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# Spiritual Needs of Taiwan's Older Patients With Terminal Cancer

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**F**rom biologic, ecologic, medical, sociologic, cosmologic, philosophic, and ethical views, death is an inevitable event and a universal process in human life (Grogono, 2000; Hsin & Macer, 2006). Older people who are closer to death and have had full life experiences may have noteworthy needs to share.

Possibly because of increased life expectancy in Taiwan, more patients are dying from cancer. According to the Department of Accounting and Statistics (2005, 2008), Taiwan's older population (aged 65 and older) has increased from 7.6% of the total population in 1995 to 10.38% in 2008. An older patient with a terminal illness faces physical, psychological, spiritual, and moral suffering. Many Taiwanese patients with a terminal illness expect healthcare providers and family members to provide appropriate end-of-life care, care that creates peace of body, mind, and spirit during the uncertainty of the death-approaching phase (Lin, 2003; Tseng et al., 2005; Yiting, Doring, Fang, Li, & Baoqi, 2005).

Shih, Gau, Lin, Pong, and Lin (2006) indicated that quality care during the dying process can turn an expected loss into a positive for patients, the patients' families, and healthcare providers. In contrast, an unsatisfactory level of care may prevent patients from achieving a peaceful passage because of physical discomforts and an unsuccessful completion to life. Some patients may even believe that their afterlife is negatively affected during the dying process. Based on patient, family member, and healthcare provider suggestions, the elements of good death care include bodily peace (e.g., effective pain and symptom management, cleanliness, integrity of the body), peace of mind (e.g., yielding, settlement of all necessary affairs, not being lonely), and peace of spirit (e.g., a meaningful life, a sense of completion, affirmation of the whole person) (Steinhauser et al., 2000).

Among the domains of care, spiritual health is at the core of a patient's existence and affects, connects, and transcends all aspects of being (Isaiah, Parker, & Mur-

**Purpose/Objectives:** To explore the core constitutive patterns from the perspective of the older patient with terminal cancer, the major foci of spiritual needs, and professional actions that manifest tangibly as spiritual care.

**Design:** Hermeneutic inquiry.

**Setting:** Two leading teaching hospitals in Taiwan.

**Sample:** 35 older patients with terminal cancer with a life expectancy of three months.

**Methods:** Participatory observation and in-depth interviews were the major data collection strategies. Hermeneutic inquiry was used to disclose, document, and interpret participants' lived experiences.

**Main Research Variables:** The perceptions of older Taiwanese patients with terminal cancer and their particular healthcare needs across various transition stages.

**Findings:** Two constitutive patterns, "caring for the mortal body" and "transcending the worldly being," each with three themes and a related transformational process emerged from the data analysis. Two foci of spiritual needs were discovering patients' concerns about their dying bodies and their worldly being and facilitating the transcendence of the spiritual being from the physical realm.

**Conclusions:** Caring for older Taiwanese patients with terminal cancer and helping them transcend the fear of the unknown when they give up worldly being can produce insights into patients' primary concerns, perceptions, and spiritual needs to help them achieve a "good" death.

**Implications for Nursing:** The knowledge gained in this study and the six major spiritual care actions identified may empower oncology nurse educators to develop culturally valid spiritual care courses. Research-based guidance for nurse clinicians who are taking care of older Taiwanese patients with terminal cancer will be provided.

row, 1999). Spirituality has long been acknowledged as a basic human need associated with quality of nursing care. The defining characteristics of spirituality include establishing belief systems; mastery of life's challenges; experiencing a sense of love (e.g., belonging, protection,

### Quick Facts: Taiwan

**Geography and population:** Taiwan is a relatively small island country in Asia that, as of June 2007, had a total population of about 23 million people.

**Economy:** Because of Taiwan's free economic environment and limited natural resources, Taiwan has transformed from a labor-intensive agricultural economy to a technology- and capital-intensive industrial economy.

**Healthcare system priorities and programs:** The Taiwan government established a national health insurance program in 1994 that provides universal medical care to all citizens. Medical expenses for children who are diagnosed with cancer are covered with the exception of a small co-pay. Cancer was the leading cause of death for Taiwanese people in 2007 and has been since 1982.

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animation, being valued, giving life); and searching for meaning, purpose, and reconciliation (central to a good death) (Delgado, 2005; Dobratz, 2002; Hinshaw, 2002; Lin, 2003; Shih et al., 2001, 2006; Tseng et al., 2005). Spiritual needs of older patients in hospice care also are related to involvement and control, a positive outlook, companionship, completing necessary business, religion, and experiencing nature (Hermann, 2001). Awareness of spiritual concerns often is magnified when the patient faces emotional distress, physical illness, or death (Shih et al., 2001). However, spirituality is a nebulous concept, shaped by culture, and often is context dependent (Sellers, 2001). Western and Eastern medicine face challenges when providing quality cultural care for older patients with terminal cancer. A wide-ranging development of spirituality, including patients' beliefs, world views, and rooted social principles, is needed to advance nursing knowledge (Dobratz, 2002).

Many nurses in Taiwan report a lack of adequate knowledge and training about providing spiritual care to patients with terminal illnesses and their families (Shih et al., 2006). Taiwanese researchers are exploring the cross-cultural commonalities reflected in the universal spiritual needs of terminally ill patients (Chao, Chen, & Yen, 2002); however, the particular and comprehensive cultural meanings of spirituality and their relationship to the care provided by nurses tending to older patients with a terminal illness is not clearly understood. In addition, a lack of spiritual care competency hinders nurses' confidence and attitudes when assisting patients with terminal illness to overcome their spiritual distress during the dying phase. To empower nurses to support patients and their families through this phase, and to help them to achieve a good death, the authors followed the dying process of a number of older patients with terminal cancer to detect their perceptions of dying and their particular

healthcare needs across the various transition stages. This project had three major aims: to explore the core constitutive patterns of the experience from the dying patient's perspective, to identify the major foci of spiritual needs, and to determine what professional actions manifest tangibly as spiritual care. The research will lead to a better understanding of patients with a terminal illness and their families and develop improved guidelines for quality care during the dying phase.

## Methods

### Study Design

Hermeneutic inquiry was used to disclose, document, and interpret the lived experiences of 35 patients with terminal cancer and to provide various viewpoints with respect to their spiritual needs. Hermeneutic phenomenology has secured a prominent position in the philosophical consideration of existential issues (Annels, 1996; De Witt & Ploeg, 2006), and the work of Heidegger (1962) has proven its ontologic depth and unveiled the shared meanings of daily practice that provide fresh insights into new ways of being (Annels; Diekelmann, Allen, & Tanner, 1989).

### Setting

With the permission of patients, their significant others (spouse, children, or other family members), and their primary physicians, older patients with cancer who were diagnosed as terminal by their primary physicians were recruited from wards or intensive care units at two leading teaching hospitals in northern Taiwan.

### Sample

The patient inclusion criteria for this study were: aged 65 years or older; life expectancy of around three months; agreement to participate from the patient, their significant others, and primary physician; and no diagnosis of alcoholism or mental illness. The participants' primary physicians referred them to the researcher.

### Procedure

With the approval of institutional ethics committees, patients and their significant others, and primary physicians, patients were individually approached to take part in the study. The purpose of the investigation and associated procedures were carefully explained, with all questions clarified before obtaining written consent.

Participatory observation and in-depth interviews were the major data collection strategies used in the study. In-depth, face-to-face interviews were tape recorded. Interview tapes and memos were securely stored and then destroyed at the end of the project. The principle investigator (PI) and a faculty member with 25 years of oncology

and terminal care experience joined participants' primary care nurses to provide patient care through three- to four-day shifts, weekly, for at least one month before participant death. Because the PI was familiar with the communication patterns and particular needs of each patient, the PI was invited to be present during the last 24 hours of life. Most participants were too fragile to express their needs. In addition, "spiritual" and "spirituality" are abstract terms that are difficult to directly analyze, which caused some issue with data collection. The researcher had to build a good trust and a caring relationship with participants to correctly analyze their responses. In fact, a great deal of nonverbal language was included in the data collection, such as "They watched their photo attentively," "They were very happy when they saw their family members coming in or relatives visiting," "They were touched or crying when people expressed their support," and "They spent more time praying, reading the Bible, or reading Buddhist sutras." However, verbal language data were the main source in the results section because of validity; such data are directly expressed by the participants. Open-ended questions and unstructured interviews were used and the participants' readiness to hold conversations was taken into consideration. The participants' reflections on spiritual needs were mainly elicited by questions such as, "At this moment in your life, what do you think of or hope for most of time?" "What has been the most important (most difficult, meaningful, or rewarding) aspect of your life?" and "What religious resources do you have and are they helpful or nonhelpful to you in any particular ways?"

### Analytic Methods and Study Rigor

Data collection and analysis took place over a 24-month time frame. De Witt and Ploeg (2006) proposed five expressions of rigor for interpretive phenomenology. To keep the emerging findings firmly grounded in the participants' actual experiences, strategies (Guba & Lincoln, 1994; Shih et al., 2001, 2006) were adopted.

- Careful use of multiple observation and interview techniques to establish a chronology of clarifications and various explanations
- Accurate transcription of the patients' words and the highlighting of data related to descriptions about dying, spiritual needs, and desired care
- Periodic reexamination of the relationship between the sequence and background rationale framing the multifaceted experiences of each patient, together with patient interaction strategies and the potential consequences under different conditions
- Managing and resolving difficulties with respect to descriptions of patients' conceptions and perceptions related to issues of dying care, spiritual needs, language, and culture
- Searching for any negative case analyses and the use of periodical peer debriefing

- Determining the relationships between spiritual needs, background meanings, and related caring actions
- Confirming the interpretation with participants, their significant others, and healthcare professionals when necessary.

## Results

A total of 35 participants (19 men, 16 women) took part in the research project. Thirty-one were married and had children, and 15 had a particular religious affiliation (Buddhism, Protestant, or Catholic), whereas the remainder followed Confucianism or Taoism (seen as philosophical belief systems by the authors). Twenty-three of the participants died in the hospital (10 in the ward units and 13 in the intensive care unit); the remainder died at home in the presence of their significant others and the PI. The mean duration between being informed of the terminal stage of cancer and death was four months (SD = 1.51) (see Table 1).

Dying is not only a physical transition, but also a unique spiritual and psychosocial journey. The participants' spiritual needs also were analyzed and revealed two core constitutive patterns: caring for the mortal body and transcending the worldliness.

### Caring for the Mortal Body

Caring for the mortal body describes the participants' perceptions of impending death and explores their primary concerns about how to live with their failing body during the dying phase. The content of this pattern consisted of three themes: a need to maintain physical and spiritual integrity associated with demanding more care and comfort; the need for companionship on this final lonely and uncertain journey, linked to a struggle with embarrassment and vulnerability; and a need for a final resting place for the body, which is associated with where the person wants to die and funeral preparations.

**The need to maintain physical and spiritual integrity:** All of the participants felt a need for healthcare professionals' help in decreasing their suffering and enhancing their comfort by providing good quality care. The supportive attitude of healthcare professionals, which was reflected in a prompt response when a consultation was needed, was particularly appreciated.

We as terminal cancer patients can hardly be expected to deal with the discomforts caused by medical treatment by ourselves. However, the confident, comforting, and gentle but professional care provided by health caregivers in all things, including preparations for dying issues, are so important to us.

Since we know little about death, most of us have a lot of questions. Health professionals' support, which is demonstrated through patiently answering our questions, is invaluable.

Table 1. Demographic Characteristics

Characteristic	n	%
<b>Age (years)</b>		
X = 75.36, SD = 3.41	–	–
65–69	6	17
70–79	20	57
80–89	8	23
≥ 90	1	3
<b>Gender</b>		
Male	19	54
Female	16	46
<b>Marital status</b>		
Married	31	89
Single or divorced	4	11
<b>Education</b>		
College	2	6
High school	4	11
Elementary school	20	57
Illiterate	9	26
<b>Religious affiliation</b>		
Confucianism or E-Quan Taoism <sup>a</sup>	20	57
Buddhism	10	29
Protestant or Catholic	5	14
<b>Primary cause of death</b>		
Respiratory failure	17	49
Heart failure	8	23
Sepsis	5	14
Multiple organ failure	5	14
<b>Location of death</b>		
Hospital	23	66
Home	12	34
<b>Months from diagnosis until death</b>		
X = 3.82, SD = 1.51	–	–
< 1.0	2	6
1.0–2.0	11	31
2.1–4.0	14	40
4.1–6.0	8	23
<b>Primary caregiver<sup>b</sup></b>		
Family members	28	80
Hired people and friends	18	52

N = 35

<sup>a</sup> E-Quan Taoism is a well-known branch of Taoism in Taiwan.

<sup>b</sup> Some patients indicated both family members and hired caregivers in their responses.

Some of the participants also were concerned about cosmetic assistance with their bodily appearance after death.

Please do not let me look ugly; I need to be good looking when I enter the afterlife.

A terrible bodily appearance, such as large scars, a nasogastric feeding tube, or a Foley catheter, might decrease my credits [karma] in my next life cycle.

Some participants obtained spiritual comfort and integrity from religious support.

The Superior One whom I have been trusting will grant me adequate strength and keep my faith, allowing me to endure nausea, vomiting, hyperthermia, and pain in my last days.

**Need for companionship linked to a struggle with embarrassment and vulnerability:** Participants felt embarrassed when they had to take the initiative and ask for their significant others’ companionship and, in particular, their help in relieving physical discomforts and psychological insecurity. The difficulties were particularly troubling for participants who considered themselves the “leaders” or “decision makers” in their families because they felt their neediness might change their identity within the family and diminish the dignity and respect felt for them.

To deal with this difficulty, nurses often acted as liaisons who communicated participants’ needs to significant others. The companionship and comfort provided by significant others was particularly important when the participants endured physical discomforts, when they were informed of their poor prognosis, and when they were concerned about unfamiliar medical therapy.

Although I feel lonely and scared because of my declining health (during the evening and night in particular), I was embarrassed to ask for my children’s comfort and companionship because I used to be their leader and protector.

I needed trusted family members to stay at my bedside to comfort me when I underwent intrusive therapy. But, I didn’t speak out because I didn’t want them to worry about me.

I was stressed whenever a physician came into my room because they always told me bad news; I felt that I had less and less time in this world. In my heart, I needed my family and close friends to stay with me to encourage me.

I couldn’t make a decision on therapy options without the help of my family and friends. Without them, I just wanted to die immediately.

**The need for a final resting place for the body:** Thirty participants (86%) said they wanted to take a good bath to cleanse their bodies and take their last breath at home, in their own bed, if possible.

Please help me take a good bath; I want my soul to leave this world nice and clean.

If I don’t die at home in my own bed after I say goodbye to my family members and close friends, my soul might get lost.

The participants reported that helping them pass away and arrange their funeral ceremony according to their religious affiliation was their last blessing in mortal life. By doing so, they would be remembered and respected better by their significant others. Buddhist participants believed that they would then earn more positive credits for a better reincarnation.



During the funeral ceremony, the contributions I have made to others and to society are acknowledged and made clear to the dependents in my families. I hope that this will inspire them to learn from my life.

If my family participates in the ceremony and feels grateful to me, I will be able to earn more positive credits for my next life.

## Transcending the Worldly Being

Transcending the worldly being described participants' worries with respect to dealing with their present and future self and their subsequent transformation. The pattern consisted of three themes: passing over without regret involving questioning or affirming the meaning of worldly being, ascertaining a sustained being in the world through the promise of maintained familial continuity, and searching for belonging in the future world by attaining a firm sense of religious affiliation.

**Passing without regret:** Thirty participants (86%) expressed the need for affirmation from their significant others of the positive worldly contributions they had made during their lives on others and society, coupled with face-to-face verbalizations of intimate feelings with significant others. Nurses assisted in this process by communicating the importance to participants and their significant others, which was greatly appreciated.

Acknowledgement of my contributions to others and to this society is rewarding for me and my significant other.

I ask myself, "What things can I leave behind that will be remembered by others?" The more positive the answers, the more peace and the less regret I have.

With the nurse's encouragement, my children told me that they needed me so much. I know it is difficult for us Taiwanese to say so. As a dying person, I'm so content and this has reaffirmed my strong sense of belonging.

I feel a relief as my sense of being needed was satisfied. With the acknowledgement and love of my family, I feel ready to leave for another world.

**Ascertaining a sustained being in the world:** Twenty-six participants (74%) who had children stressed that a commitment to continued filial piety by ongoing compliance with parental expectations and taking care of dependents, such as younger or handicapped family members and the older remaining significant others, was particularly appreciated.

I asked my oldest son to demonstrate his filial piety by compliance with my unfulfilled duties, such as taking over my role of caring for his siblings and deal with family issues.

I require each of my sons to take turns to invite their mother to live with their families.

I wish that all my children would have a good marriage and sustain their descendants.

I asked my family to promise me to stay healthy, help each other, and achieve the best in their lives.

**Searching for belonging in the future world by attaining a firm sense of religious affiliation:** Maintaining a close relationship with their god(s) during the dying phase was important for participants with a religious affiliation because it helped them secure a peaceful place in the next world. This need was particularly explicit for participants who were worried about loss of control; felt hopeless or helpless; were scared about death and the afterlife; or lacked strong feelings of belonging, being loved, or protected by their god(s) as they approached death.

I've felt very close to my god and been searching for peace of mind since the day I was informed of dying in the near future.

Living is a daily battle for an old dying person; I simply can't stay independent like I used to be. Religious support has been like cool drink of water and a crutch to help me on my daily walk through the desert.

I'm ashamed of my sins; I need my god to purify my soul before I enter the eternal world.

## Discussion

According to the results of the data analysis, two major foci of nursing care that need to be discussed to meet the spiritual needs for a good death in older Taiwanese patients with terminal cancer: discovering the patient's concerns with respect to their dying body and worldly being, and facilitating the transcendence of the spiritual being from the physical realm.

### Discovering the Dying Older Patients' Concerns With Respect to Dying Body and Worldly Being

In this project, older Taiwanese patients with terminal cancer reported that they expected their nurses to play a pivotal role in patient care and bear the ethical responsibility of preserving patients' physical and spiritual dignity through the application of humanistic attitudes and holistic care. Cartier (2003) proposed that, once patients move into an institutional setting for terminal care, they lose power, control, and their intrinsic value as whole persons. Many patients feel that institutions transform them into compromised bodies seen only in terms of their need for fundamental care, such as feeding, toileting, and bathing. Most patients with terminal illness want to retain control over the place, process, and timing of their death

(Starks, 2004). In the current study, many older Taiwanese patients with terminal cancer felt vulnerable and embarrassed when asking for help from others with end-of-life care, even if it was desperately needed.

Engagement with the human, the vulnerable, is the central source of meaning and healing at the end-of-life . . . the awareness that end-of-life care includes—in fact demands—a human relationship between the health professional and the dying person is an important step in providing dignity to those who are dying (Kaufman, 2002, p. 34).

Many older patients with terminal cancer expected that their healthcare providers would treat them and their significant others like their own relatives (this feeling was expressed in Chinese as 視病猶親). This trust relationship may be viewed as the foundation of spiritual care and, with the help of this trust relationship, the concerns of older Taiwanese patients with terminal cancer, with respect to a good death, are brought into focus, facilitating the additional development of individual medical treatment and nursing care (Shih et al., 2001). Many older patients might be concerned with respect from their significant others. Being comforted and supported by their significant others, obtaining a promise from them of continued compliance with expectations, and acknowledgment of the contributions made to the family and society were strongly stressed by the patients, helping to confirm the meaning and value associated with a life journey.

Longaker (1997) found that a large part of the inner suffering associated with dying may come from the belief that sharing the true nature of inner fears, personal frustrations, and feelings of sadness are not acceptable. Talking about illness, death, and dying are considered cultural taboos and bad luck in Taiwanese culture (Braun & Nichols, 1997); however, many older Taiwanese patients with terminal cancer appreciated the opportunity to discuss their health status and their preparations for a peaceful death (Shih et al., 2006). Facilitating family support and continuity and allowing the patient to depart without regret was important to most of the sample. Helping to create a friendly spiritual environment to facilitate the death process for patients, their bereaved significant others, and their healthcare providers, by sharing profound thoughts and intimate feelings with respect to dying and related preparations, should be encouraged (Pizzi & Briggs, 2004; Shih et al., 2006).

In the current study, 86% of the participants wished to die at home, although only 34% did. For most Taiwanese, dying at home has a unique cultural meaning that might be expressed best as the fallen leaves should return to their roots (or 落葉歸根 in Chinese). Without this, the soul of the dead cannot be reunited with his or her forebears' family and becomes lost in the metaphysical world (Tang, 2000). Starks (2004) concluded that most Western patients also prefer to die at home because they feel most

comfortable there, can maintain their sense of self through continuity and linkage with the place that has the most memories and personal meanings, and because they can assert the greatest control over the dying process there. However, transfer of patients from institutions to their homes for a palliative homecare program is challenging. Major barriers include insufficient caregivers, a poorer quality of care at home, and familial concerns with respect to emergency medical conditions (Hu, Chiu, Cheng, Chuang, & Chen, 2004). Therefore, an effective referral system, including integrative inpatient care and homecare programs for dying patients, is suggested. Nurses should discuss personal preferences for place of death with patients and their significant others to preserve patients' integrity of body and mind as death approaches.

### Facilitating the Transcendence of the Spiritual Being From the Physical Realm

Landmark, Strandmark, and Wahl (2001) noted that, as death approaches, thoughts of the patient's future in the mortal world are eradicated; the patient often loses an understanding of themselves and their own existence. Their awareness of being (intrinsic self-understanding) returns in the final stages of life and raises issues about the possibility of life after death (Benzein, Norberg, & Saveman, 2001). Because the support provided by existential medical care and an empirical epistemology system (knowledge base in this field) is limited, patients often cope with bodily discomforts, inner turmoil, and an anticipated but uncertain afterlife. Specifically, religious support is expected to help transcend the spiritual being from the physical realm.

Many of the participants reported the need for religious support that provided comfort when dealing with physical discomforts, to help them develop peace of mind, to empower inner strength to face the uncertainty of death, and to establish a blessed transcendence from this world to the afterlife through compliance with funeral rituals. Spiritual meanings and values of the funeral ceremony vary across different religions. Buddhists and Taoists believe that the funeral ceremony ensures purification of the soul, earns more credits in the afterlife, and offers the opportunity for significant others to practice caring for the deceased. By contrast, Christians may wish to demonstrate the value of their life journey and to honor their God through a funeral ceremony (Shih et al., 2001). Nurses are encouraged to understand the importance of religious support and cultural beliefs that idiosyncratically affect the dying patient, to be compassionate, and to adopt the principles when providing nursing care. By providing a greater respect for the patient's deeper needs, nurses help the patient transcend the mortal world and become a more peaceful spiritual being.

The findings affirm the results of other research reports indicating that most terminally ill patients hope

for a good death with spiritual support that meets their transcendental needs from being a mortal person (uncertain, temporary, and suffering from illness) to a hopeful afterlife (pain free and eternal). In addition, to meet the dying patients' spiritual needs, their significant others, caregivers, and religious leaders are encouraged to develop a reliable social support network for the patients. This hope for a good death gives meaning to life; contributes to patients' sense of self-wholeness, self-worthiness, and life fulfillment; offers forgiving relationships with others; and offers religious counsel to prepare for a blessed afterlife (Boero et al., 2005; Chao et al., 2002; Hu et al., 2004; Shih et al., 2006; Tanyi, 2002). In addition, research reveals that the contextual background of older Taiwanese patients' expectation for a good death has a culturally distinct emphasis, such as asking for nurses' help in supporting their family members (spouses in particular), making funeral arrangements, and communicating expectations for children and the surviving spouse. The expectations may be attributed to Taiwanese cultural ideology and ancestor worship that create a stronger desire for family continuity after death. In Taiwan, spiritual bonds for Buddhists between parents and children and between ancestors and offspring remain strong long after death. Family members often worship their ancestors as well as deities to earn blessings and health. Nurses must be aware of their clients' particular cultural background so they can provide culturally sensitive holistic care.

## Limitations

Most participants in this study were too fragile to express their needs. In addition, the terms "spiritual" and "spirituality" were too abstract to be directly analyzed, causing difficulty with data collection. Because the majority of participants were married, undereducated, and from unique cultures, their spiritual needs may not be generalized into other groups. Additional studies of older patients with terminal cancer should explore all the dimensions of spiritual needs and their relationships with age, gender, ethnicity, and religious affiliation together with their possible affect on the suggested care model for this vulnerable and valuable population.

## Conclusion

Spirituality is recognized as a cornerstone of holistic care and remains central to the essence of modern nursing. Caring for older Taiwanese patients with terminal illness and helping them to transcend their fear of the unknown after death may provide enriched insights into the natural final process, patients' primary concerns and perceptions, and their spiritual needs for a good death. This study has revealed culturally significant patterns among patients' spiritual needs and highlights the com-

plexity of a given culture's biopsychosocial transactions within specific religious contexts. Fulfillment of patients' spiritual needs during the final phase of life is not a static event but, rather, a fact of a sequence of changes along with a transactional process involving patients, their significant others, and healthcare providers. The process encompasses deep wishes for learning and caring for the failing body, leaving blessings behind as a mortal being, and pursuing an afterlife as a transcendental spiritual being. The attempts would not be possible without comfortable care for the body.

## Implications for Nursing

Nurses play multiple roles in this fostering of a good dying process. Spiritual and empathic qualities should be emphasized to secure timely and adequate support for older patients with terminal cancer and their significant others. In addition, professional knowledge, skills, and critical self-reflection also are needed to help the patient so that an interface and mediation exists with other healthcare professionals.

Exploration of the spiritual needs of older patients with terminal cancer inevitably leads to logical conclusions with respect to supportive strategies for healthcare providers. A research-based model of spiritual care may emerge in the future from this type of study that will facilitate in-depth understanding of the conceptions of a good death, help with the provision of tangible care, and generate recommendations for interdisciplinary involvement when caring for the ethnically distinct spiritual needs of older patients with terminal cancer. Six steps of potential spiritual care for the dying elders are suggested for nurse clinicians from the current research.

- The establishment of a rapport and a trusting relationship with patients, their significant others, and their healthcare providers
- The advocating of the correct and explicit individual needs in terms of spiritual care for patients and their significant others
- The coaching of the patients and their significant others to clarify their spiritual care concerns and to help provide timely and needed care during each death-approaching transition
- The helping of other healthcare providers so that their concerns about the spiritual needs of dying patients and their significant others are clarified
- A four-way integration of patients, significant others, nurses, and other healthcare providers to provide synergistic integration of the spiritual care
- The provision of quality holistic care for patients by maintaining optimal functional and spiritual well-being.

When tangible good death care practices are implemented, all involved should be challenged by the reciprocal sharing of the transforming feelings of loss



and grief, and critically reflect on the value systems of self. Nurses play an invaluable role as communicators, keeping all concerned parties informed (Shih et al., 2001, 2006). With such a trust relationship and a commitment to good dying care, nurses will have a greater opportunity to inspire the liberation and integration of the transactional powers and to add promising passages to patients' ongoing life stories by supporting each other.

The findings in this study may be useful in designing culturally sensitive spiritual care courses for nurse educators. In addition, a research-based guideline may be developed concerning spiritual care for older Taiwanese patients with terminal cancer.

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