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Supporting dignified dying in the Philippines

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Abstract

Purpose—This study aimed to assess the appropriateness of the International Classification for Nursing Practice (ICNP) *Palliative Care for Dignified Dying* catalogue for palliative nursing in the Philippines.

Methods—The study recruited 230 nurses to complete the ICNP Dignified Dying survey. Participants rated ICNP nursing intervention items and identified additional interventions for promoting dignified dying.

Results—All of the intervention items were scored on average as being at least ‘slightly important’. The three top-ranked nursing intervention categories were providing social support, maintaining privacy boundaries, and relieving psychological distress.

Conclusions—The ICNP *Palliative Care for Dignified Dying* catalogue lists nursing interventions that are appropriate to promoting dignity at the end of life in the Philippines.

Keywords

Dignified dying; Philippines; Interventions; International Council of Nurses

The International Classification for Nursing Practice (ICNP) catalogue *Palliative Care for Dignified Dying* identifies nursing interventions specific to promoting dignified dying and supports the systematic documentation of care. It identifies the clients as patients who are dying as well as their families and significant others. The catalogue was developed after identifying nursing interventions to promote dignified dying in four countries: Ethiopia, India, Kenya, and the USA (Doorenbos et al, 2006; Coenen et al, 2007). The aim of this study is to evaluate the validity of this catalogue for use in the Philippines.

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The ICNP and the Palliative Care for Dignified Dying catalogue

The ICNP facilitates standardized nursing documentation of patient care, enabling comparison of nursing diagnoses, interventions, and outcomes internationally. It also facilitates nurses' communication with other nurses, health professionals, and policy makers about their practice. For ease of use, the International Council of Nurses (ICN) develops catalogues that are subsets of the ICNP—specifically, nursing diagnosis, outcome, and intervention statements for selected client groups and health priorities. The ICNP catalogues allow nurses working in a specialty area (e.g. ambulatory cancer care or end-of-life care) or a focus area of nursing (e.g. pain management, urinary incontinence, or promoting adherence to treatment) to more readily integrate the ICNP into their practice.

Dignified dying has not been studied extensively, and few studies have focused on interventions to promote dignified dying (Chochinov et al, 2006). To date, ways in which nurses across cultures and countries maintain human dignity at the end of life have yet to be fully explored.

The ICNP catalogue *Palliative Care for Dignified Dying* was guided by the dignity-conserving care model, which assists health- care providers in considering dignity from the patient's perspective (Chochinov, 2002; McClement et al, 2004). The model specifies three major dignity categories:

- Illness-related concerns (factors caused by or associated with the underlying illness and requiring symptom relief)
- Dignity-conserving repertoire (psychological and spiritual considerations for maintaining a sense of dignity during the illness experience, such as hopefulness and a sense of meaning)
- Social dignity inventory (socially or externally mediated factors that foster a sense of dignity, such as privacy and family support).

Nursing interventions used in the Philippines have been found to accord with the dignity-conserving care model (Ramos, 2010).

Nursing models of palliative care delivery in developed countries seldom translate effectively to the developing world, and extant research on palliative care that is relevant to developing countries is minimal (Pampallona and Bollini, 2003; Kanavos, 2006; World Health Organization, 2007). Thus, to guide palliative care nursing practice to promote dignified dying, interventions must be examined across cultures and in developing and developed countries. The current study's purpose is to provide an understanding of palliative care nursing interventions in the Philippines and to validate the usefulness of the ICNP *Palliative Care for Dignified Dying* catalogue. This is one of the first studies to survey nurses from a specific country about interventions used to promote dignified dying and to validate the ICNP catalogue. Nurses are currently being surveyed in other countries to collect additional data on the usefulness of the ICNP catalogue.

Palliative care in the Philippines

The movement toward palliative care and hospice care services in the Philippines began in the late 1980s for patients with cancer (Wright et al, 2008). Malignant neoplasms are ranked as the third most common cause of mortality for Filipinos, after diseases of the heart and diseases of the vascular system (Department of Health (DH), 2010). Today, hospice care services are available for terminally ill cancer patients, patients with other life-threatening illnesses, and their families (Sharing Hospice, 2007). Palliative care concepts and principles are part of the curriculum in major medical and nursing schools in the Philippines, and

palliative care training programmes are delivered to health providers and volunteers (Gorospe and Bausa, 2006).

Key concepts to consider in understanding the Filipino perspective on death and dying include cultural values and beliefs related to religion, family, and interpersonal harmony. Religion holds a central place in the life of Filipinos (Wright et al, 2008). The Philippines is a predominantly Christian nation, with Roman Catholics making up around 81% of the population (Central Intelligence Agency, 2010). Miranda and colleagues (Miranda et al, 1998) found that deeply religious Filipinos tended to attribute illness to reasons of God or a higher power. The predominant belief in the causes of disease was the 'will of God', even though individuals also believed in personal responsibility.

The family is the basic social and economic unit of Filipino kinship. Although family is important in many cultures, the central role that the family plays in the lives of its members in the Philippines is unusually significant, with family being rated the most important source of happiness (Virola, 2010). In times of illness, the extended family provides support and assistance (Wright et al, 2008). Important values that might affect interactions between providers and patients and families in the context of terminal illness include a strong respect for elders, a strong reliance on family as decision makers in case of illness, and strong expectations of care by the family.

Published literature on palliative care and dignified dying in the Philippines is limited. Laurente and colleagues (unpublished observations) explored the phenomenon of death and dying as experienced by adult terminal cancer patients in the Philippines and their family caregivers and nurses. The nurses perceived patients with terminal cancer to be in a state of helplessness and powerlessness. The patients and family caregivers identified two important aspects of a peaceful death: first, the presence of family support and acceptance of the burden of the patient and, second, belief in God and dying as a time to surrender self.

Interventions used to promote dignified dying for patients in the Philippines have been identified through interviews with patients (C Abaquin, unpublished observations). Nursing interventions identified by the patients included ensuring comfort, safety, and privacy; providing therapeutic touch; allowing prayer and religious music as desired; maintaining a quiet, well-ventilated, and pleasant-smelling environment; and staying with the patient. In focus group discussions, nurses stated that human dignity is maintained when a patient's physical, psychological, and spiritual needs are met and when the patient is comfortable and clean; is able to participate in making significant decisions regarding the management of his or her illness; can focus on unfinished business; has loved ones attending to his or her needs; can openly express concerns, plans, and wishes; has good and healthy family relationships; is at peace with God; and maintains quality of life (C Abaquin, unpublished observations).

Methods

Design, participants, and setting

A cross-sectional study design was used, with a paper-and-pencil survey as the data collection method. A convenience sample of registered nurses in the Philippines with clinical care experience was recruited. A total of 250 surveys were sent out, and 230 were returned, at a response rate of 92%.

A Filipino country coordinator in the Philippines oversaw the data collection. The coordinator personally contacted heads of institutions from academe, clinical practice, and the Board of Nursing to ask whether they would be willing to have their institutions participate in the study. The study was approved by the University of Washington's

Institutional Review Board and by the participating institutions in the Philippines for the protection of human subjects.

Procedure

This study was conducted at hospital, clinic, and community health-care settings. The country coordinator and a trained research assistant distributed written consent forms together with the ICNP Dignified Dying survey to nurses at regularly scheduled monthly meetings. Nurses were provided time during the monthly meeting to complete the survey, which could also be completed after the meeting and returned to the country coordinator or mailed in at a later date. The nurses were informed that the information would not be used for any purpose other than this study.

The ICNP Dignified Dying survey consists of demographic items and 105 palliative care nursing intervention items from the ICNP catalogue *Palliative Care for Dignified Dying*. The palliative care interventions listed in the ICNP catalogue were developed from research conducted in various countries (Coenen et al, 2007). The catalogue was reviewed by palliative care nursing experts from around the world to establish face and content validity (Doorenbos et al, 2009). Before being administered for the purposes of this study, the survey was further reviewed for cultural relevance by three nurses that are palliative care experts in the Philippines. Each nurse reviewed the items for clarity and relevance in the Filipino nursing context.

Participants were asked to rate each intervention on a 4-point Likert response set (1 = not at all important, 2 = slightly important, 3 = moderately important, and 4 = very important). They were also asked the following open-ended question: ‘When you care for a dying patient, what specific nursing actions do you use to promote dignified dying?’ The nurses took 45–60 minutes to complete the survey.

Data analysis

Descriptive statistics were obtained for the 230 sets of responses. An average importance rating was calculated for each of the 105 nursing intervention items using numeric codes. The items were then ranked by average importance rating. All calculations were performed using SAS 9.1.

Qualitative analysis of the open-ended item asking the nurses about the nursing actions they used to promote dignified dying in their practice was conducted using a content analysis method. The content analysis was conducted by three members of the research team and agreement on the categorization of the interventions was achieved. The actions described by the respondents were assigned to one of the three major categories of the dignity-conserving care model (Chochinov, 2002). This model provided a comprehensive and empirical basis for organizing the interventions used to promote dignified dying.

Results

The total sample was 230 nurses working in the Philippines (see Table 1 for full demographic characteristics). The mean age of the participants was 35.7±12.9 years, and the majority of the nurses (58%) had 1 to 10 years’ work experience. The majority of the participants (69%) had a Bachelor’s degree in nursing, worked full time (93%), and worked in hospitals (70%). Participating nurses cared for dying patients very often (29%), often (27%), sometimes (41%), and never (3%).

Table 2 lists the top 20 ICNP palliative care interventions to promote dignified dying, based on highest average importance rating from this study. The top ten items were:

- Establish trust
- Protect patient rights
- Establish rapport
- Maintain dignity and privacy
- Protect confidentiality
- Ensure continuity of care
- Provide privacy
- Monitor respiratory status
- Collaborate with fluid or electrolyte therapy
- Collaborate with physician.

All of the nursing interventions listed in the catalogue had a mean rating of over 2—that is, they were at least ‘slightly important’ in promoting dignified dying. Table 3 lists the top 10 palliative care interventions based on rankings by the subset of nurses who cared for dying patients ‘very often’ or ‘often’—the more expert nurses—and those of the nurses who cared for dying patients ‘sometimes’ or ‘never’. The top 10 interventions of the expert nurses were:

- Establish trust
- Ensure continuity of care
- Establish rapport
- Maintain dignity and privacy
- Protect confidentiality
- Protect patient rights
- Monitor respiratory status
- Provide privacy
- Encourage rest
- Administer pain medication.

The 230 nurses provided 155 responses to the open-ended question about specific nursing interventions used to promote dignified dying in practice. The responses were classified into the three major categories of the dignity-conserving care model (Chochinov, 2002): illness-related concerns (*n*=58), dignity-conserving repertoire (*n*=62), and social dignity inventory (*n*=35). For the open-ended responses, the five most commonly cited interventions related to psychological distress, spiritual comfort, physical distress, autonomy/control, and social support. Examples of specific interventions classified as addressing psychological distress included therapeutic communication, active listening, observing silence, decreasing emotional suffering, providing reassurance, and staying with the patient when needed.

Discussion

This study found that the ICNP catalogue *Palliative Care for Dignified Dying* provides palliative care nursing interventions that are relevant for promoting dignified dying in the Philippines, as all interventions were rated as at least ‘slightly important’. The most important ICNP nursing interventions identified by the sample addressed establishing

communication and trust with the patient, maintaining dignity and privacy, and protecting patient rights and confidentiality. Nurses who care for terminally ill patients in the Philippines deemed these interventions appropriate for dealing with patients' states of helplessness and powerlessness. These findings are also consistent with findings that safety and privacy are important in palliative care interventions for patients in the Philippines (C Abaquin, unpublished observations).

Pain control is recognized as one of the major foci of palliative care in the Philippines (Wright et al, 2008). However, in this study, only those nurses who cared for the dying 'very often' or 'often' identified 'administer pain medication' as one of the top ten nursing interventions, and on average they ranked this intervention as number ten. It was ranked number 20 by average importance when all participants in the study are taken together. One potential reason for these results is that fear of addiction to narcotics is a major concern of health professionals who are less expert in the field of palliative care and thus perhaps less comfortable with administering pain medication (Galanti, 2004).

Four of the top 20 most important interventions were spiritual comfort interventions: 'encourage patient to express spiritual concerns', 'protect religious beliefs', 'provide spiritual support', and 'provide privacy for spiritual behaviour'. These interventions to promote dignified dying are consistent with Periyakoil et al's 2010 study of Filipino Americans, which reported that finding meaning in one's existence and death was one of the factors influential in preserving dignity at the end of life.

Nurses who cared for dying patients 'sometimes' or 'never' prioritized spiritual comfort interventions differently than nurses who cared for dying patients 'very often' or 'often'. The less experienced nurses placed three spiritual comfort interventions in the top 10, whereas nurses who cared for dying patients 'very often' or 'often' did not place any spiritual support interventions in the top 10. This might be because experienced nurses may see spiritual support as an underlying aspect of all palliative care rather than as a distinct intervention. Less experienced palliative care nurses may be more deliberate in delivering spiritual support.

The nurses who cared for dying patients 'sometimes' or 'never' also identified fluid or electrolyte therapy as the number one intervention, whereas nurses who care for dying patients 'very often' or 'often' did not identify this as a top 10 intervention. This might be because less experienced nurses may not be as clear about the differences between palliative care and acute nursing care. Experienced palliative care nurses realize that fluid and electrolyte therapy is not a goal in caring for the dying patient.

Limitations

A limitation of this study is that the data were obtained from a convenience sample of nurses and thus the findings might not be generalizable to all nurses in the Philippines. Furthermore, almost half of the participants only 'sometimes' cared for dying patients. Finally, how the concept of dignity at the end of life is perceived in the Philippines generally is still not well known. Research on the concept of dignity at the end of life has been conducted in other countries (Jo and Doorenbos, 2009), and a greater understanding of this concept in the context of the Filipino culture would further contribute to our understanding.

Conclusion

Palliative care is important for promoting dignity in the dying patient. This study's findings support the applicability of the ICNP catalogue *Palliative Care for Dignified Dying* for providing relevant and standardized nursing interventions for palliative care in the

Philippines. The catalogue may be used as a resource in planning and managing nursing care to promote the dignity of dying patients. It would also be useful to further test the catalogue among nurses in other countries.

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Table 1

Demographic characteristics of the sample (n=230)*

Demographic item	Frequency	Percentage
Work experience		
1–10 years	128	57.9
11–20 years	37	16.7
21–30 years	35	15.8
31+ years	21	9.5
Nursing education		
Diploma	3	1.3
Associate's degree	1	0.4
Bachelor's degree	155	68.9
Master's degree	63	27.6
Doctorate	6	2.6
Employment status		
Full time	212	93
Part time	10	4.4
Retired	1	0.4
Unemployed	5	2.2
Primary work setting		
Community	4	1.8
Hospital	160	69.9
Clinic	5	2.2
Academe	51	22.3
Other	9	3.9
Age		
20–30 years	99	43.6
31–40 years	54	23.8
41–50 years	22	9.7
51–60 years	46	20.3
61+ years	6	2.6
Frequency of care for dying		
Very often	66	29.1

Demographic item	Frequency	Percentage
Often	61	26.9
Sometimes	94	41.4
Never	6	2.6

* Missing data not included in percentages

Table 2

Top 20 ICNP palliative care nursing interventions to promote dignified dying, as ranked by average importance rating of a sample of 230 nurses in the Philippines

Rank	Survey item	Lowest rating	Highest rating	Mean	SD
1	Establish trust	2	4	3.94	0.27
2	Protect patient rights	2	4	3.93	0.28
3	Establish rapport	1	4	3.92	0.33
4	Maintain dignity and privacy	3	4	3.92	0.27
5	Protect confidentiality	2	4	3.92	0.29
6	Ensure continuity of care	2	4	3.92	0.29
7	Provide privacy	2	4	3.90	0.31
8	Monitor respiratory status	3	4	3.89	0.31
9	Collaborate with fluid or electrolyte therapy	1	4	3.89	0.38
10	Collaborate with physician	2	4	3.85	0.39
11	Encourage emotional expression	2	4	3.85	0.41
12	Encourage patient to express spiritual concerns	2	4	3.85	0.41
13	Protect religious beliefs	2	4	3.85	0.41
14	Provide safety devices	1	4	3.85	0.42
15	Provide spiritual support	2	4	3.84	0.41
16	Provide emotional support	2	4	3.84	0.45
17	Provide privacy for spiritual behaviour	2	4	3.84	0.41
18	Manage dyspnoea	2	4	3.84	0.42

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Rank	Survey item	Lowest rating	Highest rating	Mean	SD
19	Encourage rest	1	4	3.83	0.48
20	Administer pain medication	2	4	3.83	0.42

ICNP, International Classification for Nursing Practice; SD, standard deviation.

Table 3

Top 10 ICNP palliative care nursing interventions to promote dignified dying as ranked by nurses with greater and lesser experience in caring for dying patients

Rank	Nurses who care for dying patients 'very often' or 'often'	Nurses who care for dying patients 'sometimes' or 'never'
1	Establish trust	Collaborate with fluid or electrolyte therapy
2	Ensure continuity of care	Protect patient rights
3	Establish rapport	Maintain dignity and privacy
4	Maintain dignity and privacy	Establish trust
5	Protect confidentiality	Protect confidentiality
6	Protect patient rights	Provide privacy
7	Monitor respiratory status	Provide spiritual support
8	Provide privacy	Establish rapport
9	Encourage rest	Protect religious beliefs
10	Administer pain medication	Provide emotional support