Older Individuals´ Perceptions of a Good Death: A Systematic Literature Review

Tiina Järviö[a]*, Lily Nosraty[b] and Anna Liisa Aho[c]

[a]Faculty of Social Sciences, Tampere University, Tampere, Finland; [b]Faculty of Social Sciences, Tampere University, Tampere, Finland; [c]Faculty of Social Sciences, Tampere University, Tampere, Finland

Corresponding author: Tiina Järviö e-mail: tiinajarvio@gmail.com

[a]MSc student, RN

[b]PhD, Postdoctoral Researcher at Tampere University, Faculty of Social Sciences and Gerontology Research Center (GEREC). Her focus is on aging studies. ORCID: Lily Nosraty ORCIDs 0000-0003-4720-0459

[c]PhD, University lecturer and docent at the University of Tampere. She has long-term experience in death-related research, especially in grief, coping and the support of loved ones after various causes of death.

Older Individuals´ Perceptions of a Good Death: A Systematic Literature Review

The purpose of this literature review was to describe older individuals´ perceptions of a good death. A systematic data search was conducted on CINAHL, Medline, PsycINFO, ASSIA, and Medic databases from 2010 to 2020, and supplemented with a manual search. Sixteen studies were selected. The quality of the studies was assessed using the JBI critical appraisal criteria. Data were analyzed by inductive content analysis. The core elements of older individuals´ perceptions of a good death were a dignified moment of death, factors that enhance the desire to live, an active agency in adapting to death, and equal interpersonal relationships.

Keywords: older individuals; good death; systematic review

Introduction

Good death has been studied from different perspectives, for example, from the perspective of different patient groups without distinction of age (Kastbom et al., 2017; Pierson et al., 2002), the perspective of the patients' family members (Miyashita et al., 2008) and health care professionals (Doorenbos et al., 2006), as well as from the perspective of the general population without distinction of age (Mori et al., 2018). Some studies have featured older individuals´ perceptions of a good death, although this was not the actual research topic. For example, the study by Anttonen (2016) sought to develop a substantive theory of palliative care. On the other hand, in the study of Fan et al. (2019), the purpose was to explore experiences and processes of advance care planning discussions among residents of a long-term care institution. However, the results of these studies (Anttonen, 2016; Fan et al., 2019) addressed the answer to the research topic of this literature review. As older individuals´ perceptions of a good death have been given little targeted attention, it is an important step to establish a systematic review of the existing literature.

According to some researchers (Doorenbos et al., 2006), a good death can be defined in many different ways and from several different perspectives. A good and dignified death refers to how an individual can maintain one´s dignity, conscience, freedom, and responsibility in the face of the inevitability of death. Indian nurses described dignified death in expressions of the transition of the soul, end of life, and ultimate death, as well as being modest, lively, peaceful, painless, and respectful. Kastbom et al. (2017), Miyashita, et al. (2008) and Mori et al. (2018) highlighted regard for social relationships as part of a good death. In a study of South Korean war veterans, perceptions of a dignified death were determined by maintaining emotional comfort and arranging social relationships, and a high level of education and good financial situation were reflected in the participants' perceptions of what they saw as a good death (Park et al., 2019). The period before a good death was defined as the stage of life in which an individual accepts death as being inevitable, values the already lived life, and attains the unity of one´s personality (Kastbom et al., 2017; Park et al., 2019; Pierson et al., 2002).

In this literature review, a good death is defined on a general level as including the individual's ability to maintain their dignity, as well as having the ability to make autonomous decisions about matters concerning themselves, their social relationships, and having emotional security (Doorenbos et al., 2006; Park et al., 2019). However, there is an evident lack of research-based information on older individuals´ perceptions of a good death. This literature review was to describe older individuals´ perceptions of a good death.

Older individuals´ perceptions of a good death need to be clarified in face of the noticeable aging of the global population (WHO, 2020). The aging of the population is also expected to increase the need for palliative care. Globally, approximately 20 million people require palliative care each year, and some 67% of them are older

individuals. Improving the quality of palliative care involves crossing social and cultural boundaries regarding death-related beliefs (World Health Assembly 67., 2014). It is relevant because culture shapes individuals´ lives and influences them through culturally specific traditions and norms. Similarly, culture and related beliefs, or their denial, shape perceptions of death. (Koh-Krienke, 2019.) Individuals' worldview differs between Eastern and Western cultures. Eastern cultures are considered more holistic than Western cultures. (Ma-Kellams & Blascovich, 2012.) In addition to nurturing quality of life, THL (2020a) defines enabling a good and dignified death as the goal of end-of-life care.

Older individuals have been defined in many ways both socially and in research, based on chronological age (National Pensions Act, 2007; Mitchell & McCance, 2012; Paillaud et al., 2017; Shawler, 2007; Swinkels & Mitchell, 2009), the impairment of physical, mental, cognitive or social functioning (Supporting the Functional Capacity of the Older Population and on Social and Health Services for Older Persons Act, 2012), and the cultural way of defining older individuals (THL, 2020b). Age is defined differently in different cultures. An individual's cultural background contributes to how they view their aging or how they are perceived by family and the rest of the community. (Joarder et al., 2014; THL, 2020b.) In Somali culture, for example, a 55-year-old is already considered an older individual (THL, 2020b). On the other hand, in Bangladesh, where the average age is about 70 years, people aged 50 and older are considered older individuals (Joarder et al., 2014). In this literature review, the concept of an older individual is based on a culturally dependent way of defining an older individual (THL, 2020b). The definition was reached to avoid excluding potentially relevant studies from the data due to the narrow definition of an older individual.

The recent COVID-19 pandemic has affected the lives of older individuals in many ways. Higher age (individuals aged 60 years and older) has been shown to increase the risk of severe disease and poor prognosis in COVID-19 patients (Ma et al., 2020). Social distancing and isolation may also be likely to result in poor mental health for older individuals (Baker & Clark, 2020). Especially, as the coronavirus pandemic particularly affects the social dimension of the lives of older individuals, it may also affect their perceptions of a good death. For this reason, older individuals´ perceptions of a good death need to be systematically clarified so that any changes in perceptions considering a good death that may be caused by the COVID-19 pandemic can be verified in the future.

This systematic literature review aims to establish older individuals´ perceptions of a good death so that their related needs can be taken better into account in health care services. In so doing, the systematic literature review seeks to answer the following research question: What are older individuals´ perceptions of a good death?

Methods

A systematic literature review is a method in which the goal is to make an objective and comprehensive synthesis of research related to a research topic. In addition, the aim is to summarize the existing knowledge on the research topic in a single document. When conducting this systematic literature review, a carefully structured research process was followed, in which methodological care and justification were essential to ensure the trustworthiness and appropriateness of the results. (Aromataris & Munn, 2020.)

Search Strategy

Data retrieval was performed from the CINAHL, Medline, PsycINFO, ASSIA, and Medic electronic databases. The PICo method applied to qualitative research was used

to formulate the research question and to determine the keywords. P is the population (older individuals). I is the phenomenon of interest (perceptions of older individuals). Co is context (good death). (Aromataris et al., 2020.)

Database searches used Finnish keywords with their synonyms (Medic) and their English equivalents (CINAHL, Medline, PsycINFO, ASSIA). MeSH / FinMeSH (Finto), Hoidokki, Termix, Duodecim, CINAHL Subjects Headings, Thesaurus, and Medic keyword databases were used to define search terms (Bettany-Saltikov, 2012), which are presented in Table A1. The Boolean operators were used according to the instructions of different databases (Table A1) (Bettany-Saltikov, 2010). The application and selection processes were carried out in consultation with a university library information specialist and supplemented by a manual search. In the manual search, the reference lists of publications that fulfilled the inclusion criteria were reviewed manually to identify additional studies not retrieved in the electronic search.

Eligibility Criteria and Study Selection

The search was limited to peer-reviewed publications in Finnish and English which were published from 1/2010 to 5/2020. This period was chosen because an individual´s worldview and thus perceptions of death are time-dependent (Menzies et al., 2020). In Addition, each period affects the temporal manifestations of culture-related beliefs (Koh-Krienke, 2019). The study sought to elucidate older individuals' perceptions of a good death before the pandemic period. Also, the research material in the literature review needed to be as fresh as possible but still extensive enough. The inclusion criteria for this systematic literature review were that the publication answers the research question, i.e.: 1) deals with the perspectives of older individuals; and 2) deals with the perceptions of a good death. The exclusion criteria were: 1) the perspectives of

other age groups, health care personnel, people close to the older individual, or age groups that are not separated in the results section of the research article; 2) does not deal with perceptions of a good death, but for example, causes of death or treatment measures; 3) literature review; 4) duplicate studies within databases; 5) duplicate studies between databases, and 6) no full text available. A total of 1484 studies were identified via databases. Seven studies were identified via other methods. Thirty studies were considered for full-text review. Of them, sixteen studies were finally included in the literature review. The PRISMA flowchart was used to report the selection process of the studies (Page et al., 2021), which is presented in Figure 1.

[Figure 1 near here]

Quality Appraisal

The Critical Appraisal Tools developed by the Joanna Briggs Institute (JBI) were used to assess the quality of the studies (JBI, 2020). The studies used in the literature review were scored according to the evaluation criteria, and based on the quality assessment, no studies were excluded from the literature review returns. The first author (TJ) conducted the quality assessment process and discussed it with the co-author (ALA) throughout the process. There was no disagreement on the quality assessment. If there had been disagreement over the quality assessment, it would have been discussed until a consensus was reached. The scores of the qualitative studies ranged from 7/10 to 10/10, and the scores of the quantitative studies from 5/8 to 6/8. The scores of the quality assessment for each study are presented in Table 1, Table A2, and Table A3.

Data Extraction and Synthesis of Findings

The method of data analysis for the review was inductive content analysis, which

commenced by numbering and tabulating the studies (Table 1). This numbering was used in the coding process. The coding process was handled manually. The sentence or part of the sentence in each study answering the research question of the systematic review was selected as the unit of analysis, from which the original expressions were extracted and their reductions were formed (Elo & Kyngäs, 2008; Vaismoradi et al., 2013).

Reductions were grouped based on the similarities and differences between them. Subcategories were formed from substantively similar expressions, from which, by further raising the level of abstraction, upper categories were formed. The categories were named descriptively (Elo & Kyngäs, 2008; Vaismoradi et al., 2013), and the process of content analysis for one upper category is described in Table A4. The first author (TJ) performed data analysis and discussed it with the co-author (ALA) throughout the analysis process. Possible disagreement over the analysis was discussed until a consensus was reached.

Results

Description of Research Material

The literature review material consisted of 16 peer-reviewed studies. Of the studies, two were European, three were North American, one was Australian, and ten were Asian. In the Asian and European studies, the participants were drawn from the general population of each country or region. In contrast, in the North American and Australian studies, participants represented various minority groups. The demographic structure of the participants and more detailed information on the studies selected for the literature review are presented in Table 1. Six of the studies were quantitative cross-sectional studies and ten were qualitative studies. Of the qualitative studies, two analyzed the data

by inductive content analysis, two used thematic analysis, and one used both inductive and deductive content analysis. Two studies had been conducted using the grounded theory method. One study was a focused ethnography, and one study was a field study. One study was a case study in which the data were analyzed by inductive content analysis. According to critical appraisal, most studies provided clear statements of the methods and research process (see Table A2 and Table A3).

Findings

Older individuals' perceptions of a good death included a dignified moment of death (n=14), factors that enhance the desire to live (n=14), an effortless death without artificial prolongation of life (n=7), accepting the end of life (n=6), and a transparent attitude towards self and others (n=6). In addition, older individuals´ perceptions of a good death included an active agency in adapting to the death (n=9), holistic spirituality in adaptation to death (n=3), involvement in interactions (n=4), end-of-life support (n=5), equal interpersonal relationships (n=8), and leaving an intergenerational legacy (n=5) (see Table 2).

A Dignified Moment of Death

According to the older individuals´ perceptions of a good death, a dignified moment of death included, a wish for an individual moment of death (Hattori & Ishida, 2012; Liu & van Schalkwyk, 2019; Shimoinaba et al., 2019), obtaining a meaningful place of death (Akechi et al., 2012; Anttonen, 2016; Hävölä et al., 2014; Ko et al., 2013; Ko et al., 2015; Limpawattana et al., 2021; Manjavong et al., 2019; Srinonprasert et al., 2019), and a consideration of physiological factors (Fan et al., 2019; Hävölä et al., 2014; Joarder et al., 2014; Ko et al., 2013; Ko et al., 2015; Liu & van Schalkwyk, 2018) and mental factors (Akechi et al., 2012; Fan et al., 2019; Hävölä et al., 2014; Joarder et al.,

2014; Ko et al., 2013; Ko et al., 2015; Liu & van Schalkwyk, 2019; Shimoinaba et al., 2019; Srinonprasert et al., 2014).

A wish for an individual moment of death as a perception of a good death included consideration of individual death-related perceptions, cultural background (Hattori & Ishida, 2012), as well as traditional death-related rituals (Liu & van Schalkwyk, 2019; Shimoinaba et al., 2019). Obtaining a meaningful place of death included the possibility to die in one's favorite place (Akechi et al., 2012), in one's own home (Anttonen, 2016; Hävölä et al., 2014; Ko et al., 2013; Ko et al., 2015; Limpawattana et al., 2021; Manjavong et al., 2019; Srinonprasert et al., 2019), in a medical institution (Hävölä et al., 2014; Park et al., 2015; Shimoinaba et al., 2019), and the possibility to choose the place of death (Akechi et al., 2012). Consideration of physiological factors included the desire to die without general physical suffering (Fan et al., 2019), the experience of a painless death (Fan et al., 2019; Hävölä et al., 2014; Joarder et al., 2014; Ko et al., 2013), a natural death (meaning no reliance on medicine, medical technology, or medical interventions) (Ko et al., 2013; Ko et al., 2015; Liu & van Schalkwyk, 2019), the desire to encounter death in good physical condition (Joarder et al., 2014), and hoping to die from sudden physiological causes (Ko et al., 2013). Consideration of mental factors as a part of a good death was accompanied by a wish for a peaceful death (Fan et al., 2019; Hävölä et al., 2014; Joarder et al., 2014; Ko et al., 2013; Ko et al., 2015), a beautiful death (Hävölä et al., 2014), and dignified death (Ko et al., 2013). In addition, consideration of mental factors included the wish to die while sleeping (Ko et al., 2013; Ko et al., 2015), to be respected as an individual (Akechi et al., 2012), the presence of loved ones at the time of death (Hävölä et al., 2014; Joarder et al., 2014; Ko et al., 2013; Liu & van Schalkwyk, 2019; Shimoinaba et al., 2019; Srinonprasert et al., 2014), to be alone at the time of death (Anttonen, 2016), as well as

death without general suffering (Ko et al., 2013; Ko et al., 2015) or mental suffering (Fan et al., 2019).

Factors that Enhance the Desire to Live

Part of the older individuals` perceptions of a good death were factors that enhance the desire to live, which included factors that increase the meaning of life (Akechi et al., 2012; Ko et al., 2013; Limpawattana et al., 2021; Manjavong et al., 2019; Park et al., 2015; Srinonprasert et al., 2014; Srinonprasert et al., 2019), empowering emotional work (Akechi et al., 2012; Anttonen, 2016; Hävölä et al., 2014; Ho et al., 2013; Ko et al., 2015), maintaining psychological stability (Fan et al., 2019; Limpawattana et al., 2021), the meaningfulness of acting in the present (Akechi et al., 2012; Ho et al., 2013), and the need to stay connected to one's own home (Hävölä et al., 2014; Joarder et al., 2014; Shimoinaba et al., 2019).

Factors that increase the meaning of life as perception of a good death included perceived mental and general physical comfort (Akechi et al., 2012) as well as environmental comfort (Akechi et al., 2012; Ko et al., 2013). In addition, factors that increase the meaning of life were associated with the alleviation of unpleasant symptoms (Limpawattana et al., 2021; Manjavong et al., 2019; Park et al., 2015; Srinonprasert et al., 2014; Srinonprasert et al., 2019) and the presence of loved ones as needed (Limpawattana et al., 2021). Empowering emotional work included maintaining hope (Akechi et al., 2012) and pleasure (Akechi et al., 2012; Anttonen, 2016; Hävölä et al., 2014), the ability to express love, the expression of affection, dealing with anger (Ko et al., 2015), and the identification of privacy boundaries (Ho et al., 2013). As a part of the perceptions of a good death, maintaining psychological stability included the desire to be mentally aware in one´s last hours of life (Limpawattana et al., 2021), as

well as to experience mental balance as death approaches (Fan et al., 2019). Also, the meaningfulness of acting in the present included living in the moment, being present without worrying about the future (Ho et al., 2013), and fulfillment of experiencing the life cycle as a whole (Akechi et al., 2012). The need to stay connected to one's own home as a part of a good death meant a desire that older people could stay at home for as long as possible before death (Hävölä et al., 2014; Joarder et al., 2014), the opportunity for those in inpatient care to visit their home (Hävölä et al., 2014), maintaining the food culture of the country of birth, the opportunity to use their mother tongue to ensure belonging and understanding, as well as maintaining an emotional bond with the country of birth (Shimoinaba et al., 2019).

An Effortless Death without Artificial Prolongation of Life

Effortless death without artificial prolongation of life was part of older individuals´ perceptions of a good death. It included a smooth and rapid death (Fan et al., 2019; Limpawattana et al., 2021; Srinonprasert et al., 2014; Srinonprasert et al., 2019), the decision to refuse resuscitation (Fan et al., 2019; Hattori & Ishida, 2012), and the refusal of life-prolonging medical treatments (Ko et al., 2013; Ko et al., 2015; Srinonprasert et al., 2014).

A smooth and rapid death included a reluctance to prolong the process of death (Fan et al., 2019; Limpawattana et al., 2021; Srinonprasert et al., 2014; Srinonprasert et al., 2019), as well as a desire to die quickly and smoothly (Fan et al., 2019). The decision to refuse resuscitation included the refusal of resuscitation as it increases suffering and pain (Fan et al., 2019), and choosing a resuscitation ban when the patient is terminally ill (Hattori & Ishida, 2012). The refusal of life-prolonging medical treatments included death without life-sustaining medical devices (Ko et al., 2013; Ko

et al., 2015) and a reluctance toward life-prolonging treatments with poor chances of survival (Srinonprasert et al., 2014).

Accepting the End of Life

As part of older individuals´ perceptions of a good death, accepting the end of life was associated with an adaptation to the knowledge of impending death (Anttonen, 2016; Hävölä et al., 2014; Ho et al., 2013; Ko et al., 2013; Liu & van Schalkwyk, 2019) and the acceptance of death (Ho et al., 2013; Ko et al., 2015).

Adaptation to the knowledge of impending death included accepting death as part of life (Hävölä et al., 2014), accepting unfinished matters (Anttonen, 2016), the acceptance of conflicting wishes (Hävölä et al., 2014), as well as experiencing death as natural (meaning dying as a part of the course of life, and that death is not something to be ashamed of) (Anttonen, 2016; Ho et al., 2013; Ko et al., 2013; Liu & van Schalkwyk, 2019). An acceptance of death as a part of older individuals´ perceptions of a good death meant finding inner peace by giving up the fight (Ho et al., 2013) and the resolution of any internal conflicts (Ko et al., 2015).

Transparent Attitude towards Self and Others

Transparent attitude towards self and others was included in older individuals´ perceptions of a good death and meant transparency about health in relation to self and family (Ko et al., 2013; Limpawattana et al., 2021; Manjavong et al., 2019; Srinonprasert et al., 2014; Srinonprasert et al., 2019), as well as taking responsibility for life (Ko et al., 2013; Ko et al., 2015; Srinonprasert et al., 2019).

Transparency about health in relation to self and family included knowing the truth about the illness (Limpawattana et al., 2021; Manjavong et al., 2019; Srinonprasert et al., 2014; Srinonprasert et al., 2019), telling the truth to the family (Limpawattana et

al., 2021; Manjavong et al., 2019; Srinonprasert et al., 2014), and involving the family in final decisions (Ko et al., 2013). Taking responsibility for life included settling matters with loved ones (Ko et al., 2013; Ko et al., 2015), apologizing (Ko et al., 2015), and completing unfinished matters (Srinonprasert et al., 2019).

Active Agency in Adapting to the Death

An active agency in adapting to death was a part of older individuals´ perceptions of a good death and included farewell as an enabler of renunciation (Anttonen, 2016), and preparing for the end of life (Akechi et al., 2012; Anttonen, 2016; Hattori & Ishida, 2012; Ko et al., 2013; Limpawattana et al., 2021; Liu & van Schalkwyk, 2019; Park et al., 2015; Shimoinaba et al., 2019; Srinonprasert et al., 2019).

From the older individuals´ point of view, farewell as an enabler of renunciation included saying goodbye to other people, saying goodbye to things, roles, and places, and saying goodbye as a way of giving up certain situations, as well as saying goodbye in general (Anttonen, 2016). Preparing for the end of life as a part of older individuals´ perceptions of a good death included a general preparation for death (Akechi et al., 2012; Ko et al., 2013; Liu & van Schalkwyk, 2019), preparation for death from the perspective of oneself and loved ones, sharing things according to family culture (Anttonen, 2016), as well as the making of a will and financial plans (Hattori & Ishida, 2012). In addition, preparing for the end of life included obtaining insurance that entitled older individuals to care, moving to 24-hour care housing (Hattori & Ishida, 2012), the appointment of a surrogate decision-maker (Limpawattana et al., 2021; Srinonprasert et al., 2019), and funeral planning (Hattori & Ishida, 2012; Park et al., 2015; Shimoinaba et al., 2019).

Holistic Spirituality in Adaptation to Death

Holistic spirituality in adaptation to death was a part of older individuals´ perceptions of a good death and was associated with spiritual growth during life (Ho et al., 2013; Ko et al., 2013; Ko et al., 2015) and religious experiences (Ko et al., 2013).

Spiritual growth during life included seeking spiritual peace, finding spiritual peace through forgiveness, broadening the outlook on life (Ho et al., 2013), as well spirituality during life (Ko et al., 2013), and experiencing a spiritual connection (Ko et al., 2013; Ko et al., 2015). Religious experiences included religiosity during life as well as accepting God's decision on death (Ko et al., 2013).

Involvement in Interactions

As a part of older individuals´ perceptions of a good death, involvement in interactions included establishing a confidential relationship with health care personnel (Akechi et al., 2012), experiencing connection in interpersonal relationships (Akechi et al., 2012; Hävölä et al., 2014; Ho et al., 2013), presence in interpersonal relationships (Hävölä et al., 2014; Ho et al., 2013), as well as involving people in the life of the dying person (Anttonen, 2016).

From older individuals´ points of view, establishing a confidential relationship with healthcare personnel included trusting the physician, discussing treatment with the physician, as well as having good relationships with the healthcare personnel (Akechi et al., 2012). Experiencing a connection in interpersonal relationships was related to the experience of being heard (Akechi et al., 2012; Hävölä et al., 2014), good family relationships (Akechi et al., 2012), and intergenerational unity (Ho et al., 2013). On the other hand, presence in interpersonal relationships included the experience of being present in the lives of loved ones (Hävölä et al., 2014), as well as the longing to be

physically and mentally close to loved ones (Ho et al., 2013). Involving people in the life of the dying person meant sharing the meaning of people as well as sharing the value of a lived life (Anttonen, 2016).

End-of-life Support

Older individuals` perceptions of a good death included considerations of end-of-life support. It was associated with support both from social relationships (Hattori & Ishida, 2012; Ho et al., 2013; Joarder et al., 2014) and also from health care personnel (Limpawattana et al., 2021; Srinonprasert et al., 2014).

Support from social relationships included general social support (Ho et al., 2013), general support from the family, cultural expectations about the duty of family members to help, financial support, and mental support provided by the child (Hattori & Ishida, 2012) and family members acting as caregivers (Joarder et al., 2014), and the comprehensive support received from friends (Hattori & Ishida, 2012). Support from health care personnel included the holistic care of the patient (Limpawattana et al., 2021), as well as considerations of physical health, mental health, and spirituality as part of treatment (Srinonprasert et al., 2014).

Equal Interpersonal Relationships

The category of equal interpersonal relationships included an aspiration not to burden other people (Akechi et al., 2012; Anttonen, 2016; Hattori & Ishida, 2012; Limpawattana et al., 2021; Srinonprasert et al., 2019) and the avoidance of being a burden (Fan et al., 2019; Hattori & Ishida, 2012; Hävölä et al., 2014; Ho et al., 2013).

An aspiration not to burden other people included a desire not to be a general (Hattori & Ishida, 2012; Limpawattana et al., 2021), physical, or mental (Hattori & Ishida, 2012; Srinonprasert et al., 2019) burden on one´s own family, as well as a desire

not to be a general burden on people outside the family (Akechi et al., 2012; Anttonen, 2016). Avoidance of being a burden meant expressing desires for the rest of their life in order to avoid suffering for loved ones (Fan et al., 2019), a wish to reduce the consequences of death for loved ones (Ho et al., 2013), and reducing the burden on the family by preparing for the end of life and death (Hattori & Ishida, 2012). In addition, avoidance of being a burden included an aspiration to reduce the burden placed on loved ones (Ho et al., 2013), to avoid the burden of cultural parental death practices on children (Hattori & Ishida, 2012), as well as hope that loved ones will endure despite the changes caused by the disease of the older person (Hävölä et al., 2014).

Leaving an Intergenerational Legacy

Leaving an intergenerational legacy was one of the older individuals` perceptions of a good death. It involved leaving your own legacy (Ho et al., 2013) as well as taking children and grandchildren into account intergenerationally in the adaptation to death (Anttonen, 2016; Hattori & Ishida, 2012; Joarder et al., 2014; Shimoinaba et al., 2019).

Leaving your own legacy included leaving a legacy beyond death, as well as the transmission of traditions, values, and the moral belief system that sustains the family (Ho et al., 2013). Taking children and grandchildren into account intergenerationally in the adaptation to death from older individuals´ point of view included the transfer of heritage to children and grandchildren, as well as the guidance, encouragement, and comfort of children and grandchildren (Anttonen, 2016), and the discussion of preparations for death (Hattori & Ishida, 2012; Shimoinaba et al., 2019) and creating a stable foundation for children (Joarder et al., 2014).

Discussion

Review of Results

The purpose of this literature review was to describe older individuals´ perceptions of a good death. In this review, a number of categories were identified that both converge and diverge across the studies featured in the review. The core elements of older individuals´ perceptions of a good death that appeared in at least half of the selected studies were a dignified moment of death, factors that enhance the desire to live, an active agency in adapting to death, and equal interpersonal relationships. (Table 2.) Reviewing the core elements of the results of the literature review in relation to the continents on which the studies were conducted, it can be stated that older individuals´ perceptions of a good death appear to be quite similar, regardless of the continent where the study was conducted. For example, a dignified moment of death, factors that enhance the desire to live, and active agency in adapting to death manifested in the older individuals´ perceptions of a good death in Asia, Europe, Australia, and America. On the other hand, equal interpersonal relationships were not manifested in older American individuals´ perceptions of a good death. (Table 1. and Table 2.)

It is noteworthy that of the Western studies selected for the review, only the participants in the studies conducted in Finland belonged to the general population of the region by their cultural background. In the U.S. and Australian studies, participants did not belong to the region's general population by cultural background. In addition, of the sixteen studies, ten had been conducted in Asia. Thus, based on a review of the literature review, it is not possible to make generalizations between Western and Eastern cultures, for example, concerning how older individuals' perceptions of good death differ. The uneven regional distribution of studies may be because, according to Ma-Kellams and Blascovich (2012), Eastern cultures are considered more holistic than

Western cultures. They include the assumption that perceptions of positive and negative matters can coexist. In Western cultures, ideas related to death are dealt with denial of one's mortality (Koh-Krienke, 2019). While in Eastern cultures, thinking about impending death generates active thoughts and activities related to life (Ma-Kellams & Blascovich, 2012) which may affect whether death is studied from the perspective of people approaching their death based on chronological age.

The relationship of previous research on good death to the findings of this systematic literature review is as follows. In their literature review, Meier et al. (2016) explored the definition of a good or successful death from the perspectives of patients, relatives, and health care professionals. The sources of the research articles were from 1996 to 2015 and the age distribution of the participants was between 14–93 years. Thus, while the literature review of Meier et al. (2016) included older individuals, it did not differentiate this age group which may have different perspectives on a good death. The results of this systematic literature review supported the results of Meier et al. (2016) regarding the holistic way of perceiving an older individual's perceptions of a good death. The importance of family-centeredness and spirituality was more strongly emphasized in their material. However, the importance of a broader cultural and social life circle and the significance of an intergenerational legacy appeared more strongly in this literature review than in the material of Meier et al. (2016).

The results of this systematic literature review confirmed the results of a study by Miyashita et al. (2008) on the perception of a good death from the perspective of bereaved family members, and a study by Mori et al. (2018) on good death among Japanese living either in Japan or in America and among Japanese Americans regarding social relationships and caring for them as part of a good death. In this literature review

on older individuals´ perceptions of a good death, this emerged in categories of involvement in interactions and the transparent attitude towards self and others.

The results of Vig et al.'s (2002) study of geriatric outpatient clinic patients' desires for good end-of-life were confirmed by the results of this systematic literature review, in that good death is an individually-related phenomenon for older individuals. Furthermore, the results of this literature review relating to factors of a good death that enhance the desire to live also correspond with Vig et al.'s (2002) findings. The results of Pierson et al. (2002) regarding a good death from the perspective of AIDS patients of different ages were confirmed by the results of this systematic literature review in that maintaining decision-making ability over one's life, death, and care is a component of a good death, as well as adopting an accepting attitude towards the end of life. Also, Kastbom et al. (2017) have highlighted that independence is included in one of their main categories (Dying comfortably) of a good death.

According to this systematic literature review, a good death appears to be a subjective phenomenon, and the individual interpretation of a good death varies between older individuals. To summarize the key findings of this systematic literature review: older individuals´ perceptions of a good death were holistically related to different areas of life, outlining the human individual and his or her life circle from a holistic perspective. Older individuals should be addressed in health care services holistically. This means that health care professionals should take into account the psychological and physical needs of older individuals concerning a good death, as well as individual differences in how older individuals perceive themselves as part of their lives, families, social relationships, and culture. In addition, both health care workers and family members of an older individual should be aware that their perceptions of an older individual's good death may differ from those of the older individual. The results

could be used, for example, by healthcare professionals in the care discussion as guiding themes for discussion with patients in hospice care about their perceptions of a good death. In utilizing the results of this literature review, it would be important to consider the contents of older individuals´ perceptions individually rather than generalizing the results to older individuals as a homogeneous population.

Strengths and Limitations

The main strengths of this literature review are the consideration of ethical aspects and the trustworthiness of the literature review. First, this systematic literature review followed good scientific practice throughout its process, striving for honesty, diligence, and accuracy in recording, presenting, and evaluating studies and their results (TENK, 2012).

Second, the research process was systematically progressing. An assessment of the trustworthiness of the systematic literature review was performed using the Joanna Briggs Institute's Critical Appraisal Checklist for Systematic Reviews and Research Syntheses. The research question was stated explicitly and clearly. An appropriate search strategy was developed. The inclusion criteria for the review were appropriate when comparing them to the research question. A systematically progressive search strategy has been described both in writing and is shown in Figure 1 and Table A1. Before the information search, test searches were performed on each database in consultation with the information specialist of the university library. Database restrictions were justified and deemed appropriate (JBI, 2020).

A quality assessment for studies that met the inclusion criteria was performed using critical appraisal tools developed by the JBI. The synthesis of the research results was carried out using methods suitable for qualitative literature review using inductive

content analysis. The conclusions presented in the literature review, recommendations for practice, as well as the proposal for further research are in line with the results drawn from the source data (JBI, 2020).

The limitation of the literature review is that during the information retrieval process, a challenge was that little research had been done directly on good death from the perspective of older individuals, which led to supplemental information retrieval by way of a manual search. Furthermore, when considering the results of this literature review, it should be taken into consideration that in American and Australian studies participants represented various minority groups, while in European and Asian studies, participants were part of the general population in the region. In addition, the majority (n = 10) of the studies that met the inclusion criteria in the literature review were conducted in Asia, which may have contributed to the themes identified in the review.

Implications for Practice and Research

Based on this literature review, the following conclusions can be drawn. In health care services, older individuals must be individually taken into account so that they can discuss their perceptions of a good death, for example, with a nurse. As the population ages, there is a need to increase or allocate resources to develop health care services that better meet the needs of older individuals. This includes a need to increase training in caring for older individuals and address encountering death by taking into account older individuals´ perceptions of a good death. In palliative health care, when working as a nurse, one should be aware that every encounter with older individuals may be their last. Accordingly, older individuals´ perceptions of a good death should be valued in every encounter. To develop this line of care in a national context, it is important to find out the perceptions of a good death of older individuals aged 65 and older living in

Finland. Furthermore, it is important to study whether the recent COVID-19 pandemic has affected older individuals' perceptions of a good death.

Author Contributions

Research design: TJ and ALA, Implementation: TJ, Data collection and analysis: TJ, Manuscript writing: TJ, Manuscript commentary: LN and ALA; All authors have agreed to the published version of the manuscript.

Funding

This work does not have funding.

Declaration of Interest Statement

The authors declare no conflict of interest.

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Table 1. Characteristics of included studies and quality assessment.

[Table 1 near here]

Table 2. Older individuals´ perceptions of a good death.

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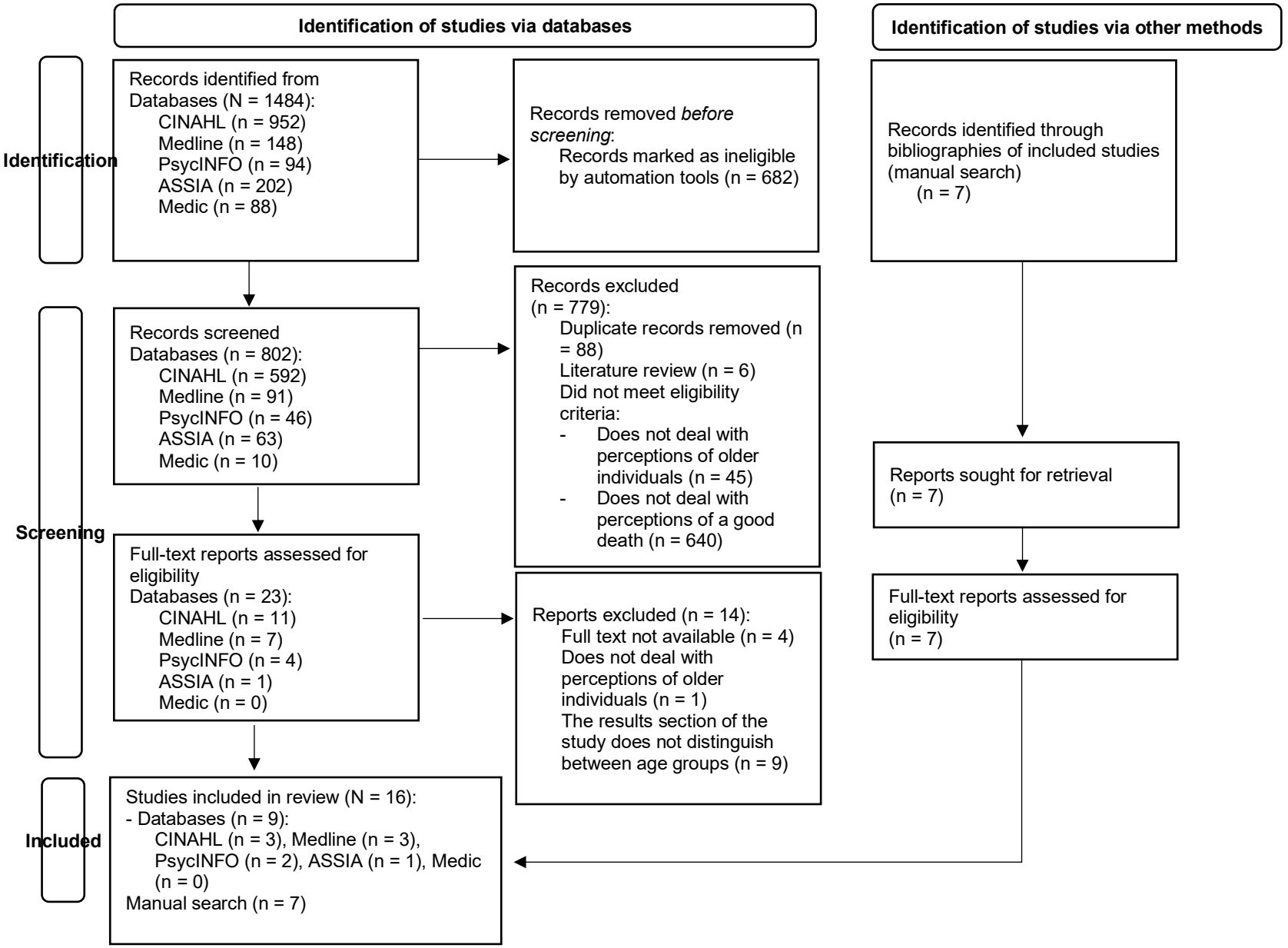

Figure 1. PRISMA Flowchart of studies selection process (Page et al., 2021).

Table 1. Characteristics of included studies and quality assessment.

Country (Authors, Year)	The Purpose of the Study	Material and Research Methods	Key Results	Quality Assessment *
1. Japan (Akechi et al., 2012)	To investigate the differences in the perception of the concept of good death between the younger adult population and the older adults, and to clarify the components of a good death in the older adults.	Survey (questionnaire) 70-79 years old (n=466) Quantitative cross-sectional study	Perceptions of a good death among 70-79-year-olds (five key domains of a good death): 1. Good relationship with medical staff, 2. Physical and psychological comfort, 3. Not being burden to others, 4. Preparation for death, 5. Natural death.	6/8
2. Finland (Anttonen, 2016)	To develop a substantive theory of palliative care describing palliative care by analyzing the experiences of adult patients with incurable cancer, their family members, and nursing staff.	Thematic interview Patients aged 57 to 87 years (n=16) Qualitative research	Factors of a good death: Leaving spiritual heritage to future generations. The process of giving up life. Preparing for death by contemplating death from one's own and loved ones´ perspective, remembering previously deceased loved ones, choosing the place of death, and easing the burden on loved ones.	10/10
3. Taiwan (Fan et al., 2019)	To explore experiences and processes of Advance Care Planning discussions among residents of a long-term care institution.	Individual interviews Persons aged 65 years or older (n=28) Qualitative research	Good death meant: Death without physical and mental suffering. Peaceful death without pain. Not prolonging the life by medical means, at the expense of loss of independence. A quick and smooth death.	8/10
4. USA (Hattori & Ishida, 2012)	Describe the predominate theme derived from a study of good death "not being a burden to family" from the perspective of elderly Japanese Americans living in Hawaii.	In-depth interviews Healthy individuals, at least 65 years old (n=18) Qualitative research	Themes of a good death: 1. "Not to be a burden on the family". 2. The process of life and death. 3.Individual views on death. 4.Japanese culture in Hawaii.	9/10

5. Finland (Hävölä et al., 2014)	To describe the hope of the patient in palliative care and the factors that strengthen and weaken it from the perspective of the patients and nurses.	Individual interviews Patients aged 68-89 years (n=6) Qualitative research	Wishes for a good death: Being heard as a person. Wishes related to impending death (beautiful, peaceful, and painless death, presence of a loved one at the time of death). Future (good survival of loved ones). Enjoying life with illness. Acceptance of conflict of aspirations.	10/10
6. Hong Kong (Ho et al., 2013)	To explore the concept of dignified life and death in a Chinese context and to explore the generalizability of Chochinov's Dignity model for older people from the perspective of palliative patients in Hong Kong.	Individual interviews Palliative care patients aged 60 years or older (n=16) Qualitative research	Most of the themes of the Dignity model were found in the Chinese cultural context of a good death. Death was seen as natural. Culture-specific content was evident in the sub-themes generativity/legacy: leaving behind a cross-generational value, resilience/fighting spirit: letting go of temporality, to achieve inner peace and comfort. New sub-themes: enduring pain, moral transcendence, spiritual surrender, transgenerational unity.	8/10
7. Bangladesh (Joarder et al., 2014)	To explore the perceptions of the older people about the meaning of death in the Bangladeshi community and to understand the impact of the meaning of death on the one´s well-being.	Participatory Rapid Appraisal/PRA Persons aged 50 and over (n=8) Qualitative field research	Good death: Peacefully, without suffering, and surrounded by family. Dying physically fit and that the lives of their children would be successfully established.	8/10
8. USA (Ko et al., 2013)	To identify and describe the domains that define good death from the perspective of healthy Mexican American older adults.	Individual interviews People aged 60 and over (n=18) Qualitative research	Categories of a good death: No suffering. Living life with faith. Having time for closure with family. Dying at home. A natural death.	9/10
9. USA (Ko et al., 2015)	To explore perspectives towards a good or bad death from the perspective of	Individual interviews	Themes of a good death: Dying peacefully. Not suffering.	8/10

	older homeless adults and their concerns about end-of-life care needs.	Older adults aged 60 and over (n=21) Qualitative research	Experiencing spiritual connection. Making amends with significant others.	
10. Thailand (Limpawattana et al., 2021, Original work first published 2019)	To examine and compare the preferences and perceptions of older patients and physicians regarding what constitutes a good death.	Survey (questionnaire) Patients aged 60 years or older (n=608) Quantitative cross-sectional study	End-of-life care wishes for a good death (five key categories): Relief from unpleasant symptoms. To know the full truth about one´s illnesses. A wish to be respected, not being treated only for diseases but also having spiritually needs met. Wanting their family to know the full truth about their illnesses. Presence of the patient's loved ones when needed.	5/8
11. China (Liu & van Schalkwyk, 2019, Original work first published 2018)	Explore how Chinese rural older individuals who are in the late stages of their lives narrate death-related issues and death preparation.	Individual interviews Older individuals (n=14) Qualitative research	Good death: A discussion of death in preparation for a good death. Rituals as part of a good death. Forgiveness, making peace with suffering.	9/10
12. Thailand (Manjavong et al., 2019)	To examine and compare the preferences and perceptions of older patients and nurses regarding to what they feel constitutes a good death.	Survey (questionnaire) Patients at least 60 years of age (n=608) Quantitative cross-sectional research	Older people´s preferences of a good death: 1. Relief from uncomfortable symptoms 2. To receive the full truth about one´s illness 3. Older individuals want their family to know the full truth about their illness.	5/8
13. South Korea (Park et al., 2015)	To compare and analyze the attitudes of older people living in care institutions and at home regarding death and their perceptions on the do-not-resuscitate (DNR) orders.	Survey (questionnaire) Older people over the age of 65 (n=300)	For a good death, the older individuals needed: In a facility: 1. physiological pain relief, 2. psychological stability, 3. religion, 4. something else, 5. support with family and friends, 6.good economic conditions. At home: 1.psychological stability, 2. physiological pain	5/8

		Quantitative, cross-sectional study	relief, 3. religion, 4. support from family and friends, 5. good economic conditions, 6. something else.	
14. Australia (Shimoinaba et al., 2019)	Address the complex cultural end-of-life needs of a client from a minority living in Australia.	Interview A 66-year-old Japanese woman diagnosed with a terminal cancer (n=1) Qualitative study	Reasons for the research participant to return home (to Japan) at the end of life: 1. traditional food, 2. mother tongue, 3. connection to the homeland, 4. death-related rituals. While living in Australia, the research participant's wish was death in a familiar palliative care unit, and a conversation with her son about her wish to return the urn to Japan.	7/10
15. Thailand (Srinonprasert et al., 2014)	To explore preferences toward end of life among Thai older persons with chronic illnesses.	Survey (questionnaire) Geriatric clinic patients (mean age 75.9 years) (n=100) Quantitative research	The most important individual wishes at the end-of-life (good death): the presence of loved ones, no life-prolonging treatments, knowing the truth about one's state. More than 90% hoped that they would not have any unpleasant symptoms and that they and their families would be told the truth about their illness. 76% did not want to receive life-prolonging treatments when the prognosis for survival was poor.	6/8
16. Thailand (Srinonprasert et al., 2019)	To determine and compare the preferences and perceptions of older individuals and their relatives regarding good death in two different medical institutions in different regions of Thailand.	Survey (questionnaire) Older individuals aged 60 years and older (n=608) Quantitative cross-sectional study	Preferences of the older individuals at the end of life (a good death): relief from unpleasant symptoms, to know the truth about one´s illness, A wish to be respected, not being treated only for diseases but have spiritual needs met. The family to know the full truth about their illnesses. To have one´s loved ones around when needed.	5/8

Note: * x/10 = Qualitative, x/8 = Quantitative (JBI, 2020).

Table 2. Older individuals´ perceptions of a good death.

UPPER CATEGORY (Number of studies)	SUBCATEGORY
A dignified moment of death [a] (n=14)	A wish for an individual moment of death
	Obtaining a meaningful place of death
	Consideration of physiological factors
	Consideration of mental factors
Factors that enhance the desire to live [b] (n=14)	Factors that increase the meaning of life
	Empowering emotional work
	Maintaining psychological stability
	The meaningfulness of acting in the present
	The need to stay connected to one's own home
An effortless death without artificial prolongation of life [c] (n=7)	A Smooth and rapid death
	The decision to refuse resuscitation
	Refusal of life-prolonging medical treatments
Accepting the end of life [d] (n=6)	Adaptation to the knowledge of impending death
	Acceptance of death
Transparent attitude towards self and others [e] (n=6)	Transparency about health in relation to self and family
	Taking responsibility for life
Active agency in adapting to the death [f] (n=9)	Farewell as an enabler of renunciation
	Preparing for the end of life
Holistic spirituality in adaptation to death [g] (n=3)	Spiritual growth during life
	Religious experiences
Involvement in interactions [h] (n=4)	Establishing a confidential relationship with health care personnel
	Experiencing connection in interpersonal relationships
	Presence in interpersonal relationships
	Involving people in the life of the dying person
End-of-life support [i] (n=5)	Support from social relationships
	Support from health care personnel
Equal interpersonal relationships [j] (n=8)	Aspiration not to burden other people
	Avoidance of being a burden
Leaving an intergenerational legacy [k] (n=5)	Leaving your own legacy
	Taking children and grandchildren into account intergenerationally in adaptation to death

Note. Studies included in the systematic literature review, from the results of which this upper category has been formed (Author, year).

[a] (Akechi et al., 2012 ; Anttonen, 2016; Fan et al., 2019; Hattori & Ishida, 2012; Hävölä et al., 2014; Joarder et al., 2014; Ko et al., 2013; Ko et al., 2015; Limpawattana et al., 2021; Liu & van Schalkwyk, 2019; Manjavong et al., 2019; Shimoinaba et al., 2019; Srinonprasert et al., 2014; Srinonprasert et al., 2019)

[b] (Akechi et al., 2012; Anttonen, 2016; Fan et al., 2019; Hävölä et al., 2014; Ho et al., 2013; Joarder et al., 2014; Ko et al., 2013; Ko et al., 2015; Limpawattana et al., 2021; Manjavong

et al., 2019; Park et al., 2015; Shimoinaba et al., 2019; Srinonprasert et al., 2014; Srinonprasert et al., 2019)

[c] (Fan et al., 2019; Hattori & Ishida, 2012; Ko et al., 2013; Ko et al., 2015; Limpawattana et al., 2021; Srinonprasert et al., 2014; Srinonprasert et al., 2019)

[d] (Anttonen, 2016; Hävölä et al., 2014; Ho et al., 2013; Ko et al., 2013; Ko et al., 2015; Liu & van Schalkwyk, 2019)

[e] (Ko et al., 2013; Ko et al., 2015; Limpawattana et al., 2021 ; Manjavong et al., 2019; Srinonprasert et al., 2014; Srinonprasert et al., 2019)

[f] (Akechi et al., 2012; Anttonen, 2016; Hattori & Ishida, 2012; Ko et al., 2013; Limpawattana et al., 2021; Liu & van Schalkwyk, 2019; Park et al., 2015; Shimoinaba et al., 2019; Srinonprasert et al., 2019)

[g] (Ho et al., 2013; Ko et al., 2013; Ko et al., 2015)

[h] (Akechi et al., 2012; Anttonen, 2016; Hävölä et al., 2014; Ho et al., 2013)

[i] (Hattori & Ishida, 2012; Ho et al., 2013; Joarder et al., 2014; Limpawattana et al., 2021; Srinonprasert et al., 2014)

[j] (Akechi et al., 2012; Anttonen, 2016; Fan et al., 2019; Hattori & Ishida, 2012; Hävölä et al., 2014; Ho et al., 2013; Limpawattana et al., 2021; Srinonprasert et al., 2019)

[k] (Anttonen, 2016; Hattori & Ishida, 2012; Ho et al., 2013; Joarder et al., 2014; Shimoinaba et al., 2019)

Table A1. Search strategy used in the electronical databases.

Database	Search terms
CINAHL	aged OR elderly OR senior OR “older people” OR geriatric
	AND
	”good death” OR ”quality death” OR ”dignified death” OR ”dying with dignity”
Medline	aged OR elderly OR senior OR “older people” OR geriatric
	AND
	MH "Comprehension" OR understanding OR sentiment OR belief
	AND
	”good death” OR ”quality death” OR ”dignified death” OR ”dying with dignity”
PsycINFO	aged.mp
	AND
	good death.mp
ASSIA	MAINSUBJECT.EXACT "Elderly people" OR MAINSUBJECT.EXACT "Terminally ill elderly people" OR MAINSUBJECT.EXACT "Housebound elderly people” OR MAINSUBJECT.EXACT "Homeless elderly people"
	AND
	MAINSUBJECT.EXACT "Good death concept" OR MAINSUBJECT.EXACT "Dying" OR MAINSUBJECT.EXACT "Death"
Medic	ikäihmi* OR vanhu*
	AND
	kuolem*

Table A2. Quality appraisal of included qualitative studies using the Checklist for Qualitative Research (JBI, 2020).

(Author, year)	Items									
	1	2	3	4	5	6	7	8	9	10
(Anttonen, 2016)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Fan et al., 2019)	U	Y	Y	Y	Y	U	Y	Y	Y	Y
(Hattori & Ishida, 2012)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
(Hävölä et al., 2014)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
(Ho et al., 2013)	Y	Y	Y	Y	Y	N	N	Y	Y	Y
(Joarder et al., 2014)	Y	Y	Y	Y	Y	N	Y	Y	N	Y
(Ko et al., 2013)	Y	Y	Y	Y	Y	Y	Y	Y	U	Y
(Ko et al., 2015)	Y	Y	Y	Y	Y	U	Y	Y	U	Y
(Liu & van Schalkwyk, 2018)	Y	Y	Y	Y	Y	U	Y	Y	Y	Y
(Shimoinaba et al., 2019)	N	Y	Y	Y	Y	N	N	Y	Y	Y

Note: Yes = Y, No = N, Unclear = U

1. Is there congruity between the stated philosophical perspective and the research methodology?
2. Is there congruity between the research methodology and the research question or objectives?
3. Is there congruity between the research methodology and the methods used to collect data?
4. Is there congruity between the research methodology and the representation and analysis of data?
5. Is there congruity between the research methodology and the interpretation of results?
6. Is there a statement locating the researcher culturally or theoretically?
7. Is the influence of the researcher on the research, and vice- versa, addressed?
8. Are participants, and their voices, adequately represented?
9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?
10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?

Table A3. Quality appraisal of included quantitative studies using the Checklist for Analytical Cross Sectional Studies (JBI, 2020).

(Author, year)	Items							
	1	2	3	4	5	6	7	8
(Akechi et al., 2012)	U	Y	Y	Y	Y	Y	U	Y
(Limpawattana et al., 2021)	Y	Y	Y	Y	U	U	N	Y
(Manjavong et al., 2019)	Y	Y	Y	Y	U	U	N	Y
(Park et al., 2015)	Y	Y	Y	Y	U	U	N	Y
(Srinonprasert et al., 2014)	Y	Y	Y	Y	U	Y	N	Y
(Srinonprasert et al., 2019)	Y	Y	Y	Y	N	U	N	Y

Note: Yes = Y, No = N, Unclear = U

1. Were the criteria for inclusion in the sample clearly defined?
2. Were the study subjects and the setting described in detail?
3. Was the exposure measured in a valid and reliable way?
4. Were objective, standard criteria used for measurement of the condition?
5. Were confounding factors identified?
6. Were strategies to deal with confounding factors stated?
7. Were the outcomes measured in a valid and reliable way?
8. Was appropriate statistical analysis used?

Table A4. Progress of inductive content analysis for one upper category.

UPPER CATEGORY	SUBCATEGORY	REDUCTION	ORIGINAL EXPRESSION
Transparent attitude towards self and others	Transparency about health in relation to self and family	Knowing the truth about the illness	”Participants agreed about the patient receiving the full truth about their illness” [a]
			”Receiving the full truth about their illness” [b]
			“To be informed of the truth of their illnesses” [c]
			“Receiving the full truth about their illnesses” [d]
		Telling the truth to the family	“Agreement with wishing for their family to know the full truth about their illnesses” [a]
			”Higher proportion of patients emphasized as being important was wanting their family to know the whole truth about their illnesses” [b]
			“To be informed of the truth of their illnesses, to both them and families” [c]
	Taking responsibility for life	Involving the family in final decisions	“Several participants felt that the family should be intimately involved in any final decisions” [e]
		Settling matters with loved ones	“Closure with family was considered an important aspect of the end of life” [e]
			”Resolving remaining issues and disagreements with family and friends was another important element of a good death” [f]
		Apologizing	“Apologizing to family and others” [f]
		Completing unfinished matters	“Completing unfinished business” [d]

Note. A study included in the systematic literature review, from the results of which this original expression is extracted (Author, year).

[a](Limpawattana et al., 2021)

[b](Manjavong et al., 2019)

[c] (Srinonprasert et al., 2014)

[d] (Srinonprasert et al., 2019)

[e] (Ko et al., 2013)

[f] (Ko et al., 2015)