REVIEW ARTICLE

Understanding perceived good death among older adults: A qualitative systematic review for model development

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ABSTRACT

The concept of a "good death" encompasses physical, psychological, social, and spiritual dimensions, emphasizing dignity and meaning at the end of life. However, the perceptions of older adults regarding this concept remain underexplored, particularly across diverse cultural and demographic contexts. This study aimed to conduct a qualitative systematic review to identify unique perceptions concerning a good death among adults aged 60 and above and to develop a comprehensive model addressing these aspects. A qualitative systematic review methodology, guided by the Joanna Briggs Institute's framework and PRISMA guidelines, synthesized 12 qualitative studies published between 2000–2022. Thematic synthesis, supported by a hybrid approach of human coding and automated analysis using DivoMiner software, then ensured robust findings through triangulation between machine-generated codes and human annotations. Five interconnected themes_emerged: (1) peaceful and dignified death, (2) family and social influences, (3) autonomy and control, (4) spiritual and cultural perspectives, and (5) challenges associated with a bad death. The desires for pain-free experiences and autonomy were balanced with cultural and familial factors, underscoring the need for compassionate, culturally sensitive care. The present study proposes a comprehensive "Good Death" model to improve nursing practices through holistic, personalized, and culturally informed end-of-life care. By integrating spiritual and cultural sensitivity and emphasizing familial involvement, the model addresses gaps for future research and policy development, ultimately enhancing the quality of life and end-of-life experiences for older adults worldwide.

Keywords:
good death; end-of-life care; nursing process; holistic care; cultural sensitivity

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INTRODUCTION

Death, though inevitable, can be improved through awareness, acceptance, symptom management, and emotional support, as emphasized by Zaman et al. Achieving a good death requires collaborative efforts across the fields of nursing science, public health, and behavioral science.[1] Nursing science emphasizes compassionate, patient-centered care, prioritizing symptom management, dignity, and emotional support,[2] with the goal of improving the quality of end-of-life experiences.[3] Prioritizing public health focuses on systemic interventions that empower patients and families, such as equitable access to palliative care and culturally sensitive practices.[4] Behavioral science provides insights into emotional wellbeing, social connectedness, and autonomy, fostering trust and resilience during end-of-life experiences.[5]

The concept of a good death is deeply influenced by cultural, spiritual, and familial factors, reflecting its social, cultural, and political dimensions.[6–9] These perspectives vary widely across faiths and regions, creating diverse practices and preferences in end-of-life care.[10] Reviews by Hattori, McCubbin, and Ishida,[11] Meier et al,[12] and Stinchcombe et al[13] highlight themes such as absence of pain, emotional wellbeing, and autonomy, underscoring the complexity of individual preferences and the need for inclusive, culturally sensitive approaches to end-of-life care.

As lifespans extend and societies age, the "good death" framework advocates for holistic, culturally specific care that balances clinical interventions with personal, spiritual, and social values,[14,15] while integrating patient autonomy with spiritual perspectives.[16] Over the century, the concept of euthanasia evolved from medically supported "easeful death" to intentional ending of life by physicians.[17] A prevalent challenge in curative care-focused systems, especially in countries with rapidly aging populations, such as Thailand, is the emphasis on curative treatments at the expense of palliative care.[18] Addressing these challenges while empowering older adults through advance directives ensures preservation of dignity and supports personalized end-of-life experiences. Järviö Nosraty and Aho[19] underscore the need for a systematic review to develop a model that addresses the unique needs of older adults, enabling healthcare services to align care with individual preferences.

While prior reviews have explored general themes surrounding the concept of a "good death," they often lack specificity regarding the lived experiences and culturally embedded perceptions of older adults.[10,12] Moreover, few studies have employed a qualitative systematic approach to synthesize these perspectives holistically. The present study addresses this critical gap by offering a culturally attuned, thematically integrated model grounded in a hybrid methodology that combines human coding and automated content analysis. To advance current knowledge and provide a novel framework tailored to the nuanced needs of aging populations in diverse sociocultural settings, this review seeks to answer the following central research question: What are the culturally informed perceptions of a good death among older adults aged 60 and above, and how can these insights be synthesized into a comprehensive model to inform holistic end-of-life care? This integration of nursing, public health, and behavioral science offers a pathway to developing culturally resonant, compassionate, and effective end-of-life care that enhances quality of life and supports dignified aging.

METHODS

Aims of the Review

To conduct a qualitative systematic review to identify the unique perceptions of older adults aged 60 and above concerning the concept of a "good death" and to develop a comprehensive model addressing these perceptions.

Design

This qualitative systematic review, guided by the PICo framework—Population (P), Phenomenon of Interest (I), and Context (Co)—aligned with best practices for qualitative evidence synthesis and aimed to explore older adults' lived experiences and culturally embedded perceptions of a good death. It employed the Joanna Briggs Institute (JBI) methodology[20] for meta-aggregation, in which the findings from primary qualitative studies served as the core units of analysis. Reporting adhered to the PRISMA 2020 guidelines,[21] ensuring methodological transparency and reproducibility.

Population (P): Older adults aged 60 and above

Phenomenon of Interest (I): Perceptions and experiences related to a good death

Context (Co): Community-dwelling older adults in diverse cultural settings

This model supported a structured and focused exploration of subjective end-of-life perspectives, enabling the development of a culturally grounded model of a "good death."

Search Strategy and Data Sources

A comprehensive literature search was conducted across multiple electronic and thesis databases (ThaiLIS, ThaiJo, PubMed/Medline, ProQuest, ScienceDirect, Wiley Online Library, Cochrane, Google Scholar, JBI, CINAHL, and EBSCO) to find qualitative studies on the concept of a good death among older adults. Searches were conducted in Thai and English between January and June 2023 and were limited to studies published between 2000 and 2022. The process followed the PRISMA 2020 reporting guidelines.

Keywords Selection

Keywords were defined using both Thai and English terms, with database-specific adaptations. For the sample group, keywords included "elderly," "older adults," "aged," "aging," "geriatric," "long-lived," "old," "senior," "65+ and 60+." The conceptual scope encompassed terms such as "perception, " " view, " " perspective, " "good death, " "peaceful death, " "religion" (including "Christianity, " "Buddhism, " " Muslim, " and "Islam"), as well as expressions like "quality of death, " "quality of dying, " "good dying, " "dying well, " "die well," " dying peacefully, " and "appropriate death" or "successful deaths. " Search terms were crafted by using the Boolean operators "AND" and "OR" to combine database-specific keywords.

Search Outcomes

The review procedures followed the PRISMA 2020 reporting guidelines of Joanna Briggs Institute's systematic review methodology,[20,22] encompassing the following steps: (1) defining the objectives and research questions, (2) establishing inclusion and exclusion criteria for research selection, (3) conducting a comprehensive literature search, (4) assessing the quality of the selected studies, (5) extracting and synthesizing data, and (6) presenting the findings. Twelve studies were included in this review as detailed in Figure 1.

Although this systematic review did not involve human participants, ethical approval based on Declaration of Helsinki was obtained from Boromarajonani College of Nursing, Saraburi, ensuring adherence to institutional research standards.

Inclusion Criteria

The inclusion criteria were as follows:

1) Population Specificity: Studies focused on older adults aged 60 and above, consistent with the WHO's definition of older persons

2) Phenomenon of Interest: Research exploring the "good death" concept through older adults' perspectives, values, or experiences

3) Study Design: Only primary qualitative studies were included (so that thematic synthesis could be performed)

4) Publication Period: Studies published between 2000 and 2022 (to reflect contemporary cultural and medical developments in end-of-life care)

Exclusion Criteria

The exclusion criteria were as follows:

1) Language and Accessibility: Studies lacking full-text access in Thai or English were excluded to ensure accuracy in analysis and interpretation.

2) Population Specificity: Studies that reported findings across mixed-age groups without distinctly isolating the perspectives of older adults were excluded to preserve thematic clarity and ensure relevance to the target population.

3) Setting Relevance: Studies focusing on participants in institutional or hospital settings were excluded to better capture experiences situated within community or home-based contexts.

Selection Process

This methodological choice aligns with the principles of qualitative evidence synthesis (QES), which systematically identifies, appraises, and interprets primary qualitative research to explore nuanced human experiences. The screening process was conducted systematically and documented following the PRISMA framework. Full-text reviews followed title and abstract screening to ensure that inclusion criteria were met. The selection process is visualized in the PRISMA Flow Diagram illustrated in Figure 1.

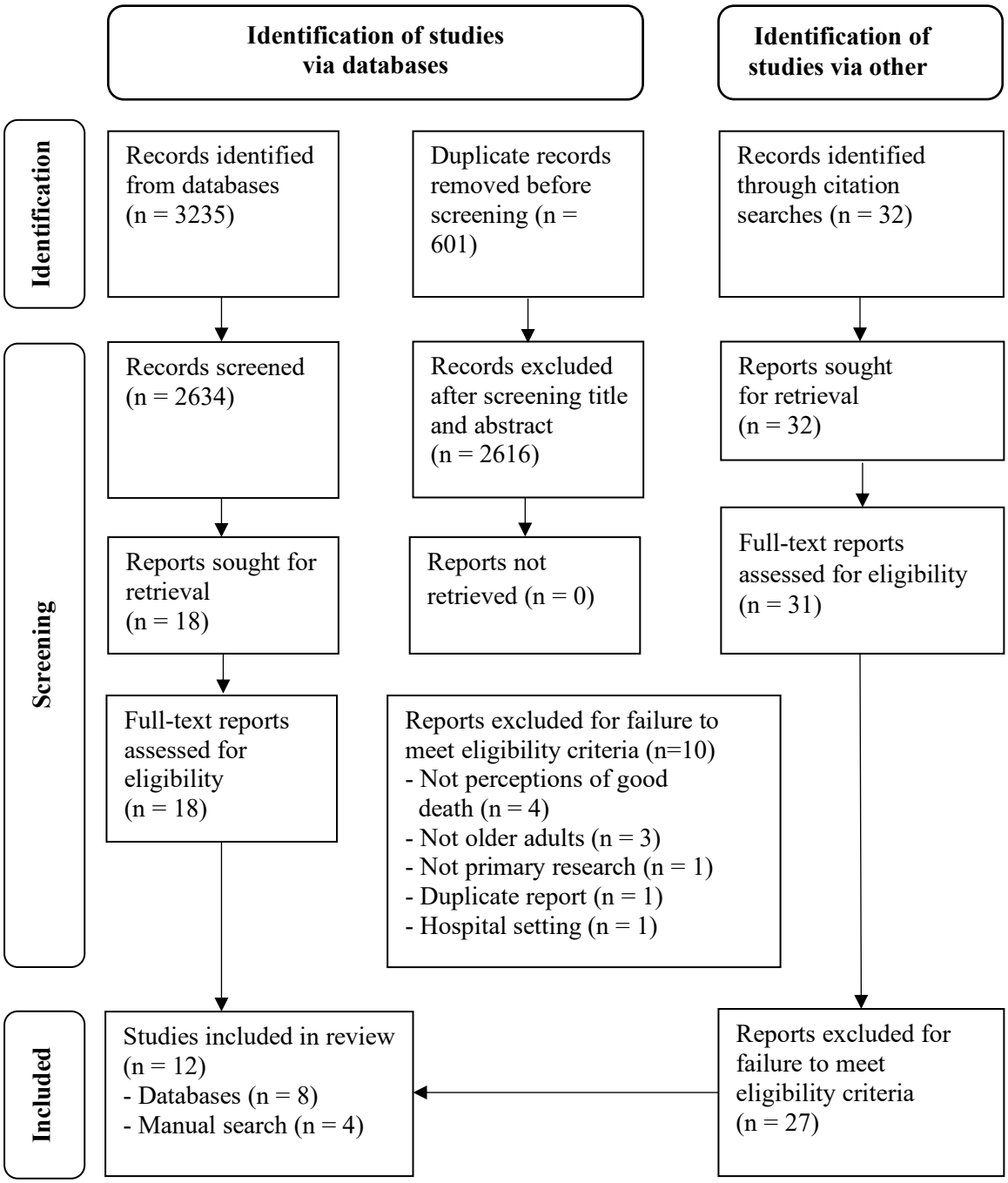

Figure 1. PRISMA Flowchart of Studies Selection Process[20]

Quality Appraisal

The Joanna Briggs Institute's Qualitative Research Credibility Assessment Tool[20] was used to ensure methodological rigor. Two independent reviewers (TK and BP) assessed each study using a standardized reliability scale. Discrepancies were resolved through discussion, with a third reviewer available as an arbitrator if needed. This process ensured consistency, transparency, and reliability in study appraisal.

Data Analysis/Synthesis

Thematic synthesis was used to analyze the extracted qualitative data, following Braun and Clarke's framework for identifying and interpreting study patterns.[24] This method supported a systematic examination of older adults'

perceptions of a good death, generating both descriptive and interpretive themes. A hybrid strategy was adopted to strengthen analytic rigor—combining inductive human coding with deductive, machine-assisted analysis using DivoMiner, an AI-powered qualitative research tool.[25] This integration balanced human interpretive insight with AI's efficiency in pattern detection, enabling comprehensive and triangulated synthesis.[1,25]

The analysis began with three purposively selected articles, independently coded by the research team. Through collaborative discussions, a refined codebook was developed to guide the analysis of the remaining studies. DivoMiner was then applied to extract machine-generated themes, which were systematically cross-validated with manual codes. This triangulation enhanced trustworthiness and confirmability, aligning with established qualitative standards.[20,25] Intercoder reliability was calculated using Holsti's formula,[23] yielding a coefficient of 0.88, which indicated high consistency.

Importantly, themes were not simply aggregated but conceptually synthesized into a model of perceived good death. This model organized findings across domains of autonomy, social connection, spirituality, cultural values, and systemic care. The approach reflects a meta-aggregative synthesis consistent with the Joanna Briggs Institute's guidelines for qualitative review.[20]

RESULTS

Data analysis revealed five interconnected themes reflecting desires for peace, dignity, and connection (Table 1). These themes emphasize the roles of family, autonomy, spirituality, and culture in end-of-life experiences, while also highlighting the importance of compassionate care to address suffering and mitigate the impact of negative or traumatic deaths.

It should be noted that the terms "good death" and "end-of-life" are often used interchangeably to describe situations in which the phase leading to a person's passing aligns with their values, wishes, and medical preferences.[26-29] "Good death" specifically refers to the quality and characteristics of dying that meet the personal and cultural standards of the individual, emphasizing dignity by maintaining autonomy and control over the dying process, avoiding dependency on others,[28-31] and experiencing comfort and fulfillment [26,28,29,32] after having a good life.[33] "End-of-life," on the other hand, broadly refers to the final phase of a person's life, but focuses on the practical and medical aspects of care during this time.[34,35] Using these terms interchangeably helps to convey a holistic approach to this sensitive period, emphasizing that medical care should be employed not only to extend life but also to ensure that death occurs according to the individual's wishes, thereby ensuring a "good death."

Table 1. Major themes, subthemes, and key findings of a "good death"

Major Theme	Subtheme	Frequency of study	Key Findings
1. Peaceful and dignified Death	Painless death	12	Universal desire for a death that is free from suffering and emotional distress, often described as "dying in sleep" or "dying naturally"[26-30,32,35-40]
	Fear of isolation	10	Fear of dying alone or being socially disconnected[27-30,35-40]
2. Family and social influences	Not being a burden	9	Avoiding physical, emotional, or financial dependency on family[27-29,32,35-37,39,40]
	Family involvement	12	Strong emphasis on family presence and support during the dying process[26-30,32,35-40]
3. Autonomy and control	Advance preparation	9	Legal, financial, and emotional readiness through wills, trusts, and funeral planning[27,29,30,35-40]
	Control over death	10	Desire for autonomy in the timing, location, and manner of dying[27-30,35-40]
4. Spiritual and cultural perspectives	Religious and spiritual beliefs	9	End-of-life perceptions often guided by spiritual traditions and practices[26-30,32,38-40]
	Cultural norms and traditions	8	Death preferences shaped by cultural taboos and traditional values[26-28,30,32,38-40]
5. Challenges of a Bad Death	Suffering and pain	9	Prolonged physical suffering or emotional distress is universally undesired[26,27,30,32,36,37-40]
	Traumatic deaths	9	Deaths resulting from violence, accidents, or sudden events are viewed as undignified[27-30,35-37,39,40]

Table 1 shows that a "good death" is defined by peace, dignity, and a painless passing, reported in 12 studies. Fear of dying alone appeared in 10 studies, while 12 highlighted the importance of family presence. Nine studies noted the desire not to burden others. Autonomy was emphasized in 9 studies (preparation) and 10 studies (control over time and place of death). Spiritual and cultural influences were cited in 9 and 8 studies, respectively. Conversely, a "bad death" was associated with pain, suffering, or traumatic events in 9 studies.

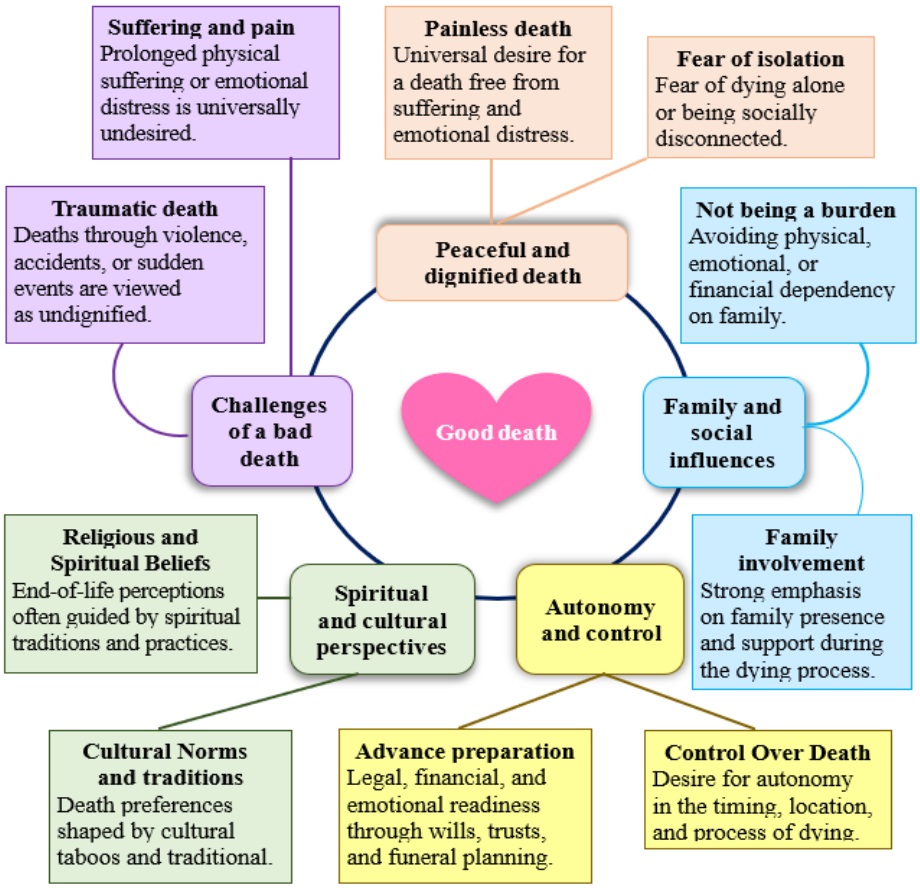

Figure 2. A proposed model of perceived good death among older adults

The components of a perceived good death, as outlined in Figure 2, emphasize the avoidance of unnecessary suffering, the retention of autonomy in end-of-life decisions, and the significance of cultural, familial, and spiritual support systems.

DISCUSSION

The findings of this systematic review highlight the multifaceted and complex components concerning "good death" as perceived by older adults. By synthesizing the findings from diverse studies, five overarching themes emerged: peaceful and dignified death, family and social influences, autonomy and control, spiritual and cultural perspectives, and avoiding a bad death. These themes underscore the interdependent nature of the multidimensional concept of a good death. Understanding this may help nurses and healthcare providers better address the holistic needs of individuals at the end of life. Insights drawn from nursing science, public health, and behavioral science substantiate the discussion of five noble components' interrelatedness.

Component I: Peaceful and Dignified Death

A peaceful and dignified death integrates physical, emotional, and social elements to address the holistic needs of individuals at the end of life. Rooted in nursing science, public health, and behavioral science, it emphasizes personalized, patient-centered care that

minimizes suffering, respects individual values, and fosters connection.

Effective Pain Management and Emotional Support in End-of-Life Care

From the nursing perspective, effective pain management is fundamental to quality end-of-life care, addressing patients' desires for a painless and natural death. Gott et al. reported that one participant—a 77-year-old woman from an urban setting with advanced heart failure—expressed a strong fear of pain at the end of life. Rather than fearing death itself, she emphasized her anxiety about the process of dying, particularly the potential for suffering and uncertainty. She remarked, "Is it going to be painful? I'm frightened of pain, I'm no hero, so it's just not knowing what's going to happen... so that's about the only concern I have, not am I going to die, but how am I going to die"[35]

Nurses play a critical role in delivering palliative care and ensuring comfort and dignity through pain management, empathetic communication, and symptom relief. Emotional isolation is another concern, with studies highlighting fears of abandonment.[30,35] Nurses address this by fostering emotional connections, involving social support systems, and offering companionship when needed.

Initiatives for End-of-Life Care and Awareness

Public health ensures peaceful and dignified deaths through systemic interventions, such as access to high-quality palliative care and community-based models such as hospice programs. These initiatives bring care closer to patients and promote family involvement. Public health campaigns normalize discussions around death, empowering individuals to express their end-of-life preferences and reducing uncertainty for families.

Psychological Needs and Social Connectedness in End-of-Life Care

Behavioral science highlights the psychological need for a painless death, consistent with Maslow's hierarchy of needs, where physiological comfort and emotional security are paramount.[41] It also emphasizes social connectedness as essential for psychological wellbeing. Social support theory[42] underscores how the presence of loved ones reassures patients and reduces feelings of abandonment, reinforcing the importance of meaningful relationships at the end of life. By integrating these perspectives, end-of-life care can uphold dignity, provide comfort, and foster peace for individuals and their families.

Component 2: Family and Social Influences

The concept of a good death is closely linked to family and social relationships, emphasizing the importance of avoiding burdening loved ones while ensuring their involvement and support at the end of life. Nursing care, public initiatives, and behavioral science address dignity, harmony, and emotional closure.

Compassionate Care Rooted in Family Dynamics

From the nursing perspective, family and social influences are essential to holistic, patient-centered care. One common concern is the fear of burdening loved ones. Hattori and Ishida [39] noted, "Participants revealed their concerns about imposing burdens on others with caregiving responsibility, especially if these caregivers would be old or frail." Similarly, Tipwong et al[38] emphasized, "Avoiding physical, emotional, and financial dependency on family was viewed as integral to a good death." Nurses address these concerns through interventions such as advance care planning and family education, ensuring dignity and autonomy.

Family involvement also plays a critical role. Thiamwong and Pungchompoo[27] stated, "Spending time with family or the presence of family nearby in the dying process is perceived to enhance comfort and sense of unity." Rodpal[26] added, "Participants sought reconciliation and moments to express love, apology, and forgiveness to family members as part of their end-of-life wishes." Nurses support these processes by fostering communication and creating a peaceful environment.

Strengthening Families in End-of-Life Care

Family and social influences call for public health policies that alleviate caregiving burdens through measures such as financial support, caregiver education, and respite care. Public health campaigns normalize conversations about death, empowering families to discuss and honor end-of-life preferences. Hospice and home-based palliative care programs further enhance family involvement by providing professional care in familiar settings.

Emotional Needs and Social Dynamics

Behavioral science highlights autonomy and social connectedness as crucial to a good death. Social support theory[42] underscores how family presence reduces isolation and fosters peace. Cultural norms also shape family roles in end-of-life care, with reconciliation and shared grief being central in collectivist societies. Behavioral science informs interventions such as counseling, support groups, and conflict resolution to help families navigate emotional challenges while maintaining unity.

Component 3: Autonomy and Control

Autonomy, which encompasses decision-making, personal values, and dignity, is central to a good death. Through nursing science, public health, and behavioral science, autonomy emerges from advance preparation, control over decisions, and emotional empowerment.

Supporting Patient-Centered Autonomy

Nursing science highlights autonomy as core to patient-centered care, where patients' values and preferences guide decisions. Nurses facilitate end-of-life discussions, ensuring patients are informed and empowered. Ko et al[28] noted, "Legal and financial arrangements, such as drafting wills or arranging funerals in advance, were seen as critical for ensuring peace of mind." Similarly, Hattori and Ishida[39] emphasized that "Organizing end-of-life decisions maintains autonomy and dignity." Nurses support this through advance care planning and emotional support.

Control over medical treatments and care settings is equally vital. Leichtentritt and Rettig[30] stated, "Maintaining autonomy and control over one's end-of-life care decisions are important aspects of a good death." Nurses advocate for plans aligned with personal values, offering options like home-based care to reinforce patients' sense of control.

Promoting Systemic Support for Autonomy

Public health plays a role in fostering autonomy through systemic efforts, such as simplifying legal processes for advance directives. Public campaigns normalize discussions on end-of-life planning, empowering individuals to make proactive decisions. Equitable access to affordable legal services and culturally tailored materials ensures that everyone can navigate end-of-life planning effectively.

Healthcare systems can institutionalize autonomy by integrating flexible palliative care options, allowing patients to decide on the intensity of

interventions and choose their preferred care environment, ensuring dignity and control.

Emotional Empowerment and Autonomy

Behavioral science highlights autonomy's psychological dimensions. Advance preparations, such as drafting wills, provide emotional empowerment and peace of mind. Leichtentritt and Rettig[30] noted the psychological benefits of autonomy, stating that it reduces anxiety and enhances emotional wellbeing.

Self-determination theory underscores autonomy's role in maintaining dignity and stability, even during vulnerability.[43] Cultural values, particularly in collectivist societies, balance personal autonomy with family collaboration, with behavioral science informing culturally sensitive care approaches.

Component 4: Spiritual and Cultural Perspectives

Spiritual and cultural beliefs shape perceptions of a good death by providing comfort, meaning, and connection during the dying process. By integrating nursing science, public health, and behavioral science, care can address these dimensions holistically and respectfully.

Providing Culturally and Spiritually Sensitive Care

In nursing, spirituality and culture are central to patient-centered care. Nurses bridge the gap between patients, families, and healthcare systems, ensuring care aligns with individual beliefs. Ko et al[28] noted, "A personal relationship with God or a higher power was a critical element to a good death." For Thai Buddhists, practices such as mindfulness and merit-making foster peace.[27]

Cultural norms also influence approaches to death, with taboos in some cultures hindering communication. Hattori and Ishida[39] observed, "Cultural taboos often limited open communication about death, impacting preparation and emotional support." Nurses build trust and tailor care to respect spiritual and cultural needs, fostering dignity and comfort.

Promoting Culturally Sensitive Systems of Care

Public health must prioritize culturally competent care by training providers to respect diverse traditions and collaborating with religious and spiritual leaders to provide guidance and support. Campaigns can encourage open discussions about death while respecting cultural values. Lei et al[32] emphasized that cultural expectations shaped rituals and attitudes toward death, often defining what was perceived as a "good death." Public health systems should ensure access to culturally sensitive palliative care, accommodating rituals, dietary restrictions, and family involvement.

Understanding Spirituality and Cultural Norms

Behavioral science emphasizes spirituality as a vital coping mechanism, helping individuals navigate existential questions and find meaning through practices such as prayer, mindfulness, and rituals. Cultural norms also play a significant role in shaping family dynamics and decision-making, with collectivist societies prioritizing shared responsibilities and collaboration. To address cultural taboos surrounding death, behavioral science offers strategies such as counseling and tailored communication to encourage open dialogue. Additionally, rituals and symbolic actions foster emotional peace and connection, providing individuals and families with a sense of closure during the dying process.

Component 5: Challenges of a Bad Death

The characteristics of a bad death—prolonged suffering, pain, and trauma—highlight the need for comprehensive, compassionate care that addresses physical,

emotional, and societal dimensions through an integrative approach combining nursing science, public health, and behavioral science.

Alleviating Pain and Supporting Dignity

From the nursing perspective, a bad death—defined by prolonged suffering and pain—contradicts holistic, patient-centered care. Fear of unrelieved distress underscores nurses' critical role in palliative care. Vig et al[29] noted, "Participants described their fear of enduring prolonged physical pain and suffering without effective medication." Nurses prioritize pain management, symptom relief, and empathetic communication to preserve dignity and ensure comfort while avoiding unnecessary interventions that prolong suffering.

In traumatic deaths, such as accidents or violence, nurses support patients and families through sudden crises. Ko et al[28] observed, "Participants were concerned about unexpected deaths caused by violence or accidents, perceiving them as abrupt and undignified." Nurses provide emotional support and compassionate care, fostering calm and respect to mitigate distress during these difficult moments.

Systemic Interventions to Prevent Suffering

From a public health perspective, addressing bad deaths requires systemic solutions, including integrating palliative care into primary healthcare, expanding trained provider access, and reducing stigma through public awareness campaigns—ensuring equitable, compassionate end-of-life care and minimizing prolonged suffering.

To address traumatic deaths, public health focuses on prevention and preparedness through initiatives such as road safety, violence reduction, and mental health programs, alongside improved emergency response protocols for timely and compassionate care. Community-based grief support, including counseling and support groups, helps families navigate complicated grief and find closure.

Addressing Fear, Trauma, and Emotional Distress

Behavioral science provides insights into patients' fear of prolonged suffering and trauma from sudden deaths, emphasizing the need for reassurance and emotional support. Clear communication about pain management strategies and fostering a sense of control can alleviate anxiety and empower patients in their care decisions.

Traumatic deaths impact both patients and families, with behavioral science highlighting the importance of grief processing and emotional closure. Crisis counseling, family therapy, and culturally sensitive interventions help individuals navigate the complexities of loss while respecting their values and beliefs.

Comparative Integration with Existing Theoretical Models

The proposed model of perceived good death among older adults extends existing theoretical frameworks by offering a culturally grounded, interdisciplinary synthesis tailored to aging populations in diverse settings.

Meier et al.[12] conceptualized a good death based on Western biomedical norms, focusing on autonomy, comfort, and closure. While our model incorporates these elements, it further integrates spiritual, familial, and cultural dimensions—highlighting relational values and collective decision-making often absent in individualistic frameworks. Unlike Meier's model, which centers on individual preferences, our model emphasizes family involvement, filial

responsibility, and communal support, enhancing its cross-cultural relevance.

Kellehear's public health model of dying emphasizes meaning-making, social relationships, and community participation.[8] Our model builds upon this foundation by incorporating systemic public health and behavioral science dimensions, including equitable care access, caregiver support, and community-based palliative infrastructure. It also introduces the theme of "challenges of a bad death," a critical but underexplored component in Kellehear's model, addressing traumatic or undignified end-of-life experiences and their implications for care design.

Hattori et al.'s ethnographic model, rooted in Japanese cultural values, underscores harmony, interdependence, and spiritual readiness.[11] While these align with our findings, our model expands in scope through multicultural synthesis and alignment with nursing, behavioral, and public health disciplines—broadening the theoretical depth and practical applicability.

Our model is further informed by Self-Determination Theory,[43] which supports autonomy, and Social Support Theory,[42] which validates the central role of relational networks. These frameworks reinforce the model's psychosocial grounding and utility in practice and policy.

In summary, this integrative model complements and advances existing theories of good death by addressing critical gaps in cultural sensitivity, systemic accessibility, and interdisciplinary application, particularly for aging populations in varied sociocultural contexts.

RECOMMENDATIONS

I. Contribution of Nursing Practices in the "Good Death" Model

The "Good Death" model enhances nursing practices by combining behavioral science principles with public health strategies to address the physical, psychological, social, and spiritual dimensions of care. By integrating these perspectives, nursing care becomes more comprehensive, patient-centered, and culturally sensitive, ensuring equitable access and improving the quality of end-of-life care.

Behavioral and Public Health Insights for Assessment and Diagnosis

Using assessment tools grounded in behavioral science and public health, nurses can evaluate patients' needs across multiple dimensions while addressing cultural and social barriers to care. Public health campaigns further support this process by promoting awareness and encouraging equitable, culturally sensitive end-of-life care.

Evidence-Based Interventions Supported by Public Health

The "Good Death" model provides evidence-based guidance for developing care plans that respect autonomy (e.g., advance care planning) and address emotional and social needs (e.g., family involvement and spiritual care). Public health initiatives, such as community-based palliative care, enhance collaboration among care teams, families, and networks, ensure accessible resources, and reduce emotional burdens. Frameworks like Maslow's hierarchy of needs and social support theory guide interventions that foster patient dignity and emotional well-being.

Dynamic Evaluation and Systemic Improvement

Ongoing feedback and evaluation processes, informed by behavioral science and public health, ensure care plans adapt to patients' changing needs and preferences. Insights generated from evaluations inform public health training programs, policies, and interventions, refining end-of-life care strategies to ensure that they remain patient-centered and inclusive.

II. Policy Recommendations

Establish Evidence-Based and Culturally Responsive Policies.

Formulate and implement policies that ensure equitable, compassionate, and culturally sensitive end-of-life care. These policies should reflect the diverse needs of aging populations and be guided by cultural norms, personal values, spiritual beliefs, and environmental contexts.

Integrate the "Good Death" Model into Strategic Health Frameworks.

Develop national and institutional action plans that embed the "Good Death" model into healthcare systems. Emphasize scalability, sustainability, and consistency in application across acute, palliative, community, and home-based care settings.

Reinforce Nursing and Interdisciplinary Practice Through Evidence-Based Guidelines.

Strengthen nursing interventions by grounding them in rigorous, context-specific evidence. Promote multidisciplinary collaboration to ensure interventions are credible, adaptable, and responsive to the sociocultural dynamics of diverse patient populations.

Operationalize the Model Through Academic and Scientific Pathways.

Incorporating the model into interdisciplinary curricula, clinical training programs, and standardized care protocols will advance its academic and practical utility. Empirical validation—combining quantitative measures (e.g., construct validity, predictive modeling) with qualitative replication across cultural settings—should uphold scientific rigor and ensure theoretical integrity and policy relevance.

III. Suggestions for Future Research

Correlation Studies

Investigate relationships and factors that contribute to a good death, offering deeper insights into elements that enhance end-of-life care.

Predictive Studies

Identify key predictors of a good death to develop targeted interventions that address individual and collective needs.

Experimental Research

Conduct experimental or quasi-experimental studies to evaluate the effectiveness of nursing programs, interventions, and activities aimed at promoting a good death.

CONCLUSIONS

A good death is a human experience that demands a thoughtful, multidisciplinary approach. Nursing science, public health, and behavioral science collectively provide a comprehensive framework to address the physical, emotional, social, and spiritual dimensions of end-of-life care. Effective pain management, emotional connection, autonomy, and systemic support are essential to fostering dignity and peace, while family and social influences underscore the importance of compassionate, patient-centered care. Culturally sensitive practices and public health programs promoting education and equitable access further ensure comfort and meaning during this critical stage.

By integrating these disciplines, end-of-life care can alleviate suffering, uphold dignity, and foster emotional and spiritual peace, enabling individuals and families to navigate this profound experience with compassion, respect, and meaning.

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The study was conducted in accordance with the Declaration of Helsinki, and approved by the Institutional Review Board (or Ethics Committee) of Boromarajonani College of Nursing, Saraburi, Thailand (protocol code EC 1-007-2565 on December 28, 2022) for studies involving humans.

AUTHORS' CONTRIBUTIONS

BP: Conceptualization, Methodology, Investigation, Formal analysis, Validation, Writing – Original Draft. TK: Conceptualization, Methodology, Investigation, Data curation, Project administration, Writing – Review and Editing. JK: Formal analysis, Interpretation, Visualization, Supervision, Writing – Review and Editing.PP: Investigation, Validatio. KU: Investigation, Funding acquisition.

CONFLICTS OF INTEREST

Conflict of Interest. The authors declare no competing financial or non-financial interests. The research was conducted independently, and no external influence affected the study design, data analysis, or interpretation.

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