

Predictors of Intention to Participate in Advance Care Planning Among People with Cancer in a University Hospital in Bangkok, Thailand: A Cross-Sectional Study

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Abstract: The rising incidence of cancer in Thailand, the poor prognosis of people with advanced-stage disease, and cultural barriers to discussions about death all contribute to insufficient awareness of the advance care planning process among the Thai population. This cross-sectional study examined factors influencing the intention to participate in advance care planning among people with cancer in a university hospital setting. A total of 155 people with cancer were recruited through simple random sampling from the oncology outpatient unit of a university hospital in Bangkok, Thailand, during November 2024 and February 2025. The following instruments were employed: the Mini-Cog assessment for cognitive screening, the Personal and Health-Related Information Questionnaire, and the Advance Care Planning Questionnaire, which comprises measures of knowledge, attitudes, subjective norms, and intention to participate regarding care planning. The data were examined through descriptive statistics and multiple regression analysis.

The results indicate that knowledge, attitudes, subjective norms, and covariates collectively and significantly predicted intention to participate in the advance care planning process among people with cancer, accounting for 42.1% of variance. Attitudes towards advance care planning were the strongest predictor, followed by subjective norms and knowledge. The findings highlight the need to cultivate positive attitudes, strengthen understanding, and actively involve key influencers to improve participation in advance care planning within this population. In particular, nursing practice should prioritize early assessment of patients' attitudes and engage family influencers in advance care planning discussions, ensuring alignment with Thai cultural values and promoting greater engagement among individuals with cancer.

Keywords: Advance care planning, Attitudes, Intention, Knowledge, Participation, People with cancer, Subjective norms

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Introduction

Advance care planning (ACP) serves as an essential element of palliative care,¹ particularly for people with advanced cancer. Cancer remains a major global public health challenge, with incidence rates steadily increasing. In 2022, an estimated 20 million

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new cancer cases were documented across the world.² In Thailand, the rising incidence of cancer and poor

prognosis at advanced stages,³ along with cultural sensitivities surrounding discussions of death,⁴ have limited awareness of and participation in ACP. These factors also influence physician-initiated communication, healthcare system practices, and family involvement in ACP.

ACP represents a process where individuals proactively establish their future healthcare preferences while still possessing decisional capacity.⁵ The ACP process involves interdisciplinary collaboration among the healthcare team, patients, and their families or caregivers.⁶ The primary objective is to align clinical care with the patient's goals and preferences for care.⁶ ACP is vital in ensuring care that is consistent with the patient's wishes, which may decrease conflicts in care decisions.^{7,8} Additionally, it can alleviate the emotional burden on families or caregivers by providing clarity during uncertainty regarding the patient's clinical condition and supporting families in more effective bereavement adaptation.¹

Although previous studies in Thailand and other Asian contexts have examined ACP-related outcomes, most have focused on the prevalence of ACP participation,^{5,9,10} or the completion of advance directives. There is limited theory-based evidence on the psychosocial predictors of patients' intentions to participate in ACP. Therefore, this theory-driven study was based on the Theory of Reasoned Action (TRA) and informed by a literature review. The findings are expected to inform the development of a targeted intervention to increase ACP participation among people with advanced cancer.

Literature Review and Conceptual Framework

This study utilized the Theory of Reasoned Action, developed by Ajzen and Fishbein,¹¹ and a review of relevant literature as its conceptual framework. This theory is based on the fundamental

belief that humans are rational beings who systematically use information and consider their actions before deciding whether to act. Therefore, behaviors are controlled by individual choices and decisions. The direct determinant of behavior is intention, which arises from two basic factors: 1) Personal factors, namely attitude toward behavior, determined by an individual's beliefs about the consequences of performing that behavior and their evaluation of those consequences as positive or negative; and 2) Social factors, namely conformity to reference groups, determined by an individual's beliefs about norms (normative belief), which is an individual's perception of the influence of society or influential figures on performing or not performing a behavior, as well as the individual's motivation to comply with that social influence.¹¹

In the context of ACP, participation in the planning process represents a voluntary behavioral decision. Individuals need sufficient knowledge and understanding to form behavioral beliefs, develop favorable attitudes toward ACP, and perceive supportive subjective norms from significant others. According to the Theory of Reasoned Action (TRA), these cognitive and normative factors collectively shape behavioral intention to participate in ACP.

Previous studies have shown that attitudes toward ACP and subjective norms are positively associated with intention or willingness to engage in ACP.^{9,12,13} These findings support the theoretical assumption that TRA evaluative and normative influences primarily determine intention. Additionally, although knowledge is not explicitly included as a core construct in TRA, evidence suggests that knowledge about ACP contributes to the formation of behavioral beliefs by enhancing individuals' understanding of its purpose, benefits, and implications.¹²⁻¹⁴ Knowledge may therefore function as a foundational cognitive factor that indirectly influences intention through its impact on beliefs and attitudes.

The enactment of Thailand's National Health Act¹⁵ has given patients the legal right to document their end-of-life wishes through Advance Directives (ADs). ACP, on the other hand, goes beyond writing one's wishes to include ongoing conversations among patients, families, and healthcare professionals. ACP engagement in Thailand is strongly family-centered decision-making and cultural avoidance of death-related discussions (i.e., often viewed as misfortune or curses).⁴ This may make it harder for patients to take part. Furthermore, healthcare professionals may contribute to this dynamic, as they may recognize the importance of ACP but still primarily discuss end-of-life issues with families instead of patients. As a result, the family becomes the main decision-maker, sometimes without the patient's consent.¹

With the above Thai context and related literature, ACP engagement among patients with cancer may be shaped by cultural sensitivities toward discussing end-of-life issues, family involvement in treatment decisions, and the influence of healthcare professionals. However, evidence regarding theory-based predictors of Thai people with cancer (PW-CA) intention to participate in ACP remains limited. Therefore, this study examined the extent to which knowledge about ACP, attitudes toward ACP, and subjective norms predict intention to participate in ACP among PW-CA in a university hospital.

Study Aim

This study aimed to investigate the association of knowledge of ACP, attitudes toward ACP, and subjective norms with PW-CA's intention to participate in the ACP process, and to determine whether these factors significantly predict intention among PW-CA at a university in Bangkok, Thailand.

Methods

Study Design: We used a cross-sectional design, and this report followed the Strengthening the Reporting of Observational Studies in Epidemiology (STROBE)

Statement, which is a set of guidelines for reporting observational studies.

Study Setting and Participants: The study was conducted from November 2024 to February 2025 at an outpatient cancer clinic of a university hospital in Bangkok, Thailand. We used a sample of PW-CA, with the sample size determined a priori via a power analysis using the G*Power 3.1.9.7 program.¹⁶ The statistical test used is linear multiple regression: fixed model, R^2 deviation from zero. The significance level (α) was set at 0.05, and the power of the test was set at 0.80. Given the limited prior evidence, the study by Ke et al.⁹ reported that a multiple regression model explained 46.3% of the variance in behavioral intentions toward ACP ($R^2 = 0.463$; $f^2 \approx 0.86$). However, differences in population characteristics, healthcare context, and cultural background limited the applicability of these findings to the present study. Therefore, a small effect size ($f^2 = 0.08$) was used for sample size estimation,¹⁷ yielding a required sample of 141 participants. To account for potential data loss and reduce the risk of Type II error, the sample size was increased by 10%, resulting in a final target of 155 participants.

Inclusion and Exclusion Criteria: The researchers selected people with cancer (PW-CA) who came to the clinic and met the following inclusion criteria: 1) aged 18 years or older; 2) cognitively intact, verified by using the Mini-Cog¹⁸⁻¹⁹ with a score ranging between 3 and 5 among those aged ≥ 60 years old; 3) able to read, write, listen, and communicate in Thai; 4) free of severe visual or hearing impairments; 5) diagnosed and aware of having cancer; and 6) provided voluntary informed consent. The exclusion criterion was fatigue or decreased consciousness to the point of being unable to communicate. Then, the researchers used the Research Randomizer program to perform simple random sampling to select the sample group from the list of eligible patients.

Ethical Considerations: This study was approved by the Human Research Ethics Committee of the Faculty of Medicine Ramathibodi Hospital,

Mahidol University (COA. MURA2024/514). Participants received information regarding the study objectives and procedures and provided written consent. Participation was entirely voluntary, and they could withdraw from the study at any time without any consequences for their treatment or ongoing care. Confidentiality was maintained by replacing participant names with codes, and the results will be presented in aggregate form.

Instruments: There were two main instruments in this study:

1) *A Personal and Health-Related Information Questionnaire*, developed by the researchers, includes: 1) Personal information—gender, age, marital status, income, occupation, insurance, and education (closed-ended); and 2) Health-related information—cancer type and stage, time since diagnosis, ACP participation, and health perception, with additional data from medical records.

2) *The Advance Care Planning Questionnaire* (ACPQ) was developed by Cheng et al.²⁰ and aligns with this study in terms of variables, nursing theories, and the Asian cultural context. Permission to use this tool was obtained from the original author, and it was translated into Thai using Brislin's back-translation²¹ performed by two experts fluent in both Thai and English. The content validity of all three subscales of the ACPQ was evaluated by a panel of three experts: an advanced practice nurse in palliative care and two nursing instructors specializing in adult and gerontological nursing. Minor adjustments were made in response to their suggestions to ensure cultural appropriateness. Subsequently, a pilot test was conducted with 20 PW-CA to assess the clarity and feasibility of the instruments. The questionnaire consists of four sections as follows:

The Knowledge of Advance Care Planning Questionnaire measures the level of understanding that PW-CA have regarding ACP, obtained through education, personal experience, or exposure to information. This 9-item true/false/do not know

questionnaire was translated into Thai, with an adaptation of question 5 to fit with the Thai context. The original item referred to recording palliative care information on the National Health Insurance (NHI) card. Such information in Thailand is documented in hospital databases. Accordingly, the item was modified from "Individuals can sign the Palliative Care or Life-Sustaining Treatment Intention Letter and register their wishes *on their NHI card* to protect their rights"^{20(p.8)} to "Individuals can sign the Palliative Care or Life-Sustaining Treatment Intention Letter and register their wishes *in the hospital database* to protect their rights." There were 6 correct items; an example of 1 item is, 'When approaching the end of life, everyone has the right to accept or refuse any examination'²⁰ were 'true.' In contrast, 3 items (an example of 1 item is, 'The health-care power of attorney must be a spouse or blood relative'²⁰) were 'false.' One point was given for each correct answer, and 0 points were given for incorrect or unsure responses. The total possible score was 0–9. A higher score indicates a greater level of knowledge regarding ACP. The knowledge levels were categorized into three categories according to the score classification criteria proposed by Best²²: low (scores 1–3), moderate (scores 4–6), and high (scores 7–9). Content validity (CVI) was 1, and pilot testing with 20 PW-CA established satisfactory test-retest reliability ($r = 0.845$) at a three-week interval. In the actual study, reliability was assessed using KR-20, with a value of 0.434.

The Attitudes toward Advance Care Planning (ACP) Questionnaire measures the feelings, thoughts, or understandings PW-CA hold about ACP, shaped by their beliefs about its consequences and their appraisal of those consequences. It is a 12-item, 5-point Likert scale questionnaire that ranges from 1 to 5 and comprises two dimensions: 1) perceived benefits of advance care planning (7 items) and 2) perceived burdens of advance care planning (5 items). An example item is, 'I believe that patients

should be adequately informed about their condition so that they can prepare for the future.^{20(p.9)} ‘The attitude toward behavior (AB) score was computed by summing the products of the belief (Bi) and evaluation (Ei) scores for each item ($AB = \sum Bi \times Ei$). *The total possible score, based on the average rating, ranged from 1 to 25*, with higher scores indicating a more favorable attitude toward ACP. The attitude levels were categorized into three categories according to the score classification criteria proposed by Best²²: low (scores 12–108), moderate (scores 109–205), and high (scores 206–300). Content validity (CVI) was 1, and Cronbach’s α was 0.783 in pilot testing and 0.871 in the actual study.

The Subjective Norms Relating to ACP Questionnaire measures patients’ perceptions of social pressure from significant others to participate in ACP, shaped by their normative beliefs about ACP and their motivation to comply with those norms. It is a 7-item, 5-point Likert scale that ranges from 1 to 5. An example item is, ‘Do you think your spouse agrees with your views on ACP?’^{20(p.10)} The questionnaire comprises normative belief (NBj) and motivation to comply (MCj). The score is computed by summing the NBj and MCj scores for each item (Subjective norm = $\sum NBj \times MCj$). *The total possible score, derived from the average rating, ranged from 1 to 25*, with higher scores indicating a stronger influence of referent groups on the patients’ participation in ACP. The subjective norm levels were classified into three categories according to the score classification criteria proposed by Best²²: low (scores 7–63), moderate (scores 64–120), and high (scores 121–175). Testing achieved content validity (CVI) = 1 and Cronbach’s α = 0.951 in pilot testing and 0.868 in the actual study.

The Behavioral Intentions to Participate in ACP Questionnaire measures the degree of patients’ commitment to participate in the ACP process. It is a 6-item, 5-point Likert scale ranging from 1 to 5 that measures the intention to conduct the ACP. An example item is, ‘I will discuss my future medical-

related decisions with family or friends.’^{20(p.9)} The score was derived from *the average rating, which ranged from 1 to 5*. Higher scores reflect a stronger intention to participate in ACP. The intention levels were classified into three categories according to the score classification criteria proposed by Best²²: low (scores 6–14), moderate (scores 15–23), and high (scores 24–30). We achieved content validity (CVI) = 1, and Cronbach’s α = 0.900 in pilot testing and 0.880 in the actual study.

Data Collection: After approval from the ethics committee and hospital, nurses from the outpatient cancer clinic approached selected participants, informed them about the study, and sought permission for data collection. The primary investigator (PI) then explained the study objectives, procedures, duration, potential benefits, confidentiality, and participants’ rights to decline or withdraw without affecting their care. Written informed consent was obtained, and participants completed the questionnaire within 20–30 minutes. Responses were checked for completeness, and participants were free to omit any items without coercion.

Data Analysis: Descriptive statistics were used to summarize participants’ characteristics, including frequencies, percentages, means, standard deviations, and minimum and maximum values. The relationships of knowledge regarding ACP, attitudes toward ACP, and subjective norms related to ACP on intention to participate in the ACP process were examined using inferential statistics. Multiple regression analysis was conducted using the Enter method, in which all independent variables, including the main predictors (knowledge regarding ACP, attitudes toward ACP, and subjective norms) and potential confounding variables (age, educational level, duration and stage of cancer), were entered simultaneously into the regression model. Before analysis, the assumptions of multiple regression, including linearity, independence of errors, normality, homoscedasticity of residuals, and absence of multicollinearity, were examined and found to be adequately met.

Results

Characteristics of the participants

The study sample consisted of 155 participants. The majority were female (60.00 %), aged 51–70 years (63.90%), with a mean age of 61.61 years ($SD = 10.96$). Of these, 41.30% held a bachelor's degree, and 32.26% were retired government officers. Regarding perceived health status, the majority rated their health as 7 or higher on a 10-point scale (66.50%), with a mean score of 7.14 ($SD = 1.91$). The most common cancer diagnosis was breast cancer (30.30%), followed by gastrointestinal (25.80%) and lung cancers (16.10%). In terms of cancer stage,

nearly half were diagnosed at stage IV (43.20%), followed by stage III (26.50%).

Relationships between key variables and intention to advance care planning

Descriptive statistics of ACP variables are presented in **Table 1**. Overall, participants demonstrated moderate ACP knowledge ($M = 5.88$, $SD = 1.28$), high attitudes toward ACP ($M = 227.45$, $SD = 45.98$), and moderate subjective norms ($M = 114.40$, $SD = 33.28$). The intention to participate in ACP was also high ($M = 25.86$, $SD = 1.28$). At the item level, the highest-rated statement regarding intention was “I will discuss my future medical-related decisions with family or friends” ($M = 4.37$, $SD = 0.78$).

Table 1. Descriptive statistics of key variables related to ACP ($N = 155$)

Variables	Range	Min-Max	Mean	SD	Categories
Knowledge of ACP	0–9	1–9	5.88	1.28	Moderate
Attitudes toward ACP	12–300	109–300	227.45	45.98	High
Subjective norm	7–175	51–175	114.40	33.28	Moderate
Intention to participate in ACP	6–30	10–30	25.86	1.28	High

Note. ACP = Advance care planning

Regarding the relationships among variables (**Table 2**), Pearson's correlation analysis revealed significant positive correlations between ACP intention and its predictors. Specifically, ACP intention was

moderately correlated with attitudes toward ACP ($r = 0.517$, $p < 0.001$), followed by subjective norms ($r = 0.443$, $p < 0.001$) and ACP knowledge ($r = 0.345$, $p < 0.001$).

Table 2. Correlation coefficients among knowledge, attitudes, subjective norms, and intention to participate in ACP among people with cancer in the university hospital ($N = 155$)

Variables	1	2	3	4
1. Knowledge	1			
2. Attitudes	0.151	1		
3. Subjective Norms	0.044	0.374**	1	
4. Intention to participate in ACP	0.345**	0.517**	0.443**	1

Note. ACP = Advance care planning, ** $p < 0.001$

Predictors of intention to participate in advance care planning

After controlling for covariates (age, educational level, duration of disease, and cancer stage), attitudes toward ACP ($\beta = 0.371$, $p < 0.001$), subjective norms ($\beta = 0.297$, $p < 0.001$) knowledge of ACP ($\beta = 0.280$,

$p < 0.001$) were significant predictors of PW-CA's intention to participate in the ACP process with attitudes toward ACP being the strongest predictor. The overall model, including covariates, explained 42.10% of the variance in the intention to participate in ACP ($R^2 = 0.421$, Adjusted $R^2 = 0.393$) (**Table 3**).

Table 3. Multiple regression analysis predicting intention to participate in advance care planning. (N = 155)

Variable	b	SE _b	Beta	t	95% CI	p-value
Control variables						
Age	-0.002	0.004	-0.025	-0.379	-0.010, 0.006	0.705
Education level	0.015	0.037	0.026	0.410	-0.059, 0.089	0.682
Duration of cancer	-0.001	0.001	-0.061	-0.951	-0.002, 0.001	0.343
Cancer stage	-0.024	0.035	-0.045	-0.682	-0.094, 0.046	0.496
Main predictors						
Knowledge	1.322	0.301	0.280	4.389	0.727, 1.917	< 0.001
Attitude	0.065	0.012	0.371	5.368	0.041, 0.089	< 0.001
Subjective norm	0.042	0.010	0.297	4.261	0.023, 0.061	< 0.001
constant	1.680	0.417		4.026	0.855, 2.504	< 0.001

Note. $R = 0.649$, $R^2 = 0.421$, $\text{Adj } R^2 = 0.393$, $\text{SE}_b = 0.519$, Overall $F = 15.296$, $p < 0.001$; 95% confidence intervals are reported for unstandardized regression coefficients (b).

Discussion

The present study provides empirical support for the applicability of the Theory of Reasoned Action, suggesting that attitudes and subjective norms are key predictors of intention to participate in ACP. The three factors identified in this study collectively explained 42.10% of the variance in intention to participate in the ACP process among PW-CA, indicating a moderate to high level of predictive power. In accordance with TRA, behavioral intention arises from individuals' attitudes toward the behavior and their perceived social expectations (subjective norms).¹¹ The findings demonstrate that the model variables account for a substantial proportion of the variance in intention. However, 57.9% of the variance remains unexplained, which may be attributable to other emotional, experiential, or contextual factors not included in the present model. Thai PW-CA participating in the study reported a high level of intention to participate in ACP. This may be associated with the relatively older age of the participants (mean age > 60 years), as older adults may have greater exposure to health-related experiences and end-of-life considerations, consistent with previous studies reporting significant associations

between age and ACP participation.^{9,23} It is worth noting that the high ACP intention score may be partly due to a ceiling effect and limited score variability.

In terms of socioeconomic characteristics, more than two-fifths held a bachelor's degree, and about one-fourth reported a monthly income exceeding 30,000 baht (approximately USD 964), and nearly half reported their income to be sufficient. These findings are consistent with previous studies, educational level and socioeconomic status were associated with ACP participation,^{5,13,23} possibly through greater health literacy. Nevertheless, these factors were treated as potential confounders and were statistically controlled for in the regression analysis.

Furthermore, nearly half of the participants (43.23%) were diagnosed with advanced-stage cancer. Thus, they might perceive the severity of their health conditions. Perceived severity has been reported to be significantly associated with intentions regarding ACP,²⁴ as awareness of illness seriousness may motivate end-of-life planning. However, this association should be interpreted cautiously, as disease stage was controlled for in the regression analysis, and the cross-sectional design does not allow causal inference.

The highest-scoring ACP intention item was discussing future medical decisions with family or friends. Consistent with collectivist Southeast Asian contexts, ACP intentions were shaped primarily by family and physician influence rather than individual decision-making.^{4,25} Physicians were the most influential referents (17.95%), reflecting strong trust in healthcare professionals among Thai patients and families.²⁶

Attitudes toward ACP as the strongest predictors

Among the three key predictors, attitudes toward ACP emerged as the strongest predictor of intention. This finding underscores the importance of personal evaluation and the perceived value of ACP in shaping an individual's readiness to participate in ACP-related discussions and planning, which is consistent with the Theory of Reasoned Action.¹¹ Participants who hold more favorable attitudes toward ACP may be more likely to perceive ACP as beneficial for facilitating communication, especially with family members, reducing financial costs, and ensuring that future care aligns with personal values and preferences, which is consistent with a recent qualitative study conducted in China.⁷

Subjective norms and the influence of Thai socio-cultural context

Subjective norms were the second significant predictor of intention, indicating the importance of perceived expectations from significant others. This finding is particularly relevant in the Thai context, where children and siblings play key roles due to caregiving responsibilities and close familial bonds, consistent with findings by Cheng et al.²⁵ and Pairojkul et al.⁴ Moreover, Participants may be more likely to consider the opinions of not only family members but also healthcare professionals when making decisions related to future care planning, which include nurses and physicians. The study revealed that, among 515 Thai registered nurses, the subject norm had a direct

effect on the intention to participate in ACP.²⁷ In contrast, physicians have a strong influence, reflecting the high level of trust in healthcare professionals within Thai society.²⁶ In a manner consistent with most Asian countries, paternalistic perspectives in Thailand serve as a contributing factor to the limited involvement of patients and their families in the decision-making process.²⁸ Taken together, the strong role of subjective norms suggests that ACP engagement among Thai PW-CA should not be conceptualized as an individual decision-making process alone, but rather as a shared process shaped by interpersonal influence and social expectations.

Knowledge regarding ACP as a modifiable personal factor

Knowledge regarding ACP was also a significant predictor of intention. This result suggests that participants who better understand ACP are more likely to express readiness and willingness to participate in the ACP process. Although knowledge is not a primary construct of the Theory of Reasoned Action (TRA), it can be considered a foundational factor in individuals' formation of behavioral beliefs. Within the TRA framework, behavioral beliefs influence attitudes toward the behavior, which, in turn, shape behavioral intention.¹¹ When individuals possess accurate and adequate knowledge about advance care planning, they are more likely to develop informed and positive beliefs regarding its benefits and relevance, leading to a stronger intention to participate in the ACP process.^{12,27,29} This finding is consistent with previous studies.^{10,13,27,29,30} In clinical practice, limited knowledge may inhibit participation, particularly if patients misunderstand ACP as being relevant only when death is approaching or think that ACP is only about documenting treatment refusal.³¹ Enhancing ACP knowledge through culturally appropriate patient education, clear communication from healthcare professionals, and allowing them to ask questions may increase intention.^{1,10,31}

Limitations

This study has several limitations that should be acknowledged. First, the cross-sectional design limits the ability to infer causal relationships between knowledge, attitudes, subjective norms, and intention to participate in ACP. Therefore, the observed associations should be interpreted as correlational rather than causal. Second, the study was conducted at a single university hospital, which may limit the generalizability of the findings to other healthcare settings or populations, despite the use of simple random sampling. Third, all variables were assessed using self-report questionnaires, which may be subject to social desirability bias. Certain items in the ACP knowledge questionnaire may also have been complex or culturally unfamiliar, and the translation of technical or legal terminology may have affected participants' understanding, which may have contributed to the relatively low internal consistency of the knowledge instrument ($KR-20 = 0.434$). Furthermore, the influence of reference groups, particularly physicians, may reflect participants' trust in professional authority rather than genuine participation in shared decision-making.

Conclusions and Implications for Nursing

Practice and Future Research

This correlational predictive study examined factors influencing the intention to participate in ACP among 155 PW-CA in a university hospital. Guided by the Theory of Reasoned Action, the study investigated knowledge, attitudes, and subjective norms as predictors of ACP intention. The findings enhance understanding of how these factors shape patients' decisions and highlight the importance of fostering ACP participation to ensure patients receive care consistent with their preferences. Promoting ACP intention among Thai PW-CA requires considerations

of both personal (attitudes and knowledge) and socio-cultural (subjective norms) aspects.

The findings provide important implications for nursing practice. As knowledge is a modifiable factor, it represents a feasible target for nursing-led interventions in outpatient oncology settings. Furthermore, ACP interventions in Thailand may be strengthened by adopting family-inclusive approaches and equipping healthcare professionals, particularly nurses, with accessible, culturally appropriate education and structured communication strategies to facilitate patient-family discussions about values, preferences, and future care goals. By improving positive attitudes, enhancing ACP knowledge, and addressing subjective norms within the family context, nursing interventions may effectively promote ACP participation. These efforts may ultimately strengthen the integration of ACP into routine cancer care.

Future research should employ longitudinal designs to clarify causal relationships among study variables. Multi-site studies involving more diverse populations, including high-risk groups and caregivers, are recommended to enhance generalizability. Future studies should also consider examining additional variables such as emotional factors (e.g., fear of death and anxiety), past experiences with serious illness, cultural beliefs, and family dynamics. Furthermore, the knowledge instrument should be refined by simplifying its language to improve clarity and internal consistency. Experimental or quasi-experimental research is also needed to evaluate the effectiveness of nursing-led educational and attitude-enhancing interventions in promoting participation in ACP.

From a nursing science perspective, this study provides empirical support for the application of the Theory of Reasoned Action in oncology nursing. It highlights the value of integrating behavioral theory into the development of nursing interventions to improve end-of-life care planning.

Author Contributions

Conceptualization, Methodology: W.T., S.C., P.P.
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Validation, Resources, Supervision: S.C., P.P.
Investigation, Visualization, Funding acquisition: W.T., S.C.
Writing—original draft preparation, W.T., S.C.
Writing—review and editing: W.T., S.C., P.P.
Project administration, Data curation: W.T.
All authors have read and agreed to the published version of the manuscript.

Generative AI

The authors used ChatGPT (OpenAI), Gemini (Google), and Grammarly to improve the clarity and refinement of English. After using this service, the authors reviewed and edited the content as needed and take full responsibility for the content of the publication.

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ปัจจัยทำนายความตั้งใจเข้าร่วมกระบวนการวางแผนการดูแลล่วงหน้าของผู้ที่เป็นโรคเมเร็ง ณ โรงพยาบาลมหาวิทยาลัยแห่งหนึ่งในกรุงเทพมหานคร ประเทศไทย : การศึกษาแบบภาคตัดขวาง

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บทคัดย่อ: อุบัติการณ์ของโรคเมเร็งที่เพิ่มขึ้นในประเทศไทยร่วมกับการพยากรณ์โรคที่ไม่ดีในผู้ที่เป็นโรคเมเร็งระยะลุกลาม และอุปสรรคทางวัฒนธรรมในการพูดคุยเรื่องความตาย ส่งผลให้ประชากรไทยมีความตระหนักรู้เกี่ยวกับกระบวนการวางแผนการดูแลล่วงหน้าไม่เพียงพอ การศึกษาแบบภาคตัดขวางนี้มีวัตถุประสงค์เพื่อศึกษาปัจจัยที่มีอิทธิพลต่อความตั้งใจเข้าร่วมกระบวนการวางแผนการดูแลล่วงหน้าของผู้ที่เป็นโรคเมเร็งในบริบทของโรงพยาบาลมหาวิทยาลัย กลุ่มตัวอย่างได้รับการคัดเลือกด้วยวิธีการสุ่มอย่างง่ายจากผู้ที่เป็นโรคเมเร็งที่มารับบริการในหน่วยตรวจผู้ป่วยนอกโรคเมเร็งของโรงพยาบาลมหาวิทยาลัยแห่งหนึ่งในกรุงเทพมหานคร ประเทศไทย ระหว่างเดือนพฤศจิกายน พ.ศ. 2567 ถึง เดือนกุมภาพันธ์ พ.ศ. 2568 จำนวนทั้งสิ้น 155 คน เครื่องมือที่ใช้ในการเก็บรวบรวมข้อมูลประกอบด้วย แบบประเมิน Mini-Cog ใช้สำหรับคัดกรองสมรรถภาพการรู้คิด แบบสอบถามข้อมูลส่วนบุคคลและข้อมูลด้านสุขภาพ แบบสอบถามเกี่ยวกับการวางแผนการดูแลล่วงหน้าซึ่งครอบคลุมการวัดความรู้ ทักษะคิด การคล้อยตามกลุ่มอ้างอิงและความตั้งใจเข้าร่วมกระบวนการวางแผนการดูแลล่วงหน้า วิเคราะห์ข้อมูลโดยใช้สถิติบรรยายและสถิติการถดถอยแบบพหุคูณ

ผลการศึกษาพบว่า ความรู้ ทักษะคิด การคล้อยตามกลุ่มอ้างอิง และตัวแปรร่วมสามารถร่วมกันทำนายความตั้งใจเข้าร่วมกระบวนการวางแผนการดูแลล่วงหน้าของผู้ป่วยโรคเมเร็งได้อย่างมีนัยสำคัญทางสถิติ โดยอธิบายความแปรปรวนได้ร้อยละ 42.1 โดยทักษะคิดต่อการวางแผนการดูแลล่วงหน้าเป็นตัวแปรทำนายที่มีอิทธิพลสูงสุด รองลงมา คือ การคล้อยตามกลุ่มอ้างอิงและความรู้ ผลการศึกษานี้ชี้ให้เห็นถึงความจำเป็นในการส่งเสริมทักษะคิดเชิงบวก เสริมสร้างความเข้าใจ และเปิดโอกาสให้บุคคลที่มีความสำคัญเข้ามามีส่วนร่วมในการวางแผนการดูแลล่วงหน้าในประชากรกลุ่มนี้ โดยเฉพาะอย่างยิ่ง ด้านการปฏิบัติการพยาบาลควรมีการประเมินทักษะคิดของผู้ป่วยตั้งแต่วัยแรก และส่งเสริมการมีส่วนร่วมของสมาชิกครอบครัวในการสนทนาเกี่ยวกับการวางแผนการดูแลล่วงหน้า เพื่อให้สอดคล้องกับบริบทวัฒนธรรมไทย และส่งเสริมการมีส่วนร่วมที่มากขึ้นของผู้ที่เป็นโรคเมเร็ง

Pacific Rim Int J Nurs Res 2026; 30(3) 572-583

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