากการศึกษาพบว่าผู้ให้ข้อมูลมีทั้งปัจจัยที่ทำให้นึกถึงการตาย ปัจจัยที่ทำให้ยอมรับความตาย การตาย วิธีการที่ทำให้ยอมรับการตาย ผลลัพธ์ของการยอมรับการตาย แต่ยังขาดความชัดเจนความหมายของการยอมรับการตายและระยะเวลาก่อนเกิดการยอมรับการตาย(คือการไม่กลัวหรือไม่) ต้องถามในครั้งต่อไปจะนำการศึกษาดังกล่าวไปถามเปรียบเทียบในรายถัดไป<br>- แต่อย่างไรก็ตาม จากการทบทวนวรรณกรรมพบว่าผู้ป่วย ผู้ป่วยที่มีการยอมรับการ |

| Statements | Open coding | Field note / Reflective thinking | Others |
|---|---|---|---|
| **ความรู้สึกครั้งแรกหลังรับรู้การวินิจฉัย**<br>*ครั้งแรกปี 45 ตอนหมอบอกว่าไตวายลุงไม่เชื่อ มีอาการผอมแต่ก็ไม่เชื่อ เพราะไม่ค่อยเข้าใจเลย เพราะมันไม่รู้จะวายได้อย่างไรเพราะมันดีอยู่นิ ให้ทำเส้นก็ไม่ทำเพราะไม่เข้าใจ แต่พอตอนอาการทรุดลงลุงเริ่มเชื่อ ตอนนั้นขณะเดินทางไปโรงพยาบาล ลุงมีอาการสับสนมาก ทำให้ตัดสินใจไม่ได้ มีอาการกึ่งเดินกึ่งคลาน ทำให้เริ่มคิดว่าต้องยอมรับฟอกเลือดแล้ว ทำให้กลับมาหาคู่มือมาอ่านจากนั้นทำให้ยอมรับเพราะปกติขับรถกระบะ ขับๆๆ ทำท่าจะลืม เลยบอกให้ยามส่งห้องฉุกเฉิน ให้ส่งผมห้องฉุกเฉินที และให้ยามเอารถไปส่งที่บ้าน ส่วนลุงไปไม่รอดแล้ว ให้ยามไปส่งโรงพยาบาล หมอตรวจแล้วก็ให้นอนโรงพยาบาลเลย ไม่ให้กลับบ้าน มาเริ่มการฟอกเลือด*<br>*หมอทำการแทงคอ ตอนนั้นเจ็บมาก แต่ตายไม่ตายไม่รู้ ตอนนั้นสวดมนต์ จนหลับไปเอง แต่พอผ่านมารุ่งเช้ามันดีขึ้น แล้วเค้าพาไปฟอกเลือด ฟอกต่อสัก 2-3 วัน ฟอกเลือด 2-3 ครั้ง ความรู้สึกจากที่มืดอำกลายเป็นสว่างเลย เริ่มอยากกินอาหาร เริ่มหิวเริ่มขออาหาร คิดว่าของเสียคงออกแล้ว กินชมพู่ได้ตอนนั้นมันรู้สึกว่ามันหวานมันสดชื่นใจเหมือนขึ้นสวรรค์เลยพอวันที่ 3 สบายและก็สบายมาตลอด พอหลังฟอกครั้งนั้นก็หลังจากนั้นเดือนก็ทำเส้นประมาณหนึ่งเดือนก็ใช้เส้นได้ รักษาหาดใหญ่ปีกว่าๆ ก็กลับมาฟอกต่อ มอ จากบัดนั้นมาบัดนี้*<br>*ครั้งแรกที่หมอบอกระยะสุดท้ายตอนนั้นลุงไม่เชื่อเลยแต่สิ่งที่ทำให้กลับไปยอมรับและเชื่อ คือการอธิบายของหมอเป็นจริงเหมือนที่หมอว่า และตัวลุงเองตั้งแต่เริ่มฟอกเลือด เริ่มหาหนังสือเยอะแยะเริ่ม* | - หลังทราบการวินิจฉัยโรคปฏิเสธไม่เชื่อว่าตนเองเป็นโรค (emotional responded in diagnosed with end stage of disease)<br>- ไม่ยอมรับการรักษาเพราะไม่มีความเข้าใจเกี่ยวกับการรักษา<br>- การมีอาการที่ทรุดลงและการอ่านคู่มือทำความเข้าใจทำให้ผู้ป่วยยอมรับการเป็นโรคและยอมรับการรักษา (method to accept end stage of disease)<br>- ความรู้สึกจากที่มืดอำกลายเป็นสว่างเลย เป็นเหตุการณ์ที่เหมือนใกล้ตายแล้วกลับมาดีขึ้นหลังฟอกไตรึเปล่า<br>- ผู้ป่วยไม่ยอมรับ เมื่อทราบการวินิจฉัยเป็นระยะสุดท้ายครั้งแรก (emotion | การตายโดยรู้สึกว่าตนเองน่าจะตาย(ปัจจุบันน้ำหนัก 64.8 กิโลกรัม)<br>- ครั้งแรกที่ทราบการวินิจฉัยจากหมอว่าเป็นไตวายระยะสุดท้าย ผู้ป่วยมีปฏิกิริยาไม่เชื่อว่าตนเองเป็นโรคไต เพราะตนเองมีอาการปกติมาตลอดจะเป็นไตวายได้อย่างไร ตอนหมอบอกให้ทำเส้นสำหรับฟอกเลือดก็ไม่ทำเพราะไม่เข้าใจ จนกระทั่งอาการทรุดลง เช่น มีอาการสับสน หลงลืม ตัดสินใจเองไม่ได้ เดินไม่ไหว<br>- สิ่งที่ทำให้ผู้ป่วยเชื่อและยอมรับว่าตนเองเป็นโรคไตวายระยะสุดท้ายคือการมีอาการทรุดลงและได้ศึกษาอ่านทำความเข้าใจเกี่ยวกับโรคที่ตนเองเป็นและพบว่าประสบการณ์อาการที่ตนเองเป็นสอดคล้องกับที่ศึกษาและที่หมออธิบายจึงทำให้ยอมรับการโรคและการรักษา ซึ่งใช้ระยะเวลาประมาณ 1 ปี<br>- ผู้ให้ข้อมูลรับรู้ว่าช่วงที่ตนเองยังอยู่ในช่วงที่ปฏิเสธ ไม่ยอมรับ การให้ข้อมูลไม่มีความจำเป็น ให้ไปก็ไม่เชื่อแต่การมาเจอประสบการณ์ดังกล่าวด้วยตนเอง | ตายจะมีการเตรียมวางแผนชีวิตแต่ผู้ให้ข้อมูลรายนี้ไม่มีการเตรียมอะไรสำหรับความตายของตนเอง ควรถามเปรียบเทียบกับผู้ให้ข้อมูลรายถัดไป<br>- มีให้ข้อมูลยอมรับการตายแต่ยังต้องต่อสู้ไม่ยากตาย เพราะเป็นหัวหน้าครอบครัว อาจเป็นเพราะผู้ให้ข้อมูลรายนี้อายุยังน้อย หรือผู้สูงอายุช่วงต้น (62 ปี) ผู้ให้ข้อมูลรายถัดไปควรดูอายุที่มากขึ้น<br>**Theoretical sampling**<br>ผู้ให้ข้อมูลที่มีการยอมรับการตายมีความคิดว่าการตายเป็นเรื่องธรรมชาติ ทุกคนต้องเดินทางไปสู่ความตาย แต่ไม่รู้เวลาตายที่แน่นอน และผู้ให้ข้อมูลอยู่ |

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| ศึกษามาตลอด จนกระทั่งยาทุกตัว ศึกษาเอาเองหมดบอกชื่อยา บอกผลข้างเคียงได้หมดเลย ลุงถ้าสงสัยอะไรลุงจะถามหมด ช่วงที่ไม่ยอมรับข้อมูลตอนนั้นไม่จำเป็นเพราะให้ไปตอนนั้นก็ไม่เชื่อนี้ แต่การมาเจอมาประสบด้วยตนเองนี้แหล่ะเชื่อเลย ทำให้ยอมรับด้วยตนเอง จากปี 44-45 ระยะเวลาหนึ่งปีจนกว่าจะเกิดการยอมรับการฟอกเลือด<br><br>ครั้งแรกที่หมอบอกเป็นไตวายเรื้อรังระยะสุดท้ายต้องเลือดเลย ถามหมอต่อว่าถ้าผมอยู่ต่อแบบนี้โดยที่ไม่รักษาผมจะอยู่ได้กี่เดือน หมอบอกว่า 6 เดือน ก็เยอะแล้ว ความรู้สึกผม 6 เดือนตายแน่เลยโทรหาแฟนแฟน มาถึงก็กอดร้องไห้กอดแฟนเหมือนในหนังเลย แต่ตอนนั้นที่ร้องให้เพราะใจเรามันหมดแล้ว มันท้อแท้เลยร้องไห้และรับรู้ว่าต้องตายแน่นๆๆ ใน 6 เดือน<br><br>ให้แฟนพาไปหายาดีที่วัดท่าราช ราชบุรี แล้วก็ไปกันเลย หายาหม้อห่อผ้าเป็นสมุนไพรแล้วเลยพ้นไปหาลูกสาว ลูกชายซึ่งไม่เคยขับรถตั้งแต่เล็ก พอพี่สาวเค้ามาเห็นถึงกับตกใจเลย พอถึงตรงนั้นเป็นจุดเปลี่ยนสำหรับลุง ขณะกินข้าว 4 คนพ่อแม่พร้อมหน้าลูกลุงร้องอีก ลูกสาวเลยพูดขึ้นมาลูกไม่ชอบคนอ่อนแอ ลุงกินไม่อิ่มลุกขึ้นไปคิดว่าคำพูดลูกมีความหมายสำหรับเรา จากที่อ่อนแอนี้เราต้องแข็งแรงแล้วนะ และเห็นคน 2 คน เป็นเหมือนกัน แต่คนหนึ่งเข้มแข็ง คนที่อ่อนแอ | response)<br><br>- ระยะเวลา 1 ปี จึงยอมรับการรักษา (time period)<br>- สิ่งที่ทำให้เชื่อ ยอมรับ คือการอ่านศึกษาทำความเข้าใจและการเจอประสบการณ์ด้วยตนเองพบว่าสอดคล้องกับที่หมออธิบาย (method to accept end stage of disease)<br>- การรับรู้ว่าต้องตายแน่ๆ ครั้งแรกทำให้รู้สึกท้อแท้ ร้องไห้ หมดใจ (emotion responses)<br>- ต้องเข้มแข็งเพราะตายไม่ได้ มีภาระเป็นหัวหน้าครอบครัว (conditions) | จะทำให้เกิดความเชื่อ<br>- ผู้ป่วยทราบว่าถ้าอยู่ต่อแบบนี้โดยที่ไม่รักษา หมอบอกว่าตนเองจะมีชีวิตอยู่ได้ 6 เดือน ก็เยอะแล้ว ผู้ป่วยรู้สึก 6 เดือนต้องตายแน่ๆครั้งแรกที่รับรู้ว่าตนเองต้องตาย ผู้ป่วยรู้สึกท้อแท้ ร้องไห้หมดใจกลับมากอดแฟน ร้องไห้ต่อหน้าลูกสาวทำให้ลูกสาวพูดออกมาว่าไม่ชอบคนอ่อนแอ คำพูดลูกมีความหมายสำหรับผู้ป่วย ทำให้ผู้ป่วยคิดว่าตนเองต้องเข้มแข็ง เพราะเคยเห็นคนที่อ่อนแอตาย คนเข้มแข็งรอด ผู้ป่วยจึงคิดว่าทำยังไงก็ได้เพื่อให้ตนเองเข้มแข็ง เพราะสิ่งที่ทำให้ตนเองตายตอนนั้นไม่ได้คือลูกและการมีหน้าที่เป็นหัวหน้าครอบครัว ต้องรับผิดชอบครอบครัว จึงได้มีการเดินวิ่ง ช่วยทำกิจกรรมที่บ้าน กลับมาฟอกเลือด จนตอนนี้ทำให้ร่างกายตนเองแข็งแรงดี ไม่เคยคิดถึงความตายอีก<br>- หลังจากฟอกเลือดมาประมาณ 8 ปี ผู้ป่วยมีหัวใจเต้นผิดจังหวะ มีวูบ ต้องส่งห้องไอซียู ความดัน 60 หลังจากนั้นก็มีอาการหัวใจเต้นผิดจังหวะเรื่อยๆ | ด้วยความไม่กังวล ไม่เคยนึกถึงความตาย มีความพร้อมในการสื่อสารเกี่ยวกับความตายได้โดยไม่อารมณ์ทางลบ ซึ่งเป็นลักษณะของผู้ป่วยที่ยอมรับการตาย ลักษณะดังกล่าวควรต้องเพิ่มเติมใน inclusion criteria<br>-จากการศึกษาพบว่าการมีประสบการณ์ในการเกือบถึงแก่ชีวิตหลายๆ ครั้ง เป็นปัจจัยสำคัญที่ทำให้ผู้ให้ข้อมูลมีการนึกถึงความตายและมีการยอมรับการตายเกิดขึ้น ดังนั้นการมองหาผู้ที่เคยผ่านประสบการณ์เกือบถึงแก่ชีวิตเป็นแนวทางในการค้นหาผู้ให้ข้อมูลในรายถัดไปหรือถามเปรียบเทียบประสบการณ์เกือบเสียชีวิตเป็นปัจจัยทำ |

| Statements | Open coding | Field note / Reflective thinking | Others |
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| *ตาย พอเป็นพันนี้เราทำยังไงก็ได้ให้เราเข้มแข็ง ตอนเช้าลุงไปเดินบ้างวิ่งบ้างรอบสระมอ. อะไรที่บ้านช่วยได้ช่วยหมด ทำได้ก็ทำหมด ทำอะไรก็ได้ทำทั้งนั้น เลยตัดสินใจกลับมาฟอกเลือด เพราะเราตายไม่ได้ภาระเรามี เราต้องรับผิดชอบ เราเป็นหัวหน้าครอบครัว แต่พอพบหมอใหม่ พอรู้ว่าฟอกเลือดแล้วมันไม่ตายและร่างกายเรากลับมาแข็งแรงดีตอนนี้ลุงไม่คิดถึงเรื่องตายเลย*<br>ตอนนั้นไม่รู้ว่าฟอกเลือดเป็นอย่างไร พบลูกศิษย์อยู่ห้องไต *คำพูดจากเจ้าหน้าที่ให้กำลังใจว่าไม่ต้องกลัว ฟอกเลือดแล้วจะอยู่ได้ตลอดไป และมีทางเลือกล้างท้อง ทำผ่านเส้น แต่มีคนแนะนำว่าอย่าเอาเลยทางหน้าท้องติดเชื้อง่าย ตอนนั้นหลังฟอกเลือด* ก็ขับรถความดันต่ำเราไม่เข้าใจ และขับรถหลังฟอกเลือดขับรถชนเสาไฟ จนกระทั่งซื้อเครื่องวัดความดัน มาวัดหลังฟอกเลือดความดันมัน 80-90 เลยรู้ว่าที่วูบเพราะความดันต่ำนี่เอง หลังจากนั้นลุงหาข้อมูลศึกษาเองหมด วันนี้ก็ไปหาหมอหัวใจเพราะลุงติดโอลเตอร์ แต่มีบ้างนะที่หัวใจเต้นผิดจังหวะ กินแต่ยาหัวใจเต้นผิดจังหวะ ยาความดันหยุดหมด<br>*หลังฟอกเลือดมาประมาณ 8 ปี พอรู้ว่าหัวใจเต้นผิดจังหวะตอนนั้นเคยคิดถึงความตายอีกครั้ง เพราะหัวใจเต้นผิดจังหวะมันจะวูบและก็หายไป เคยส่งห้องฉุกเฉินอยู่บ่อยครั้ง จนครั้งหนึ่งความดัน 60 ต้องเข้านอนห้องไอซียู ฉีดสีพบว่าเส้นเลือดลุงตันด้วย* หมอบอกว่าเพราะลุงสูบบุหรี่ควันบุหรี่ไปเกาะแต่ก็ยังมีรูเหลือ ลุงตกใจหรือตื่นเต้นไม่ได้ เพราะเวลาหัวใจสูบฉีดจะทำให้เจ็บหน้าอก แต่ไม่ร้าวไปแขนทีหลังจากนั้นก็มีอาการหัวใจเต้นผิดจังหวะเรื่อยๆ มีบ้างไม่มีบ้าง บาง | - หลังฟอกเลือดร่างกายแข็งแรงประกอบกับกลับมาออกกำลังกายช่วยทำกิจกรรมได้ไม่เคยคิดถึงการตายเลย (conditions)<br><br>- การมีหัวใจเต้นผิดจังหวะ วูบ ต้องเข้าห้องไอซียู ทำให้นึกถึงความตายอีกครั้ง (antecedence) | บางเดือนก็ไม่มีเลย แต่ไม่รุนแรง ทำให้ผู้ป่วยกลลับมานึกถึงความตายอีก ครั้ง การมีประสบการณ์ใกล้ตายครั้งหลังๆ ผู้ป่วยจะนึกถึงการตายตนเองน้อยลง<br>- นอกจากนี้การเชื่อมั่น ในการรักษาของหมอ ยา และเชื่อมั่นในความแข็งแรงจะทำให้ผู้ให้ข้อมูลไม่คิดถึงการตาย ยังมีความกลัวตายเล็กน้อยเพราะผู้ป่วยสามารถทำใจยอมรับการตายได้ เนื่องจากการนอนในห้องไตมีการเห็นการตายของคนอื่นบ่อยครั้ง<br>- สิ่งที่ทำให้ผู้ป่วยมีการนึกถึงการตายของตนเอง 1) มีอาการทรุดลง เช่น กินไม่ได้ น้ำหนักลด 2) มีอาการเกือบถึงแก่ชีวิต เช่น หัวใจเต้นผิดจังหวะ 3)มีอาการหนักต้องเข้านอนโรงพยาบาล/ห้องไอซียู และ 4) การสูงอายุ<br>- สิ่งที่ทำให้ผู้ให้ข้อมูลไม่คิดถึงการตาย คือ 1) การรักษาทำให้ร่างกายแข็งแรง ทำให้ไม่นึกถึงการตาย และไม่คิดว่าตนเองจะตาย 2) ถ้ายังมีความเชื่อมั่นในการรักษาสามารถทำให้ตนเองดีขึ้น จะนึก | ให้ยอมรับการตายในผู้ให้ข้อมูลรายถัดไปหรือไม่ |

| Statements | Open coding | Field note / Reflective thinking | Others |
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| เดือนมีบางเดือนก็ไม่มีเลย แต่ไม่รุนแรง<br>ความรู้สึกตอนรู้ว่าเป็นไตวายระยะสุดท้ายกับตอนเป็นหัวใจเต้นผิดจังหวะ*ความรู้สึกนึกถึงความตายตอนนั้นมันน้อยกว่าครั้งแรก เพราะตอนนี้หนึ่งลุงกลับมามั่นใจในมือหมอตอนนี้ เพราะเชื่อมั่นในหมอ หมอมอ. นี้ก็มือหนึ่งในภาคใต้ เชื่อยา ในยาที่รักษาเรา การกลัวตายลดลง และเชื่อมั่นในร่างกายของเราการแข็งแรงของตัวเอง ถึงมันอาจจะมีพลาดมั่ง แต่ถามว่ากลัวบ้างมั้ยก็ตอบว่ายังมีการกลัวตายบ้างแต่ค่อนข้างน้อยเพราะเราอาจจะทำใจได้ระดับหนึ่ง เพราะการนอนในห้องไตแต่คนอื่นตายข้างเคียงให้เราเห็นบ่อยครั้ง*<br><br>**ความตายที่ลุงนึกถึงตอนนั้นเป็นอย่างไร**<br>*ลุงคิดว่าความตายตอนนั้นเป็นการตายของกายตายแต่ใจไม่ตาย ตามความเชื่อลุงนะร่างกายคนเรานั้นมี 2 อย่าง หนึ่งกาย สองจิต ถ้าจิตอ่อนแอกายจะอ่อนแอไปด้วย เพราะ 2 อย่างนี้จะสัมพันธ์กัน แต่เมื่อไรที่กายตาย จิตจะไม่ตาย จิตต้องหาร่างใหม่ในความเชื่อลุง ลุงเคยเรียนของหลวงวิจิตวิชา 8ประการ ร่างกายเราประกอบด้วยสิบประการ ร่างกายเป็นสิ่งเดียวที่มองเห็นที่เหลือมองไม่เห็นและลุงเชื่อว่าตายแล้วเกิดใหม่ ช่วยให้เราไม่กลัวตาย เพราะตายแล้วเกิดน่าจะไม่นาน แต่เมื่อก่อนลุงเชื่อว่าตายแล้วสูญ ทำให้เกิดการกลัวตาย*<br><br>วิธีการที่ทำให้ตนเองไม่กลัวตาย คือ*ความคิดของเรา ความรู้สึกของตนเอง ทุกคนมันต้องตาย พอโทรมเข้าแล้วมันต้องตาย* | - การเชื่อมั่นในการรักษาของหมอ ยาที่รักษา และความแข็งแรงของร่างกายตน ทำให้นึกถึงการตายน้อยลง (antecedence)<br>- ประสบการณ์การได้เห็นการตายของคนอื่นทำให้ยอมรับการตายได้มากขึ้น (conditions)<br><br>- การตายเป็นการตายของร่างกายแต่จิตยังอยู่ (meaning of death)<br>- เคยเรียนหลักวิชา 8 ประการ (conditions)<br><br>- ไม่กลัวตาย เพราะมีความเชื่อว่าตายแล้วได้เกิดใหม่ (conditions) | ถึงการตายลดลงหรือไม่คิดว่าตนเองจะตายอีก<br>- ตอนนี้ผู้ให้ข้อมูลยังมีความรู้สึกกลัวตายบ้างไม่กลัวตายบ้าง สิ่งที่ทำให้ไม่กลัวความตายหรือยอมรับการตาย คือ 1) การที่ตนเองมีประสบการณ์เกือบตายหลายครั้ง 2)มีประสบการณ์ในการได้เห็นประสบการณ์การตายของผู้ป่วยโรคไตด้วยกัน 3) ความเชื่อว่าตายได้เกิดใหม่ ผู้ป่วยมีความเชื่อว่าตายแล้ว ไม่นานได้เกิดใหม่ ทำให้ผู้ป่วยไม่กลัวตาย (มาจากความคิดได้อย่างไร)4) ความคิดตนเองที่ว่าทุกคนเมื่อร่างกายทรุดโทรมก็ต้องตาย5) ความเชื่อทางศาสนาพุทธที่ว่าทุกคนเกิดมาแล้วต้องตาย ทำให้ผู้ให้ข้อมูลไม่กลัวตายและเกิดการยอมรับการตายศาสนาเป็นหลักในการยึดเหนี่ยวและเดินทางไปสู่ความตาย (ศาสนาเป็นการเดินทางไปสู่การตายและการยอมรับการตายอย่างไร)(ตอนหมอแทงคอฟอกไต ผู้ป่วยสวดมนต์จนทำให้หลับไป หลังฟอกเลือดผู้ป่วยรู้สึกอาการดี ขึ้น จากมืดอำกลายเป็นสว่าง และเริ่มกินได้ | |

| Statements | Open coding | Field note / Reflective thinking | Others |
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| *แต่ตายแต่กายตายแต่จิตไม่ตาย และการที่เรามีความรู้ศาสนาจากที่เรียน คนก่อนตายต้องภาวะนาพุทโธ หรือเป่าหูท่องคำพระข้างหูก่อนตาย ทำให้หูได้ยิน เสียงพระก่อนตาย* จากที่ได้เห็นได้อ่านนะดังนั้นเอาอะไรมาอิงไม่ให้กลัวตาย *ก็คือความเชื่อศาสนา หลักศสานา และการปฏิบัติตัว แต่เวลาเห็นเค้าปั้มหัวใจ เราก็ทำใจได้ แต่ก็มีบ้างที่ใจเราหวิวๆ นึกว่าตายแล้วเค้าจะไปไหนแต่ก็มีบ้างที่เห็นเพื่อนตายแล้วเครียด นึกถึงเรา แต่ถ้าเป็นเราก็นึกว่าคงไม่ต้องปั้ม เพราะมันทรมาน ปั้มแล้วรอดมาอาจจะโครงหัก แต่ฟื้นมาแล้วไม่มีไรก็โอเค แต่เห็นที่ปั้มแล้วก็อยู่ได้ไม่นานก็ตายอีก การตายเป็นแบบนี้ การตายต้องถึงทุกคน*<br>การตายเกิดจากความไม่รู้สึก เราคงไม่รู้เรื่องแล้ว ก็จากไปตอนนั้น เพราะเราไม่ได้รับรู้แล้ว *การกลัวตายจะเกิดตอนที่เรายังปกติ แต่พอถึงจุดนั้นเราก็ไม่กลัวแล้ว เพราะเราไม่รับรู้* ความตายในความคิดลุงคือ *ตายแต่กายจิตไม่ตาย ตายแต่กายจิตคือความรู้สึก* ลุงเชื่อเหมือนในหนังสมมติเราตายแล้วแต่จิตยังมายืนดูลูกหลานพี่น้อง ลุงยังเชื่อแบบนี้บางศาสนาตายแล้วเกิดบางศาสนาตายแล้วสูญ ขึ้นอยู่กับว่าใครเชื่อศาสนาไหน *การตายจะเกิดจากการกิน และรักษาพยาบาล ถ้าไม่กินตาย เจ็บไข้ไม่สบายไม่รักษาก็ตาย ทุกคนต้องเดินไปสู่การตาย แต่ไม่รู้วันไหนที่จะตาย*<br>*ศาสนาทำให้คนเรามีจุดยืน ยึดเป็นหลักในการเดินทางไปสู่การตาย เป็นที่ยึดเหนี่ยวดีกว่าคนที่ไม่มีศาสนาเลย การปฏิบัติของเราในแต่ละวันเราก็ยึดศสานามาทั้งหมดนะ สมมุติว่าเราจะอยู่วาระสุดท้าย* | - ความคิด ทุกคนก็ต้องตายทำให้ไม่กลัวตาย (method)<br>- ความเชื่อทางศาสนาทุกคนต้องตายทำให้ไม่กลัวตาย ยอมรับการตาย(factor )<br>- ยอมรับการตายได้ ไม่ปั้มหัวใจจะทำให้ทรมาน (consequence)<br>- การตายเป็นการตายของร่างกายจิตไม่ตาย (meaning of death)<br>- ถ้าไม่กินก็ตาย เจ็บไข้ไม่รักษาก็ตาย<br>- ทุกคนต้องตายแต่ไม่รู้วันไหน (meaning of death) | สะท้อนความหมายว่าอย่างไรควรมีการถามเพิ่มเติม)6) การได้เรียนวิชา 8 ประการ (คืออะไร ช่วยให้ไม่กลัวตายได้อย่างไร) 7) การมีลูก เมียเพื่อนและ หมอให้กำลังใจผู้ให้ข้อมูลรับรู้ว่าการเห็นลูกเจริญ การอยู่พร้อมหน้าพร้อมตา ถือเป็นกำลังใจ ทำให้ไม่มีการว้าเหว่ เป็นสาเหตุทำให้คิดมาก และการมีลูกทำให้วันเวลาผ่านไปด้วยรวดเร็ว, ตอนแรกตนเองไม่รู้การฟอกไตเป็นอย่างไร เมื่อได้ยินคำพูดจากเจ้าหน้าที่ให้กำลังใจว่าไม่ต้องกลัว ฟอกเลือดแล้วจะอยู่ได้ตลอดไป, และผู้ป่วยรับรู้ว่าการพบปะสังสรรค์ในสังคม ทำให้เราได้ระบาย เพื่อนให้กำลังใจและความเข้มแข็ง ไม่ใจเสาะ และเชื่อหมอและยาที่รักษาทำให้ผู้ป่วยผ่านมาได้ และ 8) การสูงอายุเพราะร่างกายทรุดโทรมลงและมีความพร้อมในชีวิต ผู้ป่วยรับรู้ว่าการตายของคนแก่กับคนหนุ่มมีความแตกต่างกัน คนแก่พร้อมที่จะตายได้แล้วเพราะเค้ามีประสบการณ์อะไรมาพร้อมแล้ว และความแก่ทำให้มีการโทรมลงเรื่อยๆการมีอายุเยอะขึ้นจะทำให้ไม่กลัวตาย และถ้าตายแล้วจิต | |

| Statements | Open coding | Field note / Reflective thinking | Others |
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| *เราก็ต้องท่องคำพระ ศาสนาคือสิ่งยึดเหนี่ยวใจตัวเองนั่นเอง*<br><br>**ปัจจัยที่ช่วยให้ยอมรับการตายไม่กลัวตาย**<br>*สิ่งแวดล้อม ลูกเมียเป็นกำลังใจ การได้เห็นลูกเจริญถือเป็นกำลังใจ วันไหนเห็นลูกกลับมาก็ตื้นตันใจ คอยพร้อมหน้าพร้อมตา การว้าเหว่อาจทำให้คิดมาก แต่การมีลูกทำให้วันเวลาผ่านไปด้วยรวดเร็ว*<br>*สังคมก็สำคัญ การพบปะสังสรรค์ในสังคม ทำให้เราได้ระบายเพื่อนให้กำลังใจ* ลุงเห็นเพื่อนตายมาไม่รู้เท่าใด เพราะไม่รู้เค้าไปหมกมุ่นอยู่กับเรื่องอะไร *ความเข้มแข็งไม่ใจเสาะทำให้เราผ่านมาได้ ลุงเชื่อหมอและเชื่อยาลุงจะตั้งนาฬิกาเลยในการกินยา*<br><br>**สิ่งขัดขวางหรือเป็นอุปสรรคในการยอมรับการตาย**<br>ไม่มี *คือคนเรามันผิดกันคนตายแก่กับคนหนุ่มจะต่างกัน คนแก่พร้อมที่จะตายได้แล้วเพราะเค้ามีอะไร ประสบการณ์อะไรมาพร้อมแล้ว เราก็จะโทรมเรื่อยๆ เพราะมันแก่ การมีอายุเยอะขึ้นจะทำให้เราไม่กลัวตาย แล้วและถ้าเราตายแล้วจิตเราจะไปหาร่างใหม่ แต่วัยรุ่นเป็นคนที่ยังไม่ได้คิดถึงการตายที พอถึงเวลาตายจิตก็จะไม่รู้ไปไหน จะวนเวียนอยู่ตรงนี้ เพราะจิตเค้าไม่ได้คิดที่จะไปหาร่างใหม่ เพราะเค้าไม่เคยเลยว่าเค้าจะตาย* ความคิดนี้คือความเชื่อในวิชา 8 ประการ<br>*ความคิดลุง การตายก็เหมือนการแทงเข็มนะตอนแทงนี้ต้อง* | - ศาสนาเป็นที่ยึดเหนี่ยวจิตใจ นำไปสู่การในชีวิตประจำวัน เป็นหลักในการเดินทางไปสู่ความตาย (method)<br><br>- ลูกเมียเป็นกำลังใจ ไม่คิดมาก (conditions)<br><br>- พบปะเพื่อนทำให้ได้ระบายและได้กำลังใจ<br>-เข้มแข็ง ไม่ใจเสาะ<br>- เชื่อหมอและยาที่รักษา (conditions)<br><br>- การตายจากความแก่ ร่างกายทรุดโทรม มีการคิดถึงและ ไม่กลัวตาย (conditions)<br>- วัยหนุ่มไม่คิดถึงการตายความเชื่อเรื่องจิต | เราจะไปหาร่างใหม่ แต่ถ้าเป็นวัยรุ่นเป็นคนที่ยังไม่ได้คิดถึงการตายที พอถึงเวลาตายจิตก็จะไม่รู้ไปไหน จะวนเวียนอยู่ตรงนี้ เพราะจิตเค้าไม่ได้คิดที่จะไปหาร่างใหม่(ผู้สูงอายุมีประสบการณ์มาพร้อมอย่างไร ในเรื่องอะไรจึงทำให้ไม่กลัวตาย)<br>- ผู้ป่วยรับรู้ว่าร่างกายคนเราประกอบด้วยกายและจิตที่มีความสัมพันธ์กัน ถ้าจิตอ่อนแอทำให้ร่างกายอ่อนแอไปด้วย ร่างกายเป็นสิ่งเดียวที่สามารถมองเห็นการตายเป็นการตายของร่างกาย แต่จิตยังอยู่เมื่อตายไปก็ต้องหาร่างใหม่ ความเชื่อดังกล่าวเป็นเพราะผู้ป่วยได้เรียนวิชา 8 ประการ ตามหลักศาสนา (เจาะลึกลงไปถึงการนำความเชื่อมาใช้ในชีวิตประจำวัน)<br>- วิธีการที่ทำให้ผู้ป่วยไม่กลัวตาย คือ1) ความเชื่อศาสนาและการปฏิบัติตัวเป็นสิ่งทำให้ไม่กลัวตาย เมื่อเห็นมีการปั๊มหัวใจทำให้ตนเองยอมรับได้ และถ้าเป็นตนเองจะไม่ปั๊ม เพราะมันทำให้ทรมาน เพราะการตายต้องถึงทุกคนศาสนาทำให้คนมีจุดยืน เป็นหลักในการเดินทางไปสู่ความ | |

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| *กัดฟันเพราะเจ็บแต่พอแทงไปแล้วก็หาย การตายก็เหมือนกันพอถึงจุดตายแว๊ปแรกก็จะเจ็บในตอนแรก แต่ความเจ็บก็จะหายไปหลังจากตายแล้ว ความตายเป็นการพ้นความทุกข์ทรมาน*<br>ผลที่ได้รับหลังจากเรายอมรับการตาย *ลุงไม่เคยคิดเลยว่าลุงเป็นคนป่วยโรคไต จะป่วยเฉพาะตอนไปโรงพยาบาลเท่านั้น เพราะกลับมาหลังฟอกเลือดกลับมานอนพัก ก็ดี ทำให้มีกำลังใจ มีความเข้มแข็งอยากอยู่ต่อ สัก 20-30 ปี ไม่เคยคิดว่าจะตายเลยตอนนี้ นอกจากมีบ้างเล็กน้อยตอนมีหัวใจเต้นผิดจังหวะเท่านั้น*<br><br>*ลุงยังไม่มีการเตรียมเรื่องตายเลยเพราะลุงคิดว่าลุงยังอยู่ได้อีกนาน* แต่ถ้าวันไหนหมอบอกว่าเราแย่ลงก็เครียดอีก แต่หมอต้องเป็นกำลังใจ หมอสมัยนี้บอกหมดเหมือนเป็นมะเร็งก็พอบอกปุ๊บคนไข้ตายเลย | - การตายเป็นเหมือนการแทงเข็มเจ็บเมื่อรับรู้ครั้งแรก (meaning of death)<br>- การตายทำให้ความเจ็บปวดหายไปเมื่อตาย (meaning of death)<br>- ไม่คิดถึงการตายรักษาอาการดีขึ้น (antecedence)<br>- คิดถึงการตายเมื่อมีหัวใจเต้นผิดจังหวะ (antecedence)<br><br>- ไม่มีการเตรียมตัวเกี่ยวกับความตายเพราะคิดว่าอยู่ได้อีกนาน (consequence)<br>- อาการแย่ลงทำให้เครียดอีก (conditions)<br>- หมอให้กำลังใจ (conditions) | ตาย เป็นสิ่งยึดเหนี่ยวจิตใจ นำไปสู่การปฏิบัติในชีวิตประจำวัน เช่นถ้าจะตายก็ต้องท่องคำพระ<br>- ผู้ให้ข้อมูลรับรู้ว่าการกลัวตายจะเกิดเมื่อยังปกติ ถ้าไม่รับรู้แล้วเราจะไม่กลัวตาย และความตายเป็นการตายแต่ร่างกาย จิตหรือความรู้สึกยังไม่ตาย<br>- ความหมายการตายตามการรับรู้ของผู้ให้ข้อมูลเป็น 1) การตายของร่างกายแต่จิตใจยังอยู่ 2) การตายเกิดจากการกินและการรักษา ถ้าไม่กินตาย ไม่สบายไม่รักษาก็ตาย 3) ทุกคนต้องเดินทางไปสู่การตายแต่ไม่รู้วันไหนและ 4) การตายทำให้หลุดพ้นความเจ็บปวดเป็นสิ่งที่ทำให้เกิดความเจ็บปวดเมื่อรับรู้ครั้งแรกแต่หายไปเมื่อ<br>ตายการรับรู้ว่าการตายเป็นเหมือนการแทงเข็ม เพราะพอถึงจุดที่รู้ต้องตายก็ทำให้เจ็บแต่จะหายไปเมื่อตาย (ขาดความหมายการยอมรับการตาย)<br><br>**ผลลัพธ์ของการยอมรับการตาย** | |

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| | | - มีความคิดจะไม่มีการปั๊มหัวใจเพราะเชื่อว่าทุกคนต้องตายเมื่อเวลามาถึงและทำให้ทุกข์ทรมาน<br>- อยู่ด้วยความไม่กังวล ไม่คิดว่าตนเองป่วยหรือว่าจะตายผู้ป่วยรับรู้ว่าตนเองจะป่วยเฉพาะตอนไปโรงพยาบาลเท่านั้น หลังรับการรักษากลับมานอนพักก็ดี ทำให้มีกำลังใจ มีความเข้มแข็ง และยังอยากมีชีวิตอยู่ต่อ สัก 20-30 ปี ไม่เคยคิดว่าจะตายเลย<br>- ผู้ป่วยไม่มีการเตรียมตัวเรื่องการตายเลยเพราะยังคิดว่าตนเองอยู่ได้อีกนาน reflect ว่าถ้าเป็นการเตรียมการคิดว่าจะต้องทำอะไรอีก | |

เคสที่ 2 นายจำเริญ COPD อายุ 73 ปี

| Statements | Open coding | Reflective thinking / Field notes | Others |
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| **ข้อมูลส่วนบุคคล**<br>- *อายุ 72 ปี 6 เดือน ประมาณ 73 ปี มีภรรยาแข็งแรงไปไหนมาไหนด้วยกัน ภรรยาอายุ 66 ปี* เป็นโรคความดันตามธรรมชาติ ยังแข็งแรงไปเที่ยวไหน มาไหน ไปเชียงใหม่ ลำปาง กำแพงเพชรด้วยกัน วุฒิการศึกษาเจ้าหน้าที่บริหารงานราชทันต์ซี 6<br>**ตาช่วยเล่าให้ฟังเกี่ยวกับการเจ็บป่วย**<br>- *โรคประจำตัวที่รักษามีโรคความดัน โรคหอบหืด โรคเก๊าท์ และโรคถุงลมโป่งพอง แต่หมอบอกไม่ถึงกับเจาะคอ แต่ต้องพ่นยาตลอด ห้ามขาดยา*เดือนที่แล้วตาจะผ่าไส้เลื่อน เค้าให้หมออายุรกรรมเช็คความดัน โรคหอบหืด ก่อนผ่าไส้เลื่อน ตอนนี้ผ่าได้เดือนกว่าๆ<br>- เริ่มแรกด้วยกันเป็นภูมิแพ้ ไซนัส จนปี 37 หมอโรงพยาบาลสงขลาเรียกพบคนที่มีอาการผิดปกติ มีความดันในจมูก มีริดสีดวงจมูก นัดผ่าตัดที่สงขลา แล้วก็ส่งมารักษาที่นี้ พอผ่าริดสีดวงจมูกตามีหอบหืด นัดเป่าปอด พบว่ามีถุงลมโป่งพอง เป็นมา 30 กว่าปี มีอาการคงที่มาตลอด แต่ต้องควบคุมด้วยยาอ่ะนะ *มาตอนประมาณ 6-7 ปี พอดีเปลี่ยนหมอที่รักษาประจำ หมอใหม่ไม่ได้ให้ยา* ขาดยาที่พ่นประจำ *ได้เดือนกว่าๆ มาหาดใหญ่ช่วงสงกรานต์หอบหายใจไม่ออก ลูกต้องพามาดูอาการที่ห้องสังเกตอาการ ใส่ออกซิเจนได้ รับยาอาการก็ดีขึ้น เป็นแค่ครั้งเดียว*<br>**ความรู้สึกตอนมีอาการหอบมาก หายใจไม่ออกตอนนั้นตารู้สึก คิด** | - โรคความดันโลหิตสูง หอบหืด เก๊าท์ และถุงลมโป่งพองเป็นโรคประจำตัว<br><br>- เป็นมา 30 ปี อาการคงที่แต่ต้องควบคุมด้วยยา (perception on illness)<br>- 6-7 ปี เคยขาดยาพ่นหอบและหายใจไม่ออก | - ผู้วิจัยเข้าหาผู้ให้ข้อมูลรายนี้ โดยตั้งต้นจาก การคัดเลือกผู้สูงอายุที่มีประสบการณ์การเจ็บป่วยที่เกือบถึงแก่ชีวิต โดยการแนะนำของหลานผู้ป่วย หลานผู้ป่วยให้ข้อมูลว่าตาของตนเองไม่กลัวตาย และผู้ป่วยมีการพูดคุยเกี่ยวกับการตายของตนเองกับหลานๆ หลายครั้ง เคยมีอาการหายใจไม่ออกเข้าออกโรงพยาบาลหลายครั้ง และตอนนี้ได้มีการบริจาคร่างกาย เพราะจากการสัมภาษณ์ผู้ให้ข้อมูลรายที่หนึ่งและจากการทบทวนวรรณกรรมพบว่าผู้มีประสบการณ์เกือบเสียชีวิตและมีการสื่อสาร การเตรียมวางแผนการตายตนเองจะมีโอกาสในการยอมรับการตายสูง<br>- สัมภาษณ์ครั้งแรก ผู้ป่วยวัยสูงอายุ กลับจากพบแพทย์ตามนัดตามลำพัง ดูสุขภาพยังดูแข็งแรง เป็นคนอารมณ์ดีขณะสัมภาษณ์ มีหัวเราะ มีความสุขช่วงที่เล่าประสบการณ์ และมี | **Constant comparative**<br>- ผู้สูงอายุรายนี้มีอายุมากกว่าผู้ให้ข้อมูลรายแรก 10 ปีพบว่า ผู้ให้ข้อมูลรายนี้ไม่ได้ห่วงลูกเรื่องลูกหลานเหมือนรายแรกเป็นประเด็นที่ควรเปรียบเทียบในผู้ให้ข้อมูลรายถัดไป<br>- โรคแตกต่างกันการยอมรับการตาย ความหมายการยอมรับการตายใกล้เคียงกัน ควรมองในผู้ให้ข้อมูลเพศตรงกันข้ามเพิ่มเติม<br>**Theoretical sampling**<br>- จากการเข้าหาผู้ให้ข้อมูลโดยคัดเลือกผู้เคยมีประสบการณ์เกือบถึงแก่ชีวิต พบว่าผู้ให้ข้อมูลมีการยอมรับการตาย ควรหาผู้ให้ข้อมูลกรณีที่ผู้ให้ข้อมูลไม่เคยผ่าน |

| Statements | Open coding | Reflective thinking / Field notes | Others |
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| **อย่างไรบ้าง**<br>- *ตอนเข้ารพ.ตอนนั้นตาก็คิดถึงการตายเหมือนกัน แต่คิดว่าถ้าเราตายให้ลูกหลานมอบศพให้ตามความประสงค์ที่เราอุทิศให้กับโรงพยาบาล ตาได้คุยเล่นๆๆ กับลูกหลานว่าถ้าเป็นอะไร หรือว่าถ้าตาตาย ที่ได้สั่ง อย่าลืมนะถ้าตาตาย ให้ไปเอาศพของตาไปมอบให้เค้าด้วย เช่นถ้าใครไม่ให้ศพตาตาบีบจมูกให้หมด (หัวเราะ)เพราะตาเป็นคนชอบพูดเล่นๆๆ กับหลานๆ อยู่แล้วประจำ*<br><br>**อะไรทำให้ตาคิดถึงความตายตอนนั้น**<br>- *การมานอนโรงพยาบาล ตาว่าที่ต้องถึงกับนอนรพ.ตอนนั้นตารู้สึกว่ามันก็ 50/50 แต่ถ้ามาตรวจตามปกติตาว่าบางทีมันยังเป็นเรื่องปกติ ถ้านอนนะเริ่มคิดว่ามันมีโอกาส จะตายยิ่งถ้าอาการหนักไปๆ มันก็มีโอกาสเรื่องตายตาว่าปกตินะ เป็นเรื่องธรรมดา แต่ตากังวลอย่างเดียวว่าลูกหลานจะไม่ให้ เพราะลูกหลานบางคนยังมีความเชื่อแบบโบราณ ว่าการตัดเนื้อตัดหนังอวัยวะมันจะไม่ครบเวลาเกิดใหม่*<br><br>**อะไรทำให้คุณตาคิดแบบนั้น ว่าการตายเป็นเรื่องธรรมดา**<br>- *ตาชอบคุยกับพระนะ ตาเชื่อว่าถ้าเราทำบุญกับคนดี ถึงจะได้* | - ตอนเข้าโรงพยาบาลทำให้คิดถึงการตาย<br>- หอบมาก และหายใจไม่ออกทำให้คิดถึงการตาย (antecedence)<br>- มีการพูดเล่น สั่งให้ลูกหลานมอบศพให้โรงพยาบาลตลอด (consequence)<br><br>- การเจ็บป่วยต้องต้องเข้านอนโรงพยาบาลทำให้ผู้ป่วยนึกถึงการตาย (antecedence)<br>- คิดว่าการตายเป็นเรื่องธรรมดา (meaning of death) | ความยินดีสำหรับการจะสัมภาษณ์ในครั้งต่อไป<br>- ผู้ป่วยอายุ 73 ปี อาศัยกับภรรยาอายุ 66 ปี) ป่วยเป็นโรคความดันโลหิตสูง หอบหืด เก๊าท์ และถุงลมโป่งพอง ยังสุขภาพแข็งแรง ไปเที่ยวไปไหนมาไหนได้ผู้ป่วยเป็นถุงลมโป่งพองมา 30กว่าปี ผู้ป่วยรับรู้ว่าตนเองมีอาการคงที่มาตลอดแต่มีชีวิตอยู่ได้ด้วยการควบคุมอาการจากยา เพราะประมาณ 6-7 ปี เคยขาดยาพ่นมีอาการหอบและหายใจไม่ออกเกือบตาย ต้องมานอนห้องสังเกตอาการ<br><br>- **สิ่งที่ทำให้ผู้ให้ข้อมูลมีการนึกถึงความตาย** คือ 1) หอบมาก และหายใจไม่ออก ตอนผู้ป่วยหายใจไม่ออกเข้าโรงพยาบาล ทำให้ผู้ป่วยนึกถึงการตาย และคิดว่าถ้าเป็นอะไร ให้ลูกหลานมอบศพให้โรงพยาบาล และมีการพูดคุยกับลูกหลานตลอดว่าถ้าตนเป็นอะไรมอบศพให้ด้วยและ 2) การเจ็บป่วยต้องเข้า | ประสบการณ์การเกือบตายจะได้มองเห็นว่าอะไรเป็นตัวสำคัญที่ทำให้ผู้ให้ข้อมูลยอมรับการตายหรือการยอมรับการตายที่แตกต่างกันออกไปอย่างไร |

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| *บุญ ถ้าทำกับคนไม่มีดี ยิ่งส่งเสริมให้ศาสนาเสื่อม ถ้าเรื่องตายเห็นว่ามันเป็นเรื่องธรรมดา ตายแล้วทำศพ น่าจะเอาเงินที่ใช้เพื่อทำงานศพนั้นมาบริจาคให้โรงเรียน ให้เด็กกำพร้า น่าจะเกิดประโยชน์* มีงานศพให้เงินกัน 300-400 แต่กินเหล้ากินไหรกัน ตาไม่เห็นด้วย<br><br>*ศาสนาพุทธสอนให้คนต้องศึกษาให้รู้ รู้แล้วนำมาปฏิบัติ* และพูดให้คนอื่นฟังได้ว่ามันดีหรือไม่มี *แต่ถ้าไม่ศึกษา ทำแค่ตามประเพณี ตาไม่เห็นด้วย เหมือนคนที่บวชแล้วจะดี ไม่ใช่ คุณธรรม ศีลธรรมเกิดจากการคิด การคิดดีนำไปสู่การปฏิบัติดี เท่านั้นเอง คนดีหรือไม่ดีตาดูที่คนนั้นคิดดี ปฏิบัติดี มั๊ย*<br>-<br>**ตาบอกว่าคำสอนศาสนาทำให้เราไม่กลัวตาย อยากทราบว่าคำสอนศาสนาในเรื่องอะไรทำให้ยอมรับการตายได้ง่าย**<br>- *ศาสนาหรือพุทธเจ้าสอนเกี่ยวกับสังขารไม่เที่ยง คนเรา เกิดแก่เจ็บตาย เป็นเรื่องธรรมดา* ตายแล้วก็ทำบุญสวนกุศลให้พ่อแม่ตายาย การทำบุญเป็นการให้ทาน ทำบุญเป็นการทำดี ทำดี แล้วได้บุญทำที่ไหนก็ได้ แต่ทำบุญตามความคิดตาไม่ใช่ว่าทำบุญแล้วจะได้บุญตลอดไปเหมือนคนมาเรี่ยไรทอดกฐินแบบนี้ เข้ากระเป๋าเองตาว่าทำบุญแบบนี้ก็ไม่ได้บุญ<br><br>**ความหมายความตายตามความคิดตาคืออะไร**<br>- *ความตายคือของแท้ ก็ต้องเกิดมาแล้วก็ต้องตาย เราเห็นคน* | - การตายเป็นเรื่องธรรมดา (meaning of death) ควรนำไปเจาะลึกต่อ<br>- ผู้ป่วยชอบคุยกับพระ (conditions)<br><br>- ศาสนาสอนให้ได้เรียนรู้ เกิดการคิดและนำไปสู่การปฏิบัติ (factor)<br><br>- คำสอนศาสนาเกี่ยวกับสังขารไม่เที่ยง การเกิด แก่ เจ็บ ตายเป็นเรื่องธรรมดาทำให้ยอมรับการตาย (method) | นอนโรงพยาบาลทำให้ผู้ป่วยเริ่มมีคิดถึงการตายเพราะมีโอกาสที่จะตาย 50/50 ในขณะที่การมาตรวจรักษาตามปกติถือเป็นเรื่องปกติ<br>- **ผู้ให้ข้อมูลได้ให้ความหมายความตาย**1) เป็นเรื่องธรรมดา เป็นเรื่องธรรมชาติตามคำพระคือ อนิจจัง เกิด แก่เจ็บตายเป็นเรื่องธรรมดา2) การตายเป็นของแท้แน่นอนที่ทุกคนที่เกิดมาต้องตาย เมื่อเห็นคนเกิดปุ๊บก็รู้ทันที่ว่าคนนั้นก็ต้องตาย และ 3) การเกิดกับการตายเป็นของคู่กันเป็นเรื่องธรรมชาติ ตามคำพระคืออนิจจัง สังขารไม่เที่ยง การ เกิด แก่ เจ็บตายเป็นเรื่องธรรมดาของคน<br>- **ปัจจัย/สิ่งที่ทำให้ผู้ให้ข้อมูลยอมรับการตาย** ประกอบด้วย 1) ประสบการณ์การพูดคุยกับคนทางศาสนา คิดว่าศาสนาสอนให้คนศึกษาเพื่อให้เกิดความรู้ เกิดการคิด และนำมาปฏิบัติที่ดีทำให้ และการได้คุยกับพระทำ | |

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| *เกิดปุบ มาเราก็รู้แล้วว่าเค้าก็ต้องตายความตายมันเป็นเรื่องเป็นธรรมชาติ* ไม่ใช่เป็นเรื่องแปลก *ถ้าเห็นคนเกิด เรารู้แล้วตั้งแต่เกิด ว่าเค้าต้องตาย ไม่มีใครที่ไม่ตาย เพราะเป็นของคู่กันภาษาพระคือ อนิจจัง หมายถึง ไม่เที่ยงแท้ เกิด แก่ เจ็บตายเป็นเรื่องธรรมดาของคน*<br><br>**มีความกังวลเกี่ยวกับความตายรึเปล่า**<br>- ถ้าถึงเวลาจะตายกังวลเรื่องเดียวว่า *ถึงเวลาจะตาย อย่าให้เป็นภาระแก่ลูกหลาน สมมติถึงเวลาไม่สบาย คนเราก็ต้องตายทุกคน เราก็นั่งหรือนอนให้สบายว่าต้องตายแน่ๆ เพราะมันเป็นธรรมชาติ ลูกหลานที่อยู่ข้างหลังก็ไม่ห่วงอะไร เพราะมีหน้าที่ให้เค้าทำ ไม่ต้องกังวลอะไร และขอให้ลูกหลานอยู่ข้างหลังเป็นคนดี แค่นั้นเราก็ตายสบายแล้ว ไปแบบสงบเหมือนที่เค้าว่ากัน*<br><br>**การที่ตาเตรียมบริจาคร่างกาย คุณตาคิดอย่างไร ถึงได้บริจาคร่างกายตรงนี้**ตาไปเที่ยวหลายๆ แห่ง *คุยกับพระ คนทางศาสนาที่เค้ามีศีลธรรม เค้าจะมอง พูดว่าคนเรานี้พอตายแล้วก็จะไม่เกิดประโยชน์อะไรแล้ว เหมือนท่อนไม้ผุท่อนหนึ่งที่ไม่มีประโยชน์อะไร และตาก็เมื่อก่อนบ้านอยู่ใกล้ๆ ป่าช้า ตาเห็นคนตาย เด็กเกิดถึงตาย ตาแลจนชิน ถึงเมื่อก่อนศพเวลาเค้าเผาเค้าดึงให้คว่ำ* ตาไปช่วยเค้าอยู่เรื่อยๆ คนแก่ก็สั่งว่าเวลาเผาช่วยดึง *ทำให้ตาได้เห็นว่าการเกิดการตายเป็นเรื่อง* | - การตายเป็นของแท้แน่นอนที่ทุกคนต้องเจอ<br>- การเกิดกับการตายเป็นของคู่กัน<br>- ความตายเป็นเรื่องธรรมชาติ คำพระคือ อนิจจัง เกิด แก่เจ็บตายเป็นเรื่องธรรมดา (meaning of death)<br><br>- ตอนจะตายไม่อยากเป็นภาระลูกหลาน (consequence)<br>- ทุกคนต้องตายการตายเป็นเรื่องธรรมชาติ (meaning of death)<br><br>- ประสบการณ์การพูดคุยกับคนทางศาสนา ชีวิตคนเมื่อตายเหมือนไม้ผุ ไม่มีประโยชน์ (factor)<br>- การได้เห็นคนเกิดคนตายบ่อยๆ ทำให้มองการ | ให้ มองว่าชีวิตคนเมื่อตายเหมือนไม้ผุ ไม่มีประโยชน์ผู้ป่วยชอบคุยกับพระ , 2) ผู้ป่วยมีบ้านใกล้ๆ ป่าช้าทำให้เห็นให้เห็นคนเกิด คนตายจนชิน ทำให้ผู้ป่วยมองเห็นว่าการเกิด การตาย เป็นเรื่องธรรมดา3) ลูกๆ ยอมรับ เข้าใจการบริจาคร่างกาย ผู้ป่วยสบายใจไม่กังวล, 4) การสูงอายุ ไม้ใกล้ฝั่ง ทำให้ผู้ป่วยคิดว่าการตายเป็นเรื่องธรรมดาผู้ป่วยเริ่มมองการตายเป็นเรื่องธรรมดาเมื่ออายุย่าง 50 เพราะผู้ป่วยสนใจเรื่องสูงวัย เริ่มมองว่าตนเองสูงไว แก่ ซึ่งความตายใกล้เข้ามาถือว่าเป็นเรื่องธรรมดา<br>, และ5) คำสอนศาสนา เกี่ยวกับสังขารไม่เที่ยง เกิด แก่ เจ็บ ตายเป็นเรื่องธรรมดา ให้ได้เรียนรู้ เกิดการคิดและนำไปสู่การปฏิบัติ<br><br>**ผู้ให้ข้อมูลได้ให้ความหมายของการยอมรับการตาย**คือ1) การยอมรับความเป็นจริงที่เป็นไปตามธรรมชาติ ที่ทุกคน | |

| Statements | Open coding | Reflective thinking / Field notes | Others |
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| *ธรรมดาของคน*<br><br>**การที่ตามีประสบการณ์ เห็นคนตายเพราะบ้านอยู่ใกล้ป่าช้าบ่อยๆ เป็นปัจจัยอันหนึ่งที่ทำให้ตาไม่กลัวตายหรือไม่**<br>- *คนเราพอตายไม่เกิดประโยชน์อะไร ตาเลยคิดว่าทำให้เกิดประโยชน์ดีกว่า* และตอนนั้นเพื่อนพาไปดูศพอาจารย์ใหญ่ ตาเห็นศพที่แขวนไว้ หลังจากนั้นตาคิดตลอดเลยว่า*ถ้าได้ทำสิ่งที่เป็นประโยชน์แบบนี้ก็คงดี หลังจากบริจาคร่างกายแล้วตาก็แนะนำต่อๆกันเป็น 10 คน เวลามีงานศพตาก็พูดในงานให้เค้าบริจาคร่างกาย ถ้าตายไปแบบมีประโยชน์กับเพื่อนมนุษย์ ตั้งแต่ หมอ พยาบาลได้ศึกษา มันดีได้บุญมากกว่าการเดินทางทอดประะปา ตาไม่เชื่อชาติหน้ามีจริง แต่คนเราในปัจจุบันนี้ถ้าทำดี ก็เห็นผลดีตอนนี้ไม่ต้องรอชาติหน้า ตาเชื่อทำในชาตินี้ก็ทำให้สบายใจ*<br>- *ตาฝังใจตั้งแต่เห็นศพนั้นมันมีประโยชน์ถ้าเค้าเอาเนื้อออกหมด และตาก็คุยกับหมอที่รักษาตา ว่าตาแน่นหน้าอก ไม่รู้ตาผิดปกติที่หัวใจมั๊ย แต่หมอบอกตาว่าหัวใจอยู่ทางนี้ๆ ตบหน้าอก ด้านซ้ายทำให้ตามีความรู้ว่ามันไม่ใช่หัวใจ และบางทีหมอเอานักศึกษาแพทย์ไปตรวจตาด้วย ตาคิดว่าถ้าเราตายแล้วเอาไปเถือเนื้อออก เซ็คดูก เห็นเส้นเอ็น นักศึกษาได้เรียน ได้เห็นจริงว่ากระดูกนี้อยู่ไหน แล้วเอาไปรักษาคนอื่น ตาคิดว่าได้บุญ*<br>- *หลังจากตาเห็นอาจารย์ใหญ่ ก็เอาไปคุยกับเพื่อนๆ บางคนก็ว่าดี บางคนว่าเมียไม่ให้ ลูกไม่ให้ บางคนเชื่อว่าไปเกิดใหม่ไม่ครบ 32* | ตายเป็นเรื่องธรรมดา (factor)<br><br><br>- หลังตายไปไม่มีประโยชน์ จึงได้บริจาคร่างกาย<br>- ไม่เชื่อชาติหน้า ทำดีเห็นผลในชาตินี้ (beliefs)<br>- บริจาคร่างกายให้คนอื่นได้เรียนรู้ทำให้ได้บุญมีความหมายอย่างไรสำหรับผู้สูงอายุ (consequence) | เกิดมาก็ต้องตาย ทำให้อยู่อย่างสบายใจ ในขณะที่คนไม่ยอมรับความจริง ทำให้อยู่จิตใจหวั่นไหว อยู่ด้วยความกลัว<br><br>- **วิธีการที่ทำให้ผู้ให้ข้อมูลยอมรับการตาย**1) ศาสนาสอนให้ศึกษา คิด เข้าใจและนำมาสู่การปฏิบัติ 2) ศาสนา/ความเชื่อทางศาสนาสอนให้คนศึกษา พิจารณานำมาสู่การยอมรับ หรือการปฏิบัติ, 3) รู้แต่ไม่ยอมรับสัจธรรมก็ทำให้ไม่สามารถยอมรับการตายได้, 4) รู้และเข้าใจเรื่องสังขาร และ ต้องยอมรับอนิจจัง ทุกข์ขัง อนัตตา, 5) การพิจารณา เข้าใจเรื่องสัจธรรมของชีวิต<br>- ผู้ป่วยรับรู้ว่าศาสนาสอนให้คนได้ศึกษา ได้คิด เข้าใจ และนำมาปฏิบัติ<br>- ผู้ป่วยรับรู้ว่าศาสนาหรือความเชื่อทางศาสนาสอนให้คนได้ศึกษาพิจารณาหาข้อเท็จจริงเพื่อนำมาสู่การยอมรับและการปฏิบัติ<br>- สำหรับการยอมรับความ |  |

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| *ขาขาดมั่ง แขนขาดมั่ง แต่ตาเชื่อว่าคนที่ทำบุญมันก็ได้บุญและเกิดมาดีเองไม่ต้อง ขออธิษฐานอะไร คิดว่าต้องบริจาค ตาคิดช่วงก่อนเกษียณอยู่ประมาณ 4-5 ปี และตอนนั้นตามาโรงพยาบาลบ่อยพาผู้ต้องขังมาตรวจ เห็นหมอตรวจช่วยคนไข้ เห็นหมอเค้ามีเจตนาดีช่วยมนุษย์ เราไม่มีโอกาสให้อะไรคนอื่นเหมือนหมอเลยตัดสินใจบริจาค*<br><br>**ตอนนั้นได้คุยกันในครอบครัวมั๊ยค่ะ**<br>*ตอนแรกลูกทั้ง 4 คน ไม่เซนต์ให้ ไม่มีใครเซนต์ให้ บอกแล้วเค้าก็เฉยๆ บอกทั้ง 4 คน มีพูดกันตลอด บอกหลายครั้งก็ยังเฉยๆ เค้าแลเป็นเรื่องสนุกหัวเราะ จนตาปลอมลายเซ็น เอง สมัครเสร็จตาก็เอาใบนี้ไปให้เค้าดู เค้าไม่ได้กลัวว่าเกิดมาจะไม่ครบ ไม่ได้กลัว ได้บัตรนี้แล้ว*<br>*เอาไปให้เค้าแล ตอนนี้ลูกผมที่เป็นผู้ชายก็เป็นอาจารย์สอนเกี่ยวด้านจิตวิทยา รู้สึกว่าเค้าจะเข้าใจการบริจาคร่างกาย มีบรรยายพูดให้พระฟัง ตอนนี้ลูกเค้ายอมรับกันทั้งหมด และตารู้สึกว่าเค้าจะภูมิใจด้วย เค้าเชิญไปพูด บรรยายให้พระฟัง ตาฟังเทปที่เค้าบรรยายเห็นเค้าพูดถึง*ถึงสังขารคน เกิด แก่ เจ็บ ตาย ตาได้ยินคำหนึ่งว่า*พ่อผมก็บริจาคร่างกาย ตาก็สบายใจที่ลูกไม่ได้กังวลเกี่ยวกับการบริจาคร่างกาย*<br>**ถ้าวันใดวันหนึ่งตาเกิดเสียชีวิต ตากังวลลูกจะไม่ให้ศพ ตามีการจัดการตรงนี้อย่างไร**<br>- *กลัวลูกไม่แจ้งให้เค้าไปรับศพตามความประสงค์ ตามีการแหลงเล่นตลอด สมมุติไม่สบายตาย้ำกับลูกหลานๆ ตลอดคุยเรื่อยๆ ใคร* | - ลูกๆ ยอมรับ เข้าใจการบริจาคร่างกายทำให้ผู้ป่วยสบายใจไม่กังวล (factor)<br><br>- มีการพูดถึงความตายกับลูกๆ หลานๆ ตลอด (consequence | ตาย ถ้าคนเข้าใจศึกษาแต่ไม่ยอมรับว่าความตายเป็นความจริง หรือไม่ยอมรับเรื่องอนิจจัง ทุกข์ขัง อนัตตา เช่นมองว่าหมอสามารถรักษาให้อยู่ได้หลายปี แต่ไม่มองว่าจุดจบคือความตาย เป็นคนที่ไม่มีสัจธรรมหรืออริยสัจสี่ ผู้ป่วยรับรู้ว่าจะรู้อย่างเดียวไม่ได้จะต้องมีการพิจารณาแบบถ่องแท้ด้วย ถึงทำให้เกิดการยอมรับ<br><br>**ผลลัพธ์ของผู้ให้ข้อมูลที่มีการยอมรับการตาย**ประกอบด้วย<br>1) มีการพูดเล่น สั่งให้ลูกหลานมอบศพให้โรงพยาบาลตลอดภายใต้ความคิดต่างๆ เช่น<br>- ผู้ป่วยมีการพูดคุย เล่นๆ กับลูกๆ หลานทุกเทศกาลถ้าตนตายไปให้บริจาคใครไม่บริจาคจะมาบีบคอ ผู้ป่วยกังวลว่าตายไปลูกจะไม่บริจาคร่างกายให้ตามความต้องการ<br>- ผู้ให้ข้อมูลกังวลว่าตายไปลูกหลานบริจาคร่างกายให้เพราะมีลูกหลานบางคนมีความเชื่อว่าการถูกตัด | |

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| *ไม่แจ้งตาแหลงเล่นตาจะมาบีบคอ เพื่อย้ำ ตาพูดตลอดทุกเทศกาล เหมือนสงกรานต์ หรือมีงานอะไร ตาจะไม่ลืมพูดให้ลูกหลานฟังทั้งวง อยากให้เค้าแจ้งให้เค้าได้มาเอาศพ ตามใจเค้าจิเอาไปทำอย่างไรก็ตาม*<br>**บางคนกล่าวการพูดถึงการตายเป็นสิ่งไม่ดี แต่ทำไมตามีการพูดให้หลานฟังบ่อยๆ**<br>- *ที่พูดให้ฟังบ่อยๆ เพื่อต้องการให้เค้าเห็น และเข้าใจว่า การตายเป็นเรื่องธรรมดา ถ้าใครตายอย่าร้องให้ รู้ว่าการเสียใจ แต่อย่าเวลาไปเสียใจกับการตาย ร้องให้จนทำโน้นทำนี้ไม่ได้ คนต้องมีความคิด การตายเป็นเรื่องธรรมดา เจ็บก็ต้องรักษา มาโรงพยาบาล*<br><br>**คุณตามีการเตรียมอย่างอื่นอีกมั๊ย นอกจากการบริจาคร่างกาย**<br>- *ไม่มีนะเพราะลูกๆ เค้า ก็สบาย อยู่สบายกันแล้ว คนไม่รับราชการก็สามารถเลี้ยงชีพเค้าได้หมดแล้ว ลูกหลานก็ศึกษา มีสามีภรรยาของเค้ามันก็เป็นไปตามธรรมชาติ เป็นไปตามกาลเวลา เหมือนตาพอแก่แล้วมันก็เหมือนไม้ใกล้ฝั่ง มันก็ธรรมดา* คิดว่าทุกวันนี้ก็สบายใจ อยู่หยอกเล่นกับลูกหลาน<br><br>**อายุเท่าไรที่ทำให้ตาเริ่มมองการตายเป็นเรื่องธรรมดา หรือตามองว่าตนเองเป็นเหมือนเราไม้ใกล้ฝั่ง**<br>- ตาว่าก็*น่าจะอายุร่วม 50 ปี นะ เพราะเราเริ่มสนใจเรื่องสูงวัย ก่อนนี้ใช้ชีวิตสำมะเรเทเมา เที่ยวไปเรื่อย จนเรามาเห็นลูกหลานบวช* | - พูดบ่อยๆ เพื่อให้คิดเข้าใจการตายเป็นเรื่องธรรมดา (consequence)<br><br>- อย่างอื่นไม่ได้เตรียมอะไรเพราะมันเป็นไปตามธรรมชาติ (ถามต่อมีความหมายอย่างไร) (consequence)<br><br>- การสูงอายุ ไม้ใกล้ | แขนตัดขาเกิดใหม่แล้วอวัยวะจะไม่ครบ<br>- ผู้ป่วยมองการตายเป็นเรื่องธรรมดา มองว่าเงินที่ใช้ทำพิธีศพน่าจะเอามาบริจาคน่าจะเกิดประโยชน์กว่า<br>- ผู้ป่วยรับรู้ว่าคนเมื่อตายไปไม่มีประโยชน์ เลยคิดทำให้เกิดประโยชน์ โดยการบริจาค ร่างกายและมีการแนะนำให้คนอื่นๆ บริจาคร่างกายเพื่อให้นักศึกษาแพทย์ พยาบาลได้ศึกษา ผู้ป่วยไม่เชื่อเรื่องชาติหน้า คิดว่าเป็นการทำดี และได้บุญ ทำแล้วทำให้ผู้ป่วยสบายใจ การบริจาคร่างกาย คิดว่าเป็นการทำประโยชน์แก่คนอื่น และได้บุญ เกิดใหม่ก็จะดีเอง<br>- ผู้ป่วยบอกว่าตอนแรกที่บอกลูกๆ ถึงการจะบริจาคร่างกายลูกๆ ไม่สนใจ เฉยๆ แต่หลังจากบริจาคร่างกายแล้วลูกๆ รับได้ และภูมิใจที่ตนเองได้บริจาคร่างกาย ทำให้ผู้ป่วยสบายใจ ไม่กังวลเรื่องการบริจาคร่างกาย<br>2) ตอนจะตายไม่อยากเป็นภาระลูกหลาน 3) บริจาคร่างกายให้คนอื่นได้ | |

| Statements | Open coding | Reflective thinking / Field notes | Others |
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| *ทำงาน เริ่มคิดว่าเราแก่ เราสูงไว เราก็นะจะใกล้ความตายเข้ามาแล้ว มันก็เป็นของธรรมชาติ*<br>**ตาคิดว่าตามีปัจจัยอะไร ทำให้ยากลำบากต่อการยอมรับการตาย หรือเป็นอุปสรรคต่อการยอมรับการตายบ้างหรือเปล่าค่ะ**<br>- ตากลัวอย่างเดียวคือ *การกลัวเป็นภาระแก่ลูกหลาน เหมือนการเป็นไข้ หรือเกิดอุบัติเหตุรถชน แล้วไม่ตายลำบากลูกหลาน เป็นภาระ* เหมือนคนนอนหลายปี *ลำบากลูกหลาน และตาคิดว่าคนที่อยู่สภาพนั้นเป็นเรื่องของเวรกรรม ทำให้เป็นเวรกรรม เป็นการชดใช้กรรม ที่เกิดจากชาติที่แล้วอาจทำทำสิ่งที่ไม่ดีเอาไว้* บางคนรวยแต่ลูกไม่ได้ดีสักคน ลูกไม่เป็นคนดี แต่บางคนจนลูกได้ดี*หมด ลุงว่ามันเป็นเรื่องกรรมเก่า* ตา*ไม่อยากเป็นภาระลูกหลาน*<br><br>**ตาเคยคิดวางแผนการรักษาไปข้างหน้าหรือไม่เมื่อว่าถ้าอาการทรุดหนักให้รักษาตาอย่างไร**<br>- *ตอนนี้ถ้าตาจะตายเราก็สามารถบอกหมอให้ปล่อยเราให้ตายก็ได้ ตาเห็นอยู่ที่โรงพยาบาลเค้าก็ติดประกาศเต็มไปหมด เคยรักษาแม่ยายมานอนที่โรงพยาบาลหาดใหญ่เค้าส่งมาจากปัตตานี มานอนใส่สายยางเสียวันสามร้อยอยู่เป็นครึ่งเดือน หมอบอกเปอร์เซ็นต์รอดไม่มีตามหลักวิชาการ หมอว่าให้นอนแล ลูกหลานได้แลแค่หายใจ ตาเลยเซนต์ยินยอมให้เค้าถอดเพราะให้นอนอยู่ทำไร โอกาสรอดไม่มี ตาจึงคิดว่านอนแลหายใจอย่ารักษาเลย ควรให้ไปพบพระ จำเริญพระมาเพราะชีวิตคนเราเป็นไปตามกรรม ไม่ได้ยืนยาว ถ้าไม่สบาย ถึงเวลา* | ฝั่ง ทำให้ผู้ป่วยคิดว่าการตายเป็นเรื่องธรรมดา (antecedence)<br><br><br>- ไม่ยากเป็นภาระลูกหลานก่อนตาย<br>- การนอนเป็นภาระลูกหลานเป็นการชดใช้กรรมจากขาติที่แล้ว<br><br><br><br>- ไม่ควรยื้อชีวิต ทำให้ทรมาน ควรปล่อยให้ไปพบพระ (consequence) | เรียนรู้ทำให้ได้บุญ(ถามต่อมีความหมายสำหรับผู้สูงอายุอย่างไร)<br>4) มีการพูดถึงความตายกับลูกๆหลานๆ ตลอดผู้ป่วยมีการพูดถึงการตายบ่อยๆ เพื่อให้ลูกหลานได้คิดและเข้าใจว่าความตายเป็นเรื่องธรรมดา หากตนได้ตายไปก็อย่ามานั่งเสียใจ<br>5)อย่างอื่นไม่ได้เตรียมอะไรเพราะมันเป็นไปตามธรรมชาติ<br>- ผู้ป่วยไม่มีการเตรียมเรื่องอื่นๆ เพราะลูกๆ มีการงานทำ หลานมีการศึกษา ตนเองแก่เหมือนไม้ใกล้ฝั่ง ซึ่งผู้ป่วยมองว่าทุกอย่างเป็นไปตามธรรมชาติ<br>- ผู้ป่วยไม่ได้กังวล ลูกหลานก็ไม่ห่วงอะไรเพราะเค้ามีหน้าที่ ผู้ป่วย กังวลเรื่องเดียวคือเวลาจะตายไม่อยากเป็นภาระลูกหลาน<br>- ผู้ป่วยกลัวอย่างเดียวคือกลัวเป็นภาระลูกหลาน ก่อนตายไม่อยาก | |

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| ตายก็ไม่ควรจะเอาไว้ หรือยื้อเอาไว้ ตาก็สั่งลูกๆ ไว้ว่าถ้าเจ็บหนักอย่าช่วยให้รอด อย่ายึดเยื้อ ปล่อยให้ตาย อย่ามาเที่ยวปั้ม อย่าใส่ท่อ บางคนใส่ท่อเท่าแต่ให้หายใจได้ออกซิเจนแต่เปอร์เซ็นต์รอดไม่มี ตาว่ามันทรมานคนไม่ใช่รักษาให้หาย แหลงกับลูกกับหลานตลอด<br>ตาเคยบอกเค้าญาติๆ อ่ะน่ะว่าถ้าหนักพันนี้ควรพาให้เค้าไปพบพระต่ะ เหมือนเค้าเรียกจำเริญอายุอ่ะน่ะ หลังจากนั้นเค้าก็พาศพ ทำพิธีศพเปิดธรรมมะให้ฟังเสียงดังมาก ตาคิดในใจ ไม่รู้มันประชดกูม้ายก็ไม่รู้ (หัวเราะ) ตาเลยมีความคิดว่าความตายนี้คนคิดไม่เหมือนกันตาเห็นเวลาเป็นนี้ควรให้กิน ตอนที่เค้ายังเป็น ยังกินได้ ตาเห็นเวลานอนพ่อแม่เดินไม่รอด ไปซื้อรถเข็นไปเที่ยวไหนมาไหน ตาว่าควรให้กินเวลากินได้ พาเที่ยวเวลาไปได้ เพราะตอนนั้นมันกินก็ไม่หรอย เที่ยวก็ไม่สนุกแล้ว<br>**การคาดหวังต่อการรักษา มารับยาตอนนี้ มีแค่ไหนอย่างไร**<br>ตาคิดว่าการที่มารับยาตอนนี้ เพื่อไม่ให้มันไม่เจ็บนะให้มันหายเจ็บเหมือนเราไอ เราหอบ เราไม่รู้บรรเทาปรือ มาหาหมอเค้าเรียนมาตามหลักวิชาการ เค้าก็บอกก็ให้ยา จะได้ไม่ต้องทรมาน ไม่ต้องมานั่งเดือดร้อนคนอื่น ไม่ได้คาดหวังให้หายขาด ก็เหมือนเวลาจะตายไม่ต้องยึดไปฝืนทำให้ทรมาน เหมือนหมอนี้เค้าช่วยให้บรรเทาอาการไม่ให้เกิดความทรมาน หรือทุเลาอาการเจ็บ พอหมอแนะนำเพราะเค้าเรียนมาตามหลักวิชาการ หมอที่เค้ารู้ ทำให้เราดีขึ้น ไม่เจ็บทรมาน ตาคิดว่าเราช่วยคนอื่นเหมือนหมอไม่ได้ แต่ถ้าเราได้ช่วยคนอื่น ความคิดถ้าเอาร่างกายเราไปให้เค้าเรียน ช่วยเหลือคนอื่นที่เจ็บเหมือนเราก็น่าจะได้ | - ความคิดต่อความตายและคนไม่เหมือนกัน<br><br>- คาดหวังการรักษาเพื่อบรรเทาอาการไม่ให้เจ็บทรมาน (consequence) | เป็นภาระลูกหลาน คิดว่าการนอนเป็นภาระแบบนี้เป็นเรื่องเกี่ยวข้องกับกรรมเก่าในชาติที่แล้ว<br>6) ไม่ควรยื้อชีวิต ทำให้ทรมาน เวลาจะตายก็อย่าไปยึดชีวิตให้เกิดความทรมาน ผู้ป่วยคิดว่าถ้าจะตาย นอนดูแค่ลมหายใจ โอกาสรอดไม่มี สั่งลูกหลานให้หมอปล่อยให้ตาย อย่ายื้อไว้ เพราะทำให้มันทรมาน เคยเห็นจากประสบการณ์การรักษาแม่ยาย ควรปล่อยให้ไปพบพระ<br>- ผู้ป่วยคิดว่าถ้าอาการหนักควรปล่อยไปพบพระเพื่อจำเริญอายุ (ถามต่อว่ามีความหมายอย่างไร)และผู้ป่วยมองว่าคนแต่ละคนมองการตายไม่เหมือนกัน ผู้ป่วยเห็นซื้อรถพาไปเที่ยวเมื่อไปไม่ไหว ผู้ป่วยคิดว่าควรพาเที่ยวให้กินในขณะที่ยังสามารถกินได้ เที่ยวได้<br>7) คาดหวังการรักษา เพื่อบรรเทาอาการไม่ให้เจ็บทรมานไม่ได้มีความหวังว่าจะให้หายขาด<br>8) อยู่แบบสบายใจจิตว่าง ไม่อยู่ด้วย | |

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| *บุญ (ชื่นชมความคิดดี)*<br>**ผลของการยอมรับการตาย ไม่กลัวตาย มีผลดีต่อชีวิตตัวเราอย่างไร**<br>*มันทำให้เราสบายใจ มันไม่ทำให้เราอยู่ด้วยความกังวล สมมุติเรานอนนั่งเล่น เราก็คิดว่าตายก็ตายเป็นเรื่องธรรมชาติ* คนแต่แรกเค้าก็ตายทั้งนั้น ถ้าเราไม่ตายแล้วเราจิอยู่ปรือ เราก็ต้องตาย *ทำให้เราอยู่จิตว่างไม่มีความกังวล ตาว่ามันมีผลต่อสุขภาพ ถ้าจิตใจเราสบาย จิตใจดีสบายใจ สุขภาพกายเราก็ดีด้วย* ถ้านั่งเศร้านี้ก็ไม่ดีต่อสุขภาพกายเราแล้ว *ตาว่าถ้าจิตใจดี สบายใจ สุขภาพกายก็จะดีถ้าเราสบายใจ ถึงเวลากินก็กิน ถึงเวลานอนก็นอนได้ ตามภาษาพระก็ว่าอยู่ตามอัตภาพ*<br>รายได้ไหรก็ไม่ต้องฟุ้งเฟ้อ ตาคิดว่าอีกอย่างเราเป็นข้าราชการบำนาญ เป็นสิ่งที่ดีสำหรับตา เพราะตาเห็นคนเพื่อนรุ่นเดียวกับตา บางคนเค้าไม่มีรายได้ มีเงินผู้สูงอายุ 600- 700 บางทีมันอาจจะไม่พอ เราโชคดีอย่างไรไม่ทำงาน ยังได้กินบำนาญ อยู่สองคนตายายสบายๆ ได้ไปไหนมาไหน<br>ชีวิตคนเราที่อยู่ได้นานนี้ ตาว่าสุขภาพจิตนี้สำคัญ คนที่จิตใจไม่ดี บางคนลูกหลานสร้างปัญหา มาบวชตอนแก่ก็มี แต่ตาว่าไม่ใช่การแก้ปัญหาที่ถูกต้อง ไม่ใช่การแก้ปัญหา อยู่บ้านไม่มีรายได้ตาว่าปลูกต้นไม้ เล็กน้อยๆ ข้างบ้านยังน่าจะความสุขมากกว่า<br>**ตามีความเชื่อต่อการทำบุญอย่างไร เชื่อการทำบุญในชาตินี้มีผลต่อชาติหน้าเมื่อตายไปบ้างหรือไม่**<br>การทำบุญ เป็นการทำตามประเพณีสืบทอด พระพุทธเจ้าหรือ*ศาสนาพุทธนี้ สอนให้ศึกษาและนำมาปฏิบัติ ศาสนาสอนให้ ใช้* | - การยอมรับการตายทำให้อยู่แบบจิตว่าง สบายใจ<br>- สุขภาพจิตที่ดีมีผลต่อสุขภาพกายที่ดี (consequence) | ความกังวล, และ<br>9) สุขภาพจิตที่ดีมีผลต่อสุขภาพกายที่ดี ถ้าสบายใจถึงเวลากินก็กินได้ เวลานอนก็นอนได้ | |

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| *วิจารณญาณ ให้เห็นสิ่งไหนดีไม่ดี แล้วนำมาปฏิบัติ* ตาว่าการทำบุญก่อนทำหลังทำเรามีความศรัทธาก่อน ไม่ใช่ทำตามเพื่อนชักชวน เวลาทำก็ศรัทธา คนเราก็ต้องศึกษาด้วยชีวิตตนเอง ไม่นั้นก็ปฏิบัติต่อไม่ถูกด้วย เหมือนการรับศีลก็เป็นพิธีกรรมทางศาสนา มีไว้ *พุทธเจ้าสอน ให้เข้าใจและนำไปปฏิบัติ*<br><br>**คำว่าการยอมรับการตายตามความคิดคุณตาคืออะไร**<br>- *การยอมรับเป็นธรรมชาติ เกิดมาแล้วก็ต้องตาย ถ้าเราทำใจได้ เราก็อยู่ได้การยอมรับความตายเป็นการยอมรับความเป็นจริง ที่เป็นไปตามธรรมชาติ ทุกคนต้องตาย ที่ต้องตายแน่ การยอมรับการตาย ทำให้สบายใจ*ตายไปสมบัติติดตัวสักชิ้นก็เอาไปไม่ได้ เหมือนไม้ท่อนหนึ่ง ที่เผาไปไม่ประโยชน์ เหมือนคนที่บ้าคือ *คนที่ไม่เค้ายอมรับความจริง ไม่ยอมรับสุขภาพจิตเค้าก็จะเขว ร้องไห้ หวั่นไหว คนที่กลัวตาย คือคนประเภทนี้ก็จะกลัวไปหมดไม่ว่าจะอะไร* พอมีดนิดก็กลัวผี คนที่กลัวตายก็น่าจะคนที่ขี้ขลาด<br>**ศาสนาช่วยอย่างไรเรื่องการยอมรับการตาย**<br>*ความเชื่อศาสนาคือ ข้อเท็จจริง เหมือนกัละปะสูตร ที่พุทธเจ้าสอนให้เชื่อสิ่งที่ควรเชื่อ อย่าเชื่อในสิ่งที่เล่าลือ ให้เห็น ได้ด้วยศึกษาพิจารณาด้วยตนเอง พระพุทธเจ้าสอนให้หาข้อเท็จจริง ให้เชื่อมั่นในตนเอง ให้เข้าใจความเป็นจริง เหมือนความตายถ้าเข้าใจก็จะยอมรับ ถ้าไม่เข้าใจเรื่องสังขาร ไม่ได้ศึกษา หรือศึกษาแล้ว ไม่ยอมรับเรื่องอนิจจัง ทุกข์ขัง อนัตตา มีความรู้เรื่องนี้ แล้ว แต่ไม่ยอมรับหรือเห็นว่า* | -ศาสนาสอนให้ศึกษา คิดใช้วิจารณญาณ และนำมาสู่การปฏิบัติ (method)<br><br>- การยอมรับการตายคือการยอมรับความเป็นจริงที่เป็นไปตามธรรมชาติ ทุกคนเกิดมาต้องตาย (meaning of accepting death)<br><br>- ศาสนา/ความเชื่อทางศาสนาสอนให้คนศึกษาพิจารณานำมาสู่การยอมรับหรือการปฏิบัติ (method)<br>- รู้แต่ไม่ยอมรับสัจ | | |

| Statements | Open coding | Reflective thinking / Field notes | Others |
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| *การตาย เป็นเรื่องที่ไม่จริง บางคนเชื่อว่าหมอรักษาจะช่วยได้อยู่เป็นสิบๆ ปี ไปหาหมอไม่สาจิตายเลย ไม่มองว่าอย่างไงสุดท้ายจุดจบก็ต้องตาย หมายถึงแลไปไม่ตลอด ไม่มีสัจธรรม ไม่มีอริยสัจสี่ หรือไม่แลให้มันครบถ้วน รู้อย่างเดียวไม่ได้ ต้องหาความจริง ด้วยบางคนไม่เข้าใจเรื่องวิจารณญาณหรือการพิจารณาแบบถ่องแท้* | ธรรมก็ทำให้ไม่สามารถยอมรับการตายได้ (method)<br>- รู้และเข้าใจเรื่องสังขาร และ ต้องยอมรับอนิจจัง ทุกข์ขัง อนัตตา ทำให้ยอมรับการตาย (method)<br>- การพิจารณา เข้าใจเรื่องสัจธรรมทำให้ยอมรับการตาย (method) | | |

**เคสที่ 3 ลุงจารึก COPD อายุ 67 ปี**

| Statements | Opening codes | Reflective thinking / Field notes | Others |
|---|---|---|---|
| **ข้อมูลโรคและประจำตัว**<br>- *ลุงจารึก อายุ 67 ปี มีโรคประจำตัว (หัวใจวาย) จากเส้นเลือดหัวใจตีบ ยังต้องทำบอลลูนต่อ แต่ยังไม่ได้ทำเลยเลื่อนไปก่อน เคยหมดสติจากหัวใจและเบาหวาน นี้เป็นแรกอายุ 50 ขึ้น (8 ปี)*รักษาอยู่ มอ.ไปไหนต้องพายาไปด้วย<br>- *เคย ลืมกินยา 2 ครั้ง อันตราย อาการเกือบตาย ทั้ง 2 ครั้ง 2 คราา ลืมกินยาทั้งชุด เช้าเย็น ครั้งแรกเดือนตุลาคม 2558* ไปกระแสสิน ลืมยาทั้งชุด เช้า เย็น ไม่ได้พายาไป *ตื่นมา เที่ยงคืนกว่า* หลานตื่นมาตัดยาง พบตาแน่น *หายใจไม่ออก พาไปกระแสสินธ์ ส่งมาสงขลา และก็ส่งตัวมา โรงพยาบาล มอ. ทัน ล่าสุด เดือน ธันวาคม พบเพื่อน เพื่อนพากินข้างนอกบ้าน กลับมา 3 โมงไม่ได้กินยาเลย ตอนเย็นเปิดทีวี นอน กลางคืน หลับไปเลย ลูกนำไปมอ. ตอนนั้นลุงหลับไม่รู้สึกตัวไปแล้ว ถ้าไม่ไปมอ. ก็ตายอย่างเดียว เคยใส่ท่อด้วย ตอนนั้นใส่ง่ายเพราะตาไปแบบไม่รู้สึกตัวแล้วทั้ง 2 ครั้ง*<br>***สมาชิกครอบครัวมีใครบ้าง***<br>- มีลูกสาว 3 คน คนโต อายุ 41 ปี จบปริญญาโทเป็นอาจารย์ คณะอก. ที่ มอ. ลุกสาวคนกลาง 40 ปี ทำงานสื่อสิ่งพิมพ์ ทำไวนิล กล้องขนมเค้ก ป้ายโฆษณาบ้านหลังติดกัน และลูกสาวคนเล็ก อายุ 38 ปี ทำวางระบบ อินเตอร์เน็ตที่กรุงเทพ ยังไม่มีใครมีครอบครัว | - เคยมีประสบการณ์เกือบตาย 2 ครั้ง หมดสติ หายใจไม่ออก | - ผู้ให้ข้อมูลรายนี้ผู้วิจัยได้เข้าหาผู้ให้ข้อมูล จากคำแนะนำของพยาบาลหอผู้ป่วยวิกฤตตาม inclusion criteria ก่อนเข้าไปสัมภาษณ์ผู้ให้ข้อมูล นักวิจัยได้โทรติดต่อลูกสาวซึ่งเป็นผู้ดูแลหลักของผู้ให้ข้อมูล ผู้วิจัยสอบถามมุมมองความตาย ความสามารถยอมรับความตาย ความรู้สึกต่อความตายของผู้ให้ข้อมูลจากลูกสาว จากการประเมินของลูกสาวคิดว่าพ่อยอมรับการตายได้และสามารถสื่อสารการตายได้ ให้เบอร์ติดต่อกับผู้ให้ข้อมูลโดยตรง<br>- การติดต่อผู้ให้ข้อมูลครั้งแรกพบว่าผู้ให้ข้อมูลกำลังจะไปร่วมงานศพญาติที่บ้านเดิม ผู้วิจัยได้สอบถามพูดคุยความสัมพันธ์ผู้เสียชีวิต ถามความรู้สึกต่อการเสียชีวิตของผู้ตาย ผู้ให้ข้อมูลตอบว่า คนเราเกิดมาก็ต้องตาย การตายเป็นเรื่องธรรมดา ผู้วิจัยจึงได้บอกวัตถุประสงค์ที่ได้ติดต่อไป ผู้ให้ข้อมูล | **Constant comparative**<br>ผู้ให้ข้อมูลรายนี้อายุ 67 ไม่แตกต่างกันมากจากผู้ให้ข้อมูลรายแรก แต่ไม่มีคำพูดตายไม่ได้เพราะลูก?ประเด็นที่น่าสนใจหรือเปรียบคือความรู้สึกของผู้ให้ข้อมูลที่เกิดขึ้นระหว่างลูกยังเรียนอยู่กับลูกที่สำเร็จการศึกษามีงานทำเรียบร้อยแล้วเป็นประเด็นที่ทำให้มีการยอมรับการตายต่างกันหรือไม่<br>**Theoretical sampling**<br>จากการศึกษาพบว่าการยอมรับการตายคือการยอมรับความเป็นจริงตามธรรมชาติ และการไม่กลัวตายคนที่ยอมรับการตาย 1) มีการพูดคุยเล่นๆ วางแผนงานศพของตนเอง, 2) มีการเตรียม |

| Statements | Opening codes | Reflective thinking / Field notes | Others |
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| **ช่วงวิกฤตแบบนั้นคิดถึงความตายบ้างหรือไม่ ความตายตามความคิดลุง คืออะไร**<br>- ไม่เคยคิดถึงเลย คนเราจิตายก็ตาย เพราะความตายก็คือ ไม่มีความรู้สึกในตัวเอง อวัยวะหยุดทำงาน เลยตาย *ลุงเคยซ๊อคหลับไป 12 วัน จากเบาหวาน* หมอยื้อไว้ ร่างกายกลับมาทำงานได้เลยฟื้นมาอีกรอบ<br><br>**ก่อนมาซ๊อคลุงเคยคิดถึงความตายบ้างมั๊ย**<br>- ลุงเคยทำงานเริ่มขับรถ ปี 2520 จนถึงปี 2553 และก็เกษียณ ปี 2554 ขับรถ อยู่ 34 ปี มหาวิทยาลัยทั่วไทยไปมาหมด ลุงทำงานตรงนั้นเพราะลุงไม่กินเหล้า เพราะหลายชีวิตที่มีค่าฝากชีวิตไว้กับเรา<br>**เมื่อไหร่ที่ลุงมีการคิดถึงการตาย**<br>- จนถึงปี 2554 *ลุงมีการคิดถึงความตาย เพราะ ลุงเหมือนตายไปแล้ว เพราะตอนนั้นลุงหมดสติหลับไป ไป 12 คืน ถึงมาตอนนี้ตายก็ตาย ไม่เคยคิดว่าจะตาย* ไม่เคยคิดถึงความตายเลย *ตายก็ตาย ลุงไม่กลัวตาย เพราะลุงคิดว่าความตายเป็นธรรมชาติ ทุกคนต้องเจอ มันไม่เกี่ยวกับตัวเรา มันอยู่ที่ร่างกาย เมื่อไหร่ที่ร่างกายไม่ทำงานหยุดทำงาน มันก็ตาย นี้คือการตาย ลุงไม่กลัว ลุงไม่คิดถึงภพหน้า ไม่เชื่อเรื่องวิญญาณ เชื่อเรื่องภพหน้า ไม่เชื่อว่าตายแล้วต้องไปเกิดตรงโน้นตรงนี้ลุงไม่เชื่อ*เรื่องทำบุญแล้วได้บุญ ไม่มีๆ เป็นสิ่งที่บรรพบุรุษเค้าสอน | - การตายเป็นการหยุดทำงานของร่างกาย (meaning of death)<br>- ไม่คิดถึงการตาย เพราะคนเราจะตายมันก็ตาย<br><br>- มีประสบการณ์เหมือนตายไปแล้วทำให้นึกถึงการตาย (antecedence)<br>- ไม่กลัวตาย เพราะคิดว่าการตายเป็นเรื่องธรรมชาติทุกคนต้องเจอ (method)<br>- ไม่มีความเชื่อชาติ | นัดนักวิจัยในการพูดคุยด้วยตนเอง<br>- วันสัมภาษณ์ ผู้ให้ข้อมูลอยู่กับภรรยา 2 คน ที่บ้านลูกสาวคนโต บ้านแฝดหลังใหญ่โต ซึ่งเป็นบ้านลูกสาวคนโต ลูกสาวไปทำงาน บ้านอยู่ติดกับบ้านลูกสาวคนกลาง ระหว่างสัมภาษณ์ภรรยาเข้ามาร่วมพูดคุยสนทนาด้วย<br>- ก่อนเริ่มสอบถามเริ่มต้นด้วยการสนทนาเรื่องการเจ็บป่วยทั่วไป ของผู้ให้ข้อมูล พบว่าผู้ให้ข้อมูลมีสัมพันธ์ภาพดีกับนักวิจัย ระหว่างการ พูดคุยเรื่องความตายผู้ให้ข้อมูล พยายามถ่ายทอดประสบการณ์ มีส่วนร่วมตอบคำถามทุกคำถามด้วยท่าทีที่เข้มแข็ง ไม่มีอารมณ์อ่อนไหวเกิดขึ้น หลังจากสัมภาษณ์เสร็จมีการสั่งถ้าขาดเหลือประเด็นใดให้มาหาสอบถามพูดคุยได้อีก ผู้ให้ข้อมูลสั่งนักวิจัยว่า สามารถมาได้เลยโดยไม่ต้องนัดก็ได้ เพราะรู้จักบ้านแล้ว<br>- ผู้ให้ข้อมูลดูสุขภาพแข็งแรง ยินดีให้ความร่วมมือในการตอบคำถาม มีความพร้อมในการเล่าประสบการณ์ และ | งานศพให้พ่อแม่ มีพูดเรื่องงานศพตนเองกับลูกบ้าง เพราะมองเรื่องการเตรียมวางแผนการตายไม่ได้เป็นการสาปแช่ง, 3) ไม่ได้มีความคาดหวังต่อการรักษาจะต้องหายขาด, 4)สุขภาพจิตดี ไม่เครียด อยู่ด้วยความสบายใจ ซึ่งควรใช้ลักษณะดังกล่าวในการหาผู้ให้ข้อมูลรายถัดไป<br>และพบว่ามีทั้งปัจจัยที่ขัดขวางและปัจจัยที่สนับสนุนให้เกิดการยอมรับการตาย ควรเพิ่มเติมคำถามในผู้ให้ข้อมูลรายถัดไป<br>- จากการศึกษาทั้ง 3 รายเห็นองค์หระกอบสัมคัญของการยอมรับการตายแต่ยังไม่เห็นกระบวนการที่ชัดเจนของการเดินทางมาสู่การยอมรับการตาย ควรเจาะเพิ่มเติม การยอมรับการตาย |

| Statements | Opening codes | Reflective thinking / Field notes | Others |
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| - *การที่ลุงไปวัดตรงโน้นตรงนี้ กลับไปทำบุญที่เกาะใหญ่บ้านเดิม เพื่อเป็นการแสดงให้รู้ว่าลุงยังได้เจอกับเพื่อนบ้าน แต่ที่ลุงไปทำบุญที่บ้าน เผื่อได้เห็นพี่น้อง เวลาตาย เพื่อนได้พาไปเผา ไม่ได้เชื่อทำบุญชาตินี้ส่งไปถึงชาติหน้า*<br><br>**การที่ลุงมองการตายเป็นธรรมชาติ ทุกคนต้องเจอ อะไรทำให้ลุงคิดได้แบบนั้น ลุงคิดว่าเป็นเพราะ ศาสนามั้ย**<br>- เรามอง ชีวิตเป็นเรื่องธรรมชาติ ไม่ใช่เพราะการปฏิบัติตามศาสนา ศาสนาสอนให้คน ทำดี เชื่อว่าต้องทำดี หรือมีการ*ปฏิบัติกัน คนเรา*ไม่จำเป็นต้องเข้าวัดทุกอาทิตย์ *สมาธิ สวดมนต์ ลุงไม่ได้ทำ แต่เป็นเพราะเราได้เห็นและเกิดความคิดแบบมีสติว่า คนเราพอ ตายไปแล้ว เหมือนท่อนไม้ ตายแล้วก็เหมือนเถ้าถ่าน* พอตายปุ๊บก็ไม่มีประโยชน์ กระดูกที่จริงก็ไม่ต้องเก็บเพราะลูกหลานเดี๋ยวนี้ไม่ไปไหว้กันแล้ว<br><br>**การที่ลุงเคยมีประสบการณ์เกือบตาย ลูกๆ ครอบครัว คิดยังไงบ้าง**<br>- ถ้ามีการสูญเสียบรรพบุรุษ ในครอบครัวการเสียใจก็ต้องมีมั่งนะมันเป็นเรื่องธรรมดา แต่ลูกๆ ก็ไม่กลัว ลุงเคยพูดเล่นๆ กับลูก กับเมีย ให้เค้าฟัง แต่ไม่ได้จริงจังอะไร นะว่า ตายก็คือตาย ไม่ต้องห่วง ไว้ศพสัก 3 วัน 7 วันก็พอ | หน้า ตายแล้วเกิดใหม่ หรือการทำบุญแล้วได้บุญในชาติหน้า (beliefs)<br><br>- ร่วมทำบุญที่บ้านเพื่อพบปะญาติพี่น้อง ตายได้ไปเผากัน<br><br>- การได้เห็น และคิดแบบมีสติทำให้มองการตายเป็นเรื่องธรรมชาติ (method)<br><br>- มีการพูดคุยเล่นๆ เรื่องการทำศพ (consequence) | สามารถตอบคำถามได้ทุกคำถาม<br>- ยังมียากินหลายชนิด ผู้ให้ข้อมูลมีการจัดยาไว้เป็นชุดๆ เช้า-เย็น ประกอบด้วยยา รักษาโรคหัวใจ ละลายไขมัน ยาขับปัสสาวะ และยาเบาหวาน<br><br>- สมาชิกครอบครัวมีลูกสาวทั้งหมด 3 คน ยังไม่มีครอบครัวผู้ป่วยอายุ 67 ปี มีโรคประจำตัว โรคหัวใจและเบาหวาน เคยมีประสบการณ์เกือบตาย 2 ครั้ง เพราะลืมกินยา เป็นครั้งแรกเดือนตุลาคม 2558 อาการหายใจไม่ออก ล่าสุดเดือนธันวาคม นอนหลับหมดสติไปเลย ผู้ป่วยรับรู้ว่าถ้าถูกพาไปโรงพยาบาลไม่ทันคือต้องตาย<br><br>- **ปัจจัยที่ทำให้ผู้ให้ข้อมูลนึกถึงการตาย** 1) การมีประสบการณ์เหมือน | ของผู้ให้ข้อมูลแต่ละราย มีจุดตั้งต้นตอนไหน ใช้ระยะเวลาอย่างไร มีความเหมือนความต่างกันแต่ละบริบทอย่างไร |

| Statements | Opening codes | Reflective thinking / Field notes | Others |
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| - *ความเชื่อเรื่องการทำบุญ ลุงก็มีความเชื่อบ้าง เชื่อว่าทำแล้วเราได้สบายใจ การไปทำบุญเราได้เจอคนโน้นคนนี้ เราก็ได้คุยกัน ลุงไปเอาพัดลม ไปให้โรงพยาบาลกระแสสินที่ลุงเคยนอน ลุงคิดว่าได้ใช้ มอ มีเยอะแยะ วัดพาไปเค้าก็ไม่ได้เอามาให้คนอื่นใช้ คนอื่นได้เห็นได้ทำตามมั่ง ทำแล้วทำให้เรารู้สึกสบายใจ อยากให้คนอื่นได้ทำต่อ* เหมือนลุงให้ของลูก ลุงอยากเห็นลูกให้คนอื่นต่อ ไม่ต้องเอามาคืนลุง อยากให้สืบต่อๆ<br>**ลุงมีความคาดหวังต่อยาที่กินหรือที่รักษาอยู่ตอนนี้แค่ไหน**<br>- *ถ้าเราต่อต้านตรงนี้เราก็ไม่ต้องไป โรงพยาบาล การที่เราเจ็บป่วย ถ้าหยุดกินยาสัก 2 วันนี้ก็คือตาย มันก็จบ ไม่ได้คิดว่าหายหรือไม่หาย เมื่อป่วยก็ต้องกินยา หมอก็ให้ยาตามข้อมูลที่เราให้ ตามอาการเค้าก็ไม่ใช่ผู้วิเศษหรือเทวดา มันเป็นไปตามธรรมชาติ*<br><br>**ในครอบครัวเคยมีการพูดคุยกันบ้างหรือไม่**<br>- *ก็มีพูดเล่นๆ มั่งแต่ไม่ได้จริงจังหรือสั่งอะไรไว้ เพราะตายก็ตายอ่ะน่ะ ก็สั่งพูดเล่นๆ ไว้มั่ง ไม่ได้จริงจังอะไร ไม่บ่อย ไม่ได้คิด ไม่ได้เครียดกับการตาย*ลูกๆ ก็มีบ้างความกลัวแต่ของพันนี้เราไปห้ามไปสอนเค้าไม่ได้ มันอยู่ที่การคิด การเรียนรู้<br>เมื่อก่อน เหมือนของ*พ่อกับแม่ ลุงเตรียมไว้หมดแล้ว ตอนนั้นแม่แกอายุ 84 ปี ลุงคิดว่าการพูดถึงความตาย การเตรียมไม่ได้เป็นสาปแช่งพ่อแม่ ทุกอย่างของที่ระลึกงานศพทำไว้ล่วงหน้าหมด โลงศพ ผ้าผูกรถ เขียนแผนที่ ไว้ให้เสร็จ พอวันนั้นมาถึงก็โทรไปแปปเดียวก็* | - การทำบุญทำให้รู้สึกสบายใจ (religion practice)<br><br>- เจ็บป่วยต้องรักษา ไม่ได้คาดหวังให้หาย (expectation on treatments)<br><br>- มีการพูดสั่งไว้เล่นๆ ในครอบครัว (consequence)<br>- การกลัวหรือไม่กลัวตายอยู่ที่การคิดและการเรียนรู้ของแต่ละคน (method) | ตายไปแล้วผู้ป่วยมีการคิดถึงการตายเมื่อ 5 ปี ที่ผ่านมา เพราะมีประสบการณ์เหมือนได้ตายไปแล้ว จากการหมดซ๊อคสติไป 12 คืน จากเบาหวาน<br>2) การสูงอายุ คนแก่ก็เหมือนกล้วยสุกงอมผู้ป่วยรับรู้ว่าคนแก่ก็เหมือนต้นกล้วยพองอมสุกเป็นลูกก็ต้องตาย เหมือนคนพอร่างกายหยุดทำงานก็ต้องตาย ร่างกายไม่ทำงานก็ตาย<br>3) ระดับความรู้สึกตัวลดลงผู้ป่วยเตรียมการตายให้พ่อกับแม่ล่วงหน้าประมาณเกือบ 2 ปี เพราะตอนนั้นเค้าเริ่มไม่รู้สึกตัว จึงคิดว่าน่าจะอยู่ได้ไม่นาน<br>**ผู้ให้ข้อมูลได้ให้ความหมายความตาย**<br>1) การตาย เป็นการหยุดการทำงานของร่างกายหรืออวัยวะ ตอนหมดสติไป 12 คืน จากเบาหวาน ไม่ตาย ฟื้นขึ้นมาเพราะร่างกายกลับมาทำงานได้อีก<br>2) การตายเป็นเรื่องธรรมชาติ ทุกคนต้องเจอ เมื่อร่างกายหยุดทำงาน คนเราก็ตาย<br>- **สิ่งที่ทำให้ผู้ให้ข้อมูลยอมรับการตายหรือไม่กลัวตาย** | |

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| *เสร็จ เพราะความพร้อม ลุงเห็นมาแล้วว่ามันไม่มีความพร้อมสักงาน ไม่ว่างานใคร ลุงเลยเตรียมไว้หมดทั้งของพ่อของแม่* ไม่คิดว่าเป็นการแช่ง มันไม่ได้เสียหายตรงไหนเลย ดีกับตัวเองเสียหลาว<br>**ตอนนั้นที่เตรียมให้พ่อกับแม่นานมั๊ย**<br>- ตอนนั้นผมเตรียมให้แม่ ก็เตรียมไว้ล่วงหน้า ประมาณปีกว่าๆ ไม่ถึง 2 ปี ก่อนนั้นพ่อแม่เสีย ก็เสีย ลุงเป็นคนเตรียม *เพราะตอนนั้นเค้าไม่รู้สึกตัวแล้ว ลุงเห็นเค้า ป้ำๆ เป๋อๆ หลงๆ ลืมๆ ลุงคิดว่าเค้าน่าจะอยู่ได้ไม่นานเลยเตรียม*<br>*ตามความคิดลุงนะ คนแก่ถึงพันปรือๆ มันก็ต้องตาย หนีไม่รอด ไม่ได้เป็นการแช่งถึงการเตรียมตรงนั้นมัน ไม่ได้เสียหายตรงไหนเลย* มันดีเสียหลาวที่ได้เตรียม หมดแล้ว<br><br>**ลุงคิดว่าการยอมรับการตายตามความคิดลุงคืออะไร**<br>- *การยอมรับตาย คือการไม่กลัวตาย นี้มันคือธรรมชาติ ทุกสิ่งทุกอย่าง เป็นธรรมชาติ ทุกสิ่งทุกอย่างมันต้องตาย เหมือนต้นไม้ ต้นกล้วยพอเป็นลูก* ให้เรากินก่อน จนสุกปั๊บมันก็ต้องตาย *คนแก่ก็* | - เคยเตรียมวางแผนการตายให้พ่อแม่ (consequence)<br>- การเตรียมสำหรับการตายไม่ได้เป็นการสาปแช่ง (consequence)<br>- พ่อแม่มีอาการหลงๆ ลืมๆ และไม่รู้สึกตัว คิดว่าอยู่ได้ไม่นาน จึงเตรียมการตายให้พ่อแม่ (antecedence)<br>- สูงอายุยังไงก็ต้องตาย ไม่สามารถหลีกหนีความตายได้ (factor)<br><br>- การยอมรับการตายคือการไม่กลัวตาย (meaning of accepting death) | 1) การคิดว่าการตายเป็นเรื่องธรรมชาติ ทุกคนต้องตายผู้ป่วยมีประสบการณ์เห็นผู้อื่นตายมามากแต่ไม่กลัวตายของคนเหล่านั้นเพราะผู้ป่วยมองการตายเป็นเรื่องธรรมชาติ<br>2) การสูงอายุไม่นานก็ต้องตายผู้ป่วยคิดว่าคนถ้าสูงอายุ ยังไงก็ต้องตาย เป็นสิ่งที่หลีกหนีไม่พ้น 3) ลูกไม่ได้เป็นตัวขัดขวางการยอมรับการตายผู้ป่วยคิดว่าลูก คนในครอบครัว ไม่ได้เป็นสิ่งที่ทำให้ผู้ป่วยไม่ยากตาย เพราะลูกมีการมีงานทำ แค่ถึงลูกจะยังเรียนไม่จบก็ไม่ได้เป็นตัวขัดขวางเพราะผู้ป่วยมองเรื่องนี้เป็นเรื่องธรรมชาติ และแก้ปัญหานี้ได้ ถ้ามีการเตรียมอยู่ตลอด<br>**ปัจจัยขัดขวางการยอมรับการตาย คือ**<br>1) การกลัวตายหรือการคิดไม่เป็นผู้ป่วยรับรู้ว่าสิ่งที่เป็นตัวขัดขวางไม่ให้ยอมรับการ คนที่กลัวตายหรือคิดไม่เป็นเป็น<br><br>**ความหมายของการยอมรับการตายคือ**<br>1) การไม่กลัวตาย การตายเป็นเรื่อง | |

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| *เหมือนต้นกล้วย พอสุกปุ๊ป ก็ต้องตาย คนก็เหมือนกัน กล้วยพองอมหัวตกแล้ว เพราะร่างกายหยุดทำงานก็คือตายก็เท่านั้น วิญญาณนี้ช่วยไม่ได้ไม่มี มันประคับประคองร่างกายไม่รอด มันอยู่ได้กับร่างกาย ถ้าร่างกายทำงานได้ก็อยู่ ถ้าร่างกายไม่ทำงานก็ตาย ไม่กลัวตาย มองการตายเป็นธรรมชาติ* | - การตายเป็นเรื่องธรรมชาติทุกสิ่งจะต้องตาย (meaning of death)<br>- คนแก่เหมือนต้นกล้วยสุกงอมและก็ต้องตาย (factor)<br>- ไม่กลัวตายเพราะมองการตายเป็นเรื่องธรรมชาติ (factor) | ธรรมชาติ สิ่งมีชีวิตทุกสิ่งก็ต้องตาย เช่น ต้นกล้วยพอเป็นลูกตามมาก็ต้องตาย<br>2) การยอมรับความเป็นจริงตามธรรมชาติผู้ป่วยรับรู้ว่าคนที่ไม่ยอมรับการตาย จะอยู่กับความหลอกลวงเพราะเค้าไม่สามารถยอมรับความจริง | |
| **อะไรทำให้ลุงคิดว่ามองว่าการตายเป็นธรรมชาติ**<br>- *เพราะจากประสบการณ์ลุงเห็นคนไม่ยอมรับการตาย เป็นคนที่ไม่ยอมรับความจริง เค้าจะอยู่กับสิ่งที่หลอกลวง* เคยบวช 1 พรรษา และตอนหายป่วยเพราะลูกหลานบ่นไว้ ก็บวชอีกประมาณเดือนกว่า แต่ลุงคิดว่าการบวช*ก็ไม่ได้ช่วยทำให้จิตใจดีหรือยอมรับการตาย แต่มันอยู่ที่จิตใจเรา อยู่ที่การรับรู้ เราเรียนรู้มา ศาสนาก็ไม่ได้ช่วย พอเราเห็นจากประสบการณ์ ทำให้เกิดการเรียนรู้ เกิดความคิด ถ้าเรารู้แล้วไม่ปฏิบัติ เรียนไปทำไม บางอย่างไม่เรียน ก็ปฏิบัติได้เพราะเรียนรู้ด้วยตนเอง* | - คนไม่ยอมรับการตายคือคนที่ไม่ยอมรับความจริง (meaning of accepting death)<br>- การยอมรับการตายเกิดจากการเรียนรู้ การคิดได้ด้วยตนเอง (method) | **ผู้ให้ข้อมูลมีวิธีการในยอมรับการตาย** โดย<br>1) การได้เห็น และคิดแบบมีสติจนทำให้มองการตายเป็นเรื่องธรรมชาติผู้ป่วยรับรู้ว่าการที่มองความตายเป็นธรรมชาติ ไม่ใช่เพราะศาสนา เป็นเพราะการเรียนรู้ได้เห็น ทำให้คิดแบบมีสติ ว่าเมื่อตายแล้วก็เหมือนท่อนไม้ เหมือนเถ้าถ่าน เมื่อตายก็ไม่มีประโยชน์ | |
| **เคยมีประสบการณ์การเสียชีวิตคนรอบข้างบ้างหรือไม่**<br>- *การเสียชีวิตของคนลุงก็เห็นมาบ่อย แต่ไม่กลัวเพราะลุงมองเป็นเรื่องธรรมชาติ* เมื่อก่อนลุงขับรถตุ๊กๆ ด้วย ตอนนั้นพอคนตายปุ๊บลุงไปไปบรรทุกให้เค้าทันที ทำแล้วทำให้รู้สึกประทับใจที่ได้ | - ไม่กลัวการตายเพราะมองการตายเป็นเรื่องธรรมชาติ (factor) | - ผู้ป่วยคิดว่าบางคนรู้ว่า การตายเป็นเรื่องธรรมชาติ แต่ไม่สามารถยอมรับการตายได้ ขึ้นอยู่กับการความพร้อม การคิด และการมองการรู้จักธรรมชาติ รู้จักเข้าใจ สรีระภาพคนที่เป็นไปตามธรรมชาติเป็นสิ่งที่ทำให้ไม่เครียด | |

| Statements | Opening codes | Reflective thinking / Field notes | Others |
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| ช่วยคน ในขณะที่คนอื่นเค้ากลัว การบรรทุกศพ กลัวไม่กล้าทำ<br><br>**ตัวขัดขวางไม่ให้เรามองการตายเป็นเรื่องธรรมชาติ**<br>- *คือคนที่ไม่กล้า คนกลัว คนที่ไม่คิดไม่เป็น เหมือนคนที่ชอบขัดเหมือนการเตรียมงานให้พ่อกับแม่ แต่ก็มีญาติพี่น้องขัด ขวางนี้คือเป็นตัวขัดขวาง*<br><br>**การที่มีลูก คนในครอบครัว เป็นห่วงลูก และครอบครัวเป็นตัวทำให้เรากลัวตาย ไม่ยากตายบ้างหรือไม่**<br>- *ลุงไม่ห่วงเพราะลุงว่ามันเป็นเรื่องธรรมชาติลูกๆ ก็เรียนจบมีการมีงานทำ แต่ถ้าสมมุติเค้ายังไม่จบ เราก็แก้ปัญหาก่อนได้ มันก็ต้องมีการเตรียม ตอนนั้นลุงทำงานลุงก็เตรียมซื้อประกันอุบัติเหตุไว้ทุกปี ๆ แล้วแต่พร้อมไม่พร้อมสมมุติเกิดอะไรมาลูกพร้อมที่จะเดินต่อไปได้การเตรียมความคิดสร้างสรรค์นี้ช่วยได้มากที่สุด*<br>ถ้าเรามี ความเครียด ความกลัว ไม่ได้ช่วยอะไร *ความกลัวตายทำให้เกิดความเครียด จะไปงานไม่กล้าไป กลัวเดินทางรถจน มันไม่ได้อะไรขึ้นมา มันบ้าเสียเปล่าๆ และสุขภาพจิตมันเสียเปล่าๆ ถ้าจิตเสียร่างกายก็จะโทรมมันโยงกันไปหมด บางคน รู้ความตายเป็นเรื่องธรรมชาติ แต่ก็ทำใจยอมรับไม่ได้ มันขึ้นอยู่กับความพร้อม ความคิด การเตรียม การรู้จักคิด การรู้จักธรรมชาติ มองเป็นธรรมชาติ เราต้องปรับให้เป็นไปตามธรรมชาติ สรีระร่างกายของคนเรามันไม่เท่ากัน ขนาดคนอยู่ดีกินดีกว่าก็อาจจะร่างกายแย่กว่าก็ได้ อยู่กับธรรมชาติของแต่ละคน การ* | - การกลัวตาย คิดไม่เป็น จะเป็นตัวขัดขวางการยอมรับการตายเป็นเรื่องธรรมชาติและการเตรียมตัวสำหรับการตาย (factor)<br><br>- ลูกไม่ได้เป็นตัวขัดขวางการทำให้ผู้ป่วยไม่ยากตายหรือยากต่อยอมรับการตาย (factor)<br>- การมองการตายเป็นเรื่องธรรมชาติ ทำให้มีการคิดการเตรียมทำให้ลูกเดินต่อไปได้ (method)<br>- การกลัวตายทำให้สุขภาพจิตไม่ดีทำให้ร่างกายทรุดโทรมไปด้วย (consequence) | 2) ประสบการณ์ การเรียนรู้ และการคิดของแต่ละคน ผู้ป่วยรับรู้ว่าการบวช และศาสนาไม่ได้ทำให้จิตใจดีขึ้น หรือทำให้ยอมรับการตาย การยอมรับการตายจะอยู่ที่การรับรู้ ประสบการณ์ทำให้เกิดการเรียนรู้ การคิด และปฏิบัติ บางอย่างไม่จำเป็นต้องเรียนรู้ ก็ปฏิบัติได้ถ้ามีการเรียนรู้ด้วยตนเอง<br>**ผลลัพธ์ของการยอมรับการตาย**<br>การยอมรับการตายส่งผลให้เกิดสิ่งเหล่านี้ตามมา<br>1) มีการพูดคุยเล่นๆ วางแผนงานศพของตนเองผู้ป่วยได้มีการพูดคุย เล่นๆ โดยการสั่งลูกๆ ไว้บ้าง แต่ไม่บ่อย เพราะผู้ป่วยคิดว่าตายก็ตายไม่ได้เครียดกับเรื่องการตาย แต่ผู้ป่วยบอกว่าลูกๆ อาจมีกลัวกันบ้าง ผู้ป่วยไม่สามารถไปห้ามไม่ให้ลูกกลัวได้เพราะผู้ป่วยคิดว่าเรื่องแบบนี้อยู่ที่การคิดและการเรียนรู้ของเขา<br>2) มองเรื่องการเตรียมวางแผนการตายไม่ได้เป็นการสาปแช่งมีการเตรียมงานศพให้พ่อแม่ | |

| Statements | Opening codes | Reflective thinking / Field notes | Others |
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| *เข้าใจธรรมชาติเป็นสิ่งทำให้เราไม่เครียด*<br><br>**การที่เราไม่กลัวความตายส่งผลชีวิตอย่างไร**<br>- *การไม่กลัวตายส่งผลเราอยู่ด้วยความไม่เครียด สุดท้ายก็สบายใจ และมันก็จะส่งผลดีต่อทางกาย* | - การยอมรับการตายอยู่ที่การคิดและการรู้จักเข้าใจธรรมชาติ (method)<br><br>- การอยู่แบบเข้าใจธรรมชาติทำให้ไม่เครียด (consequence)<br>- ไม่กลัวตาย สบายใจ สุขภาพดี (consequence) | ผู้ป่วยเคยเตรียมการตายให้พ่อกับแม่ มองการได้เตรียมเป็นการดีเสียอีกไม่ได้เสียหาย แต่เป็นความพร้อม เมื่อมีการตายเกิดขึ้น ที่ผ่านมาไม่เคยเห็นงานใครพร้อม<br>3) ไม่ได้มีความคาดหวังต่อการรักษาจะต้องหายขาดผู้ป่วยรับรู้ว่าการเจ็บป่วยของตนเองถ้าหยุดยาสัก 2 วัน มันก็จบด้วยการตาย การที่รักษาเพราะคิดว่าเจ็บป่วย เป็นเรื่องธรรมดาที่ต้องรักษาไม่ได้คาดหวังว่าจะให้หาย<br>4) สุขภาพจิตดี ไม่เครียด อยู่ด้วยความสบายใจผู้ป่วยคิดว่า การกลัวตายเป็นสิ่งที่ทำให้เกิด ความเครียด ทำให้สุขภาพจิตไม่ดี นำไปสู่ร่างกายทรุดโทรมไปด้วยเพราะมันโยงกันหมด<br>- ผู้ป่วยรับรู้ว่าการไม่กลัวตาย ทำให้อยู่ด้วยความสบายใจ ส่งผล ทำให้ดีต่อสุขภาพทางกาย<br>5) ผู้ป่วยไม่เคยคิดถึงการตายเลยเพราะคิดว่าคนเราจะตายก็ตาย<br>**ความเชื่ออื่นๆ ทางศาสนา**<br>- ผู้ป่วยไม่มีความเชื่อเรื่องจิต | |

| Statements | Opening codes | Reflective thinking / Field notes | Others |
|---|---|---|---|
| | | วิญญาณหรือชาติหน้า ไม่เชื่อตายแล้วต้องเกิดใหม่ในที่ต่างๆ ไม่เชื่อการทำบุญแล้วจะได้บุญ<br>- ผู้ป่วยรับรู้ว่าการทีตนเองทำบุญที่บ้านเพื่อได้พบปะเพื่อนบ้าน พี่น้อง เผื่อตอนตนเองตายเพื่อนพี่น้องได้พาไปเผา<br>- ผู้ป่วยรับรู้ว่าถ้าตนเองเสียชีวิตลูกและภรรยาอาจเสียใจบ้างเป็นเรื่องธรรมดา แต่ลูกๆ ไม่ได้กลัว ในครอบครัวมีการพูดคุยเล่นๆ ถ้าตนเองตายไม่ต้องห่วง ให้ไว้ศพ<br>- ผู้ให้ข้อมูลเชื่อว่าการทำบุญทำให้ ทำแล้วทำให้รู้สึกสบายใจ การไปทำบุญทำให้ได้เจอเพื่อนพูดคุย | |

**Objectives of the Research**

To discover the process of death acceptance among Thai Buddhist older persons with chronic organ failure

| Research questions | Axial coding | | Selecting coding |
|---|---|---|---|
| | subcategories | categories | |
| **Antecedence** | -มีประสบการณ์เหมือนตายไปแล้วทำให้นึกถึงการตาย (3) | มีประสบการณ์เกือบเสียชีวิต | |
| | - ความ แก่ มีอายุเยอะขึ้น ทำให้ร่างกายทรุดโทรมมีการคิดถึงความตาย (1)<br>- คนแก่เหมือนต้นกล้วยสุกงอมและก็ต้องตาย (3)<br>- สูงอายุยังไงก็ต้องตาย (3)<br>- การสูงอายุ เหมือนไม้ใกล้ฝั่ง (2)<br>- ความแก่ มีอายุเยอะขึ้นทำให้ร่างกายทรุดโทรม(1) | ร่างกายทรุดโทรมจากการสูงอายุ | |
| | - การต้องเข้านอนโรงพยาบาลทำให้ผู้ป่วยนึกถึงการตาย (2)<br>- การมีหัวใจเต้นผิดจังหวะ วูบ ต้องเข้าห้องไอซียูทำให้นึกถึงความตายอีกครั้ง | ต้องเข้านอนโรงพยาบาล | |
| | - หอบมาก หายใจไม่ออกทำให้คิดถึงการตาย (2)<br>- มีอาการที่ทรุดลงหรือแย่ลง กินไม่ได้ น้ำหนักลดมีการนึกถึงความตาย (1)<br>- คิดถึงการตายเมื่อมีหัวใจเต้นผิดจังหวะ (1)<br>- พ่อแม่มีอาการหลงๆ ลืมๆ และไม่รู้สึกตัว คิดว่าอยู่ได้ไม่นาน จึงเตรียมการตายให้พ่อแม่ (3) | มีอาการทรุดหนัก | |
| **Perceptions** | - การตายเป็นเรื่องธรรมชาติทุกคนต้องเจอ (3) | เป็นเรื่องธรรมชาติ | |

| Research questions | Axial coding | | Selecting coding |
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| | **subcategories** | **categories** | |
| | - คิดว่าการตายเป็นเรื่องธรรมดา (2)<br>- การตายเป็นเรื่องธรรมดา(2)<br>- ทุกคนต้องตายการตายเป็นเรื่องธรรมชาติ (2)<br>- ความตายเป็นเรื่องธรรมชาติ คำพระคือ อนิจจัง เกิด แก่เจ็บตายเป็นเรื่องธรรมดา (2)<br>- การตายเป็นของแท้แน่นอนที่ทุกคนต้องเจอ (2)<br>- การเกิดกับการตายเป็นของคู่กัน (2) | | |
| | - การตายเป็นการหยุดทำงานของร่างกาย (3)<br>- การตายเป็นการตายของร่างกายแต่จิตยังอยู่ (1)<br>- การตายเป็นการตายของร่างกายจิตไม่ตาย (1)<br>- ถ้าไม่กินก็ตาย เจ็บไข้ไม่รักษาก็ตาย (1) | การหยุดการทำงานของร่างกาย | |
| | - การตายเป็นเหมือนการแทงเข็มเจ็บเมื่อรับรู้ครั้งแรก (1)<br>- การตายทำให้ความเจ็บปวดหายไป (1) | ทำหลุดพ้นความเจ็บปวด | |
| **Perceptions of accepting death** | -การยอมรับการตายคือการไม่กลัวตาย (3) | การไม่กลัวตาย | |
| | - คนไม่ยอมรับการตายคือคนที่ไม่ยอมรับความจริง (3)<br>- การยอมรับการตายคือการยอมรับความเป็นจริงที่เป็นไปตามธรรมชาติ ทุกคนเกิดมาต้องตาย (2) | การยอมรับความเป็นจริง | |
| **Methods** | - การได้เห็นและคิดแบบมีสติทำให้มองการตายเป็นเรื่องธรรมชาติ (3) | การเรียนรู้และการคิด | |

| Research questions | Axial coding | | Selecting coding |
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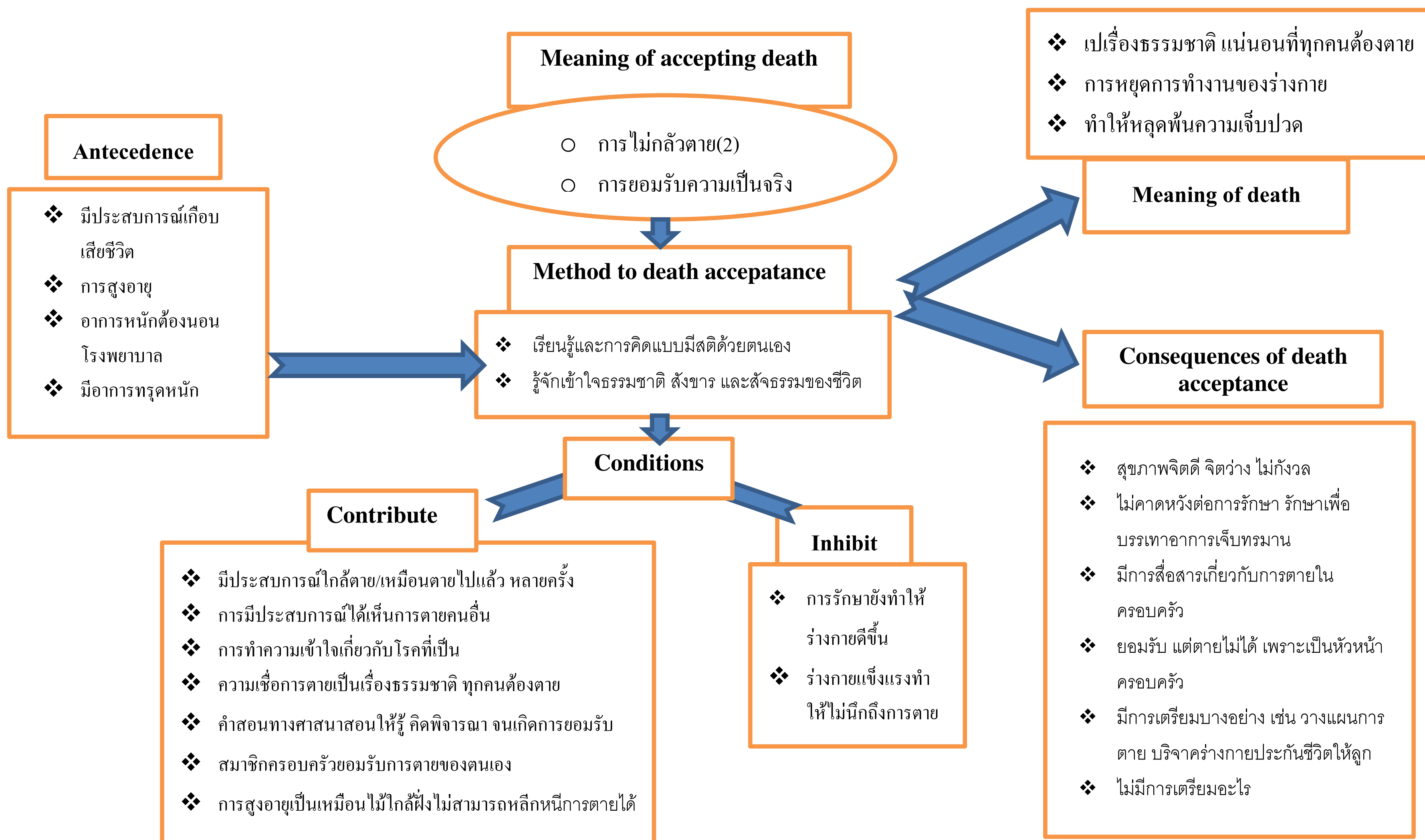
| | subcategories | categories | |
| | - การยอมรับการตาย เกิดจากการเรียนรู้ การคิดได้ด้วยตนเอง (3)<br>- การกลัวหรือไม่กลัวตายอยู่ที่การคิดและการเรียนรู้ของแต่ละคน (3) | แบบมีสติด้วยตนเอง | |
| | -การยอมรับการตายอยู่ที่การคิดและการรู้จักเข้าใจธรรมชาติ (3)<br>-รู้แต่ไม่ยอมรับสัจธรรมก็ทำให้ไม่สามารถยอมรับการตายได้ (2)<br>-รู้และเข้าใจเรื่องสังขาร และ ต้องยอมรับ อนิจจัง ทุกข์ขัง อนัตตา ทำให้ยอมรับการตาย (2)<br>- การพิจารณา เข้าใจเรื่อง สัจธรรมทำให้ยอมรับการตาย (2)<br>- การรับรู้ว่าต้องตายแน่ๆ ครั้งแรกรู้สึก ท้อแท้ ร้องไห้ หมดใจ (1) | รู้จักเข้าใจธรรมชาติ สังขาร และสัจธรรมของชีวิต | |
| **Factors** | -เคยมีประสบการณ์เกือบตาย 2 ครั้ง หมดสติ หายใจไม่ออก (3)<br>- ไม่กลัวตายคือการผ่านประสบการณใกล้ตายมาหลายครั้ง (1) | มีประสบการณ์ใกล้ตายเหมือนตายไปแล้วหลายครั้ง | |
| | - การได้เห็นคนเกิดคนตายบ่อยๆ ทำให้มองการตายเป็นเรื่องธรรมดา (2)<br>- ประสบการณ์การได้เห็นการตายของคนอื่นทำให้ยอมรับการตายได้มากขึ้น (1)<br>-การมีเจอประสบการณด้วยตนเองอ่านศึกษาทำความเข้าใจ ทำให้เชื่อ ยอมรับ (1) | การมีประสบการณ์ด้วยตนเองและการได้เห็นการตายคนอื่น | |
| | -การมีอาการที่ทรุดลงและการอ่านคู่มือทำความเข้าใจทำให้ผู้ป่วยยอมรับการเป็นโรคและยอมรับการรักษา (1) | การทำความเข้าใจเกี่ยวกับโรคที่เป็น | |
| | - ไม่คิดถึงการตายเพราะคนเราจะตายมันก็ตาย (3) | ความเชื่อการตายเป็น | |

| Research questions | Axial coding | | Selecting coding |
|---|---|---|---|
| | subcategories | categories | |
| | - ไม่กลัวการตายเพราะมองการตายเป็นเรื่องธรรมชาติ (3)<br>- การกลัวตาย คิดไม่เป็น จะเป็นตัวขัดขวางการยอมรับการตายเป็นเรื่องธรรมชาติและการเตรียมตัวสำหรับการตาย (3)<br>- ความคิด ทุกคนก็ต้อง ตายทำให้ไม่กลัวตาย (1)<br>-ความเชื่อศาสนาทุกคนต้องตายทำให้ไม่กลัว/ยอมรับการตาย (1) | เรื่องธรรมชาติ ทุกคนต้องตาย | |
| | - ฟอกเลือดร่างกายแข็งแรงไม่เคยคิดถึงการตายเลย (1)<br>- การเชื่อมั่นในการรักษาของหมอ ยาที่รักษา ความแข็งแรงของร่างกายตน ทำให้นึกถึงการตายน้อยลง (1)<br>- เข้มแข็ง ไม่ใจเสาะ (1)<br>- เชื่อหมอและยาที่รักษา (1)<br>- ไม่คิดถึงการตาย ถ้ารักษาอาการดีขึ้น (1) | การรักษายังทำให้ร่างกายดีขึ้น แข็งแรงทำให้ไม่นึกถึงการตาย | |
| | - ศาสนา/ความเชื่อทางศาสนาสอนให้คนศึกษาพิจารณานำมาสู่การยอมรับหรือการปฏิบัติ (2)<br>- ศาสนาสอนให้ศึกษา คิด เข้าใจและนำมาสู่การปฏิบัติ (2)<br>- ประสบการณ์การพูดคุยกับคนทางศาสนา ชีวิตคนเมื่อตายเหมือนไม้ผุ ไม่มีประโยชน์ (2)<br>- คำสอนศาสนา เกี่ยวกับสังขารไม่เที่ยง การเกิด แก่เจ็บ ตายเป็นเรื่องธรรมดาทำให้ | คำสอนทางศาสนาสอนให้รู้ คิดพิจารณา จนเกิดการยอมรับ | |

| Research questions | Axial coding | | Selecting coding |
|---|---|---|---|
| | **subcategories** | **categories** | |
| | ยอมรับการตาย (2)<br>- ศาสนาสอนให้ได้เรียนรู้ เกิดการคิดและนำไปสู่การปฏิบัติ (2) | | |
| | - ต้องเข้มแข็งเพราะตายไม่ได้ มีภาระหัวหน้าครอบครัว (1)<br>- ลูกไม่ได้เป็นตัวขัดขวางการทำให้ผู้ป่วยไม่อยากตายหรืออยากต่อยอมรับการตาย (3)<br>- ลูกเมียเป็นกำลังใจ ไม่คิดมาก (1)<br>- พบปะเพื่อนทำให้ได้ระบายและได้กำลังใจ (1) | ยอมรับ แต่ตายไม่ได้เพราะเป็นหัวหน้าครอบครัว | |
| | - คนแก่เหมือนต้นกล้วยสุกงอมและก็ต้องตาย (3)<br>- สูงอายุยังไงก็ต้องตายไม่สามารถหลีกหนีความตายได้ (3)<br>- การสูงอายุ ไม้ใกล้ฝั่ง ทำให้ผู้ป่วยคิดว่าการตายเป็นเรื่องธรรมดา (2)<br>- ความ แก่ มีอายุเยอะขึ้น ทำให้ร่างกายทรุดโทรม ทำให้ไม่กลัวตาย (1) | การสูงอายุเป็นเหมือนไม้ใกล้ฝั่งไม่สามารถหลีกหนีการตายได้ | |
| | -ลูกๆ ยอมรับ เข้าใจการบริจาคร่างกายทำให้ผู้ป่วยสบายใจไม่กังวล (2) | สมาชิกครอบครัวยอมรับการตายของตนเอง | |
| **Consequences** | - การอยู่แบบเข้าใจธรรมชาติทำให้ไม่เครียดการกลัวตายทำให้สุขภาพจิตไม่ดีทำให้ร่างกายทรุดโทรมไปด้วย (3)<br>- ไม่กลัวตาย สบายใจ สุขภาพดี (3)<br>- การยอมรับการตายทำให้อยู่จิตว่างสบายใจ (2) | อยู่อย่างสุขภาพกายดีและสุขภาพจิตว่าง ไม่กังวล | |

| **Research questions** | **Axial coding** | | **Selecting coding** |
|---|---|---|---|
| | **subcategories** | **categories** | |
| | - สุขภาพจิตที่ดีมีผลต่อสุขภาพกายที่ดี (2) | | |
| | - คาดหวังการรักษา เพื่อบรรเทาอาการไม่ให้เจ็บทรมาน (2)<br>- เจ็บป่วยต้องรักษาไม่ได้คาดหวังให้หาย (3)<br>- ไม่ควรยื้อชีวิต ทำให้ทรมาน ควรปล่อยให้ไปพบพระ (2) | ไม่คาดหวังต่อการรักษา รักษาเพื่อบรรเทาอาการเจ็บทรมาน | |
| | -มีการพูดเล่น สั่งให้ลูกหลานตลอดให้มอบศพให้โรงพยาบาล (2)<br>-พูดบ่อยๆ เพื่อให้ลูกหลานคิดเข้าใจการตายเป็นเรื่องธรรมดา (2)<br>- มีการพูดถึงความตายกับลูกๆ หลานๆ ตลอด (2)<br>- มีการพูดสั่งไว้เล่นๆ ในครอบครัว (3)<br>- มีการพูดคุยเล่นๆ กับลูกเกี่ยวกับการวางแผนงานศพ (3) | มีการสื่อสารเกี่ยวกับการตายในครอบครัว | |
| | - การเตรียมสำหรับการตายไม่ได้เป็นการสาปแช่ง (3)<br>-เคยเตรียมวางแผนการตายให้สำหรับพ่อแม่ (3)<br>- การมองการตายเป็นเรื่องธรรมชาติ ทำให้คิด เตรียม ทำให้ลูกเดินต่อไปได้<br>-บริจาคร่างกายให้คนอื่นได้เรียนรู้ (2) | มีการเตรียมบางอย่าง เช่น บริจาคร่างกาย เตรียมประกันชีวิตให้ลูก วางแผนการตาย | |
| | -ไม่มีการเตรียมตัวเกี่ยวกับความตายเพราะคิดว่าอยู่ได้อีกนาน (1)<br>-อย่างอื่นไม่ได้เตรียมอะไรเพราะมันเป็นไปตามธรรมชาติ (2) | ไม่มีการเตรียมอะไร | |

# Selecting Coding



## APPENDIX E

## CONSTANT COMPARATIVE AND THEORETICAL SAMPLING

| Constant comparative and theoretical sampling | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **No** | **Gender** | **Ages** | **Marital status** | **Education level** | **Occupational status** | **Type of diagnosis** | **Time period of diagnosed (years)** | **Type of treatments** | **Theoretical sampling** | **Remarked** |
| 1 | Male | 73 | Married | High school | retired | COPD | 30 | Inhaler | Preparing for their death (donated their body before retilement) | Accepted their death before he had been diagnosed with end stage of disease (near death experienced) |
| 2 | Male | 62 | Married | High school | retired | ESRD | 15 | H/D | Difference disease, Male with low ages | Accepted their death after he had various near death experiences |
| 3 | Male | 67 | Married | Primary school | unemployed | CHF, COPD | 17 | medications | Who had experienced of near death, Difference disease, | Accepted their death when he had near death experienced |
| 4 | Female | 65 | Widow | Primary | unemployed | HT, | 5 | CAPD | Time of | Accepted their death |

| Constant comparative and theoretical sampling | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **No** | **Gender** | **Ages** | **Marital status** | **Education level** | **Occupational status** | **Type of diagnosis** | **Time period of diagnosed (years)** | **Type of treatments** | **Theoretical sampling** | **Remarked** |
| | | | | school | | DM,ESRD | | | diagnosed lower, difference gender | after their children had graduated and had their own family. |
| 5 | Female | 60 | Widow | Primary school | unemployed | HT, ESRD | 4 | H/D | Female , Difference of treatment | Accepted their death after their children had graduated and had their family. |
| 6 | Female | 66 | widow | Primary school | unemployed | Thyroid, CHF | 30 | Medications | female, difference of disease, long time of diagnosed | Accepted their death after she had no one in their life. |
| 7 | Male | 81 | Married | Primary school | employed | COPD | 19 | Medications | Male with high age | Accepted their death after he had several near death experiences. |
| 8 | Male | 65 | Widow | Primary school | unemployed | COPD, CHF | 5, 10 | Medications | Male with lower aged, short time of diagnosed | Accepted their death when their wife died. |
| 9. | Male | 62 | Married | Primary | unemployed | HT, | 14 | H/D | Male, low | Accepted their death |

| Constant comparative and theoretical sampling | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **No** | **Gender** | **Ages** | **Marital status** | **Education level** | **Occupational status** | **Type of diagnosis** | **Time period of diagnosed (years)** | **Type of treatments** | **Theoretical sampling** | **Remarked** |
| | | | | school | | ESRD | | | age, long time of diagnosed | after he had many near death experiences. |
| 10 | Female | 81 | widow | Primary school | unemployed | HT, ESRD | 12 | H/D | Female, High ages, long time of diagnosed | Accepted their death before being diagnosed with ESRD, no need someone need to concerned, and she had reached a good age. |
| 11 | Female | 84 | widow | Primary school | unemployed | HT, ESRD | 9 | H/D | Female, High age, long time of diagnosed | Accepted their death after diagnosed with ESRD and she had been seeing the death experiences of other. |
| 12 | Male | 61 | Married | High school | retiled | HT, ESRD | 12 | H/D | Male, low age, long time of period | Accepted their death after their children had graduated and families.. |
| 13 | Female | 67 | Married | High school | retiled | DM, HT, MI, CHF | 1 | Medication | Female, difference of disease , | Accepted their death after her children had graduated and she had |

| Constant comparative and theoretical sampling | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| **No** | **Gender** | **Ages** | **Marital status** | **Education level** | **Occupational status** | **Type of diagnosis** | **Time period of diagnosed (years)** | **Type of treatments** | **Theoretical sampling** | **Remarked** |
| | | | | | | | | | married | learned about death from Buddhist practicing.. |
| 14 | Male | 65 | widow | Primary school | unemployed | MI, CHF | 4 | Medication | Male, Widow, same disease and same age | Accepted their death from having expeiences seeing death of others. |
| 15 | Female | 60 | Married | Primary school | unemployed | DM, ESRD | 3 | H/D | Female, married, Low age, short period of time diagnosed | Accepted their death in initial of diagnosed with ESRD. |
| 16 | Male | 64 | Married | High school | retiled | HT, STEMI, CHF | 4 | Medication | Male, low age, difference of disease | Accepted their death after their children had graduated. |

# APPENDIX F

## CODES, CONCEPTS, SUB-CATEGORIES, AND CATEGORIES

| **Category 1: Negotiating of their own death** | | |
|---|---|---|
| **Recognizing their own death but not ready to die**<br><br>**Encountered the life threatening situation**<br>- Informed by their medical doctors their disease reached the end stage and was not reversible.<br>- Experienced life threatening situation with worsening symptoms.<br>- Facing near death experience<br>**Feel fear of their own death because they were more concerning both their children and their families** | **Taking action to maintain health**<br>- Learning more about their illnesses and treatments by searching for health information and reading books regarding how to manage their illnesses.<br>- Modifying health behaviors or trying to do everything to get better.<br>- Adhering to medical treatments as long as possible.<br>- Seeking emotion support/ Holding the spirit | **Hoping for a longer life.** |
| **Category 2: Neutralizing fear of death** | | |
| **Realizing that death is inevitable**<br>- Repeating experienced life-threatening situations and were hospitalized due to acute exacerbated symptoms.<br>- Repeated experiences of near death.<br>- Getting older and their health became deteriorated due to the progression of their disease(s) | **Thum-jai: reflecting on their own death.**<br>**- Confronting with experienced seeing death sense of others.** (Friends with similar disease, their relative and significant persons. | **Accept the truth of life and death.** |

| Category 3: Affirming impending death | | |
|---|---|---|
| **Mobilizing Buddhist faith. Their previous experiences of the Buddhist teachings.**<br>- Anatta<br>- The principle of natural law (Born, old, sick, and death which are normal things for human life.<br>- The principle of rebirth and the law of Kamma (cause-effect). | **Engaging in religious practice.**<br>- Making merit makes our mind comforting<br>- Meditation for being with conscious and mind comforting.<br>- Chanting or praying for forgiveness and peaceful in mind<br>- Dhamma reading make a comforting | **Accepting their own death.**<br>- Understand the truth of life/ accept the reality of life<br>- Reassuring (Thum-jai) that one day the death will come<br>- Being with not fearing on death.<br>- Letting go with their death/ let it go |
| **Category 4: Transcending of death acceptance** | | |
| **Having mindfulness and being in a peaceful state of mind** | **Preparing a peaceful death**<br>**Preparing self**<br>- Making merit (Doing good thing before death)<br>-Making a treatment plan to die peacefully.<br><br>**Preparing others**<br>- Talking over death issues within family members.<br>- Managing business task, funeral and death rituals. | **Living well**<br>- Harmonious stage both body and mind<br>- had a purpose in life.<br>-a desire to continuous living while being ready to die any moments.<br><br>**Dying well**<br>- Being ready to die at any moments.<br>- Being able to communicate about death as normal and auspicious. |

## APPENDIX G

## ETHICS COMMITTEE APPROVAL

ที่ ศธ ๐๕๒๑.๑.๐๕/ ๒๖๔๘

คณะพยาบาลศาสตร์
มหาวิทยาลัยสงขลานครินทร์
ถ.กาญจนวนิชย์
อ.หาดใหญ่ จ.สงขลา ๙๐๑๑๐

หนังสือฉบับนี้ ให้ไว้เพื่อรับรองว่า นางสาวทัศนีย์ ขาว รหัสนักศึกษา ๕๖๑๐๔๓๐๐๐๗ นักศึกษาหลักสูตรปรัชญาดุษฎีบัณฑิต สาขาวิชาการพยาบาล (หลักสูตรนานาชาติ) คณะพยาบาลศาสตร์ มหาวิทยาลัยสงขลานครินทร์ มีความประสงค์ที่จะทำวิทยานิพนธ์ เรื่อง "Life Journey to Death Acceptance among Thai Buddhist with Advanced Chronic Organ Failure" โดยมีรองศาสตราจารย์ ดร.กิตติกร นิลมานัต เป็นอาจารย์ที่ปรึกษาวิทยานิพนธ์ ทั้งนี้ วิทยานิพนธ์ของนักศึกษาได้ผ่านการพิจารณาด้านจริยธรรมจากคณะกรรมการประเมินงานวิจัยด้านจริยธรรม และสอบโครงร่างวิทยานิพนธ์ผ่านเมื่อวันที่ ๑๙ พฤษภาคม ๒๕๕๙ แล้ว

ให้ไว้ ณ วันที่ ๒ พฤศจิกายน ๒๕๕๙

(รองศาสตราจารย์ ดร.อรัญญา เชาวลิต)
คณบดีคณะพยาบาลศาสตร์

# VITAE

**Name** Miss Tusanee Khaw

**Student ID** 5610430007

**Educational Attainment**

| Degree | Name of Institution | Year of Graduation |
|---|---|---|
| Master of Nursing Science (Adult Nursing) | Faculty of Nursing Prince of Songkla University | 2008 |
| Bachelor of Nursing Science(Nursing and Midwifery) | Faculty of Nursing Prince of Songkla University | 2002 |

**Scholarship Awards during Enrolment**

1. Research grant from Graduate School, Prince of Songkla Universisty, Thailand.
2. Grand support for 50% PhD from Faculty of Nursing, Prince Songkla Universisty and Prince of Songkla Universisty.

**Work – Position and Address**

From 2009 to the present, Lecturer in Adult and Elderly Department (Medical Nursing), Faculty of Nursing, Prince of Songkla University, Hat Yai, Songkhla, Thailand, Prince of Songkla University.

From 2002 to 2009, register nurse in female medical ward, Songklanagarind Hospital, Faculty of Medicine, Prince of Songkla University, Hat Yai, Songkhla, Thailand.

**List of publication and presentation**

Khaw, T., Thaniwattananon, P., & and Kongsuwan, W. Palliative Care Programs in Elderly Patients: A literature Review. (2015, 16-17 May) Oral presented Award in *More than 2 Decades of Graduate Nursing Study Faculty of Nursing, Prince of Songkla University,* Songkla, Thailand.

Khaw, T., Nilmanat. K., Thaniwattananon, P., & Kongsuwan, W. (2017, 20-22 October). Perception of Death among Thai Buddhist Elderly with Advanced Chronic Organ Failure: An Empirical Study. Oral presented in *International Nursing Research Conference 2017 in area of Culture, Co-creation, Collaboration for Global Health,* Bangkok, Thailand.