The Perception for Good Death of Community Dwelling Japanese and Thailand respondents

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Abstract

Having a "good death" is a very important goal of palliative care, and it is useful for nurses to understand cultural differences in the perception of a good death to propose nursing care. The purpose of this study was to compare the perception of a "good death" among community-dwelling Japanese and Thai people. Three hundred sixty-nine respondents completed the Good Death Questionnaire. The research design was a cross-sectional study. The scores of the Japanese respondents on "good relationships with medical staff," "being respected as an individual," and "fighting against cancer" were higher among Thai respondents. On the other hand, "environmental comfort," "unawareness of death," "control over the future," and "religious and spiritual comfort" were higher among the Japanese respondents. Among the Japanese, the score for "life completion" was significantly correlated with "role accomplishment and contribution to others." Among the Thai respondents, the score for "good relationships with family" was significantly correlated with "physical and cognitive control." The implications of these results were that Japanese respondents preferred medical treatments, maintaining a good relationship with physicians, and demanding to be respected as an individual. Thai respondent's preferred "environmental comfort" and "religious and spiritual comfort." In the future, medical staff members will need to consider these cultural differences when proposing nursing care.

Keywords: good death, Japanese people, Thai people, cultural difference

The elderly population is increasing and the number of aging people is expected to increase in Japan. Therefore, many people will die and a problem is how people will die. An important goal of palliative care is achieving a "good death" or a "good death process." In many countries, elaborate efforts have been devoted to conceptualizing a good death (Haishan, Hongjuan, Tieying, & Xuemei, 2015; Steinhauser et al., 2001). There is no universal definition of a peaceful death or a good death; however, the core qualities are common such as accepting death, being at peace, being comfortable, being with loved ones, following an individual's wishes and religious tradition, the death taking place at an appropriate time, and being natural and dignified (Hattori, McCubbin, & Ishida, 2006; Kongsuwan, Keller, Touhy, & Schoenhofer, 2010; Kongsuwan & Locsin, 2010).

Culture is also important to consider in advanced care planning at end-of-life care (Johnstone & Kanitsaki, 2009). A common view is that the world can be divided into two cultures: individualist (e.g., North America and Northern Europe) and collectivist/family-focused (e.g., Asian and Southern Europe), and many studies have investigated the differences between these two cultures (Morita et al., 2015). However, studies have shown differences in the practice of palliative care among Asian countries. The current study investigated differences between two countries in Asia.

In their investigation on the point of view in Western countries, Steinhauser et al. (2001) showed

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that matters such as symptom management, preparation for death, achieving a sense of completion, decisions about treatment preferences, and being treated as a "whole person" are consistently important among patients, bereaved family members, and physicians and other health care providers to patients, family members, and staff members.

Based on a quantitative survey conducted in Japan, Miyashita, Sanjo, Morita, Hirai, and Uchitomi (2007) clarified the concepts that Japanese people perceive as important for a good death. They identified 18 domains that contributed to a good death. Domains classified as consistently important were "physical and psychological comfort," "dying in a favorite place," "good relationship with medical staff," "maintaining hope and pleasure," "not being a burden to others," "good relationship with family," "physical and cognitive control," "environmental comfort," "being respected as an individual," and "life completion." Moreover, they identified eight domains as mixed importance such as "natural death," "preparation for death," "role accomplishment and contributing to others," "unawareness of death," "fighting against cancer," "pride and beauty," "control over the future," and "religious and spiritual comfort." Including these domains, they made the Good Death Questionnaire.

Morita et al. (2015) conducted a cross-sectional survey among palliative care physicians in Japan, Taiwan, and Korea by using the Good Death Questionnaire. Japanese physicians regarded physical comfort and autonomy as significantly more important. Taiwanese physicians regarded life completion and being free from tubes and machines as significantly more important. Korean physicians regarded being cognitively intact as significantly more important. The Morita study demonstrated differences in perception by physicians among Asian countries. However, studies from the point of view of patients or ordinary people (i.e., people who are not medical specialists) may be needed because medical services are provided to ordinary (i.e., nonmedical) people. Moreover, several studies have been conducted in Korea, Taiwan, China (Haishan et al., 2015), and Japan (Miyashita et al., 2007; Miyashita et al., 2015); however, there are very few studies which have compared the perception of a good death between Japanese and Thailand people.

Thailand is located in South-East Asia and > 90% of Thai people are Buddhist (Ministry of Public Health, 2007). Having a peaceful death is a common wish among Thai Buddhists (Kongsuwan, Locsin, & Schoenhofer, 2011). Although there are previous studies on the perception of a peaceful death that are focused on the intensive care unit (Kongswan, et al., 2010; Kongswan, et al., 2011; Kongswan & Locsin, 2010), there are a few studies about ordinary people.

Similar to Thailand, in Japan, Buddhism is also their main religion. Therefore, there may be similarities between these countries, but there may also be differences. In Japan and Thailand, cancer is the leading cause of death and patients may experience physical and psychological suffering. Therefore, enhancing palliative care may be a priority in both countries. We can learn characteristics from each country mutually from a cross-cultural study and also provide culturally suitable end-of-life care. The purpose of this study was to compare the perception of a good death between Japanese and Thai people by using the Good Death Questionnaire.

Method

Design

This study was a cross-sectional anonymous study. We compared the mean differences between Japanese and Thai respondents on a survey asking them about their perception of a good death. The research question was whether there would be a difference in the perception of a good death between Japanese and Thai people.

Participants

The inclusion criteria were participants (a) over the age of 20 years, (b) not medical specialists, and (c) who had the ability to understand the questionnaire. Through random sampling, 162 ordinary Japanese people were selected. In Thailand, the researchers used random sampling about province, district, and community and selected institutions in Bangkok and Nonthaburi province. After obtaining permission from these institutions, we (the researchers) met with 240 people who went to the health centers and aging clubs. The sample size was determined by the statistic reference. The researcher created the face sheet which included questions about demographic data. Although there were several demographic questions asked to participants during this study, the focus was only on age and sex. We analyzed the other demographic responses for another study.

Data Collection

For the Japanese participants, we used the Japanese version of the Good Death Questionnaire (Miyashita et al., 2007). The questionnaire has 10 components and measures how participants perceive a good death or a desirable death process. Cronbach's alpha coefficients of the Japanese version ranged from 0.61 to 0.88, except for a natural death. The Cronbach's alpha coefficients for the Japanese translated questionnaire was 0.82. Validity and reliability

are shown in Miyashita et al. (2007).

For the Thailand participants, the Japanese version of the Good Death Questionnaire was translated into English and then translated into the Thai language. There were some difficulties in translating, but the researchers met to discuss and resolve these issues. The Cronbach alpha coefficients for the Thai version of the questionnaire was 0.83, which shows there was reliability.

The Good Death Questionnaire has 18 components, which were selected from a previous study (Hirai, Miyashita, Morita, Sanjo, & Uchitomi, 2006) and a review of the literature. The 18 components included "physical and psychological comfort," "dying in a preferred place," "good relationship with medical staff," "maintaining hope and pleasure," "not being a burden to others," "good relationship with family," "physical and cognitive control," "environmental comfort," "being respected as an individual," "life completion," "natural death," "preparation for death," "role accomplishment and contributing to others," "unawareness of death," "fighting against cancer," "pride and beauty" (i.e., not having a change in one's appearance), "control over the future," and "religious and spiritual comfort." Validity and internal consistency were examined in a previous quantitative study. Participants rated the importance of each component of a good death on a seven-point Likert scale: (1 = absolutely unnecessary, 2 = unnecessary, 3 = somewhat unnecessary, 4 = unsure, 5 = somewhat necessary, 6 = necessary, and 7 = absolutely necessary).

In Japan, the general population was sampled using random sampling methods described in a previous study (Miyashita et al., 2007). Miyashita et al. (2007) identified 5,000 individuals in the general population by a stratified two-stage random sampling method of residents from four areas (Miyagi, Tokyo, Shizuoka, and Hiroshima; these cities included urban and urban-rural areas). They mailed 5,000 questionnaires to residents, and 2,670 were returned. After excluding questionnaires with missing data, 2,548 responses were useful. For the current study, we selected 162 of those questionnaires obtained by Miyahsita et al. by generating random numbers. We obtained permission from the subjects to use their questionnaires for this study.

In Thailand, the researchers selected institutions by using convenience sampling. Institutions were health centers, aging clubs, and those within the community. The researchers contacted the head of the institutions, and they recruited volunteers for this study. The research study was explained to the volunteers, and when they agreed to participate, they signed the consent form to permit an interview. At some of the institutions, the researchers interviewed the participants. They then completed the questionnaires voluntarily. The duration of the data collection was about three weeks. Ethical approval was obtained from Tokyo University in Japan and St. Louis College in Thailand before the study began.

Data Analysis

Demographic data were summed up as descriptive statistics. We performed Pearson's *t*-test scores of the questionnaire on the concept of a good death by using SPSS ver. 23. The significance level was .05. Although we selected 162 Japanese data, some subjects didn't answer all of the questions, so this attributed to missing data.

Results

The majority of Japanese respondents were between 60 and 69 years old, and the Thai respondents had a similar age range (Table 1). Approximately 60% of respondents from Japan were female, and approximately 70% of respondents from Thailand were female.

Table 1. *Background of Participants*

Age (years)	Japan		Thailand	
Age (years)	*N* (162)	%	*N* (207)	%
40-49	34	21.9	57	27.54
50-59	41	26.5	50	24.16
60-69	51	32.9	50	24.16
70-79	29	18.7	50	24.15
Gender				
Male	66	42.3	61	29.5
Female	90	57.7	146	70.5

Percentages do not add up to 100% due to missing values.

The results of the independent *t*-test on the Good Death Questionnaire domain are shown in Table 2. For Japanese people, the scores for "good relationships with medical staff" (question item: trusting physician), "dying in a favorite place" (question item: being able to stay at one's favorite place)," and "physical and psychological comfort" (question item: being free from pain and physical distress) were high in the total good death components. For Thai people, the scores for "natural death" (question item: dying a natural

death), "good relationships with medical staff," and "environmental comfort" (question items: living in calm circumstances) were high for the total good death components.

The scores for "good relationships with medical staff," "being respected as an individual," and "fighting against cancer" were statistically higher among the Japanese respondents than among the Thai respondents ($p < .001$, $p < .001$, and $p < .05$, respectively). However, the scores for "environmental comfort," "unawareness of death," "control over the future," and "religious and spiritual comfort" were higher among the Thai respondents compared to the Japanese respondents ($p < .001$, $p < 0.001$, $p < .001$, and $p < .001$, respectively).

Table 2. *Mean Scores of the Good Death Questionnaire*

	Japan	Thai	
Domains of the Good Death Questionnaire	*M (SD)*	*M (SD)*	*p-value*
1. Physical and psychological comfort	5.69 (1.16)	5.43 (1.93)	$p = .14$
2. Dying in a favorite place	5.93 (0.98)	5.85 (1.52)	$p = 0.55$
3. Good relationship with medical staff	6.39 (0.78)	6.00 (1.35)	$p = .001$
4. Maintaining hope and pleasure	5.79 (0.84)	5.62 (1.61)	$p = .22$
5. Not being a burden to others	5.76 (0.99)	5.56 (1.91)	$p = .22$
6. Good relationships with family	5.74 (1.06)	5.82 (1.57)	$p = .62$
7. Physical and cognitive control	5.75 (0.83)	5.61 (1.58)	$p = .33$
8. Environmental comfort	5.50 (1.02)	6.00 (1.47)	$p < .001$
9. Being respected as an individual	5.92 (1.17)	5.14 (2.04)	$p < .001$
10. Life completion	5.50 (1.22)	5.58 (1.58)	$p = 0.62$
11. Natural death	5.81 (0.96)	6.17 (1.34)	$p = 1.34$
12. Preparation for death	5.34 (1.26)	5.54 (1.74)	$p = .24$
13. Role accomplishment and contributing to others	5.43 (1.08)	5.28 (1.80)	$p = .36$
14. Unawareness of death	4.83 (1.37)	5.66 (1.66)	$p < .001$
15. Fighting against cancer	5.56 (1.20)	5.13 (2.07)	$p = .02$
16. Pride and beauty	4.86 (1.25)	5.08 (1.86)	$p = .21$
17. Control over the future	4.64 (1.52)	5.52 (1.74)	$p < .001$
18. Religious and spiritual comfort	4.22 (1.57)	5.99 (1.55)	$p < .001$

Moreover, we performed a correlation analysis of the domains for the Japanese data and for the Thailand data. For the Japanese respondents, the score between domain 10 (life completion) and domain 13 (role accomplishment and contributing to others) was $r = 0.57$. The scores between domain 4 (maintaining hope and pleasure) and domain 5 (not being a burden to others) and domain 4 and domain 6 (good relationships with family) were $r = 0.47$ for each. The score between domain 2 (dying in a favorite place) and domain 9 (being respected as an individual) was $r = 0.47$.

For the Thai respondents, the score between domain 6 (good relationships between family) and domain 7 (physical and cognitive control) was $r = 0.48$, and between domain 1 (physical and psychological comfort) and domain 5 (not being a burden to others) was $r = 0.45$. The score between domain 4 (maintaining hope and pleasure) and domain 6 (good relationships with family) was $r = .44$. The score between domain 7 (physical and cognitive control) and domain 8 (environmental comfort) was $r = .44$. These correlation coefficients have significance at the level 1% ($p < .01$).

Discussion

We compared the perception of a good death between Japanese and Thai people. The scores of "good relationships with medical staff," "being respected as an individual," and "fighting against cancer" were higher among the Japanese participants than among the Thai people. However, the scores of "environmental comfort," "unawareness of death," "control over the future," and "religious and spiritual comfort" were higher among the Thai participants compared to the Japanese participants.

For Japanese people, the high score for "good relationships with medical staff" and "being respected as an individual" were supported in a bereaved family study (Miyashita et al., 2008). This perception of "good relationships with medical staff" may be influenced by paternalism, which is traditional in the Japanese culture. Some Japanese want to rely on physicians or medical staff members for decision-making. The high score for "fighting against cancer" shows that some Japanese people may require as much medical treatment as possible. This tendency supports a

previous study by Miyashita et al. (2015) in which cancer patients required much more medical treatment than physicians.

For Thai people, the score for "environmental comfort" was high. Many terminally ill patients would prefer to stay and die in their home (Tipseankhum, Tongprateep, Forrester, & Silpasuwun, 2016), and palliative home care was a significant factor that enabled patients to experience their desire of dying at home (Nagaviroj & Anothaisintawee, 2016). However, palliative care and hospice services in the home are limited (Nilmanat et al., 2010) and substantially more education or training may be required.

The high score of Thai people for the item "religious and spiritual comfort" may be influenced by Buddhism. Thoughts about death in the Thai society are based on the Buddhist doctrine (Nilmanat & Street, 2007). When Buddhists perform good acts and thoughts, their minds are at peace and they believe they will go to a good place after death; the nurses proposed care that was based on this belief (Kongsuwan & Locsin, 2009). Thus, Thai people perceived religious and spiritual comfort as important. Although Japanese people feel a familiarity to Buddhism (Nishi, 2009), the score for the item "religious and spiritual comfort" was the lowest. It may depend on the individual.

The score for "unawareness of death" was high among Thai respondents. Since a previous study showed that many Japanese people do not want to know the seriousness of their condition (Morita et al., 2015), this tendency may be similar between the two countries. However, this tendency is different from results of American patients who want to "know what to expect about one's physical condition" to achieve a good death (Steinhauser et al., 2001) and Korean people who want to see and say goodbye to a dying patients before death (Glass, Chen, Hwang, Ono, & Nahapetyan, 2010).

In the correlation analysis between the domains of the Good Death Questionnaire, the coefficient between "life completion" and "role accomplishment and contributing others" was higher among the Japanese respondents. This finding demonstrates that Japanese people may regard life completion as important, and they may hope to accomplish their roles and contribute to others. On the other hand, the coefficient between "good relationships with family" and "physical and cognitive control" was high among the Thai respondents. Thai people may regard relationships with family as important and hope to have physical and cognitive control. This finding may indicate that they hope to spend time with family and have physical and cognitive control.

Implications for Nursing

There are some differences in the perception of good death among Japanese people and Thai people. Therefore, nurses need to reflect on these differences when providing nursing care. Because Japanese people perceived "good relationships with medical staff," "being respected as an individual," and "fighting against cancer" as important, it is useful for nurses to provide good relationships by using high-quality communication skills, proposing nursing care with respect, and maintaining a patient's hope or desire to fight against cancer. By contrast, because Thai people perceived "environmental comfort," "unawareness of death," "control over the future," and "religious and spiritual comfort" as important, it is useful for nurses to realize the importance of environmental comfort for a patient, spend time with the patient as usual (e.g., be sensitive to the patient's desire not be aware of an illness), and provide for the patient's religious and spiritual comfort. As for its importance to Asian and Pacific Islanders, the aging population is increasing in these countries and it is important for nurses to know cultural differences on how a good death is perceived in order to propose care tailored to these differences. Lastly, many people in these countries often interact as an international society and understanding of the perception for good death may be useful.

Limitations

This study had some limitations. One, the participants in Japan were selected from a previous study performed by Miyashita et al. (2007), whereas the participants in Thailand were selected from other institutions. Therefore, a strict comparison may be difficult. Two, we did not use the standardized Good Death Questionnaire for Thai version, although we did obtain Cronbach's alpha. We need to resolve these problems in a future study.

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