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THE PROCESS OF SEEKING HEALTH CARE OF PEOPLE WITH HEART FAILURE WHO LIVE IN SOUTHERN THAILAND

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ABSTRACT

The purpose of this study was to explore the process that southern Thai people with heart failure (HF) use when seeking health care. The study findings highlighted the process of seeking health care. The certainty in living with heart failure was the core category of the seeking health care process, which consisted of four phases. In the first phase, *HF symptoms emerging*, participants learned to seek care for relieving their symptoms by themselves. Once they recognized that they had serious health conditions, they moved to the second phase, *hesitation to live with HF symptoms*. Participants recognized that they had serious health conditions during this phase, so they sought health care services in order to know what their health conditions were. At the end of this second phase, they perceived that they had HF. Their learning experiences have moved to the third phase, *uncertainty living with HF*, which participants were uncertain about their HF conditions. They tried to find their own ways in seeking care from both professional and non-professional care providers regarding diagnosis confirmation and proper care. The consequence of this third phase led to having certain health goals. The learning experiences during the final phase were *living with HF*. All patients perceived that they achieved their health goals, and they had certainty in living with HF.

Keywords: HF, grounded theory study, seeking health care, certainty living with HF.

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INTRODUCTION

Heart failure (HF) is a serious problem that affects individual health, public and family health care burdens, and health care expenditure at national and global levels, including the region of southern Thailand. In Thailand, there is no existing evidence report the burden of the HF population. However, the prevalence of HF may be characterized from reports of the population base of heart disease (HD). HD has been considered as a major cause of mortality in Thailand from 1967 to 2006, and has been annually ranked as one of the top four causes of death (Wibulpolprasert, 2008). The prevalence of HF in southern Thailand is deduced from mortalities citing the cause of death as HD currently in the top five causes annually in the provinces, which were selected as study areas in this study.

Since HF has been defined as a complex clinical syndrome, HF patients usually endure suffering with various health conditions that affect them physically, mentally, and socially throughout all phases of the illness. Human health and social well-beingamong people with HF who live in southern Thailand has been referred to in the findings of Suwanno (2007). It was shown that most of 400 HF patients living in southern Thailand had poor health status. In addition to this observation, it was found that many HF patients were still living at home in grave conditions, but did not want to go to hospital, and some of them were still performing daily activities for living. One of interesting is to tackle challenges regarding health and social well-being of HF people who live in southern Thailand concerning their perceptions in what, when, and how the seeking of health care.

It has been shown that several studies on seeking health care have been focused on its delay and the impacts in patients with coronary heart disease (CAD). In fact, the onset of symptoms in HF patients is a signal onset of the cell injury process that contributes to high risk for morbidity and mortality with increased burden of care and cost (Deswal et al., 2001; Hare and Johnson, 2003; Lee et al., 2004; Ruz and Lennie, 2008). It has been documented that one reason for seeking acute care in HF patients is due to lack of trust regarding their care to influence delays in seeking acute care (Patel et al., 2007). However, there is no evidence in western world regarding the seeking care process in the HF patients, and resulting in a lack of quality for HF care services, increased cost of care, and reduced human health and social well-being.

One study by Rerkluenrit (2008) was conducted using grounded theory to explore the emphasis on self-care in 35 Thai people with HF who had received care from cardiac clinics in three tertiary care hospitals located in and around Bangkok. The findings showed that participants were urged to seek complementary therapies and modern medical treatment when they suffered from serious HF symptoms that might cause a crisis in their life. Once they become a person with HF, they confronted mainly with unpleasant experiences caused by the effects of HF and health care services where they sought for information, material, and emotional/spiritual support. However, the aspect of health care seeking behavior has never been explored during the period of the development of self-perception of patients regarding health and social well-being issues. There is no information regarding behaviors of participants why they stopped or continued in seeking care among HF patients who were treated in excellent cardiac care centers.

The behavior of seeking health care among HF patients has been defined as cognitive processes in deciding upon the actions of individuals who perceive their lives or health conditions (Kasl and Cobb, 1966). The process of seeking health care by HF patients will be included to be explored in this study employing grounded theory as the methodology.

The purpose of the study was to understand the experiences health care seeking behavior throughout all phases of the illness that received care from the tertiary health care service in one province in southern Thailand. Specific objectives were dealing with both the explanation of the process of seeking health care and the conditions that influenced the seeking of health care behavior.

The findings regarding the process of seeking health care were expected to be applicable in practical areas for developing appropriate health care services; improved human health and social well being, reduced high risk, morbidity and mortality, and decreased costs of care in HF patients.

METHODOLOGY

Regarding to seeking health care was defined as the cognitive process including decision and action of a person based on their own perception and associated with socio-culture condition, grounded theory was employed as the methodology in this study.

Participants. All participants were recruited from patients who had received or had history of receiving care at one tertiary hospital of southern Thailand. The eligibility criteria for recruiting participants were including the ability to communicate, express emotions, and share ideas. Ethical approval for this research was obtained from the Faculty of Graduate School's Human Research Ethics Committee, Burapha University, and from relevant ethics committees at each hospital sites from which data were collected. Participants were informed of the study's purpose, process and were required to sign an agreement. In addition, each participant was informed that they could leave the study at any time.

A purposive sampling method was employed in this study, and there were two steps for recruiting participants. In the first step of data collection, 10 participants were involved, where six participants were from outpatients department and four of them were from inpatients department of the local hospital. In the second step, 26 participants were enrolled in the study based on the theoretical sample required to achieve complete explanation about the process of seeking health care among HF people who live in southern Thailand. Additional participants were required throughout all process of data analysis. They ensured variety of category development, density of data, and relationships among categories were validated and completed.

All participants in the study were protected from physical, mental, and social risk. The researchers shared or provided health care information upon the participants' request after the interview was completed. Others stakeholder, such as family members, caregivers, or people that participants felt comfortable with could be present during the interviews.

Data collection. A total of thirty-six patients that were diagnosed with HF and over 18 years old were participated as informants in this study. Data collection was carried out from June 2009 to May 2010, and analyses were conducted simultaneously until theoretical saturation was achieved.

Data were collected by reviewing medical health documents, in-depth-interviews, and thorough observation. Both in-depth interviews and observation were conducted following a semi-structured interview guide and observation guide. In the preliminary study, 10 participants recruited, where six of them were from outpatient departments and four of them were from inpatient medical departments, were interviewed with open questions in order to bring their attentions regarding several topics, i.e., topics related to find out about HF care, their view about HF, setting health goals, deciding and acting on seeking health care, to learn about seeking health care from others, and their perceptions of what facilitated or impeded achieving their goals. They were asked, for example, "How did you know you had HF?", "What did you think about HF?", "How did you act to seek care?", "How did you seek health care?", and "How did you manage to seek care for achieving health goals?"

Data collection was conducted in parallel with data analysis. Major categories emerged and were summarized in the findings of the preliminary study. Those categories found were consisted of *relieving symptoms and desire for a cure, knowing what their health conditions, survival* and *endurance*, and *certainty in living with HF*. Subsequently, the question-interview guide was revised based on the findings of the preliminary study and literature. A revised interview guide was used to gain more data about major categories. In addition, the researcher was strictly concerned about asking relevant questions, and thus, new questions were developed after finishing each interview. Other stakeholders, such as family members, caregivers, or people with whom the participants felt comfortable could be present during the interviews. Each in-depth interview lasted about a few hours per visit (including rest times). Each participant was interviewed 3-4 times over a 6-8 week period dependent upon the participant's health and availability to ensure that the completeness of data was obtained. In-depth interviews were conducted either in the private room at the hospital or at the participant's own home depending on the needs of the participant in order to make it more privacy as much as possible.

Data analysis. According to the strategies of the grounded theory method by Strauss and Corbin (1990) and Corbin and Strauss (2008), which were used in the analysis including the coding process (open coding, axial coding, and selective coding), theoretical sampling, memos and diagrams, a constant comparison of analysis was applied throughout all processes in order to find a core category. The theoretical sampling, memos, and diagrams were also used in conjunction with the coding process. All analysis was conducted in parallel with data collection. Finally, the "certainty in living with HF" was emerged as the core category in this study.

Rigor of the study. It had been shown that rigor established the trustworthiness of qualitative study. According to the study of Guba and Lincoln (1985), the four criteria of rigor used, which included the credibility, fittingness, audit-ability, and confirm ability were employed in this study.

In order to enhance credibility, the researcher conducted the following four methods. First, participants who had been diagnosed with HF and with a variety of profiles were selected. The researcher spared some times in developing trust before in-depth interviews were carried out. The triangulation method was used for both data collection and data analysis. The triangulation method required several factors, i.e., various sources of data, settings, and data collections methods, to be used in order to ensure the validity of data. The analysis process of data was done in collaboration with one more person who had experience using grounded theory study. Finally, nine participants examined the processes of seeking health care. In addition, the findings were discussed among researchers in collaboration with one advance practice nurse (APN) who had experiences in health care services for HF patients.

Concerning the increase in fittingness, the discussion was done with two advance practice nurses (APNs) who had experiences in health care services for HF patients, and one colleague who was in a sub-area position in cardiovascular nursing. Three more HF patients who had similar profiles to the participants in this study were selected to confirm the findings. Regarding to the audit ability, the researcher recorded their activities and thinking through out all processes of the study in order to evaluate the consistency of the study. The confirm ability refers to the freedom from the bias against the process while conducting the study. All of these would be achieved when those aforementioned three criteria were met.

RESULTS

The significant finding of this study was the '*certainty in living with heart failure*' that could represent as the core category, because certainty in living with heart failure was the major concern with health care seeking behavior of the participants. Once HF symptoms had emerged and the participants realized that they were living with health declination, the process of seeking for HF care began. The objective of the health care seeking behaviors in this study was an attribution of health care seeking in each phase with changes and transfer of dependence upon perceived health conditions, and their impacts on participants that were presented in the causal condition in each phase of the process. Certain health goals also affected the objectives of seeking care in the final phase. Other objectives of health care-seeking behaviors were to relieve symptoms, look for a cure, eliminate of reluctant concerns of the health condition, as well as to survive and endurance in living with HF as stated in phases 1, 2, and 3, respectively, as shown in Figure 1. The decision-making and actions performed in the care-seeking behaviors of participants in all phases were related to aspects of care-seeking management and learning development with suitable health care seeking tracks associated with the cognition and behavior of individuals. In particular, these aspects were related to influencing conditions including personal conditions and socio-cultural contexts.

Phase 1 - Emerging of heart failure symptoms. **All participants** perceived that their health and well-being declined following the emerging of heart failure symptoms. Most participants were aware of underlying health conditions, so they thought differently about the cause and meaning of health declination, resulting in different decisions leading to different actions in seeking health care. However, most of participants need healthy conditions without symptoms. In this phase, the cutting point began at the point where the emergence of HF symptoms occurred, which evolved the seeking knowledge and objects including the purchase of medications and methods that necessary for relieving symptoms by themselves without seeking and accessing health care services for investigation, diagnosis, and health care. All initial decisions and actions for seeking health care in this phase involved seeking information from both internal (the participants' stored knowledge) and external sources. If the participants did not achieve their goals, they would look for more new information or new ways of relieving symptoms as described in the following messages.

A 56 - year old woman who had been diagnosed with valvular heart disease (VHD) and HF said,

> "During the last 2-3 years, I have felt tired when I have finished working on the farm. I thought it was the result of sterilization - - People who have been sterilized should not perform heavy work, but I did - -I thought my good and strong health would come back to me- -Someone told me I had "*pat*" (an effect) from sterilization because I had fewer menses- -Therefore, I procured and took *ya satri benlo* (Thai traditional medicine to increase menstrual flow)- -But I did not feel the symptoms had improved- -I thought I should seek a new way to improve my power - -I asked other people- -until someone told me that I should take 1-2 cups/day of *Kopi* (coffee)- -I followed her suggestion- -I drank 1-2 cups of Kopi a day. After that, I felt good with increased muscular power."

The consequences of this phase were recognized as living with worsening health condition and ability to develop basic tracks for seeking HF care. Eventually, when HF had progressed, the participants had and recognized worsening symptoms.

Causal condition	Influencing factors (Influencing conditions/contexts)	Actions/strategies	Consequences
Perceived declination in health and well-being	- Experience care- seeking with prior health conditions	- Seeking information	- Recognized being with worsening health condition
	- Stored knowledge with illness, resources, and seeking care	- Seeking objects, resources, and method for relieving symptoms	- Able to develop basic care seeking track for HF care
	- Belief in health and care	- Initially developed track of seeking care related to HF symptoms	
	- Personal data: economic status, educational attainment		

Figure 1. Phase I- Emerging of heart failure symptoms.

Phase 2 - Hesitation to live with HF symptoms. Participants had experienced worsening symptoms, but they were unaware that they were living with HF. They perceived the seriousness of their health conditions, so they were anxious and lost confidence about survival. They sought health care services in order to know what their health conditions were. The process of this phase started at the onset of the recognition of their worsening health conditions, start-seeking access to acuity, receipt of health care and HF diagnosis, respectively. At the end of process, they realized that they were person with related HF. Health care-seeking behaviors of HF patients during the second phase included searching for information, seeking an access to obtain health care, learning how to develop care-seeking tracks for acute HF, and learning how to recognize care-seeking with surrogate seekers who play the role of the seeker on behalf of participants. The surrogate seeker is an informal title which is naturally established and accepted by participants. As a consequence of the given process, the participants perceived of what they were becoming person with HF or related HF. However, they had no confidence about living with HF and recognized their dependence. Many participants were able to develop tracks for seeking for acuity as described in the following messages.

A 65-year old woman who was diagnosed valvular heart disease (VHD) and HF described,

> "I had mild shortness of breath seven days ago - - I tried to endure it - - then my shortness of breath became severe. My brother found my symptoms quite serious, so he took me to seek acute health care at a community hospital by motorcycle - - After that, the doctor at the community hospital told me that I had a severe illness and he could not cure me. Thus, he referred me to this hospital - - I thought I would take a short cut to this hospital if I was confronted with this sickness again."

Causal condition	Influencing factors (Influencing conditions/contexts)	Actions/strategies	Consequences
Perceived serious health conditions	- Belief in health and care	- Seeking information	- Perceived diagnosis with HF or related HF
Worry and fear about losing survival	- Trust health care providers and quality of health care service	- Seeking access to care: : Seeking help and support : Seeking access to health care service	- No confidence about living with HF
	- Personal data: economic status, educational attainment, and family roles	- Learning to develop care-seeking track for acute HF	- Recognized being with dependence
	- Perceived support	- Learning to recognize care-seeking with surrogate seekers	- Ability to develop care-seeking track for acute HF

Figure 2. Phase 2- Hesitation to live with HF symptoms.

Phase 3 - Uncertainty living with heart failure. The demarcation of Phase 3 began when participants already recognized that they were initially living with HF. They were uncertain of being lived with HF. The majority of participants felt bad emotions that related to perception about symptoms sufferings, limited physical function, and social activity. Many participants felt fear to be a sudden death because they defined the meaning of HF as a warning sign of death, and required a cure, which led them to seek the best health care services for the confirmation of HF diagnosis and health care in which the health services from both professionals and laymen. They also sought for consultation and networks, developed certain health goals, learned to share authority with surrogate seekers in seeking care and learned to develop basic suitable tracks for seeking health care for HF. By the end of this phase, most participants were able to develop basic suitable tracks for seeking health care, had accepted changing health conditions and their impact, and could develop certain health goals. The evidences were summarized in the following messages.

A 56-year old woman who had been diagnosed as VHD and HF said,

> "Although I believed the doctor, I thought I might have another disease that might be cured. My disease might be related to "pat" (a belief that she might have been punished by the supernatural) - -"Mor-phee" (witch doctor) told me that I was punished by "jom-plaug" (termite mound), so I made a sacrifice to the "jom-plaug" - - My son told me that the best cardiac specialists were available in Bangkok. I went to Bangkok and met a doctor. The doctor in Bangkok told me that I had VHD and HF that required surgery. What he told me was similar to what the doctor at this local hospital had said."

A 49-year old man who had been diagnosed with myocardial infarction (MI) and HF said,

> . "- I thought I should do something else if I wanted to be healthy, so I did some exercise. Then my friend had suggested using "ka-min-rhu-si" (an herb) for the improvement of my heart condition, so I sought and took it. After that, I took ka-min-rhu-si and the doctor's medicine together."

A 47-year old woman who had graduated with a master degree described her experience as follows.

> "- - My doctor told me that I had to wait for the laboratory diagnosis before receiving treatment. I would spend a long time waiting- - I consulted someone for a fast track to use this service and she suggested that I asked about accessing a fast track treatment."

A 49-year old man who had been diagnosed with MI and HF said,

> . "I needed to recover my health because I had more subordinates, I had a heavy burden- -my child must study."

The consequences of the above-mentioned phase were that the participants might know how to develop suitable tracks for seeking health care. They had both lessons in developing suitable tracks for seeking health care and sharing authority with surrogate seekers in seeking health care. They certainly had certain health goals in their minds.

Phase 4 - Living with heart failure. This phase was assigned as the end of the health care-seeking process based on the core category, "certainty in living with HF". All nine participants in this study had accepted the changing health conditions with their impacts, and they had certain goals in their minds. Participants defined the meaning of living with HF as a trigger of fight, shadowy disease, chronic health conditions, and disastrous dimensions of life. All of these meanings were the influenced factors, which they had to decide and act of seeking health care among participants in this phase. There were two essential actions of health care seeking in this phase that were developed with complicated tracks for seeking health care and actions to achieve health goals. They had learned to give and share experiences in health care seeking behaviors with others. The most important thing was that the actions for achieving certain health goals and future life. All participants used authority and more strategies to follow and change the complicated care-seeking track for achieving certain health goals.

Although a few participants felt they had lost partial authority and transferred it in care-seeking management to surrogate seekers, they discovered new power called the "power of love and care" instead of their previous power. The health care-seeking actions induced "certainty in living with HF", which was related to confidence in living with HF, confidence in care-seeking ability. They continued seeking care to maintain health goals. If they evaluated care-seeking tracks as ineffective for achieving health goals, they would move to develop new care-seeking tracks. The evidences were described as follows.

A 59-year old man who had been diagnosed as renal failure and HF said,

Causal condition	**Influencing factors (Influencing conditions/contexts)**	**Actions/strategies**	**Consequences**
Being with suffering, fearing, limited function and fluctuating emotions	- Trust health care provider and quality of health care services	- Seeking both professions and lay for confirmation and caring	- Lessons developing basic suitable track of seeking care
	- Beliefs in health and care	- Seeking consultant and network	- Lessons sharing authority with surrogate seeker for seeking care
	- Perceived burdens and dependence	- Developing certain health goals	- Accepted changing health conditions and their impact
	- Perceived ability of surrogate seeker	- Learning to share authority with surrogate seeker for seeking care	- Certain health goals
	- Personal data: economic status, educational attainment, age, and family roles	- Learning to develop basic suitable tracks for seeking HF care	

Figure 3. Phase 3- Uncertainty living with heart failure.

> "- -The doctor reduced my medications. Finally, I had mild symptoms in shortness of breath and exhaustion. I quickly decided to seek a private clinic where I had previously received health care and a referral treatment. I had three reasons for selecting this private clinic. My first reason was that I did not think the symptoms were serious, so the private clinic would be able to care for me. The second reason that worried me

was lost my income. While I would have to spend a whole day at the hospital, I would only have to spend about 30-60 minutes at the private clinic. The third reason was that I knew I had exacerbated symptoms because I had reduced my medication dosage. I would be able to modify my medication dosage, but I did not want to face the problem with the professional doctors. I needed to preserve my relationships with the professional doctors at the hospital because I would have to depend on them when I had progressive renal failure in the future. Therefore, I took my medication to the doctor at the private clinic to modify the dosage. It was safe for me because the professional doctors respect one another prescription. In addition, I knew the doctor at the private clinic would only modify my medication dosage because I had only mild symptoms and the characteristics of the symptoms had not changed. I knew that the doctor would not change the type of medication, and I could save money."

Causal condition	**Influencing factors (Influencing conditions/contexts)**	**Actions/strategies**	**Consequences**
Accepted changing health conditions and their impact	- Trust health care provider and quality of health care services	- Learning to develop complicated tracks for seeking care and acting to achieve health goal and future life	- Confidence in living with HF
Certain health goals	- Belief in health and care	- Learning to give and share experiences in health care seeking with others	- Satisfying and confident seeking HF care
	- Perceived burdens and dependence		- Acting a model of wise seeker
	- Perceived ability of surrogate seekers		- Able to develop complicated care-seeking track
	- Personal data: economic status education attainment, age, and family roles		

Figure 4. Phase 4- Living with heart failure.

Influencing factors. Influencing factors were defined as conditions, which influenced conditions/contexts by promoting or inhibiting decision-making, and actions in seeking health care for achieving certainty in living with HF. These influencing factors involved both personal factors and contextual factors. **Personal factors** involved personal responses to health condition, personal data, personal beliefs about health and care, and experience with health conditions and seeking care. **Personal responses to health conditions** were presented as the meaning of HF conditions based on participants' perspectives. The meanings of HF conditions were associated with causal conditions and directly influenced care-seeking decisions and actions. Experiences with previous/underlying health conditions and health care-seeking behaviors, health beliefs, and stored knowledge influenced to define the meaning of HF conditions. For example, when participants recognized that they were becoming person with HF, they defined the meaning of HF as relevant to death due to a perceived threat to life, and the interpretation of the name and health belief (the heart was essential for life and survival). Thus, many participants defined HF health condition as a warning sign of death. **Personal data** represented an economic status and educational attainment that were presented in the first phase. However, when participants perceived the seriousness of their symptoms and recognized that they were HF people with uncertainty to live, family roles, and age as demonstrated in the second and third phases, respectively. These four aspects regarding personal data remained as basic information until the end of phase, "living with HF".

Beliefs in health and care of individual were influenced by socio-cultural factors, especially religion. Religion emphasizes the promotion of spiritual health beliefs and influenced decisions and actions in seeking spiritual health support, as shown in Phases 3 and 4.

Experience with health conditions and care seeking was due to the development of HF from other health conditions, such as CAD and VHD. Most participants had previous experience with seeking health care. Experiences with previous health conditions affected the providing meanings of HF symptoms in both Phase 1 and Phase 2, while care-seeking decisions and actions were affected at all phases.

Contextual factors refer to social environment which influences by either supporting or obstructing decision making, learning health care-seeking tracks, and performing actions toward health care-seeking. In this study, social environment involved both family structures and systems, community, the health care services of both professionals and laymen, and transportation. The aspects of family type, family roles, relationships among family members, responsibility, distributed support and participations in decisions and actions in the process of seeking care were explored. It was found that family type either nuclear or extended family might not influence the process of seeking care. Although participants had nuclear families, they were strongly supported by surrogate seekers who were relatives/neighbors/friends. Other aspects of family were influenced the health care seeking process during all phases. **Community environment** in this study referred to resources, networks and systems. The findings showed that lack of transportation in community importantly affected care-seeking decisions and actions. Strong **informal networks** among people in community might have influenced the process of health care-seeking behavior, especially taken acute care and information provided by the health care services of both professionals and laymen. Community systems influenced beliefs about the health and care of participants. Health care service systems offered by both professionals and laymen could influence health care-seeking behavior. Trust in health care providers and quality of care was an influencing factor in the process of health care seeking behaviors for confirmation of diagnosis, suitable care and learning to develop health care seeking tracks. Interestingly, some participants had had lessons with failure in seeking care for accessing quality health care services. An example of evidence was described as follows.

A 38-year old woman who had been diagnosed as chronic kidney disease (CKD) and HF said,

> "About 4-5 months ago, I found that I had edema and mild pain in my leg- -I went to a clinic (physician) and the doctor only gave me a balm. When I was working, these symptoms would recur- - I promptly had severe symptom of shortness of

> breath. I was admitted and received intravenous fluids and a number of oral medications. The doctor just told me that my heart and kidneys were functioning abnormally. I did not understand. About two weeks after my hospital discharge, I had recurrent edema. My mother thought it might be related to a previous pledge with the supernatural, so I made a votive offering at a temple in this province- -The last two nights, I had severe edema, nausea and vomiting with severe symptom of shortness of breath, so the nuns called an ambulance from a community hospital and took me to acute care- - I was referred to this hospital- -Today, I felt good. I survived- -The doctor told me that I would be discharged from hospital tomorrow but I did not know what happened to me and what my illness was- - I think I should go to temple to continue my votive offering (after that, she cried).

DISCUSSION

In the findings of this study illustrated the process of health care seeking based on perspective of southern Thai people with heart failure. This process consisted of four phases which were moved association with changing perceived phenomenon with HF of participants, including emerging HF symptoms, hesitation to live with HF symptoms, uncertainly living with HF, and living with HF. The purposes of health care seeking were followed phenomenon about health condition perception of participants that involved relieving symptoms and desire a cure, clarity their health conditions were, survival and endurance in living with HF, and certainty in living with HF, respectively. The influencing conditions were both personal factors and socio-culture factors. The action/strategies were congruent with influencing conditions and goals of seeking care could be divided to three aspects, including action seeking things for diagnosis and suitable care, developing care-seeking track, and learning to share authority of seeking care with surrogate seekers and be the wise seeker. The consequences were as the outcome of action/ strategies. This essential consequence was the attribution of certainty in living with HF that included confidence in living with HF, ability about developing complicated care-seeking track, satisfaction and confidence seeking HF care, and action as a model a wise seeker.

According to Health Belief Model (HBM) (Becker, 1974; Sheeran and Abraham, 1996) which is social cognitive theory, which use to explain health behavior of individual, it provides the influencing factors, which are able to predict health behavior, including determined seeking care. The finding in this study shows that influencing conditions which related to severity of health condition with HF perception, such as perceived serious health condition, life threaten, and death relevance influenced to determine seeking care among participants. Moreover, participants concern impact and barrier of seeking care, such as economic status, family survival, health care provider approach and quality of care.

Kasl and Cobb (1966) applied the health belief model to illness behavior and provided the knowledge those individuals who perceive and believe their illness act to seeking information and seeking method or intervention or health care service for clarity and improving health status through the process of perception with signs or symptoms. The findings in this study supported Kasl and Cobb's study. In phase1, participants who perceived symptoms sought information both inner self and other and sought method for relieving symptom. In phase 2, participants perceived serious symptoms and life threaten; they sought information and health care providers to receive diagnosis and care. In phase 3, they recognized that they were HF people but most of them could not accept to be HF people, thus they sought information and health care service for confirmation diagnosis and selecting the suitable care.

The seeking care was presented in some sections of the study process self-care process in Thais with HF (Rerkluenrit, 2008). This study was conducted in 35 Thais with HF and grounded theory was used to explore focusing self-care which consisted of three phases, including before becoming a person with HF, becoming a persons with HF, and living with HF. The seeking care was as a part of all actions of self-care in this study. The findings in this study showed that participants acted to seek assistance when they perceived serious symptoms. In the phase of becoming a person with HF, participants had unpleasant experience, including physical limitation, difficulty following treatment regimens, having negative emotion, financial support, and unpleasant experience at the hospital that led to seek care both modern and complementary treatment. In addition, they sought support involving seeking health information support, seeking material support, and seeking emotional and spiritual support. These findings of Rerkluenrit's study were congruent aspects of causal condition and action of seeking care in the phase 2 and phase 3 of this study. However, Rerkluenrit's study focused to explore all self-care aspects, it did not explain seeking care all phases, especially phase of living with HF and it could not be deeply explained the process of health care seeking.

In this study, the meaning of heart failure was considered by the participants as "a warning sign of death". This was similar to previous studies, such as Rerkluenrit's study (2008) in which 35 Thais, when first faced with heart failure, described this condition as a disease of life or death. Commonly, Thai society uses the term "heart failure" to explain and identify causes of death often, from a Thai perspective, referring to the stopping of the pumping of heart as a major category cause of death. Although people may have died from other causes, such as septic shock, cerebrovascular disease, and pneumonia, family members or relatives were told by health care providers that the final cause of death was heart failure referring to the cessation of the pumping of the heart. Moreover, most people in Thai society believe that the heart is vital for life. Therefore, Thais perceive and believe that heart failure is a term used for people near death.

On the aspect of support, Rerkluenrit's study (2008) presented emphasis on family support possibly due to the fact that more than half of all participants lived in urban society, i.e., nearly half of the participants lived in Bangkok. In this study, all participants were people who lived in provincial areas who had close interpersonal relationships in their communities, while many participants also received strong support from other people, such as relatives, neighbors, and friends, in seeking care. Therefore, if health care providers in provincial areas promote surrogate seekers in achieving seeking care, they should be concerned with real surrogate seekers that may not be family members. Lack of trust in care was found to influence delays in seeking acute care in HF patients (Patel et al., 2007). Similarly, trust in health care providers and quality of care was an influencing factor in the process of seeking care. In this study, however, it was also explained as influencing care-seeking decision-making and actions and learning to develop care-seeking tracks by many HF patients covering three aspects, i.e., acute care, confirmation of diagnosis and maintenance of well-being. The findings of this study strongly suggest implications for the practice of health care providers, especially in nursing practice. Health care providers, especially nurses, should understand the process seeking health care based on Thai settings with heart failure perspectives in order to achieve certainty in living with HF that leads to develop suitable health care service for gaining quality and reducing cost of care. In addition, the findings stimulate health care providers to become concerned and set mutual goals with other people with heart failure, while encouraging the achievement of goals leading to certainty in living with HF. Further research is required to clinically and empirically validate the process. In addition, the competency roles of the seeker should be explored for confirmation.

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