Original Article

Death with Dignity in End-of-Life Nursing Care: Concept Analysis by Rodgers' Evolutionary Method

Abstract

Background: The concept of dying with dignity is being discussed in various fields, including psychology, sociology, medicine, and nursing, with different definitions available for this concept. However, few studies investigated the concept of end-of-life nursing care, which plays an important role in the implementation of the concept. This concept can also affect people's perception, attitude, and behavior toward practicing dignified death in health-care centers. The current study aimed to clarify, understand, and further recognize the concept of death with dignity in end-of-life nursing care. **Materials and Methods:** Rodgers' evolutionary concept analysis was used to clarify the concept of death with dignity in end-of-life nursing care. MEDLINE, BLACKWELL, PROQUEST, Science Direct, and CINAHL databases and national databases of SID and Iran Medex were systematically searched to identify relevant studies using various combinations of the following keywords: "dignity," "dignified death," "dying with dignity," and "dignifying death" in combination with "end-of-life care." All articles with the above-mentioned terms in their title, abstract, or keywords and published in English from 2006 to 2020 were included. A total of 21 articles were finally identified for review. **Results:** Characteristics of dying with dignity were categorized into two dimensions of human dignity and holistic care. The antecedents included professional and organizational factors, and outcomes included good death and career promotion. **Conclusions:** This study demonstrated that end-of-life nursing care is an important dimension of clinical nursing that plays a unique role in admission and facilitating the process of dying and, eventually, dying with dignity.

Keywords: *Nursing care, patient rights, terminal care*

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Introduction

Death is a major existential concern of mankind that causes severe anxiety, mainly through denying it.[1] The introduction of modern intensive care and supportive treatments, intended to increase chances of patients' survival, changed the boundary between death and life, prolonged the dying process, and, consequently, caused greater suffering of patients and their families.[2] Therefore, a new definition of death was presented, and a moral dilemma was raised that whether the newly available equipment can save the lives or only postpone death.[3] Death is conceptualized as the end-of-life moment as well as a transitional process,[4] but its time is not predictable, even despite technological advances. Therefore, defining a clear border between care, relief of suffering, and dignified death is difficult.[2] In the middle of the twentieth century, important debates were raised about the possibility of dying with dignity, and it became clear that patients' independence in choosing death or life can be expanded.[3] Therefore, medical treatment is not just to prolong life but also to facilitate critically ill patients to die with dignity.[5] Some studies reported that prolonging life using technology fades dignity.[6] Nevertheless, a question remains to be answered: whether every life is worth living?

The concept of dying with dignity depends on the cultural background and includes interventions to facilitate the maximization of physical, mental, social, emotional, spiritual, and existential comfort of patients at the end of their life. It is also defined as relaxation in tranquility in suffering. In addition, it is also defined as a nursing phenomenon.[7] It is also referred to as gradual improvement through physical and psychological–spiritual care[8] as well

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as dying with respect. Moreover, there are definitions referring to limited invasive interventions without futile examinations and treatments or death without fear in a safe environment, an environment where the patient does not feel loneliness, and death occurs in a quiet and private place.[9]

Every concept has special characteristics that distinguish it from other concepts. The concepts of building blocks constitute theories and contribute to the evolution of theories.[10] Many approaches have been used by researchers to develop concepts, including the concept analysis approach,[11] that provide researchers and theorists with an intrinsic understanding of the underlying features of concepts in order to achieve a clear definition of the problem to construct hypotheses that reflect the accuracy of the relationships between concepts. Rodgers' evolutionary view is an inductive approach that is based on the continuous change and evolution of concepts. Based on Rodgers' view, examining the underlying aspects of concepts leads to a proper understanding of the situation in which the concept is being applied, especially in cases where concepts are being applied in different situations by people with diverse views.[12] While the concept of dying with dignity has been frequently used in various contexts such as psychology, sociology, medicine, and nursing, this issue is not well studied in end-of-life nursing care.[9]

Therefore, a variety of definitions are available for this concept, each focusing on a particular attribute. Hence, its definition is ambiguous, which may lead to problems in its practical implementation. This concept also affects people's perception, attitude, and behavior toward dignified care in health-care centers. It is also worth noting that few studies have investigated these definitions from the perspective of nursing staff. Thus, the current study aimed to clarify the concept of dying with dignity, and its characteristics, antecedents, and consequences in end-of-life nursing care.

Materials and Methods

This study is a concept analysis was performed from October 2020 to June2021. Contemporary nursing believes that human truth and its related phenomena are constantly changing. As this perspective is in line with Rodgers' evolutionary method for concept analysis, this method was applied in the present study. Rodgers' evolutionary method of concept analysis including; identifying the concept of interest and its surrogate and related terms, identifying and selecting an appropriate setting and sample for data collection, collecting the relevant data to identify the attributes of the concept and its contextual bases including interdisciplinary, sociocultural and time-dependent variations (antecedents and consequences, analyzing the data to identify the attributes of the concept, identifying a model case (an exemplar), and identifying implications and hypotheses for further development of the concept, was used. Rodgers believes that the study process is nonlinear, rotational, and flexible, and many of the six activities are carried out simultaneously. This method is based on an inductive approach and is focused on the collection and analysis of raw data in social, cultural, and contextual fields.[12]

The MEDLINE, BLACKWELL, PROQUEST, Science Direct, and CINAHL databases and national databases of SID and Iran Medex were systematically searched to identify relevant studies using various combinations of the following keywords: "dignity," "dignified death," "dying with dignity," and "dignifying death" in combination with "end-of-life care." All articles with the above-mentioned terms in their title, abstract, or keywords and published in English from 2006 were included, mainly because special attention has been paid to the concept of palliative care during this period. In addition, this period is long enough to show the changes in this concept. The initial search yielded several articles. Identified articles were all screened for duplication. Finally, 21 articles were found eligible [Table 1]. It is worth noting that national databases were searched using the Persian equivalents of the English keywords, and no eligible study was found. Then, data were extracted according to the objectives of the study, and Rodgers' evolutionary method was applied for data analysis, which is a type of theme analysis.

For this purpose, all selected articles were numbered and then carefully reviewed to extract data on characteristics, antecedents, and consequences. In addition, alternative and related words were summarized and coded. According to Rodgers' method, each class of data (characteristics, background information, and references) should be examined separately to determine the important themes.[12] For this purpose, initially, all eligible articles were reviewed to extract sub-themes related to dying with dignity, including attributes, antecedents, consequences, surrogate terms, and related concepts. It is worth noting that all identified sub-themes were recorded using separate cards. After achieving data saturation, extracted data were categorized and labeled, to shorten the process. The number of related concepts and alternative words was very low, and, therefore, categorization was not necessary.

Ethical considerations

The authors declare that they have avoided plagiarism at any form and have never manipulated the data for their own benefit. The results of the analysis were completely honest.

Results

The results are briefly shown in diagram 1. The first step to performing the analysis is to identify the attributes of the concept, which gives a real definition of the target concept.[12]

Table 1: Literature's support for the concept of "death with dignity"

References	Context	Findings	Main idea
Reckziegel & Coninck (2016)	Dignified death in Brazil.	Dying inside a desirable esthetic and ethical care environment, prevent and relieve pain and suffering Patient's better chances to improve his quality of life and dignity while alive.	Artificial devices postponing death.
Poles & Bousso (2011)	Dignified death: involving nurses and doctors in pediatric intensive care units	Clear and effective communication between medical team, child, and family, establishing a partnership between team and family, family's satisfaction with end-of-life care.	Dignified death related to decisions made by the multidisciplinary team as well as those related to care of the child and the family.
Martí-García *et al*. (2020)	Perception of nursing students of dying and dignified death.	Free of pain or suffering with the best possible Quality of Life (QoL) and comfort after the course. Dying surrounded by loved ones, with minimal anxiety, patients' ability to decide their own end-of-life process.	Palliative care learning modifies the perception by nursing students of death and their understanding of a dignified death
Park & park. (2021)	The relationships between oncology nurses' attitudes toward a dignified death	Maintenance of emotional comfort, arrangement of social relationships, lack of suffering, autonomous. Education related to death should be included in the nursing college curriculum.	Death-related education to reduce the stress that arises from providing end-of-life care.
Coenen & Doorenbos (2007)	Nursing interventions to promote dignified dying in four countries.	Presence of spiritual mentors, praying with the patient and family. Family-focused interventions, listening and acknowledging patient perceptions, helping to fulfill their last wishes, offering privacy, a homelike environment, a quiet room, soft music and lighting, "not leaving the patient alone."	Identify specific interventions for future research and applies the Dignity-Conserving Care Model to further understand dignified dying from an international nursing perspective.
Guo & Jacelon. (2014)	An integrative review of dignity in end-of-life care.	A human right, respect, being human and being self, meaningful relationships, dignified treatment and care, existential and spiritual, satisfaction, privacy, safe and calm environment.	Clarified the meaning of dying with dignity and synthesized common aspects of dignity in end-of-life care.
Karlsson *et al*. (2006)	Dying with dignity according to Swedish medical students.	Without suffering, with limited medical interventions, with a sense of security, with respect of autonomy. Death in the company of others, accepted death and feels ready to die, feeling that life is over and that there is a satisfaction in life.	Medical system is over-treating patients and sometimes causing harm to dying patients.
De Lora & Blanco. (2013)	Dignifying death and the morality of elective ventilation	Given the chance to control their dying process, either by refusing elective ventilation or by other measures that they deem as futile, or even by asking for doctor-aid in dying if they don't want to suffer.	Elective ventilation provides patient's chances of survival, and harvesting of organs, but to put some dignity in the dying process.
Weisleder (2007)	Dignified death for severely impaired infants.	Right to avoid futile treatment, right to self-determination, right to a natural death, right to a life worth living.	Use of palliative instead of intensive care for severely impaired newborns.
Hemati *et al*. (2016)	Dying with dignity: A concept analysis.	Protecting the privacy of the patient in all aspects, not being a burden on family and friends, Interaction between caregiver and patient on the verge of death.	Considering the dignity of dying patients commensurate with their culture.
Efstathiou & Walker (2014)	Intensive care nurses' experiences of providing end-of-life care.	Holistic approach which recognizes the needs of the patient and families, caring for the dying patient and their family, providing and encouraging presence.	Providing end of life care after a decision has been taken to withdraw treatment.

Contd...

Table 1: Contd...

References	Context	Findings	Main idea
Fernández *et al*. (2020)	Nursing professionals' attitudes, strategies, and care practices toward death	Respect for the rights of the patient, preserve their hopes, beliefs, and confidence, good spiritual care necessary to increase the training in dignified dying that professionals receive.	Lack of training in the basic care of terminally ill patients.
Jors *et al*. (2014)	Dying in cancer centers.	Structural conditions (staff, time, room) education/training, working environment.	Cancer centers invest more in staffing, adequate rooms for dying patients and training in end-of-life care.
Souza *et al*. (2013)	Dignified death for children	Valuing humanized care, learning to cope with death and dying, need for education, opening the communication channel, providing holistic care.	extend the understanding of terminal care and postulates a theoretical framework that integrates the knowledge and actions.
Hunt *et al*. (2018)	Experiences of health professionals caring for patients who are dying.	Preserving human identity, ease the suffering of dying, culturally valued, without too much pain, not feeling abandoned.	Need to make more space for palliative, alongside curative, approaches to care in situations of humanitarian crises.
Díaz-Cortés *et al*. (2018)	Promoting dignified end-of-life care in the emergency department.	Provide spiritual solace, redesign the physical space, redesign paths, health-care protocols, redesign training of professionals.	Redesigning environmental conditions, and reorienting the health-care system to maintaining dignity in end-of-life care.
Chan *et al*. (2020)	Nurses' perceptions of and barriers to the optimal end-of-life care	Private rooms and unlimited visiting hours for families, families cultural/religious support, receiving palliative training.	Essential elements for optimal end of life care not only involving patients and families.
Morais *et al*. (2016)	Dignified death for students and doctors.	Presence of family members, good control over pain and symptoms, good relationship with the family, medical team and environmental well-being.	Must be contemplated in the professional practice and in the education of health professionals.
Choo *et al*. (2019)	Reciprocal dynamics of dignity in end-of-life care.	Involves family caregivers and health-care providers, self-determination, personal sanctuary, existential liberty, familial connection, care continuity.	Providing insights on how compassionate care and self-compassion can serve as the foundation of dignified care.
Tersek (2020)	Palliative care as an integral part of the right to life and dignified end of life.	Painless as possible, peaceful and humane a manner as possible, fundamental human right, relieving a patient of physical and psychosomatic suffering.	There is only one death with dignity.
Bhojaraja *et al*. (2021)	The case for a dignified withdrawal	Comprehensive symptom control, optimal quality of life, ability to engage in enjoyable activities, capacity and desire for independent functioning.	Palliative care teams should be involved to provide holistic care for the patient.

Attributes

In the present study, attributes of dying with dignity were human dignity and holistic care [Figure 1]. The former includes natural death, preservation of human values, and respecting patients' rights. Natural death, as a characteristic of good death, is caused by old age, illness, or injury[13] and is characterized by not receiving unnecessary and futile examinations,[14,15] which means not using advanced equipment to postpone death. Life-supporting medical interventions should not be provided for a long time and without justifiable reasons, which means avoiding prolonging life using medical equipment.[9] Therefore, prolonging life using medical equipment is not dying with dignity,[16] as it degrades human dignity.[17] Also, dying with dignity is a death that occurs at the right time, not at a young age, and not after prolongation of death (e.g., vegetative state), that is, the patient feels that his/her life is over and loses interest in life. Therefore, discontinuation or ceasing unnecessary treatments, avoiding referral for receiving further treatments, and rejecting unnecessary interventions are important attributes of this concept.[3] Medical ethics reserve a special position for dignity in care and define it as one of the ethical responsibilities of caregivers. Hence, it can be argued that nurses play an important role in maintaining and improving patients' dignity at the end of life.[18] Human dignity is also of high value in the nursing profession, and there is a special emphasis on human rights, including cultural rights, the right to live, and the right to choose the treatment.[7] It is also characterized by having moral peace and satisfaction with spiritual needs, by emphasizing cultural and religious characteristics, as well as respect for the body and beliefs of the patient and his/her family.[16] The patient's social rights determine the quality of access to health care, including rights to health care,

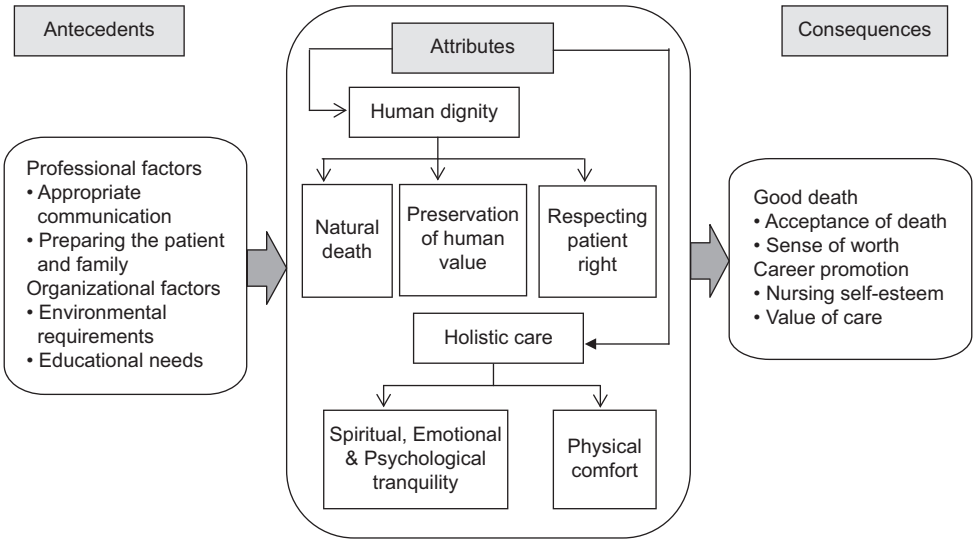

Figure 1: Antecedents, attributes, and consequences of "death with dignity" concept.

access to information, choice, participation, dignity in care, confidentiality, and compassion, which can be investigated from a social, individual, or humanity perspective.[19] Gaining independence in all issues related to illness and the right to participate in all decisions, particularly those related to the disease and treatment process, are among the main characteristics of dying with dignity. In addition, special attention has been paid to respecting patients' privacy, which has different meanings in different cultures. While patients are interested in participating in decisions related to their treatment process, they are often passive recipients of care. Engaging patients in the treatment process and considering them as a member of the medical team improves the overall performance.[20]

The comprehensive care attribute of dying with dignity is characterized by two main attributes of physical comfort, and spiritual, emotional, and psychosocial tranquility. Dying with dignity is the absence of physical pain and discomfort while benefiting from the support of family to achieve the maximum comfort,[2] and death without suffering includes good control over physical symptoms such as pain, thirst, fever, convulsion, and anxiety, which are components of dying with dignity.[9] Therefore, it seems that pain relief and providing emotional and mental peace for end-stage patients play a unique role, particularly in alleviating pain and controlling severe pain of end-stage patients.[21] Nurses consider pain, shortness of breath, nausea, anxiety control, and symptom control, respectively, as symptoms that require nursing interventions to promote dying with dignity.[7] Meanwhile, the importance of satisfaction with spiritual needs, regarding religious and cultural characteristics of dying with dignity, as well as managing the distress and anxiety, should not be ignored.[22] Therefore, all signs that remind individuals of old painful experiences should be kept away from end-stage patients. In addition, special attention should be paid to staying away from severe psychological and mental problems. Also, as inclination to religion grows at the end of life, particularly tendency to spiritual affairs, providing access to religious services to respect religious rituals is of crucial importance. In addition, patients should be ensured that in the absence of consciousness in the later stages of life, all religious rituals would be performed.[23] Spiritual well-being, achieved through providing spiritual care, not only helps patients to experience a quiet death but is also useful in relieving the grief of patients' relatives and health-care professionals who witnessed the patient's death. Also, lack of financial concerns and not feeling like a burden are important to maintaining psychological and social peace and are reported as one of the components of good death.[24]

Antecedents

Antecedents are prerequisites of analyzing a concept and affect its occurrence.[12] In this study, the antecedents of the concept of dying with dignity were classified into professional and organizational factors [Figure 1]. The former is characterized by appropriate communication and preparing the patient and family. While it is believed that the participation of patients and their families is a core component of dying with dignity in the process of end-of-life care, the evidence rejects this belief.[25] Communication skills and establishing effective communication by the medical team are among the prerequisites of dying with dignity. The ability to talk freely with family, expressing ideas, and creating a sense of closeness and empathy cannot be achieved without appropriate communication. The medical team should always be open to talking to patients and answering their questions to remove ambiguities.[26] Lack of enough time to communicate with patients is a major obstacle toward achieving this goal.[27] Strengthening trust between patients, families, and nurses can increase the effectiveness of the provided care, and dying with dignity can only be achieved when health-care professionals benefit

from the support of patients and their families.[28] Also, preparing or supporting patients and enabling quiet death in bed are among the major concerns of the nursing staff, which can be achieved by supporting patients, families, and health-care professionals through the complete life cycle of patients. Nursing teams must support patients, based on their spiritual level, and their role in providing care should continue even after death.[29] The dimension of organizational factors includes environmental requirements and educational needs. From the perspective of medical students, a safe environment results in feeling safe and being fearless.[9] Also, patients should not be alone while dying and should have appropriate access to health-care staff. Some also mentioned the presence of family members and friends when dying as a core component of dying with dignity. One of the main tasks of the nursing staff is to protect patients against negative effects, particularly those related to mediocracy or rigid processes.[30] Therefore, creating a sense of security for patients[31] and establishing a safe environment by the nursing team is of vital importance, because anxiety and fear of dying may prevent dying with dignity.[16] Interventions such as using the patient's preferred religious song, creating a quiet place, good ventilation, and a pleasant environment are recommended to facilitate dying with dignity.[32] Because of the shortage of nursing staff, nurses are often subjected to heavy workload in Iran, which means lack of enough time to communicate with patients or even train them and their families about death.[33] The results show that lack of knowledge and experience are among the biggest challenges facing end-of-life care, and nurses should receive adequate training in this field.[20]

A study on public health students reported that the majority of participants were not ready to provide health care to end-stage patients.[5] Another study linked unwillingness to communicate with end-stage patients to lack of training and clinical experience of death.[33] Therefore, nurses need to become more familiar with the various components of dignified care as a prerequisite for dignified death.[34] Nurses and physicians should be aware of the method for the transition from curative services to palliative care and how to control patients' pain and distress by pharmacological and non-pharmacological interventions.[35] Physical changes in therapeutic environments and determining private rooms for dying patients and their family members can improve the quality of end-of-life care. In general, the high workload of nurses and their inadequate training, as well as limitations related to physical space (i.e., insufficient number of private rooms for dying patients and their families), are reported as the main obstacles to achieving this goal.[36,37] In general, it can be said that the main antecedents for a dignified death is dignified care. In one study, these antecedents were placed in six categories, including respect, empathy, trust, privacy, autonomy, and communication.[38]

Consequences

In this study, the consequences included good death and career promotion [Figure 1]. The latter promotes nursing self-esteem and the value of care. Health-care providers can also prove to be external sources of dignity. The process of preserving the dignity of dying patients by the nursing team also strengthens their self-esteem and allows them to continue providing care while expressing their sympathy.[39] That way nurses feel that they have done their duty to patients, which results in a sense of victory and success. However, it also increases the value of care for patients.[27] It can also lead to personal and professional growth and a positive attitude toward death care.[40] It is also essential to revise the curriculum of health-care professionals at regular intervals in order to place more emphasis on dying with dignity.[2] The dimension of good death includes the two attributes of acceptance of death and a sense of worth. Practicing dying with dignity may result in developing a sense of security[31] and worth in patients[41] while facilitating the dying process. This process can also effectively improve the patient's quality of life (QoL) during the last days of their life.[42,43] The International Council of Nurses mentioned respect for humanity, self-esteem, and patient rights as an inseparable component of nursing, but some studies reported that dignified death in elderly patients is ignored. The elderly are the largest group of health-care users, and the opportunity to use hospice services should not be overlooked with increasing age.[17] Therefore, immediate interventions are needed in this regard.

Related concepts and surrogate terms

Surrogate terms are intended to express a concept using terms other than those used by the researcher. Surrogate terms involve some studied associations of the intended concept, not all of them. Hence, there should be a differentiation between these two. Surrogate terms are based on the fact that there are various methods of describing the same concept. A study mentioned "good death," "ideal death," "desirable death," and "dying well" as surrogate terms for dying with dignity.[2] Our literature review revealed that the term "good death" is closely associated with dying with dignity and is sometimes used interchangeably. A good death is defined as a spiritual, peaceful, and natural death with control, comfort, a sense of empowerment, trust in caregivers, and a feeling of respect for their values and beliefs.[16] In another study, the term "peaceful death" is used as the surrogate term and included notions of respect, empathy and dignity, independence, and hope for a quick, painless death or suffering.[44] However, another study argued that dying with dignity is a component of good death. In fact, a good death is a broader term and includes more attributes than dying with dignity and is at the top of the hierarchy.[9] Euthanasia and palliative care concepts are related to the concept of

dying with dignity. Orthothanasia is also defined as a death that was not postponed by medical equipment.[3]

Euthanasia is the practice of intentionally ending the life to relieve pain when a patient is at the end-stage of life and cannot endure the suffering. Euthanasia is a mild and easy death, especially in the case of painful and incurable diseases[45] and is meant for patients with incurable diseases or those who cannot live longer with dignity, especially to relieve them of their suffering.[46] Everyone should have the right to die with dignity, which does not mean euthanasia. A natural and dignified death can occur even after providing appropriate care to relieve patients' pain, that is, without the need for euthanasia. In most cases, euthanasia intends to relieve pain and discomfort. Enabling patients to access appropriate health care can change their mindset, and the public and government should take measures toward strengthening currently available health-care services, instead of promoting euthanasia, to help end-stage patients. Patients who ask for euthanasia must be heard and noted. However, the term "dysthanasia" refers to bad death and prolongation of a patient's life who is in a critical situation. The term is also synonymous with "futile treatment," which is referred to as "therapeutic obstination" in Europe and "medical futility" in the United States, and represents the right to preserve the life of patients reaching the end of life, even those with great suffering.[47]

This results in prolongation of the death process, not the life. The prolonged death process causes high anxiety and suffering, which is rejected by most ethicists due to its conflict with one's dignity and its impact on the QoL of both patients and their families as well as caregivers.[46] Another surrogate term is "palliative care," which is the science and art of promoting QoL when reaching the end of life and is not only about helping end-stage patients but also can be applied to patients with chronic diseases.[48] The above-mentioned study mentioned "palliative nursing" and "palliative service" as surrogate terms for palliative care. It can be argued that dying with dignity is among the main goals of palliative medicine.[9]

Identifying a model case (an exemplar)

Mr. M is an 80-year-old patient with advanced colon cancer in end-of-life stage at ICU. His physician believes that the patient is in his final days of life and the nurse, after discussing the condition with the health team and securing the patient's permission, invites the family members to the hospital for talk. The nurse answers the family members' questions and with respect to the patient's independence, helps him to make a choice. Given the bad experience of previous chemotherapies, the patient is reluctant to do chemotherapy and the physician believes that more chemotherapy only prolongs the process a bit more. With respect to the patient's rights, the medical team decides not to perform invasive procedures and instead provides maximum peace and tranquility to the patient using palliative interventions (pharmaceutical and non-pharmaceutical). The nurse provides holistic care to the patient along with respect to his humanity and ethical and professional principles. None of the patient and his family's rights is neglected in the process. To ensure the patient's spiritual and mental peace and after consulting with the patient and family members (to learn about their personal and familial cultural and religious beliefs) a clergy is invited to the patient's death bed in the final hours of his life. The patient dies in a peaceful environment with good ventilation where a religious music that the patient liked is played. After the death, the nurse still treats the body with respect and preserves the family's dignity by providing emotional support to them. The family has complete satisfaction with the care and appreciates the nurse and medical team's work. The nurse feels that along with the patient and family's dignity, her profession and dignity are also improved and her work has been appreciated. This makes her feel better about her job and care services.

This case contains all the conditions and standards about the concept of dying with dignity and also highlights the important role of the nurse in the process.

Discussion

In this study, the attributes, antecedents, and consequences of dying with dignity were analyzed, which were further categorized into human dignity (natural death, preserving human values, and respecting patients' rights) and holistic care (physical comfort and emotional, spiritual, and psychosocial tranquility). Dignity at the end of life encompasses a wide range of dimensions, from issues directly related to the symptoms of the disease through the internal dimensions of the patient to the social dimensions associated with support and communication.[35]

Two types of dimensions of dignity are emphasized in the literature: intrinsic and inherited. The former is rooted in our nature as humans, and sometimes called human dignity. In this study, respecting human values was identified as an attribute of dying with dignity, which seems to be consistent with the aforementioned attribute of dignity. The other attributes of dignity are personal and variable, are related to cultural and social values, and therefore it is also referred to as social dignity.[16] It seems that nurses can initiate interventions toward promoting this dimension of dignity. The findings of the present study, concerning dimensions of spiritual, emotional, and psychosocial peace, are in line with this attribute of dignity. We included in the study only articles in English. Exclusion of articles published in other languages might have limited our understanding of the dignified death concept. Also it should be noted that despite the systematic approach, there may be some articles that were not included in this study due to their unavailability.

Conclusion

Based on the findings of this study, it can be argued that dying with dignity is an important attribute of nursing care, which includes providing health-care services while paying respect to ethical principles, human values, and patient rights until the end of life and after. Apart from improving the social position of the nursing profession, this is also useful in preserving the human dignity of the patient and enhancing the satisfaction of his/her family and the self-esteem of the patient. Therefore, it is necessary to prepare students to provide end-of-life care and especially emotional care by revising the curriculum of health-care professionals in order to place more emphasis on this important concept. The findings of the present study can be used to guide providing end-of-life care and help health-care providers in providing more effective services to about-to-die patients, which will ultimately translate into high-quality and dignified death through care strategies.

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Conflicts of interest

Nothing to declare.

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