CHAPTER 4

DATA EXERCISE: DEFINING TRAINING NEEDS FOR NURSES REGARDING PALLIATIVE CARE

4.1 Introduction

Those who enter a caring profession come quickly face to face with death. Many doctors and nurses, whose education has been largely centered around the knowledge of treatment or cure can, when faced with the fact that there is no cure, feel failure and helplessness, especially when facing anguished relatives (Robbins & Moscrop, 1995). It is the nurse who is most likely to have intimate contact with death fairly soon after commencing clinical experience and who has to cope also with distraught relatives.

In the West, considerable attention is being paid to palliative medicine and its nursing aspects. Studies have been carried out and training curricula have been designed to meet the needs. The western society has been described as a death-denying society. Contemporary society in general, and professionals who care for dying patients in particular, are therefore continually reinforced in their fear of dying and death (Copp, 1994). Professionals acknowledge that facilitating nurses in the development of appropriate emotional and behavioral responses towards dying patients and their relatives is an important part of the curriculum.

They recognize that this is one of the most difficult and demanding, yet crucial, aspects of nursing (Chambers & Haughey, 1993).

Up to the present, nurses in Thailand get little education related to palliative care. Some colleges teach a course on comparative religions, others have a few hours about ethical issues. However, during their last year of training, there could be scope for this teaching during the 'electives' (Professor Farida Ibrahim, personal communication, April 1996).

Thai nurses are part of their society: how do they and their society perceive death and dying? How does religion have an impact on the society related to death and dying? How do the nurses experience this influence?

Do nurses encounter problems in dealing with death and dying? By conducting this qualitative research, I tried to explore the attitude of Thai people and Thai nurses towards death and dying. The aim of this study can be formulated as follows: to define training needs for Thai nurses related to palliative care, taking into account the cultural aspects related to death and dying and the influence of Buddhism on the society's perception of death and dying.

4.2 Rationale

Nurses are the professionals which are in close contact with terminal patients: they build a relation with the patient and the family, and they are also faced with anguished relatives. In palliative care the nurse is a member of the multidisciplinary team. Because of her close relation with the patient and the family she is in a position to report efficiently to the team concerning needs and preferences of the patient.

Nurses also have to cope with their own feelings, and they are part of the society. It is therefore important that their needs be defined regarding palliative care in order to function more effectively.

Moreover, I found it safer to go for exploration into a field with which I am more or less familiar since I am a nurse myself, and the basics of nursing are similar, all over the world. This helped me in understanding situations and concerned feelings. I also wanted to explore the context of the proposal (see chapter 3) and possible solutions, because nurses are also members of the team in palliative care.

4.3 Research Questions

To obtain the required information I concentrated on four main topics:

1. Thai nurses are part of their society: how do they and their society perceive death and dying?
2. How does the religion have an impact on the society related to death and dying?

   How do the nurses experience this influence?
3. Which problems do Thai nurses encounter in dealing with death and dying?
4. What knowledge, skills and attitude are expected from Thai nurses in dealing with terminal patients?

4.4 Methods

4.4.1 Sampling

To obtain an answer to the questions, I choose for the semi-structured interview method. This would provide the possibility to have personal contact and to use probing questions in between (Robson, 1995). All interviewees were asked the same questions, so that I would be able to compare the answers later on. They received the questions one or two days in advance, so that they could prepare themselves in order to save time.

For the selection of the interviewees, I employed nonprobability convenience sampling: for this I could count on the valuable help of a Thai professor who introduced me to people who could speak English and who were interested in palliative care because of their profession. I promised the interviewees not to use their names in my report, to guarantee then anonymity.

4.4.2 Interview guidelines

In order to meet my research objective: to identify the problems of nurses in coping with death and dying, I had to cover wider areas. Before drafting the questions I talked to several Thai nurses and to the professor in ethics. The result was that the attitude of the Thai people in general had to be included, as well as the influence from the religion.

I grouped the questions before, so that it would be easier to analyze. I intended to obtain information about:

- the Thai people's attitude towards death and dying,
- the influence of the religion concerning death and dying,

- problems encountered by nurses in caring for terminal patients,
- knowledge of nurses regarding the topic,
- attitude of nurses,
- skills of nurses,
- required changes in knowledge, skills and attitudes,
- the role of the social worker regarding terminal patients.

All the interviews were guided by the same questions, related to the topics of the research questions:

Society in general:

1. What is the Thai people's attitude towards death and dying?
   Do people question death and dying?
   How do they react when a family member dies?
2. Is there a difference in perception by common people and middle class people?
3. How would you describe the difference in perception between urban people and rural people?
4. How would you define "quality of life" for somebody with a terminal disease?

Religion in Thai society:

5. How does Buddhism influence people's attitude towards death and dying when comparing with other religions?
6. Could you explain what "a peaceful death" means for Buddhist people?
7. How do you see the role of the monk in dealing with terminal patients and their family?

8. Are there influences of other religious or cultural aspects?
   Superstition?

Problems of nurses and the educational aspect:

9. What kind of problems do nurses encounter with dying patients?
10. Is there a policy about informing patients about their diagnosis?
    Do patients want to know the truth about their condition?
    Whom do they ask for explanation: the doctor or the nurse?
11. Could you explain what knowledge you expect a nurse to have who has to deal with dying patients and their families?
    Could you also point out where the nurses' knowledge is weak?
12. Could you explain what attitude you expect a nurse to have who has to deal with dying patients and their families?
    How is the attitude of nurses today?
    Where would you prefer a change?
13. Could you explain what skills you expect a nurse to have who has to deal with dying patients and their families?
    What are the strong and the weak points of nurses today regarding skills?
14. If you look at the points where you find that a change is necessary, could you explain how the change could be realized?
    Who should be involved?

The task of the social worker:

15. How do you see the role of the social worker in dealing with terminal patients and their family? Where could he/she be of any help?

4.5 Procedure

The interviews were conducted in the work places of the respondents during March and April 1996. Each interview took between 40 and 90 minutes. Although the topic was a sensitive one, people talked freely, sometimes they had difficulties with expressing feelings since the majority of the interviews was in English and the interviewees were not used to talk in English about the topic of death and dying. Some of the respondents answered at great length on some of the topics, so that I obtained additional information and consecutively a better understanding of the situations regarding terminal patients.

I used the semi-structured interview technique and interviewed eight people who are interested in palliative care because of their profession. To obtain a notion about the work environment of the Thai nurses, I conducted an observation exercise in two governmental hospitals.

For the interviews I had in total I had 15 questions, or 15 main topics, some were followed by simple probing questions. Throughout the interviews I used small probing questions, I tried to summarize and I checked if I understood the answers clearly.

I recorded all the interviews, took notes in the meanwhile and typed out the conversations afterwards.

In total I interviewed eight persons, they were:

- two nurses: one with only one year experience and another with twenty years experience,
- two teachers of nursing colleges,
- a professor in ethics, teaching at several nursing and medical colleges in

Bangkok,

- a department head of a cancer-ward at Siriraj Hospital,
- a monk who has a responsible position in the Mahachulalongkorn University for Buddhist Monks,
- and a social worker of Rajavitee Hospital.

After having interviewed these people, I showed the results to a Canadian professor, who is a psychiatrist and living in Thailand for over thirty years. He is involved in counseling for people with AIDS. I asked for his opinion, this was a means of providing triangulation for my research.

Apart from the interviews, I also did an observation exercise in two wards of governmental hospitals in Bangkok: Ramathibodi Hospital and Rajavitee Hospital. The aim of the exercise was to obtain a view of the work environment of Thai nurses in these hospitals. I could obtain permission to visit both places outside visiting hours (in the morning).

The observation exercise took place in two wards of governmental hospitals in Bangkok: on 03.04.96 in Ramathibodi Hospital and on 10.04.96 in Rajavitee Hospital. I was accompanied by a teacher the first time, and by a social worker the second time. This was needed because of the language problem: I could not talk to the staff, nor to the patients. As an outsider it was also unacceptable to visit the wards without a clear aim.

4.6 Limitations

The topic is a very sensitive one, death and dying deal deals with feelings and emotions and these have to be converted into words.

The interviews were done in English, which is the second language for the respondents and it was found to be inadequate to express the right emotions.

For the interviews of the nurses I had to work with a translator, and this created another problem: different values are attributed to different words and the outcome can have different interpretations. It is important that the translator understands very well the interviewer and the respondents.

Another limitation was time: to carry out a proper research I would definitely need more time. This would have provided the possibility to use different methods, both quantitative and qualitative and of course it would have enhanced validity and credibility.

Further there is the use of nonprobability sampling: this sampling does not allow generalization of the findings beyond the sample.

4.7 Findings of the Interviews

The questions were not all answered by all the interviewees. People who are not familiar with teaching found it difficult to separate knowledge, skills and attitude; others had few comments on the religious aspects.

On the following pages I reproduce the key-thoughts from the answers per question.

4.7.1 Thai people's attitude towards death and dying

One of the teachers said that attitude towards death and dying is different according to people's background, education, religion and life

experience. This was confirmed by two other interviewees, but the general attitude is clear throughout all the answers: it is according to the religious belief. Thai people do not see death as the end, they see it as a situation which results in a change from a present life to a future one. Thai people see birth and death as a cycle: there is a continuity of life after death. What happens in this life influences the next life: people have to prepare themselves. Still, they are afraid of death: it is something that is unknown, and it involves separation from the loved ones. They hope they will meet their loved ones again in their next life.

Both the teachers and one of the nurses said that Thai people do not talk about death, it is a hidden issue. This is related to the Thai culture: it seems to be cruel if you talk directly about death to anyone. Thai people are evasive: you have to cover it up.

The monk said: "Because of this attitude, they do not like to raise the question about death itself. I hardly find any person dealing with, or any seminar on the problem of death, or philosophic questions on it in Thai society."

The head nurse of the cancer-ward told that people always question death: why me? They want to know what is happening to them: they do not want to know when they are going to die because they want to go on living with hope. She also told that several people can deal with death because they believe in karma: they have a lot of pain, but they never complain. Patients say that they accept this suffering because they believe that they will not have to suffer in their next life if they go through it now. People in Thailand should be better informed about caring for dying patients, more articles have to be published about this topic.

Another nurse said that people question what will happen when they die. For young people it seems to be far away, but older people are more concerned, they tend to prepare themselves. Some people really want to know when they are going to die, in order to prepare themselves.

4.7.2 Difference in perception by common people and middle class people

The meanings were divided: some people answered that there was no difference, or that it depends on the education or on the religious beliefs. Several people stressed that for religious people it made no difference at all.

One of the nurses said that preparing to die is hard when you have lived a happy, healthy and wealthy life. People who suffered a lot in this life and who are poor want to die: they do not like that their family has to borrow money to help them, they do not want to die because they want to leave this life, only to make it less troublesome for their relatives. Rich people try to delay death by using money. Poor people would like to do the same, but they cannot afford it. It would be good if this economic burden would be solved, because everybody wants to postpone, everybody wants to live with hope. An event to come can keep people alive for a while: a son who is going to become monk, or a daughter who will come back from abroad.

The monk said that well-to-do people in the urban society are more materialistic, their minds are scientific and they have doubts about life after death, they have questions about faith. If there is any difference it would be this.

4.7.3 Difference in perception between urban people and rural people

Some interviewees said that it is more difficult for urban people to accept death, because they are more attached to materialistic things. They are more afraid of death because they cannot control it: other things they can control with money. Rural people are often more religious, they lead a simple life and are not so materialistic, although this is also changing now. The beliefs of the rural people are mixed with many elements from tradition and from Hinduism. They believe in ghosts and are very superstitious.

One of the nurses told about the difficulties that urban people have due to the traffic when a relative is dying in hospital. The relatives have to come, sometimes after their work, and have to spend many hours in the traffic. They are tired and cannot cope with the situation. Of course the patient feels this tension and the patient feels guilty because the family has to do all these efforts for her. The nurse related the story of a patient on her department who cried every time after her daughter had left, not because she felt lonely, but because she felt guilty that her daughter spent so much time for her in stead of being with the little children. Pain clinics are partly a solution for this problems: pain killers can be provided, the reporting is done by telephone and somebody can collect the medicine.

One of the teachers said that rural people usually receive much more support from the community than urban people and they are often more religious than urban people.

Two of the interviewees were of the opinion that there was no difference in rural and urban people if they have the religious belief.

4.7.4 "Quality of life" for somebody with a terminal disease

Two of the interviewees answered that it should be according to the wish of the patient.

The majority of the respondents agreed that patients should be free of pain and that they should feel comfortable, that wishes should be granted and that they would be provided with psychological support from staff and relatives. It is a general understanding among the interviewees that suffering means not only physical suffering. The holistic approach in the terminal care was clearly explained by two of the teachers. Spiritual support and peace of mind was mentioned several times.

One of the teachers also explained about the importance of being able to leave this life without a burden: whenever patients are going to die, all efforts have to be made to help the patient, to ask if something has to be done. Sometimes the patient will ask to bring food to the monks, another time a business matter has to be solved or a problem among relatives. If there are unsolved problems, the patient can not go in peace and he will die 'with open eyes'. This expression is used by Thai people to express that people could not go with a peaceful mind.

Two teachers added that spiritual support and peace of mind was important and one teacher explained that burdens should be taken care of.

The monk saw quality of life in another dimension: "There are two kinds of basic values: the first one is the inner peace of mind, the second one is the social value. Concerning the inner peace of mind: if life is to be meaningful, you have to live for something, for a purpose: for the development of mind, 'mindfulness'. This goes together with a lot of contemplation. If you die you have to die with a clear mind, this is also in

our Thai culture. The key word is '*suttee*'. This means mindfulness. If you have a pure mind, you can expect a good existence in your next life, maybe go to nirvana. So, before you die you have to do something good to purify: by contemplation or meditation. The monk can come to recite the mantra, this can make the mind of the patient peaceful.
Life has also a social value: you have to live as a light, as a torch for the society, your life has meaning for your loved ones and you have something to contribute to society."

4.7.5 Influence of Buddhism comparing with other religions

All the respondents agreed that for Buddhists death and dying is the normal way of life, that it is part of the reincarnation cycle and that life is influenced by karma.

One of the teachers explained about karma, that it has two aspects, positive and negative. People do not understand what the exact meaning of karma is, even educated people, they think karma is only the bad part of life, but it is also the good one, it is present and past.

One of the nurses told that most people, even if they are not very religious, accept and believe in the law of karma. When death approaches, most people think that they were not good enough in this life, they need the help of the family, they need to give donations to the monks.

The monk explained that in Buddhism people had 'to let go'. There should be no attachment any more and the patient should listen to citations of the sutra, to have calmness of mind. To die as a Buddhist means: no worries, to accept death with the mind in a state of wholesomeness.

The monk told that some people do not want to die in the hospital in the midst of all the new technology, because they do not have the occasion to prepare themselves and to concentrate. Sometimes the family interferes at this point and the wish of the patient is not honored. The monk also explained about karma: "Karma means 'action' in Pali. The action you perform can be good or bad. Actions that you perform are stored in your mind, it becomes your personality, it is an accumulation of karma. The recorded qualities of mind would determine your destiny, if the actions are good, you will be born in a good next life. *Bhab* = bad karma, *bhun* = good karma. This is the teaching in the scripture, but the Thai people talk in the same sense about karma as people in the West. e.g. Car accident: you hit somebody in your previous life, so you have to repent now. This is the belief of people. Another thing is '*wiema*' - which means consequence for the action. People mix up consequence and karma. Karma is the cause, *wiema* is the consequence. You have to repent for the consequence of a karma from your previous life."

Two of the nurses said that it was easier to die for Christians and for Muslims: they could go to their God or Allah.

4.7.6 The meaning of 'a peaceful death' for Buddhist people

The teacher of ethics explained that a peaceful death means 'a good death'. According to the Buddhist concept, it means that the mind is in a state of mindfulness, it is relieved from suffering, there are no worries about anything. It also means a non-violent death, this is a natural death which is not painful, so that there is time to prepare: to say good-bye to

relatives and to have time to meditate and to listen to the mantra, recited by relatives.

One of the teachers said that patients should be able to reach a situation in which they become very peaceful and not restless. The patient should be told that he can go in peace when his time has come, that the relatives will manage. When patients die in a hospital ward, the environment should be facilitated for this as much as possible.

4.7.7 The role of the monk in dealing with terminal patients and their family

Opinions were divided: four of the interviewees answered that the monk should not come to the hospital ward because people associate the view of the monk on the ward with death, and this is bad.

The other four were of the meaning that the presence of the monk would bring peace for the patients.

A teacher explained that in rural areas family often invites the monk to their house, to give offerings to the monk for a good karma in the next life of the dying person. The person himself knows that it is the end of this life for him. This custom is also changing, it depends on the family.

The head-nurse of the cancer ward explained that the role of the monk can not be compared with that of the chaplain in Christian religions: monks are not trained in guidance of sick and dying people.

The monk told that in the time of the Buddha people would send for a monk to come to the house, to talk to the dying person and to give the last tuition. Personally he thinks it would be good if the monk could sit with the terminal patient in the hospital, but most of the relatives would not welcome

this project. He also explained that monks have to fulfill often the role of a counselor, perhaps not at the time of death, but people often visit the monks to talk about their problems and to ask for guidance.

4.7.8 Influences of other religious or cultural aspects / superstition

Two people told that offerings were made when a relative was dying: caged birds are set free, fish is put back into water or a cow which is going to be slaughtered is bought. People believe that this will prolong life.

One of the nurses said that dying patients were very often covered by their own clothes, so that they could go to their next life dressed in their own clothes. This is a custom for Chinese people, Thai people dress the dead afterwards. For Thai people it is the custom that a well loved object, such as a purse is put in the coffin, together with the deceased.

The monk explained about the Hindu influence: the washing of the hands of the corpse. The washing of the hands means that the one who performs the action wants to forgive the deceased if anything wrong happened during his life, that he wants to purify the body.

A Thai cultural influence is the washing of the corpse's face with coconut juice just before the cremation. This is done to purify the body from unwholesomeness: from greed, hate and delusion.

4.7.9 Problems that nurses encounter with dying patients

One of the teachers told that nurses do not like to talk to terminal patients or to the relatives, they have had no training for this. They often simply deny death, it is a troubled subject and they do not like to talk about it. There is a big lack of knowledge concerning this point.

Another teacher expressed it as follows: there is fear, big fear. It is related to our culture, we believe in ghosts and the ghost of the dying patient will visit you in your dream. There is also a feeling of helplessness, they cannot do anything for the patient. Moreover, nurses choose a way to separate themselves from the patient, not to get involved personally. They are afraid to face death.

A nurse told that caring for the dying was very bad at the beginning, but that young nurses would work together with senior nurses. One of the most difficult things was handling the relatives of the terminal or dead patient. They often cried loudly and disturbed other patients on the ward, which would also get upset.

4.7.10 Policy about informing patients about their diagnosis. Do patients want to know the truth about their condition?

All the interviewees agreed on the following: there is no policy about informing the patient about the diagnosis. It depends very much on the case, most of the time the relatives are informed.

All the respondents also assumed that this was very different in the West: that over there patients were always informed about the diagnosis.

The head nurse of the cancer ward thought it is better to tell the truth to the patients about the diagnosis, but not about the prognosis, they want to live with hope and you should not take this away from them. If patients are not told the truth, they know something is wrong and not being truthful adds to their problems. She explained that this does not mean that doctors or nurses have to tell things bluntly, they have to do it very carefully and see and feel how much they can take. Some doctors do not want to tell

the truth, and it is very difficult to change their opinion. The nurse thought the biggest problem was not with the patients, but with the nurses: they are not prepared to cope with the reactions of the patients. The argument will come up that patients can not cope with the truth, this is clearly a staff problem. Health care providers need to be trained for this.

A teacher said it was right to tell the truth to the patients, they had the right to make decisions about their own life. She also said that there were many limitations in treating terminal patients, sometimes specific treatment is not available or the patient cannot afford it. The health care policy of the country needs to be changed, problems are overlooked.

The monk told that patients simply do not expect to be told the truth, most of the time the close relations are informed and some patients die without even knowing what happened to them. He also thought that the right of the patient to know about his situation is not a question in Thai society: patients trust doctors and nurses, they have confidence. So far there is no campaign from the side of the patient.

Seven of the eight interviewees said that they would like to know themselves about the diagnosis if they had a terminal disease.

4.7.11 Knowledge expected of a nurse when dealing with dying patients and their families

The answers differed on this point, but all the respondents agreed on the required basic medical knowledge and physical nursing care.

One of the teachers stressed the holistic approach, she explained that the 'caring' concept had to be taught again: nurses need the medical and technical knowledge, but they need also the psychological and spiritual

knowledge. Caring in nursing has been re-defined in the past decade and this is needed.

Another teacher pointed out that knowledge of nurses is weak regarding symptom and pain control. She said that people keep on talking about drug abuse, there are problems about how to manage administration of drugs.

One of the nurses said that they had to know about the needs of the patient, but also about the needs of the relatives.

Three people, a teacher, the head-nurse and the monk, thought that knowledge about spiritual caring was required: nurses not only care for the body, also for the mind.

The teacher of ethics explained that nurses need knowledge about the different religions (this is taught in nursing colleges): Buddhism, Christianity and Islam. This is needed because all the other courses are scientific.

4.7.12 Attitude expected of a nurse in dealing with dying patients and their families

The respondents agreed that in general the attitude of the nurses is OK. One of the teachers told that it depends very much on the family background, but nowadays nurses have become too worldly: they should see the real values of life. There is a change needed, not only for nurses, but for the society, people have to look at life in a holistic way, not only in a materialistic way.

The head-nurse of the cancer ward did not have difficulties with the attitude of the nurses, but with the doctors: she said they should come out

of their 'medical science world' and realize that they can not perform miracles. Dying is something natural, it is not a failure of their career. She said that a change was necessary for the whole system: this counted for doctors as well as for nurses. Experience with dying patients should be talked about. If people experience themselves things differently, changes will come.

4.7.13 Skills expected of a nurse in dealing with dying patients and their families

All interviewees agreed that nurses should be able to assess the needs of the dying patients and their relatives. Six of the people mentioned the holistic approach: not only physical needs, but also psychological and spiritual.

One of the nurses explained about the importance of spiritual values: "When a patient says something the nurses often see it too superficial and comment: oh, he's a bit crazy! But patients need somebody to listen to them, nurses should ask 'what do you mean?', 'can you explain it a little bit?'. Questions have to be asked. If patients want to offer food and flowers to the monks, it goes farther than psychological care, this is on the spiritual level. The nurses working in the ICU have to understand very well about spiritual care: e.g. A man who had a heart transplantation was very restless, even under heavy sedation. He could express that he wanted to offer food to the monks as a gift to the person from whom he got the heart, so that the other person could proceed to the nirvana. Instruments are not able to fulfill this needs!"

A teacher explained about the skill of being able to collect relevant data about the patient, so others could be informed and help the patient, e.g. the social worker.

Two teachers and the head-nurse of the cancer ward talked about communication skills, because nurses do not know what to say and how to behave when faced with dying patients and their relatives. This needs special training.

4.7.14 Changes necessary: how to realize, who should be involved

A summary of the necessary changes mentioned is that there needs to be: communication skills need improvement, the holistic approach needs to be stressed, special emphasis for the spiritual guidance of dying patients, and knowledge about pain control and symptom control.

One of the teachers said that a national policy needed to be implemented: people are becoming aware of the problem of terminal care because of the AIDS problem in Thailand. AIDS patients have no place to go: before they went to the temples, but monks have no medical skills or materials.

All the teachers and the head-nurse thought a special training was needed for nurses who had to deal with terminal patients: the basics should be taught in the normal curriculum, but special training should be organized as a post graduate training. Two of the nurses suggested that it would be added in the electives during the fourth year of training.

The head-nurse and one of the teachers said that personal experience with death is very important in dealing with the dying and their relatives.

4.7.15 Role of the social worker in dealing with terminal patients and their family

Five people talked about bad experiences regarding the social workers: they were only concerned about whether the patient was able to pay or not.

One of the teachers said they also saw the social worker when a baby had to be adopted. She mentioned that it would be good if the social workers could come and talk with the relatives about how to cope with dying.

Some people had a different view: that social workers looked at the terminal patients from a different perspective; the social worker herself explained about the personal relation between nurses and social worker.

The monk stressed the importance of the social worker regarding the acceptance of the AIDS patients in the community. He said: "The AIDS problem is in front of us, there will be many people dying and we are not prepared for this; we do not have plans. This is the Thai attitude: they do not like to be confronted with bad things, they are evasive and polite. They will not show to your face that they are angry with you; they remain polite. It is the same with the AIDS problem."

The social worker herself explained about her work with the dying: about the contacts she had and the effective talks with patients and relatives. She explained about a young woman who was dying, and how she helped the husband to take care of the practical problems regarding school for the children and other problems in the household. She also told about a couple of patients who needed help in organizing their estate.

4.8 Findings of the Observations

In Table 4.1 I wrote the findings of the observation exercise. In the left column I simply state the observations, in the right column I wrote my impressions and questions about the situation.

Table 4.1

Observation Exercise.

Observations:	Interpretation:
Setting: Not much space between the beds, especially in Ramathibodi , where there were 40 beds in one ward.	Setting: Partitions between the beds were flimsy. All sounds and scents were shared. Was there enough privacy for the patients in that setting? Could they talk about personal matters without being overheard? Did the patients need the close presence of other patients?

(table continued)

Table 4.1

Observation Exercise. Continuation.

Observations:	Interpretation:
Patients: They were all dressed in hospital gowns. Very few personal belongings on the night-stand. Some terminal patients had visitors with them.	Patients: Hospital gowns were clean and good for hygiene. No difference between patients. Did all those people like being dressed in hospital gowns? Did it feel as if they lost part of their personality? No personal belongings: did they feel lost? Part of a big setting? Overwhelming? Did they question these things? Did the relatives of the terminal patients get any attention from staff?
Female patient on stretcher, waiting to be transported to other department. Patient was about 35-40 years, had a bladder catheter and looked yellowish, specially the white of her eyes.	The woman looked very calm. It was the cancer ward, so she had probably cancer and her liver must be involved. This patient did not have much longer to live, she had to go to another department: for treatment or for examinations? Had she been asked if she agreed with it? Wouldn't she be better at home with her relatives?

(table continued)

Table 4.1

Observation Exercise. Continuation.

Observations:	Interpretation:
Nurses: The nurses were friendly to the patients while they were administering nursing care, but businesslike.	Nurses: All the nurses who were present were busy, a lot of work had to be finished. Everybody had been assigned specific tasks. In the morning nurses had only time to fulfill their tasks, there was no spare time to sit with patients or to talk to relatives. Would there be time later on? Will they pay attention to it?

4.9 Discussion

The aim of this study was to define training needs for Thai nurses related to palliative care, taking into account the cultural aspects related to death and dying and the influence of Buddhism on the society's perception of death and dying.

4.9.1 Methods and procedure

As mentioned earlier I selected the techniques of semi-structured interview since this method provided the necessary flexibility and offered scope for additional information by asking probing questions and by visiting the interviewees in their working environment.

While preparing the study I needed to obtain information about the Thai society and some ceremonies related to the death of relatives. I could find some books on Thai ways, a book on Thai culture and one on the psychology of Thai people. These books provided a basic knowledge.

The contacts with several Thai people were a great help: I was introduced to a professor in ethics by my colleagues of the college and this professor introduced me to all the other interviewees. I could not have managed this on my own, specially with the sensitive subject that I was to explore. I learned and experienced that personal relations are very important in Thai society.

The questions for the interview were prepared carefully, I did a small pre-test with a Thai nurse, but afterwards I could see there was some overlapping: the questions about middle class & common people and about urban & rural people resulted in nearly the same answers. For people who are not accustomed to the terms of knowledge, attitudes and skills it is difficult to make the right distinction, those questions could have been formulated in another way, to make them more clear. I could have asked for a Thai translation of the key words.

To ensure a reliable outcome I had a variation of people who were all interested in palliative care because of their profession. A problem was the nurses: I had to interview them with the help of a translator, and this translator was their previous teacher. It would have been better if I had organized those in interviews in another hospital with the help of a colleague from the college.

I am sure that I could obtain the most important ideas about the topic because of the vast experience of the interviewees. A better method

would still have been a self-completed questionnaire for nurses and their teachers, with open questions. This was not possible because of limitations of time and language. After finishing the interviews and writing out the information, I realized that these interviews provided me with a valuable background to compose such a questionnaire. If I had to repeat the exercise I would include in-depth interviews, but in Thai.

As means of triangulation I could talk to the Canadian psychologist, who is living in Thailand for many years and who has a critical and realistic view on the society and the problems related to AIDS, which includes the problems of death and dying.

4.9.2 Discussion of the findings per topic

a. Thai people's attitude towards death and dying.

The Thai people's attitude toward death and dying is clearly influenced by the religion and by the culture. People believe in the cycle of life, although it is questioned by some. Death is never spoken about directly because Thai people are evasive and do not talk openly about topics which are less congenial. This makes death and the related problems more difficult to handle, it needs an indirect approach.

The more materialistic tendency in society renders a certain superficiality of its members and thereupon the nurses.

b. Influence of religion on death and dying.

Religion has a significant influence regarding death and dying: the majority (95%) of the population are Buddhist and when death approaches all people seem to turn their hope towards the next and better life.

The way that the teacher of ethics explained that a peaceful death means 'a good death', seemed to be a general expression of most people's feelings. A good death means that the mind is in a state of mindfulness, it is relieved from suffering, there are no worries about anything. There is time to prepare: to say good-bye to relatives and to have time to meditate and to listen to the mantra, recited by relatives. Great importance is given to the ceremonies related to dying and to the preparation of the cremation.

People identify the sight of the monk in a hospital ward with death, few people see the monk as a reassuring presence. The role of the monk is not well defined, it depends on the personal preference and also the personal relation with the monk.

The importance of spiritual guidance was stressed several times. Caring for the spiritual dimension means helping the patient with life-giving hope rather than with life-destroying fear. Experience shows that with faith it is indeed possible to face up to death, this may be stated more in hindsight than a priori in the case of any individual (Robbins & Moscrop, 1995). It is clear that nurses have to be aware of the spiritual needs of the patients and relatives, and that they even can guide the patient know where efficient help is available.

c. Problems that nurses encounter when faced with death and dying.

The problems that nurses encounter when dealing with terminal patients are related to the organization of the work. Nursing is organized in such a way that the nurses have to be alert all the time because the administration of drugs and preparations of intravenous infuses have to be carried out carefully, complications can occur and need immediate action: this is contradictorily when we have to do with patients for whom

therapeutic measures do no longer work, these patients need a quiet environment.

Nurses are working in shifts and this makes it difficult to build relations with patients and relatives. When faced with anguished relatives and terminal patients, nurses do not know what to say or how to behave. Medicine is directed towards cure and death is seen as a failure, it goes together with a feeling of helplessness, of not being able to help the patient.

Further there is the personal fear of facing death and trying to avoid it. According to my own experience feelings of western nurses are exactly the same as those of the Thai nurses. Encountering death is a reminder of one's own mortality: these feelings have to be sorted out by nurses before they can help others. It takes time, but they will be able to cope in a caring way, yet emotionally detached (Lavery, 1993).

Being at a loss for words when meeting anguished relatives and a dying patient is nothing abnormal: caring for the dying and offering support to bereaved relatives is demanding and stressful. The greatest input in the terminal phase of a person's illness will come from the nursing staff. Often the more junior staff and students have the closest relations with the patients. This can give job satisfaction, but it can also cause strain: support and supervision by senior staff should be readily available (Robbins & Moscrop, 1995). Communication skills play also an important role at this point.

Moreover, effective symptom control is impossible without effective communication. The most powerful analgesics will be of little value if health-care professionals do not have an accurate understanding of the patient's pain, and this can be obtained only by effective communication

(Buckman, 1993). Skills are interlaced, for symptom control needs knowledge about pain and symptom management; communication is not only talking about the pain, it is also listening, breaking bad news and conversing with family and friends of the patients.

d. The importance of the social worker.

During the preparation of the interviews, I had picked up scraps of conversation which pointed towards a negative attitude of the social worker on the hospital wards in contacting patients. In palliative care, the social worker is part of the interdisciplinary team, his role is as important as that of the physician or the nurse to provide holistic care. The interview with the social worker provided me with more accurate information and I could see for myself on the wards that patients knew her and greeted her with friendly respect.

I have the impression that the social worker in general is not very well accepted by the nursing staff, this could be caused by a lack of contact, of not being informed about the other's responsibilities. If palliative care will receive more attention in future, so will the task of the social worker. Monroe (1993) explains that there are three forces which shape the social work role in palliative care: "The non-medical social goals that palliative care team set themselves; the teamwork and multidisciplinary skills required to meet these social goals; and the expectations of patients, relatives and the various palliative care professionals of social work and social workers." (p. 565)

e. Discussion of the observation exercise.

The observation exercise resulted in interpretations which are strictly personal, I did not discuss them with any Thai nurse. I cannot draw any conclusion, I restrict myself to leaving the questions open.

The fact that there was little space in between the beds and that all patients were dressed in the same hospital gowns gave me the impression that there was little privacy and a loss of personality. Did the patients experience this also, or did they accept this as a normal fact? Do they need a closeness of other people all the time?

The patients that I saw on the cancer ward, the woman that was waiting for radiation and also the other patients, made me wonder if they would not be better of, if they stayed at home with their family for the time they had left. What meant 'quality of life' to them on that moment?

The nurses were busy with nursing activities which had to be completed in time, they had to be observant and on guard all the time. Is it possible for the nurses, in this infrastructure, to approach terminal patients with an open mind, with the intention to help them, using the poor means which still make sense for them? It did look like a difficult task.

4.10 Conclusion

Looking at the problems of nurses regarding death and dying, which were expressed by the respondents, the expected knowledge and skills, and the overall picture of the work environment, certain training needs come forward.

Taking into account the limitations of this research, I would suggest that following points regarding these training needs could be taken into consideration regarding the curriculum for Thai nurses:

- pain management, symptom management;
- spiritual care in Buddhism;
- coping with own feelings regarding death and dying;
- communication skills.

These needs do correspond by the aims set for terminal care education: knowledge and technical skills of symptom management and palliation, improvement of communication skills, and bolstering of personal coping capacities (Field, 1993). The curricula developed in the UK can serve as references.

These aims for terminal care education are focused on death and dying, rather than on the enhancement of quality of life in chronic diseases. Corner (1993) is of the opinion that a shift in thinking will be necessary in the nursing curricula, similar to that of the health care system, before a truly integrated and comprehensive approach to palliative care education will be seen.

4.11 References

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