



Research article

Stakeholders' perspectives of a good death: A qualitative study from Thailand



Pawapol Keratichevanun^a, Nisachol Dejkriengkraikul^a,
 Chaisiri Angkurawaranon^{a,b}, Kanokporn Pinyopornpanish^{a,b},
 Lalita Chutarattanakul^a, Nopakoon Nantsupawat^a, Nutchar Wiwatkunupakarn^{a,b},
 Wichuda Jiraporncharoen^{a,b,*}

^a Department of Family Medicine, Faculty of Medicine, Chiang Mai University, Thailand, 110 Intawaroros Rd, Sriphum, Muang, Chiang Mai, 50200, Thailand

^b Global Health Research Group, Chiang Mai University, Thailand, 110 Intawaroros Rd, Sriphum, Muang, Chiang Mai, 50200, Thailand

ARTICLE INFO

Keywords:

Palliative care
 Health personnel
 Terminal care
 Death
 Qualitative research

ABSTRACT

Background: A 'good death' is one of palliative care's main goals. However, there are different perspectives on what a good death is. Perspectives from three groups of people involved in the dying process: patients, caregivers, and healthcare providers; are crucial because how they interact will affect the overall quality of end-of-life care.

Objective: The aims were to 1) explore what is a good death and 2) how to achieve it from the perspectives of those involved in patient care.

Methods: A qualitative study was conducted between February to August 2019. The recruitment triad of stakeholders consisted of one patient with their primary caregiver and their physician. Interviews were conducted by researchers who had no prior relationship with the participants and were not a part of the healthcare team. Each research aim was analyzed separately using thematic content analysis. Data saturation was reached when no new or emerging themes emerged. Fourteen people were interviewed; five patients, five caregivers, and four physicians.

Results: Regarding perspectives of a good death, four themes emerged: 1: Peaceful natural progression and symptom-free, 2: Acceptance of death and dignity, 3: Readiness for death is facilitated by social support and the environment, and 4: Faith and religious values can bring peace. For the second research question regarding how to help the patient achieve a good death, three themes emerged: 1: provide supportive care, 2: good communication, and 3: prioritize the patients' wishes.

Conclusion: In the Thai context, the meaning of a good death relates to symptom control, acceptance of death, social support, and faith. However, a clear understanding of each individual's meaning of good death is required due to individualized needs and perceptions. Physicians and stakeholders looking to support good death should focus on providing supportive care, good communication, and prioritizing the patient's will and wishes.

* Corresponding author. Department of Family Medicine, Faculty of Medicine, Chiang Mai University, Thailand.
 E-mail address: wichuda.j@cmu.ac.th (W. Jiraporncharoen).

<https://doi.org/10.1016/j.heliyon.2023.e15775>

Received 12 July 2022; Received in revised form 18 April 2023; Accepted 20 April 2023

Available online 25 April 2023

2405-8440/© 2023 The Authors. Published by Elsevier Ltd. This is an open access article under the CC BY-NC-ND license (<http://creativecommons.org/licenses/by-nc-nd/4.0/>).

1. Introduction

For about two decades, a ‘good death’ has been discussed as a quality indicator for end-of-life care [1–4]. The process of dying can sometimes be complicated with grief and suffering, in part from increasingly aggressive medical care such as repeated hospitalizations or admission to an intensive care unit [5]. Previous literature suggested that a good death could be understood when examined holistically [3,4,6–8]. A natural, symptom-free death, with emotional peace through the acceptance of death based on cultural and religious beliefs, was often desired [6,7,9–12]. Support from families and healthcare providers may also play a key role in helping patients achieve a ‘good death’ [1,6,10,13,14]. Patients also often wished to be prepared for their death so that they were not a physical, emotional, or financial burden to others [1,13,15].

However, perspectives on what a good death is can still vary amongst cultures [2,15,16]. Western cultures may consider autonomy to be more relevant than Eastern cultures. Life completion and dignity are considered core components of a good death in Western cultures [12]. In middle eastern cultures, patients’ perspective of a good death includes autonomy, psychological support, and spiritual care [17]. Even among Eastern cultures, different meanings of a ‘good death’ can be found. Literature from China suggests that value is placed on being cared for by family members, while studies from Japan and Korea suggest that ‘not being a burden to others’ ranked highly [2,14,15] in the meaning of a ‘good death’. While in the Thai context, the conspiracy of silence is prevalent, and good death definitions are not frequently studied [18]. This variation in the meaning of a ‘good death’ is possibly one of the factors contributing to increased distress for patients, especially when the patient’s perspective of a good death is not fulfilled [12,19].

In addition to variation by culture, perhaps, more importantly, the perception of a good death may differ among those directly or closely involved in inpatient care. Patients may want a quick death in their sleep, while their families may desire more time to say goodbye [6]. Physicians tend to focus more on completing unfinished business, being prepared to die, and saying goodbye [20]. Perspectives from three groups of people involved in the dying process: patients, caregivers, and healthcare providers; are crucial because how they interact will affect the overall quality of end-of-life care [15,21]. To our knowledge, a few quantitative studies have examined the meaning of a good death among these three groups [22–25]. By attaining this understanding, we may enhance the current palliative care approach to aid the healthcare team in improving end-of-life care.

The current study aimed to gain a deeper understanding of the perspectives on a good death from three stakeholders: patients, caregivers, and physicians, by using a qualitative approach. Specifically, the study aimed to

- (1) examine the perceived meaning of a ‘good death’ among these three different populations
- (2) explore perceptions of how stakeholders can help patients achieve a ‘good death’ in their respective roles.

These two linking aims will allow a deeper understanding to what are the important aspects of achieving a good death and what those involved can do to help patients achieve it.

2. Material and methods

A qualitative exploration was conducted through semi-structured interviews of patients, caregivers, and physicians. Exploring different perspectives may provide deeper insight into the phenomena of good death [26]. The study was reported according to The Standards for Reporting Qualitative Research (SRQR) guidelines. The SRQR is a list of 21 items that are recommended to help complete transparent reporting of qualitative research. The item checklist includes the article’s title and abstract; problem formulation and research question; research design and methods of data collection and analysis; results, interpretation, discussion, and integration; and other information [27].

2.1. Study population, sampling, and recruitment

The recruitment triad of stakeholders consisted of one patient with their primary caregiver and their physician. The inclusion criteria of patients consisted of (a) speaks Thai; (b) able to participate (good consciousness, controlled symptoms); (c) their caregivers were also available for interview. The caregiver was defined as the person involved in daily self-care or identified as having the primary responsibility of providing care [28]. The physician was defined as the patient’s primary physician during admission. Patients in their last hours of life were excluded, and patients were recruited only if they had a palliative performance score (PPS) of at least 30%. Literature from Thailand suggests that the median survival time for those with a PPS score of 30% and above is between 2 weeks to several months [29]. In addition, patients who did not know their diagnosis were excluded. Based on similar qualitative studies, it was expected that between 8 and 18 participants were needed to achieve data saturation [1,7,13]. Participants were selected by convenience sampling from patients consulted for palliative care by different inpatient departments.

2.2. Setting

The study was conducted at Chiang Mai University Hospital, Chiang Mai, Thailand.

2.3. Data collection

Semi-structured in-depth interviews were conducted between February to August 2019. There were two parts to data collection [1]:

participant characteristics and [2] in-depth interviews about the perspectives of a good death. Finding the patients' name list with no exclusion criteria was done by LJ, a palliative physician. The patient interviews were conducted in Thai by researcher PK, a male family medicine resident with three years of clinical and palliative care experience. He was trained in the interview method and interview questions by the senior author WJ. The senior author (WJ) is a female family physician and a qualitative researcher with over ten years of clinical experience. The researchers had no prior relationship with the participants and were not a part of the healthcare team for the participants during admission. Each interview lasted between 15 and 30 min and was conducted in a private counseling room to help ensure comfort and confidentiality. Each interview was audio-recorded with the participant's consent, followed by verbatim transcription. PK and WJ subsequently reviewed the audio record, and any issues which needed further exploration were discussed and patients were invited for re-interviews if required. Only the first two participants at the beginning of the data collection were re-interviewed for further clarification.

Participant characteristics, including gender, age, occupation, and religion, were recorded for the patients. Patients' diagnoses, palliative performance scale (PPS), and disease duration were also gathered. For the caregiver, information was obtained on age, gender, the relationship with the patient, and the duration of care as the caregiver. For physicians, information was obtained on age, gender, specialization, years of clinical experience, and total duration of care for the particular patient enrolled in the study.

The open-ended interview guides were designed and then piloted to make sure that participants were allowed to share their thoughts freely. The first few interview questions were identical for all participants, accompanied by another set of queries according to their role. Patients were asked to give their meaning of a 'good death' and were further asked if they think their meaning of a 'good death' would differ from their caregiver and provider and how physicians can help achieve a good death. Similarly, when caregivers and physicians were interviewed, they were asked to give their meaning of a good death and whether they thought their meaning would differ from the other groups, and how physicians can help achieve a good death. (Table 1)

2.4. Data analysis

All interviews were used to examine the two different aims of the project. For the first aim, we followed the Framework Method for analysis of qualitative data [30]. This method allows the use of a working analytical framework before applying, charting, and refining the framework using an inductive approach. Each transcript was read multiple times by two researchers (PK and WJ) to aid familiarization and to check the accuracy of each transcript. The World Health Organization's (WHO) four components of health for palliative care [31] were used as the working analytical framework to help identify key issues, concepts, and themes. The WHO's four components of health were chosen for their comprehensiveness in covering all domains of health (bio-psycho-social-spiritual). Direct content analysis was then used to identify codes. The codes were compared, and researchers discussed the similarities and differences until a consensus on the emergent themes and subthemes were reached. Then the preliminary results were interpreted with KP, CA, LC, ND, and NN. The association between themes and the meaning of the results was considered by the selected verbatims from each theme and or subtheme together with the clinical experiences of the researchers. All authors read and contributed to the manuscript. NVivo version 12 was used in data analysis by KP and WJ. For the second aim, we followed a similar approach but did not have a pre-defined working analytical framework.

2.5. Ethical approval and consent to participate

Written informed consent was obtained from all participants. If the patient agreed to participate, their main caregivers and primary

Table 1

Interview questions used for the group of participants.

Part 1 Questions for all participants
<ul style="list-style-type: none"> • What is death? • Do you have any experiences with death? What are they? • What is the meaning of a good death?
Part 2 Specific questions for each group
<p>Patient</p> <ul style="list-style-type: none"> • Do you think your caregiver would give the meaning of a good death differently? How? • How can healthcare providers help achieve a good death? <p>Caregiver</p> <ul style="list-style-type: none"> • If you were the patient, do you think your caregiver would give the meaning of a good death differently? How? • As a caregiver how can you help achieve a good death? • How can healthcare providers help achieve a good death? <p>Healthcare provider</p> <ul style="list-style-type: none"> • If you were the patient, do you think your caregiver would give the meaning of a good death differently? How? • As a healthcare provider, how can you help achieve a good death?

physicians were then later recruited into the study. Written informed consent was also obtained from the main caregivers and primary physicians. Our project was reviewed and approved by the Research Ethics Committee at the Faculty of Medicine, Chiang Mai University, on October 31, 2018 (FAM-2561-05654). All methods were carried out in accordance with relevant guidelines and regulations (The Declaration of Helsinki).

3. Results

Fourteen people were interviewed, consisting of five patients, five caregivers, and four physicians (Table 2). All of the participants were Buddhists. All five patients had diagnoses of advanced cancer with PPS ranging from 30 to 50%. The primary physicians were interns or residents, ages 24–29 years, with one to four years of clinical experience.

3.1. Research aim 1: perspectives of a good death

The perspective of a good death has many aspects. Four main themes were identified 1) peaceful natural progression and symptom-free, 2) acceptance of death with dignity, 3) readiness for death is facilitated by social support and the environment, and 4) faith and religious values can bring peace. The details of the themes and subthemes identified are summarized in Table 3.

Theme 1: peaceful natural progression and symptom-free

For this theme, two subthemes emerged: 1.1) Being symptom-free and 1.2) a sense of a peaceful and natural progression of the disease. In particular, pain was the most common symptom of concern for participants. Other symptoms of concern were dyspnea and agitation. All participants indicated that being symptom-free was an important factor in achieving a good death. For some participants, an example of a good death would be someone passing away naturally (in their sleep); their death was neither hastened (such as being killed by an accident or homicide) nor prolonged (such as being resuscitated)

“Pain ... I felt so much pain. Where am I supposed to go? My children asked me if I wanted to go to a hospital and which hospital. They would take me anywhere. I got in the car, and here I am, (death) would be good without the pain” - female patient

“A good death, like the elder near my wife’s home. She slept and was just gone. She was eighty to ninety years old and very healthy. She passed in her sleep in peace. There was not any obvious cause or sign. She had never been to a hospital, never really sick. That is why they say that it is a good death. Nothing to worry about.”

- male caregiver

Theme 2: acceptance of death with dignity

The three subthemes that emerged from this theme were 2.1 Autonomy, 2.2 Self-Worth, and 2.3 Acceptance of Death/Dying

Table 2

Participant characteristics (n = 14).

Patients					
	Gender	Age (year)	Occupation	Diagnosis, PPS (%)	Duration of disease
1	Female	37	Merchant	Lung cancer, 50	2 months
2	Male	41	Construction manager	Rectal cancer, 50	4 years
3	Female	73	Farmer	Lung cancer, 30	6 months
4	Male	55	Subdistrict governor	Prostate cancer, 40	2 years
5	Male	29	Merchant	Burkitt lymphoma, 40	9 months
Caregivers					
	Gender	Age (year)	Occupation	Relationship with patient	Duration of caregiving
1	Male	41	Merchant	Husband	2 months
2	Male	30	Driver	Grandson	1 year
3	Female	35	Housewife	Daughter-in-law	6 months
4	Female	50	Cloth designer	Wife	2 years
5	Male	53	General worker	Father	1 month
Physicians					
	Gender	Age (year)	Specialty in training	Clinical experience (year)	Duration of care involved with participant
1	Female	24	Otolaryngology	1	2 weeks
2	- Not available for interview -				
3	Male	29	Orthopedics	4	2 weeks
4	Female	27	Medicine	4	1 week
5	Male	28	Medicine	4	1 week

All of the participants had **Buddhism** as their religion.

PPS; Palliative performance scale.

Table 3
Theme, subthemes, and quotations of Perspectives of a Good Death (New).

The Perspective of a Good Death		Patient	Caregiver	Physician
Theme 1 Peaceful natural progression and symptom-free				
1.1 Symptom-free	No pain, dyspnea, or agitation	"A good death is probably without pain."	"When in pain, doctors can help, giving him medication to relieve his pain."	"Not in pain, no suffering. Dying in your sleep might be a fair option."
1.2 The peaceful and natural progression of the disease	No suffering from the disease or unnecessary interventions	"Dying in your sleep, just gone. Not murdered."	"Never having to see a doctor, never really sick. Being able to spend life normally. Then she was just gone, without an obvious cause, without suffering."	"Sometimes invasive procedures might not be what the patient wants, fighting without getting any benefit in this painful cycle."
Theme 2 Acceptance of death with dignity				
2.1 autonomy	Knowing the disease/prognosis, being able to choose/plan, staying conscious, having sufficient time to prepare, and death not sudden	"When talking with doctors, even if it is not good news, at least it helps me think about things I have not thought of before."	"People with diseases: if they know it is not getting any better and can prepare, they can have a good death."	"Knowing what diseases they have. Getting everything ready, preparing everything, and having sufficient time to do so."
2.2 Self-worth	Fulfilling the duty/role of a parent/child, setting a decent example, and leaving something good behind	"My morale came from my mother, so I do not want to die before her. I want to take care of her first."	"She must be worried for her mother. If she can return the favor, she will be at peace." "Do something beneficial for society, for the public, for the ones we left behind."	
2.3 acceptance of the death/dying process	Understanding the cycle of life, knowing how to deal with it, letting go, being at peace (not worried), happy (self and others),	"Understanding death more, not being afraid to die. We let go and accept more." "If we are comfortable, others will feel it too. But if we are not at peace, others may feel helpless."	"Calm our minds before we go, do not worry. Even if we do, we would not be able to help those left behind." "Be happy. If we know that we are going to die next week, be your best self and make others happy."	"Having nothing to worry about. The family might feel sorrow but accepts death."
Theme 3 The readiness for death is facilitated by social support and the environment				
3.1 Support from others: family and providers	Giving encouragement, communicating sincerely, being present, and not abandoning Caring, dependable, well-mannered, have good medical expertise	"Communication: it makes our state of mind and overall conditions better." "Devoted, taking care, and communicating makes you feel wonderful and not abandoned."	"Make her comfortable, not stressed. Learn about her cancer and provide the best care." "No one is likely to be more able than doctors. I believe in them, in the science." "When doctors explain, the patient will listen to them more than us, promoting insight."	"Provide information to the patient and his parents. Consult with the specialists. Prepare necessary equipment. And encourage every day." "I feel that if we could stop the bleeding (control the symptom) better, things would be better."
3.2 Not being a burden	The physical, financial, and psychological burden	"If we die unhappy, agitated, crying, not wanting to expire, others will feel miserable."	"Not being a burden to ones left behind, do your best in life."	"We have to manage existing problems: familial, financial, work because dying without preparation will be burdensome to those left behind."
3.3 place of death	Peaceful comfort of home	"The place has to be quiet and peaceful, like home."	"Home is good; the family can closely take care of him. Hospital is also decent, with doctors and nurses."	"Dying at home, a place where we are familiar with, feeling comfortable."
Theme 4 Faith and religious values can bring peace				
4.1 faith	Merit making, released from suffering, the afterlife	"Dying peacefully, without disturbance. I will meditate until I am gone."	"Die peacefully and go to heaven because of the merits we made."	"When we die, we might be reborn in a better place or go to heaven."

Process. Most of the participants would like to know about their diseases and prognoses. It would allow them to make decisions and plans better while they were still conscious, being in control of the situation. A vegetative state would be devastating to one's autonomy, as one would not be able to communicate their wishes to others. Having sufficient time to prepare and resolve unfinished businesses and unhealthy relationships as desired. A feeling of self-worth was also an important psychological factor in the meaning of a good death, such as fulfilling the duty/role of being a parent/spouse or child, setting a decent example for loved ones, and leaving something good behind. Lastly, acceptance of the death and dying process was also mentioned. Participants mentioned the Thai teaching of the life cycle: you're born, you're aged, you will become ill, and you die. A good death should be regarding how to accept and prepare for impending death, which participants believe would be easier to let go of when there is nothing to worry about.

"If I know that I am going to die next week, I will attempt to do my very best. Make people around me happy. At that moment, if we think of doing something, just do it. Do things that are not beyond your capabilities so as not to disturb others. Do what you can to make yourself happy and others happy." - male caregiver

“... Do your best in life. I think that this is a good thing. Or do something beneficial for society, the public, and the ones we left behind. That is my good death ...” -male caregiver

“A good death is understanding about death more, not being afraid to die. In the past, I was terrified of dying. When someone mentions death, I feel that I have to leave the people I love. But for now, if you ask me, is that fear still here?.....yes but as we start to grow up, we know more, we let go and accept more.” - female, patient

Theme 3: The readiness for death is facilitated by social support and the environment

The subthemes emerging from this theme consist of: 3.1 supporting from family and providers, 3.2 not being a burden to others, and 3.3 peaceful place of death. Social support was essential to a good death. Patients, caregivers, and physicians all agreed that giving encouragement was helpful. Sincere communication would allow the patient to start thinking about their future and help strengthen trust. Participants fear abandonment, with a family presence for the dying contributing to a good death. Physicians can promote a good death by securing the patient's and family's trust. Patients and family members want a trustworthy provider to manage the patient to the best of their ability and provide information that will assist them with careful planning. Not being a burden was also mentioned. The feeling of burden could manifest in a few ways: physical burden from dependency (inability to perform activities of daily living), financial burden from decreased income (inability to work) and increased medical expense, or psychological burden upon caregivers having to make difficult decisions and experiencing sorrow. Place of death can contribute to the idea of a good death. The participants mentioned that dying in the peaceful comfort of home could be a place where peaceful and familiar surroundings can be achieved, and family members can provide close care.

“If I am the patient, I would like my doctor to be straightforward with me. Can this disease be cured? Give percentages of whether this cancer will be cured or metastasized. Talk truthfully so the right treatment can be done Talk, encourage, together with the family that is the best.” - male caregiver

Theme 4: Faith and religious values can bring peace.

For our participants, who were all Buddhist, values thought by Buddhism impacted the perception of a good death, namely beliefs about karma, death as an end of suffering, and hope for a better place in the afterlife.

“When we die, we might be reborn in a better place or go to heaven” - female physician

3.2. Research aim 2: the ways of assisting patients to achieve a good death

When asked how participants think the perspective roles of different stakeholders can help patients achieve a good death, three themes emerged: 1) provide supportive care, 2) good communication, and 3) support patients' wishes. Supportive care included symptom control and caregiving from families and healthcare staff. Good communication could serve several purposes. It could range from telling the prognosis of the disease to order for the patient and family to understand their situation. Cheering up and giving realistic hope may strengthen mental health and possibly affect the patient's overall well-being. Communicating with all stakeholders (including the patient, family, primary physician, and other specialists) to agree and act upon the same direction of care could guarantee better results. It would be even more advantageous if this were coherent with the patient's wishes. The details of subthemes of how providers can assist patients in achieving a good death are as follows:

Theme 1: Provide Supportive Care.

Supportive care included symptom control and caregiving from families and healthcare staff.

“It's the physical symptoms. If there is no pain, the emotional state will be good. I will be able to live normally. If there is pain, then there will be no peace.” - male patient

“Give medication as appropriate, make us comfortable, that's enough. I do not want anything when I am dying, no cardiopulmonary resuscitation (CPR), no revival, nothing. If it is time to go, just go; I want to die only once, naturally” - male, patient

“Take care of him to his last breath. Staying together all the way.” - male caregiver

Theme 2: Good Communication.

3.3. Cheer up: allow hope, talk about concerns

“Give lots of encouragement. Comfort him. Cheer him up. Do not be stressed; everything will be better. The doctors will come soon.” - male caregiver

“Cheer him up every day to keep fighting. His morale seems to improve, not as strained.” - male physician

3.4. Tell prognosis/truth: talk about death/the future, allow time to accept and prepare

“If we know about the disease prognosis, we may be able to guide them on whether they have time to prepare. Telling the exact timing might be difficult, but approximation should help them plan, so they will have the moment to prepare.” - female physician

3.5. Assist patient and family in the same direction: discuss together

“I wish the doctors could explain to help the patient understand, and also the family. If she knows and understands, she will be able to cope better.” – female caregiver

“We have to communicate if the ideas are not coherent. Bring the family in to clear things up: what the patient wants, see if the family is okay with that.” – male doctor

3.6. Collaborate with other healthcare teams for patient care

“Consult with the palliative care team. I will do my best, coordinating with the hematologist for palliative chemotherapy.” – male physician.
Theme 3 *Prioritize the Patient’s Wishes.*

Along with good communication in healthcare, the provider should identify and follow the patient’s wish

We have to take care of him the best we can. If he had told us something before, we would have to follow what he said. If he wants to listen to dhamma, we will find it for him, prepare it for him.” - female caregiver

4. Discussion

This study aimed to understand the definition of a good death from different perspectives of those most likely to be involved in the dying process. For a good death, four main themes were identified covering aspects of symptom control, acceptance of death with dignity, social support, and faith. The study also provided insights for care providers on how to help patients and families achieve a ‘good death’ in the Thai setting.

The most prevalent theme raised in this study was controlled symptoms, with pain being brought up almost exclusively. A pain-free state was universally sought [6,7,9–12,32,33]. Patients tend to opt for death at home [2,8,34] but a good place of death usually depends on the quality of comfort it can provide [1,6,11,14,35]. Caregivers gravitated toward the patients’ intentions but worried about symptom control and the inability to handle emergencies. On the other hand, hospitals provide a sense of reassurance due to the availability of healthcare providers. Physicians wished to follow the patient’s choice [10], acknowledging the benefits of both places: enabling patients to return home if their conditions were relatively stable or to stay at the hospital if they pleased [8].

Even though other studies had found that defining a good death was limited by heterogeneity between participants [6,7,32] and diversity amongst individuals and cultures [2,15,16], it was not beyond the biopsychosocial-spiritual domains. For example, another cross-sectional study in Thailand concluded that Thai cancer patients and their relatives gave importance to a preferred place of death, physical and psychological comfort, and good relationship with families and medical staff. Religion could also be related to the participants’ concept of a good death. For example, in the Thai context, most Buddhist patients believe that death is a part of impermanence which would support their death acceptance process and allow open-mind about death [36]. Similar to the previous study of Thai Buddhist families’ perspective of a peaceful death, our study reports the concept of a good death as not suffering, being not alone, having a peaceful state of mind, and being aware of impending death [37]. Differences were seen regarding some domains, including being a physical or psychological burden, preparedness, and receiving life-prolonging treatments. However, all were within the biopsychosocial-spiritual domains [2]. The focus should then rather be on the meaning each person gives to each aspect of a good death.

Based on our study, stakeholders can help patients achieve good death by providing supportive care, good communication, and compliance with the patient’s wishes. For physicians and providers, accurate prognostication using appropriate patient assessment, such as the Palliative Performance Scale, should be provided to the patients and caregivers to improve the quality of supportive care [29]. Among stakeholders, effective communication was a foundation for trust and healthy relationships, uplifting the sense of support [1,11,18]. Engaging in sincere conversation, listening with empathy, and giving encouragement should be exercised [8,9,11]. The National Institute for Health and Care Excellence (NICE) has suggested that living will and advanced care plans could be useful tools for communication among patients, families, and healthcare providers so that the patient’s goals and wishes can be achieved [38]. Alongside the Thai standard advanced care plan form and its standard operating procedures developed by the Thai National Health

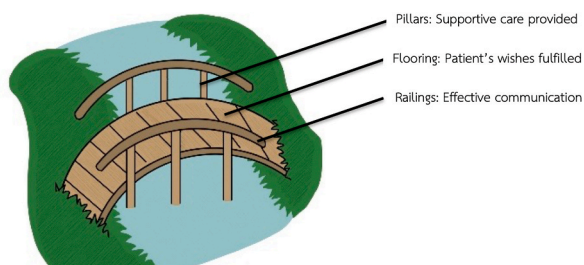


Fig. 1. The three bridge components of achieving a good death.

Commission Office (NHCO) in 2021, benefits and accommodation to the patients' and caregivers' needs might have been enhanced [39]. This would aid decision-making, as it could clear discrepancies between perspectives, leading to a good death [2,15,32,34]. Suppose death can be imagined as a person's journey crossing a river from this life to "another place". In that case, the three themes identified in the study could be illustrated metaphorically as a bridge to help cross the river. When all three bridge components are whole and aligned, the best passage will be secured; thus, a good death can be achieved. (Fig. 1).

4.1. Strength and limitations

While one of the major strengths of the study was from exploring the meaning of good death among different perspectives from three groups, we believe the data from three perspectives could be considered as a way to help triangulate our findings from the different perspectives of a good death. Based on this, the data reached saturation, as no new or emerging themes emerged from the participants in the latter interviews [40]. While our sample size ($n = 14$) was small, it was higher than the minimum of interviews required to achieve saturation in the published literature [41]. However, we acknowledge that the sample for each subgroup was small, and results are unlikely to be generalizable within the subgroups. We used the WHO's four domains of health as the working analytical framework for analysis, which was not an inductive approach. However, we have chosen this method as it allows our findings to contribute to previously established frameworks [42]. Using the WHO's framework will enable our findings to contribute to a deeper understanding and allow some aspects of our results to be generalizable and potentially replicable if a similar framework is applied.

Another limitation of our study was that all of the patients were adults diagnosed with terminal cancer. Their PPS ranges from 30 to 50%, reflecting that the median survival time for the participants can be expected at between 2 and 6 weeks [29]. Our findings, therefore, might not transfer to the perspectives of adolescent patients or patients with lesser advanced stages or with other advanced diseases, such as end-stage organ failures or frail elderly patients. All participants were Thai Buddhists, so this study might not be able to represent different cultures and religions well. The young physicians in residency training might not give the same perspective as more experienced physicians or other healthcare specialists. However, these physicians were primary physicians for the patients and the ones spending the most time with the participants. Nurses are important providers for palliative care patients but were not interviewed in our study. This was because, in the Thai context, primary physicians have the final authority to make decisions regarding any medical treatment provided in the hospital. Given that nurses have more bedside experiences with the patient than physicians, it may be possible that their perspectives could be a mixture of the patients'/caregivers' perspectives and the physicians' perspective [43], and more detailed research is needed to explore this issue.

5. Conclusions

In the Thai context, the meaning of a good death relates to symptom control, acceptance of death, social support, and faith. However, due to individualized needs and perceptions, a clear understanding of each individual's meaning of good death is required. Physicians and stakeholders looking to support good death should focus on providing supportive care, good communication, and prioritizing the patient's will and wishes.

Author contribution statement

Pawapol Keratichevanun, Nisachol Dejkriengkraikul, Wichuda Jiraporncharoen: Conceived and designed the experiment; Perform the experiment; Analyzed and interpreted the data; Wrote the paper.

Chaisiri Angkurawaranon, Kanokporn Pinyopornpanish, Lalita Chutarattanakul: Conceived and designed the experiment; Analyzed and interpreted the data; Wrote the paper.

Nopakoon Nantsupawat, Nutchar Wiwatkunupakarn :Analyzed and interpreted the data; Wrote the paper.

Data availability statement

Data will be made available on request.

Declaration of interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgments

The authors would like to express our sincere thanks and gratitude to the fourteen participants in this study.

References

- [1] F. Toscani, C. Borreani, P. Boeri, G. Miccinesi, Life at the end of life: beliefs about individual life after death and "good death" models - a qualitative study, *Health Qual. Life Outcome* 1 (2003) 65.
- [2] J. Chindaprasirt, N. Wongtirawit, P. Limpawattana, V. Srinonprasert, M. Manjavong, V. Chotmongkol, et al., Perception of a "good death" in Thai patients with cancer and their relatives, *Heliyon* 5 (7) (2019), e02067.
- [3] E. Robert, D.P.R. Rakei, *Textbook of Family Medicine*, ninth ed., Elsevier Saunders, Philadelphia, 2016.
- [4] K.E. Steinhauser, J.A. Tulsky, Defining a "good" death: oxford university press, in: *Oxford Textbook of Palliative Medicine*, 2015.
- [5] A.A. Wright, N.L. Keating, J.Z. Ayanian, E.A. Chrischilles, K.L. Kahn, C.S. Ritchie, et al., Family perspectives on aggressive cancer care near the end of life, *JAMA* 315 (3) (2016) 284–292.
- [6] G.L. Lee, I.M. Woo, C. Goh, Understanding the concept of a "good death" among bereaved family caregivers of cancer patients in Singapore, *Palliat. Support Care* 11 (1) (2013) 37–46.
- [7] E.K. Vig, N.A. Davenport, R.A. Pearlman, Good deaths, bad deaths, and preferences for the end of life: a qualitative study of geriatric outpatients, *J. Am. Geriatr. Soc.* 50 (9) (2002) 1541–1548.
- [8] C.E. Johnson, P. McVey, J.J. Rhee, H. Senior, L. Monterosso, B. Williams, et al., General practice palliative care: patient and carer expectations, advance care plans and place of death-a systematic review, *BMJ Support. Palliat. Care*. 0 (2018) 1–10.
- [9] Y. Murakawa, Y. Nihei, Understanding the concept of a 'good death' in Japan: differences in the views of doctors, palliative and non-palliative ward nurses, *Int. J. Palliat. Nurs.* 15 (6) (2009) 282–289.
- [10] S.A. Payne, A. Langley-Evans, R. Hillier, Perceptions of a 'good' death: a comparative study of the views of hospice staff and patients, *Palliat. Med.* 10 (4) (1996) 307–312.
- [11] K.E. Tenzek, R. Depner, Still searching: a meta-synthesis of a good death from the bereaved family member perspective, *Behav. Sci.* 7 (2) (2017).
- [12] E.A. Meier, J.V. Gallegos, L.P. Thomas, C.A. Depp, S.A. Irwin, D.V. Jeste, Defining a good death (successful dying): literature review and a call for research and public dialogue, *Am. J. Geriatr. Psychiatr.* 24 (4) (2016) 261–271.
- [13] K. Hattori, D.N. Ishida, Ethnographic study of a good death among elderly Japanese Americans, *Nurs. Health Sci.* 14 (4) (2012) 488–494.
- [14] H. Haishan, L. Hongjuan, Z. Tieying, P. Xuemei, Preference of Chinese general public and healthcare providers for a good death, *Nurs. Ethics* 22 (2) (2015) 217–227.
- [15] Y.H. Yun, K.N. Kim, J.A. Sim, E. Kang, J. Lee, J. Choo, et al., Priorities of a "good death" according to cancer patients, their family caregivers, physicians, and the general population: a nationwide survey, *Support. Care Cancer* 26 (10) (2018) 3479–3488.
- [16] M. Hong, S. Hong, M.E. Adamek, M.H. Kim, Death attitudes among middle-aged Koreans: role of end-of-life care planning and death experiences, *Int. J. Aging Hum. Dev.* 86 (1) (2018) 51–68.
- [17] A. Fereidouni, M. Rassouli, T. Kianian, M. Elahikhah, H. Sour, S. Azizi, et al., Factors related to good death in the Eastern Mediterranean Region: a systematic review, *East. Mediterr. Health J.* 27 (8) (2022) 601–609.
- [18] K. Pinyopornpanish, C. Angkurawaranon, P. Gomutbutra, M. Pinyopornpanish, Factors affecting family members' decisions to reveal cancer diagnoses to patients: a qualitative study, *J. Med. Assoc. Thai.* 100 (2017) 808–814.
- [19] E.J. Emanuel, L.L. Emanuel, The promise of a good death, *Lancet* 351 (1998) SII21–S29.
- [20] P. Limpawattana, V. Srinonprasert, M. Manjavong, K. Yonggrattanakit, S. Kaiyakit, Comparison of the perspective of a "good death" in older adults and physicians in training at university hospitals, *J. Appl. Gerontol.* 40 (1) (2019) 47–54.
- [21] A. Tan, D. Manca, Finding common ground to achieve a "good death": family physicians working with substitute decision-makers of dying patients. A qualitative grounded theory study, *BMC Fam. Pract.* 14 (2013) 14.
- [22] S. Hales, C. Zimmermann, G. Rodin, Review: the quality of dying and death: a systematic review of measures, *Palliat. Med.* 24 (2) (2010) 127–144.
- [23] T.O. Gafaar, M. Pesambili, O. Henke, J.R.N. Vissoci, B.T. Mmbaga, C. Staton, Good death: an exploratory study on perceptions and attitudes of patients, relatives, and healthcare providers, in northern Tanzania, *PLoS One* 15 (7) (2020), e0233494.
- [24] D. Özyalçın Özcan, B. Çevik, Opinions of cancer patients, their relatives, and nurses on good death, *Omega: J. Death Dying* (2021), 00302228211053473.
- [25] Y.H. Yun, K.-N. Kim, J.-A. Sim, E. Kang, J. Lee, J. Choo, et al., Priorities of a "good death" according to cancer patients, their family caregivers, physicians, and the general population: a nationwide survey, *Support. Care Cancer* 26 (10) (2018) 3479–3488.
- [26] S. Crowe, K. Cresswell, A. Robertson, G. Huby, A. Avery, A. Sheikh, The case study approach, *BMC Med. Res. Methodol.* 11 (2011) 100.
- [27] B.C. O'Brien, I.B. Harris, T.J. Beckman, D.A. Reed, D.A. Cook, Standards for reporting qualitative research: a synthesis of recommendations, *Acad. Med.* 89 (9) (2014) 1245–1251.
- [28] K. Pinyopornpanish, W. Wajatieng, N. Niruttisai, N. Buawangpong, N. Nantsupawat, C. Angkurawaranon, et al., Violence against caregivers of older adults with chronic diseases is associated with caregiver burden and depression: a cross-sectional study, *BMC Geriatr.* 22 (1) (2022) 264.
- [29] P. Prompantakorn, C. Angkurawaranon, K. Pinyopornpanish, L. Chutarattanakit, C. Aramrat, C. Pateekhum, et al., Palliative Performance Scale and survival in patients with cancer and non-cancer diagnoses needing a palliative care consultation: a retrospective cohort study, *BMC Palliat. Care* 20 (1) (2021) 74.
- [30] N.K. Gale, G. Heath, E. Cameron, S. Rashid, S. Redwood, Using the framework method for the analysis of qualitative data in multi-disciplinary health research, *BMC Med. Res. Methodol.* 13 (1) (2013) 117.
- [31] World Health Organization, *Palliative Care*, Available from: <https://www.who.int/health-topics/palliative-care>.
- [32] L. Kastbom, A. Milberg, M. Karlsson, A good death from the perspective of palliative cancer patients, *Support. Care Cancer* 25 (3) (2017) 933–939.
- [33] K.E. Steinhauser, N.A. Christakis, E.C. Clipp, M. McNeilly, L. McIntyre, J.A. Tulsky, Factors considered important at the end of life by patients, family, physicians, and other care providers, *JAMA* 284 (19) (2000) 2476–2482.
- [34] A. Davies, J. Todd, F. Bailey, A. Gregory, M. Waghorn, Good concordance between patients and their non-professional carers about factors associated with a 'good death' and other important end-of-life decisions, *BMJ Support. Palliat. Care* 9 (3) (2019) 340–345.
- [35] S.D. Stonington, On ethical locations: the good death in Thailand, where ethics sit in places, *Soc. Sci. Med.* 75 (5) (2012) 836–844.
- [36] R. Upasen, S. Thanasilp, L. Akkayagorn, J. Chimluang, W. Tantitrukul, D.L. Doutrich, et al., Death acceptance process in Thai buddhist patients with life-limiting cancer: a grounded theory, *Glob. Qual. Nurs. Res.* 9 (2022), 23333936221111809.
- [37] W. Kongsuwan, O. Chaipetch, Y. Matchim, Thai Buddhist families' perspective of a peaceful death in ICUs, *Nurs. Crit. Care* 17 (3) (2012) 151–159.
- [38] C. National Guideline, Evidence Review: Advance Care Planning. End of Life Care for Adults: Service Delivery, Evidence Review F. London, 2019, National Institute for Health and Care Excellence (UK) Copyright © NICE, 2019.
- [39] National Health Commission Office, National Health Commission Office And Partners Develop 'Advance Care Plan' Form To Be Used In All Health Care Levels, 2021. Available from: <https://www.nationalhealth.or.th/index.php/th/node/3169>.
- [40] B. Saunders, J. Sim, T. Kingstone, S. Baker, J. Waterfield, B. Bartlam, et al., Saturation in qualitative research: exploring its conceptualization and operationalization, *Qual. Quantity* 52 (4) (2018) 1893–1907.
- [41] K. Vasileiou, J. Barnett, S. Thorpe, T. Young, Characterising and justifying sample size sufficiency in interview-based studies: systematic analysis of qualitative health research over a 15-year period, *BMC Med. Res. Methodol.* 18 (1) (2018) 148.
- [42] M. Young, L. Varpio, S. Uijtdehaage, E. Paradis, The spectrum of inductive and deductive research approaches using quantitative and qualitative data, *Acad. Med.* 95 (7) (2020).
- [43] S.E. Shannon, P.H. Mitchell, K.C. Cain, Patients, nurses, and physicians have differing views of quality of critical care, *J. Nurs. Scholarsh.* 34 (2) (2002) 173–179.