ANALYZING THE PROCESS OF A GOOD DEATH: A SCOPING REVIEW

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Abstract

Background

Dying well represents a major challenge for terminal patients, families, and healthcare staff due to emotional, existential, and structural barriers entailed in it.

Aim

To explore how terminal patients, families, and healthcare staff relate to the good death by synthesizing the existing empirical evidence through the prism of the SWOT framework.

Design

A scoping review was conducted to identify and outline key factors enhancing or hindering the process of the good death.

Data Sources

A systematic search via PubMed and JSTOR was performed in accordance with the PRISMA guidelines. Thirteen empirical studies addressing terminal patients in hospital, hospice, or home care settings were reviewed.

Results

Strengths included a preference for dying at home, effective symptom management, and applying supportive interventions for terminal patients and families. Weaknesses involved inadequate support, limited patient participation in decision-making, and ethical dilemmas delaying end-of-life care. Opportunities focused on improving symptom management with emotional support and strengthening patient- and family-centered care. Threats included overmedicalization, overtreatment, and ethical challenges that hinder a good death.

Conclusion

The good death extends beyond symptom relief and physical condition. Ensuring more patient-centered communication, provision of emotional support, effective symptom management, and overcoming ethical barriers are essential to ensure a good death.

Keywords: *Good death; Palliative care; end-of-life care.*

Background

General conceptualization of the good death

The "good death" concept has been investigated across a plethora of domains, including medical ethics, psychology, and palliative care medicine. It is typically associated with values and rights such as dignity, autonomy, freedom from suffering, and alignment with personal, cultural, and religious beliefs (Omoya et al.,2022). Omoya et al. (2022) conceptualize good death as the outcome of holistic end-of-life care and incorporate four interdependent domains: physical comfort, psychological adaptation, relational support, and spiritual existential meaning.

In this framework, effective symptom management is considered a foundational prerequisite, enabling patients to engage emotionally and cognitively with the process of dying. Psychological readiness is fostered through empathetic communication and emotional support, facilitating acceptance of death and reducing related distress. Relational care, particularly family involvement and shared decision-making, shapes the quality of the dying experience by aligning care with patients' values and social contexts. Spiritual and existential dimensions promote dignity and meaning-making at the end of life. Omoya and her colleagues maintain that these domains operate within broader organizational settings, including interdisciplinary collaboration, professional training, and access to palliative services, which collectively determine whether (or not) the end-of-life care culminates in a dignified death or remains a fragmented, medically driven process.

This integrative framework suggests that the good death does not emerge from isolated interventions but from the coordinated interaction of psychological, relational, and structural factors. However, the uniform definition of a good death remains challenging due to varying interpretations of this term across cultural, clinical, and psychological domains (Özbek Güven et al.,2024). Additionally, healthcare staff frequently encounter emotional strain, ethical dilemmas, and systemic constraints that hinder their ability to provide dignified end-of-life care that aligns with patients' values during the process of death (Belanger et al.,2019; Wong et al., 2020).

The good death and related stakeholders

From a psychological perspective, terminal patients and their families often experience the same stages of emotional processing, including denial, anger, bargaining, depression, and acceptance. Reaching acceptance allows death to be perceived as more peaceful and value-congruent, supporting openness to the planning of the end of life and enhancing psychological readiness for the process of death (Wong et al.,2020). Emanuel and Emanuel (1998) further described the psychological symptoms that terminal patients are likely to experience, such as anxiety, depression, and confusion.

Family members play a central role in shaping the end-of-life experiences of their loved ones. According to Cottrell and Duggleby (2016) and Campbell (2020), the presence and engagement of family members may enhance the patients' emotional well-being, defined as a cluster of psychological constructs, including life satisfaction, a sense of purpose, and positive emotions (Borgstrom et al.,2019). The presence and the engagement of family members may also support the decision-making process at the end of life (Emanuel & Emanuel, 1998; Cottrell et al.,2016). However, family-related challenges may also negatively affect the end-of-life experience. As noted by Cottrell and Duggleby (2016), family distress, unresolved conflicts, or limited preparedness for death are likely to increase patient and/or family anxiety and complicate decision-making processes. Therefore, providing adequate support to families is essential for facilitating the good death.

Another essential element in enabling a good death is the internal capacity of healthcare professionals to provide high-quality end-of-life care to terminal patients. Providing such care often exposes healthcare staff to repeated experiences of loss, emotional strain, and moral complexity, which may affect their psychological health. Such as the ability to fulfill basic psychological needs that promote well-being and effective adaptation in the workplace, supported by both personal and organizational resources (Campbell,2020). Over time, this psychological burden is likely to contribute to burnout, potentially influencing both healthcare professionals' attitudes toward death and the quality of end-of-life care provided to terminal patients (Omoya et al., 2022). For this reason, structured death-education initiatives have been introduced not only for healthcare professionals, including nurses and social workers, but also for the general public (Feller et al., 2018).

Shu et al. (2023) also suggest that participation in such initiatives is likely to reduce the nurses distress and psychological health while treating a terminal patient fostering more constructive attitudes toward death and the process of dying. However, such initiatives require substantial time and emotional investment that is not always available in routine clinical practice. At the same time, healthcare staff often face unresolved ethical dilemmas related to life-prolonging interventions. These dilemmas may further impede the provision of end-of-life care aligned with patient values and preferences, compromising the implementation of the good death practices (Gilbert, 2009; Shu et al., 2023).

Related literature

Several reviews and empirical studies have examined the concept of the good death from different perspectives. Omoya et al. (2022) explored healthcare professionals' perceptions through qualitative interviews with emergency department physicians and nurses. Their

findings revealed professional differences: nurses emphasized physicians' role in communicating prognosis and supporting families, whereas physicians focused on treatment decisions and end-of-life care planning. However, the study did not examine barriers related to potentially burdensome interventions or factors that may delay a good death.

Zaman et al. (2021) identified key contributors to a good death, including preferred place of death, symptom control, and management of emotional distress. Although they highlighted the importance of emotional support and end-of-life rituals, their review focused mainly on family support and did not explore organizational barriers, healthcare professionals' emotional support, or ethical challenges such as assisted dying.

Cottrell and Duggleby (2016) examined factors that may hinder a good death, including unpredictable disease trajectories, difficulties recognizing the dying phase, and the concept of the "wrong good death," in which the dying process conflicts with individual expectations. However, their review provided limited attention to positive facilitators of dying well and did not incorporate patients' perspectives.

Krikorian et al. (2020) emphasized the influence of cultural, religious, clinical, and demographic factors on perceptions of a good death. They highlighted how different disease trajectories and patient characteristics, such as age, may shape end-of-life preferences and preparedness. Nevertheless, their review primarily focused on patients' perspectives and did not integrate the experiences of families or healthcare professionals.

The current review

Previous studies have explored the good death from multiple perspectives, including healthcare professionals' experiences, patient preferences, cultural influences, and structural barriers. However, much of the literature examines these dimensions separately, limiting the integration of clinical, psychological, relational, and organizational factors that shape end-of-life experiences.

This review examines the good death through the lived experiences of terminal patients, families, and healthcare professionals, exploring how symptom management, communication, emotional support, and shared decision-making contribute to or hinder dying well. To synthesize empirical findings, we applied the SWOT (Strengths, Weaknesses, Opportunities, Threats) framework (Krikorian et al., 2020; Puyt et al., 2023). Originally developed for strategic analysis, SWOT has been adapted to healthcare research to identify internal and external factors influencing care quality. In this review, the framework provides an integrative approach for linking end-of-life practices with patient, family, and professional perspectives. The research question was: What factors support or hinder the experience of a good death within end-of-life care?

Within this framework, strengths represent factors that facilitate dying well, including compassionate communication, shared decision-making, culturally responsive care, emotional support, and preferred place of death. Weaknesses reflect barriers such as inadequate symptom control, limited psychosocial support, and communication challenges. Opportunities highlight future directions, including expanded palliative care access, interdisciplinary collaboration, psychological support, and patient-centered policies. Threats include systemic constraints, overmedicalization, limited policy guidance, and sociocultural barriers that may compromise a dignified and value-concordant dying process.

Methods

This scoping review aimed to identify gaps in the literature and inform future systematic reviews. Following Arksey and O'Malley's (2005) framework, we systematically identified relevant studies, applied selection criteria, mapped evidence, and synthesized findings. Scoping reviews allow refinement of selection criteria during the initial search process based on emerging insights.

We focused on empirical literature addressing the concept of the good death and included only studies that directly examined its characteristics, processes, or outcomes. We extracted and charted data according to predefined criteria, including study characteristics, participant groups, and key findings. We then synthesized the evidence to identify common themes, facilitators, barriers, and knowledge gaps regarding the conceptualization and implementation of good death in clinical practice.

Search strategy

This review included articles retrieved from two electronic databases: PubMed and JSTOR. Each author searched independently in one database between January and March 2025 using the same set of keywords. The search strategy used a combination of keywords, including *palliative care*, *good death*, and *psychology*. The goal of the search was to identify studies that explicitly addressed the concept of the good death by investigating perceptions, attitudes, or applications related to the good death concept among terminal patients, their families, and healthcare staff, particularly medical doctors and nurses, including the attributing factors and attitudes toward its implementation in practice. To ensure a structured, transparent, and reproducible process, the review adhered to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Arskey & O'Malley, 2005). All identified articles were screened against predefined inclusion and exclusion criteria. The process was supervised by Prof Krasimir Ivanov to ensure independent article screening.

Selection criteria

All empirical studies (full-length articles or short communications) that examined the good death process among healthcare professionals, terminal patients, and/or their families. Eligible studies focused on adult populations (≥18 years) in hospital or hospice settings and explicitly addressed good death concepts were included. non-empirical publications (e.g., abstracts, protocols, editorials, and opinion articles), as well as studies involving pediatric, obstetric, neonatal, primary psychiatric, or cognitively impaired populations were excluded. Studies focusing on unrelated clinical domains, including surgery, gynecology, and general mental health care. To ensure contemporary relevance, we included only English-language articles published from 2019 onward were excluded. These criteria followed the Population, Concept, and Context (PCC) framework (Wang et al., 2025).

Data extraction

The initial search identified 758 articles from both databases. After title screening, we excluded 603 studies unrelated to good death, palliative care, or psychology. Abstract screening of the remaining 155 articles led to the exclusion of 14 additional studies. We assessed the full texts of 141 articles and excluded 97 studies that did not directly address the review objectives. Two authors independently reviewed the remaining studies and resolved disagreements through discussion, excluding 34 non-empirical or low-relevance articles. Ultimately, 13 empirical studies were included in the scoping review. We did not perform reference-list screening because the identified literature was considered sufficiently comprehensive. We documented the screening process in Microsoft Word without using specialized review software. The authors independently screened studies, extracted data, and met regularly to resolve discrepancies regarding study inclusion and SWOT categorization. Given the exploratory nature of the review, we did not conduct methodological quality assessment (Fealy et al., 2019). Data extraction included author, country, study aim, design, population characteristics, and main findings. The following table summarizes the findings (see Table 1).

Table 1- ***Empirical articles related to Good Death, Psychology, and palliative care based on the SWOT findings***

Domain	Terminal Patients	Families	Healthcare Staff
Strengths	Preferences, death preparedness, symptom control (Chang et al., 2023; Mayland et al., 2021; Spear et al., 2021; Wu et al., 2021)	Emotional support interventions and preferred place of death alignment (von Blanckenburg et al., 2021; Schellekens et al., 2021)	Rituals and practices supporting meaningful dying (Kawashima, 2019)
Weaknesses	Overtreatment, limited decision-making, symptom challenges (Wu et al., 2021; Koyauchi et al., 2021; Chang et al., 2023)	Insufficient psychosocial support (Mayland et al., 2021)	Ethical dilemmas in end-of-life care (Bélanger et al., 2019)
Opportunities	Advance care planning and integrated palliative support	Family-centered care approaches (Borgstrom et al., 2019)	Advocacy, communication, and symptom management enhancement (Oliphant & Frolic, 2021; Rutherford, 2021; Wong et al., 2020)
Threats	Overmedicalization and difficult symptom control (Koyauchi et al., 2021; Chang et al., 2023)	Communication barriers and emotional distress (Mayland et al., 2021)	Emotional burden, ethical/religious barriers (Wong et al., 2020; Oliphant & Frolic, 2021)

Results

Descriptive statistics

A total of 13 empirical studies were reviewed. Of them, seven were conducted in Europe (Germany, the U.K., the Netherlands), four in Asia (Taiwan, Japan), two in Canada, and two in Australia. As for study design, six studies employed qualitative methods, four were quantitative, two used mixed-methods designs, and one was experimental.

The SWOT analysis

Strengths

Patient and family preferences for the place of death

A recurring theme across several studies was the importance of the place of death in shaping perceptions of the good death. Respecting patient and family preferences regarding where death should occur emerged as a key strength in end-of-life care. When individuals can die in their preferred setting—most often at home—they tend to report feeling more comfortable, less anxious, and better supported.

Three studies referred to this issue. In the study by Chang et al. (2023), participants described home as a familiar environment that promotes emotional comfort and a sense of peace of mind. Similarly, Mayland et al. (2021) found that dying at home—when consistent with patient or family wishes—allowed individuals to farewell, resolve unfinished matters, and maintain dignity. Spear et al. (2021) also noted that the majority of their participants preferred receiving the end-of-life care at home rather than in institutional settings such as nursing homes.

Enhancing emotional well-being and death acceptance

Respecting the preferences of patients and families for the place of death strengthens emotional well-being and facilitates their acceptance of the dying process by providing familiar and supportive settings that align with their values and emotional needs. Two articles addressed the psychological domain of the end-of-life experiences. In the study by von Blanckenburg et al. (2021), 168 healthy adults received value-based, motivation-focused, or combined psychological interventions.

The participants exhibited a small but statistically significant increase in the acceptance of death immediately following the intervention. However, this effect did not last long as the death acceptance scores returned to their baseline levels within two weeks. Chang et al. (2023) reported that terminal patients receiving home-based palliative care exhibited improved emotional and spiritual well-being, as reflected in lower palliative care problem severity (PCPSS) scores in the psychological/spiritual domain.

Enhancing the readiness for the end-of-life discussions as a facilitator of the good death

Two articles referred to this domain. The majority of the participants in the study by Von Blanckenburg et al. (2021) expressed greater willingness to engage in end-of-life conversations after taking part in supportive interventions such as a motivation-focused intervention and a combined intervention. Additionally, the life partners of dying patients in the study of Schellekens et al. (2021) reported that mindfulness-based stress reduction (MBSR) therapy helped both family members and their dying partners to regulate their thoughts and emotions regarding the process of dying. Furthermore, MBSR facilitated acceptance of their illness trajectory and prognosis, enabling open discussions about life after their partner's passing away.

Rituals and professional practices facilitating the good death

One article referred to this domain. Kawashima (2019) analyzed how Japanese emergency room staff facilitated the Mitori practice, a series of ritual actions performed by the healthcare staff, aimed at honoring the terminal patient and the family in the last moments of patient's lives in the hospital settings. First, the medical staff ceases the resuscitation process in an appropriate time. Then, medical doctors deliver the death announcement to the family in a

storytelling format. This is followed by a ritualized death confirmation process conducted in the presence of the family. Next, medical staff and family members engage in a mutual bow as a sign of respect. Finally, the staff prepares the body for the final encounter with the family.

Symptom management as a facilitator of the good death

One study addressed this factor. Wu et al. (2021) used the Good Death Scale to evaluate the quality of dying among terminal cancer patients. They found that providing patients with artificial hydration (AH) (86–445 cc) was significantly associated with higher scores on the Good Death Scale, indicating improved quality of dying and greater acceptance of death.

Weaknesses

Interventions that complicate the end-of-life care

One study addressed the role of AH in end-of-life care. Wu et al. (2021) found that AH did not lead to symptom improvement among terminal patients. Both the intervention group receiving AH and the control group demonstrated an increase in the symptom burden after seven days of observation. Moreover, patients in the AH group reported increased fear of dying following the intervention. These findings suggest that AH, in some cases, might negatively affect the psychological well-being of patients, thereby representing a potential barrier to reaching the good death.

Inadequate intangible support

One study addressed the experiences of bereaved relatives during the COVID-19 pandemic. Mayland et al. (2021) identified two factors associated with the good death: emotional support and psychosocial support. Emotional support referred to the support provided by healthcare staff and family members that aimed at helping patients cope with the dying process on the affective level and improve their overall experience. Psychosocial support is related to the broader social support patients receive, including relationships and social connectedness, which facilitate a more positive end-of-life experience.

The authors found that nearly half of their participants rated the emotional support they received for their dying relatives as insufficient. As much as 30% of them reported inadequate psychosocial support, such as family visits, and felt that their needs were not fully addressed by healthcare staff, with an additional 30% perceiving emotional support as “poor.” In addition, 71% of respondents highlighted their inability to meet dying relatives face-to-face as a significant concern. Families reported receiving better support from nurses than from medical doctors in hospitals (48.4% vs. 31.1%). Collectively, these findings suggest that insufficient support may hinder the quality of the dying experience, thereby making it difficult to reach the good death.

Barriers in the end-of-life decision-making for terminal patients

One study addressed this domain. Koyauchi et al. (2021) used the Good Death Inventory scale to examine end-of-life symptoms among patients with cancer and those with interstitial lung disease. Their findings showed that patients with interstitial lung disease experienced more severe symptoms at the end of life as compared to patients with lung cancer. Such symptoms include shortness of breath, cough, pain, fatigue, insomnia, anorexia, and weight loss. In addition, fewer patients with interstitial lung disease than those with lung cancer have made a life-sustaining care decision 48 hours before death. Moreover, patients with interstitial lung disease were less likely than patients with lung cancer to be referred to palliative care specialists despite their suffering from breathlessness (8.5% vs 54.3%, respectively).

Additionally, not only were the diagnosed patients with interstitial lung disease less likely to participate in the end-of-life discussions, but also such discussions were initiated only one month before their death. Furthermore, patients with interstitial lung disease were not involved in the decision-making process before their death. However, interstitial lung disease patients were more likely than patients with lung cancer to undergo unnecessary medical interventions such as receiving antibiotics, blood transfusions, a large volume of infusion, and life-prolonging procedures (e.g, vasopressor agents, nasoenteric feeding, invasive mechanical ventilation, and non-invasive ventilation).

Ethical and professional gaps in the end-of-life care

Two studies examined physicians' ethical and professional concerns regarding end-of-life practices. Bélanger et al. (2019) found that the majority of the interviewed physicians opposed voluntary active euthanasia (VAE), arguing that it compromises the opportunity to assess and alleviate suffering and undermines the role of palliative care in promoting comfort in the end of life. They also mentioned the existence of the tension between respecting patient autonomy in choosing the timing or the manner of death and their professional commitment to neither intentionally hastening death nor prolonging life. Finally, they expressed disagreement with the Canadian government framing VAE as a mechanism to improve end-of-life care.

In addition, in the study of Oliphnant & Frolic (2020), the healthcare staff, which included medical doctors, nurses, and other professionals, considered a bad death as one that does not honor the patient's wishes in the end-of-life. However, their religious beliefs prevented them from taking part in the medical-assisted dying practices, such as euthanasia.

Opportunities

Enhancing healthcare attitudes towards the good death

Three articles addressed this domain. The healthcare staff in the study of Oliphnant and Frolic (2020) maintained that death is shaped by individual life experiences. Furthermore, they considered the desire to advocate for vulnerable individuals as the main motivator for their involvement in medical assistance in dying practices. Similarly, medical doctors in the study by Rutherford (2021) viewed the relief from suffering as their core duty for patients.

Additionally, they highlighted the need to support the patient autonomy to decide what is best for them and how to die well. However, their support for voluntary-assisted dying was shaped by the political views they held, their prior experiences, and the legal frameworks they were previously exposed to. Finally, oncologists interviewed in the study by Wong et al. (2020) maintained that high-quality care is essential to ensure that a dignified death is provided for the terminal patients.

Integrating families into the end-of-life care

This domain was discussed in two articles. Participants in the study of Borgstrom et al (2019) reported that the good death should involve active family participation in the dying process. Additionally, the authors (ibid) stated that current policies should be extended beyond the individual-focused care and recognize the role of families in shaping the end-of-life experiences of patients. To achieve that, families should get proper support to handle the end-of-life care issues. Some of the patients in the study of Spear et al. (2021) expressed a wish to die well at their home with adequate medical and family support.

Threats

Communication and emotional challenges for healthcare providers

Two articles addressed this domain. Family members in the study by Mayland et al. (2021) expressed dissatisfaction due to communication issues with healthcare staff, including difficulties in contacting them by phone. Additionally, some of the oncologists in the study by Wong Broom and Kirby (2020) reported struggling to inform the terminal patients about their prognosis due to emotional difficulties that arise when treating terminally ill patients.

Challenges in the home-based end-of-life care

One study referred to this domain. The patients in the study of Chang et al. (2023), who preferred to die at home, experienced greater challenges achieving symptom relief. Such symptoms include breathing issues, sleep disturbances, and decreased appetite.

Discussion

This review aimed to explore the factors that support or hinder the good death, drawing on the perspectives of terminally ill patients, their families, and healthcare staff. Thirteen empirical studies were analyzed using the SWOT framework to identify practical facilitators and inhibitors that shape end-of-life experiences. The discussion below interprets these findings through related theoretical perspectives and draws on their wider implications.

Strengths

One strength identified across studies is the preferred setting for end-of-life. Dying at home is often viewed as the preferred alternative of the dying patient and their family (Shu et al., 2023; Mayland et al., 2021). It allows patients to maintain control over their final days and the conditions in which they die, thereby supporting autonomy and comfort (Shu et al., 2023; Krikorian et al., 2020). However, for that to happen, a dying patient should undergo the good death process with adequate medical care, symptom management control[14,31], and emotional support (Moher et al., 2009).

Another strength identified is emotional well-being, which constitutes a significant component of the good death process. One approach to supporting emotional well-being involves mindfulness-based interventions. As reported by Schellekens et al. (2021), such interventions are likely to facilitate acceptance of death and encourage open discussions between patients and their life partners regarding the end-of-life preferences. In addition, motivation-based interventions have been suggested as another means of enhancing emotional well-being. These interventions are likely to assist individuals in engaging in open conversations about the end of life and death and support them as they approach the dying phase. However, as von Blanckenburg (2021) notes, these types of interventions may not always be beneficial in cases of acute or sudden deterioration, where patients and families are not well-prepared to confront or accept the forthcoming death.

Another factor that may enhance the process of the good death is the presence of end-of-life rituals. The Mitori practice, for example, allows terminal patients and their families to separate with a sense of dignity and honor. However, it must be noted that this ritual is culturally specific and may not necessarily apply or fit other cultural contexts. In addition, it is primarily practiced in hospital settings, where most deaths occur, rather than in home settings (Kawashima, 2019. Furthermore, the implementation of such practices in hospitals requires healthcare professionals to have an adequate palliative care orientation, as well as sufficient healthcare staff to support these processes (Omoya et al.,2022).

Weaknesses

Despite the abovementioned strengths, several internal barriers limit the consistent implementation of the good death across settings and populations. Notably, non-cancer patients remain underrepresented in palliative care services, resulting in less comprehensive symptom management, fewer opportunities for shared decision-making, and overall lower quality of the end-of-life care compared to cancer patients[14]. This inequality undermines the principle of person-centered care, ultimately underpining the good death.

Moreover, although continuity of care and holistic support were highlighted as strengths, symptom control in home-based care is frequently challenging. Common distressing symptoms such as dyspnea, appetite loss, and sleep disturbances are often insufficiently managed outside institutional settings (Krikorian et al., 2020), thereby compromising comfort and dignity during the dying process. These gaps indicate that while supportive frameworks do exist, their implementation remains inconsistent, thereby hindering patients' and families' experiences of the good death.

Emotional support from healthcare teams is often lacking, thus affecting both patients and their families (Krikorian et al., 2020). Part of this challenge originates in the internal barriers faced by healthcare staff in their daily practice—struggling with ethical uncertainty, coping with an emotional burden of patient suffering, and feeling unprepared due to limited training. These obstacles create tension for healthcare professionals, especially when navigating complex situations such as voluntary-assisted dying. Some clinicians see it as a way to relieve suffering and honor patient autonomy, while others experience profound moral conflict shaped by their personal beliefs and the culture of their workplace (Von Blenckenburg et al., 2021; Schellekens et al., 2021). Without adequate support and guidance, these emotional and ethical struggles can limit the ability of the healthcare staff to respond fully to the end-of-life preferences of their patients, hence making it harder to provide compassionate care that patients and families need (Belanger et al., 2019; Schellekens et al., 2021).

Moreover, an absence of supportive structures, such as mentorship, ongoing ethics education, or peer reflection opportunities, can contribute to emotional fatigue and avoidance of taking part in critical conversations. These weaknesses not only affect the quality of delivered care but also shape the attitudes toward death and dying held by the staff, ultimately distancing clinical practice from the good death ideals (Omoya et al., 2022).

These findings can be interpreted through the lens of Terror Management Theory. According to this theory, awareness of mortality generates existential anxiety that individuals attempt to manage by maintaining a sense of self-worth and meaning within their cultural

worldview (Wong et al., 2020). Projecting this postulate on the current discussion, it can be maintained that when confronted with reminders of death, such as caring for dying patients, healthcare professionals are likely to experience psychological discomfort that threatens these protective mechanisms. As a result, they may adopt defensive coping strategies, including emotional distancing, avoidance of discussions about death, or reluctance to engage in complex end-of-life decision making.

Within palliative care contexts, such responses may contribute to the difficulties observed in providing consistent emotional support, initiating conversations about dying, or participating in ethically challenging practices such as voluntary-assisted dying. These reactions do not necessarily reflect a lack of compassion but rather the psychological strain associated with repeated exposure to mortality. Terror Management Theory, therefore, helps explain why healthcare professionals may struggle with the emotional and ethical demands of end-of-life care, particularly in the absence of adequate training, mentorship, and institutional support. In this sense, the theory provides a useful framework for understanding how fear of death and existential anxiety can shape professional behavior and influence the quality of care provided to patients at the end of life.

Opportunities

The analysis highlighted several ways to enhance experiences of the good death. Interventions such as mindfulness-based stress reduction (MBSR), motivation-focused approaches, and culturally sensitive rituals (e.g., the Japanese Mitori ritual) offer support that addresses both psychological and spiritual needs of patients and their families (Mayland et al., 2021; Spear et al., 2021; Van Lange et al., 2012). Integrating these approaches with educational programs for healthcare professionals can improve communication skills, strengthen emotional support, and prepare staff to engage in end-of-life discussions (Schellekens et al., 2021; Oliphnant&Frolic, 2021; Park et al., 2023).

Organizational adjustments that prioritize family involvement and align care structures with patient needs also help establish conditions for higher-quality end-of-life care and more meaningful perceptions of the dying process for patients, families, and healthcare staff (Omoya et al., 2022). Morgan and Gazarian (2023) draw on Kubler-Ross's theory of acceptance, emphasizing that the good death can be understood both as a process and as a moment. They suggest that patient awareness of their condition can foster acceptance of dying, while in some cases, medical assistance or euthanasia may help patients reach the good death according to their values.

Threats

Threats pose risks to reaching the good death. Institutional fragmentation, over-medicalization, and legal ambiguities surrounding death-hastening options create barriers to patient-centered care (Von Blanckenburg et al., 2021). Moral conflicts healthcare professionals might have, and insufficient training they might receive, are likely to limit their willingness or ability to fully comply with the patient's end-of-life preferences (Belanger et al., 2019; Schellekens et al., 2021). Without addressing these threats, patients and families may face dying experiences misaligned with their values, hence undermining the very concept of the good death.

This SWOT-guided discussion synthesizes key factors shaping the good death perceptions from multiple perspectives, offering an integrative model that can inform policy, clinical education, and care planning. Ultimately, addressing weaknesses and threats while leveraging strengths and opportunities will be essential to advancing end-of-life care that respects patient autonomy, alleviates suffering, and promotes meaningful dying processes.

Strengths and Limitations

A major strength of this review is the use of the SWOT framework, which provided a structured approach to identifying factors that facilitate or hinder a good death, as well as opportunities and threats affecting end-of-life care. Independent screening by both authors and predefined eligibility criteria enhanced methodological rigor by ensuring the inclusion of relevant empirical studies. However, this review did not capture variations in individual experiences across patients, families, healthcare professionals, or institutions. In addition, limiting the search to two databases may have reduced the number of eligible studies.

Contribution to the Literature

This review advances the international literature by providing a systematic structure of factors that shape the transition from general end-of-life care to implementation of the good death. By applying the SWOT framework, we distinguished between structural and relational interventions and linked them to the perceptions of dignified dying held by patients, families, and healthcare staff. Unlike prior reviews that focused primarily on clinical symptom management, this scoping review emphasized the role of communication, care settings, and family support as critical facilitators in reaching the good death.

Moreover, this review clarified that while end-of-life care addresses clinical and logistical management, the good death represents a value-congruent outcome arising from these processes. We show that the ethical readiness and the engagement in complex practices by healthcare staff, such as voluntary assisted dying, significantly influence whether the end-of-

life period is experienced as a truly meaningful and dignified death, rather than merely a medically managed decline.

Implications for Practice

Healthcare professionals should receive training in empathic communication, advance care planning, shared decision-making, and culturally sensitive end-of-life care. Families should be offered emotional support and guidance, while healthcare professionals should recognize grief responses that may influence communication and treatment decisions. Healthcare organizations should provide ongoing education, ethical consultation, and reflective support to reduce clinicians' emotional burden and promote patient-centered care (Lifshits et al., 2025). Finally, healthcare systems should improve equitable access to palliative care, ensuring that all patients receive high-quality symptom management, psychosocial support, and opportunities to participate in end-of-life decision-making.

Conclusions

To facilitate the good death, the patient-centered approach is essential—one that respects individual preferences, ensures effective symptom management, and provides psychological and emotional support to both terminal patients and their families. Structured interventions and clear, empathetic communication can enhance readiness for end-of-life discussions. At the same time, healthcare systems must address barriers such as limited access to palliative care, insufficient professional training, and unresolved ethical dilemmas to fully support patients, families, and healthcare providers throughout the dying process.

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