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Moving Toward Peace: An Analysis of the Concept of a Good Death

Karen A. Kehl, MS, RN, ACHPN

One of the primary outcomes of end-of-life care should be the experience of a good death by the patient and the family. Yet there is no clear, shared understanding of what a good death is. This analysis of the concept of a good death has been guided by Rodgers' evolutionary method of concept analysis.[1] Forty-two articles were analyzed. There was the strong agreement that the concept of a good death was highly individual, changeable over time, and based on perspective and experience. Medical, nursing, and patient perspectives, as well as literature in sociology, include the following attributes of a good death, listed in order of frequency of appearance in the literature: being in control, being comfortable, sense of closure, affirmation/value of the dying person recognized, trust in care providers, recognition of impending death, beliefs and values honored, burden minimized, relationships optimized, appropriateness of death, leaving a legacy, and family care.

Keywords: attitude to death; palliative care; terminal care

Over the past decade, health care clinicians, researchers, and policy makers have combined their efforts toward improving end-of-life care. There are few who would question the idea that one of the primary outcomes of end-of-life care should be the experience of a good death. Yet there is no clear, shared understanding of what the characteristics of good death are. There is considerable confusion among closely related concepts in end-of-life literature, in particular, the differences and similarities between the concepts of quality of life at the end of life, quality of care at the end of life, and quality of dying. Terms such as *good death*, *dying well*, *peaceful death*, *appropriate death*, *desired death*, and *dignified death* are used interchangeably in some manuscripts and with different meanings in others.

While there have been numerous articles and books addressing the concept of a good death, the works analyzing the concept are somewhat fragmented. Some articles[2-5] have provided excellent reviews of the literature. Steinhauser et al[6] reviewed the literature and delineated the evolution in measuring the quality of dying, which is an important aspect of examining the concept. However, since Emanuel and Emanuel's 1998[7] article titled "The Promise of a Good Death," there has been no article devoted to a complete, systematic, inductive method of describing the current use of the concept. Related concepts such as quality of care at the end of life[8,9] and quality of life for dying persons[9] have been examined using conceptual analysis techniques.

There are numerous definitions of a good death, the most widely cited being the definition given in the 1997 Institute of Medicine (IOM) report on the end-of-life care[10]: "A decent or good death is one that is: free from avoidable distress and suffering for patients, families, and caregivers; in general accord with patients' and families' wishes; and reasonably consistent with clinical, cultural, and ethical standards." Even in this definition, there is a confusion of terms, with *decent* and *good* death being used interchangeably. In addition, like many definitions, it gives general direction but is rather vague. After reading this definition, it would be hard for a clinician to know specifically what to assess and how to structure care to achieve a good death, beyond relieving or preventing distress or suffering, following patient and family wishes, and meeting various standards. While doing these things will assist in achieving the outcome of a good death, it is not clear if there are other situations that are necessary for a good death

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to occur, if there are other components or attributes of a good death, and what the consequence of a good death is for patients, family, and health care providers.

The Evolution of the Concept of a Good Death

Because the current use of this concept carries with it shades of previous meanings and interpretation, it is important to review the changes that have occurred concerning the concept of a good death over time. In selecting articles to review for this analysis, some historical articles from 1966 to present relating to a good death were also collected and reviewed.[11-23] These articles revealed a significant shift in the understanding and use of the concept of a good death over the past 4 decades.

The literature from the 1960s and 1970s was primarily opinion articles, essays, and letters.[11-16] They represented a variety of disciplines including nursing, medicine, behavioral science, and psychiatry. At that time, the primary use of the term *good death* was as a synonym for euthanasia and referred to situations in which life was deliberately ended, either actively or passively, and by the patient or another at the patient's request.

In the 1980s the use of the term *good death* broadened. While it was still used to refer to euthanasia,[19] others had begun discussion of what makes any death good.[17,18] Writers in oncology[17] and other areas began discussing good death. The first attempt at defining a good death was made by O'Neil,[18] who defined death as good if the timing of the death is appropriate, the dying process allows the person to retain control, those involved in the dying situation observe basic moral principles, and the death style of the person is logical. O'Neil was primarily discussing the situations that needed to be present for appropriate euthanasia to occur, but because of his manner of framing the issue as a definition of a good death, it had much wider implications. Shadows of his definition can still be found in the attributes of a good death as the concept is currently used, particularly the issues of the timing of the death being appropriate and the person retaining control.

The early 1990s saw a continuation of the concept of a good death overlapping with euthanasia. Particularly for renal patients, issues of discontinuing a life-prolonging treatment were first addressed in terms of euthanasia and then in terms of what constitutes a good death for patients on life-supporting or life-prolonging treatments or equipment.[23,24] Physicians and nurses also discussed good death in relationship to hospice.[22] Both nurses and physicians wrote about a good death. Studies examining good death began with Dozor and Addison's 1992 study examining residents' practices with dying patients.[20] The authors of this study described the outcome of a good death as the goal of medical residents treating seriously ill patients who were unlikely to recover.

Since the middle of the 1990s, the term *good death* has continued to be used interchangeably with *euthanasia*,[25-27] although the use of this terminology seems to be diminishing. As the concept of a good death is taking shape as a separate but related concept, most authors have been selective in using the term that best fits the concept of interest. Remnants of the concept of euthanasia linger, especially in the public perception, and therefore in that of many patients and families.

Method

This analysis has been guided by Rodgers' evolutionary method of concept analysis[1]; a method is designed to be used for concepts that may change based on contextual or temporal elements. Rogers' method is an inductive, descriptive means of examining a concept through a historical or evolutionary review. It has been used to synthesize information on how a concept is used across time and disciplines. Since death is an area that is studied in many disciplines and often is best approached from an interdisciplinary perspective, the evolutionary method was chosen for this inquiry. Rodgers' method is appropriate for the concept of a good death since it is a concept that is not fixed; it is changeable with time, situation, role, and experience.[4] Thus, the family member and clinician at the same death may have different perspectives on whether the death is a good death. Moreover, the idea of what is a good death may change after that family member has witnessed a death.

Sample Selection

There have been many articles written concerning a good death. For example, a search of PubMed using *good death* reveals more than 7000 entries. A MEDLINE search from 1966 to 2004 identifies 198 articles

published from 1973 to 2004 with *good death* as a keyword. In addition, numerous books have been written that address having a good death. For this inquiry, only articles in English and concerning adults (aged 18 and older) were sought. Initial searches were conducted using the keyword *good death* in the MEDLINE and CINAHL databases. In PubMed, the term *good death* was used for a title word search because of the large volume of articles (3632 in English from 1995 to 2004) using *good death* as a keyword. Years of the search were limited to 1995 to 2004. This period was selected because of the increased attention to end-of-life issues following the 1993 IOM workshops on dying, decision making, and appropriate care; the 1994 birth of the Project on Death in America funded by the Soros Foundation; and the 1995 publication of the SUPPORT study, which highlighted some of the problems in end-of-life care.

Because of the volume of literature available by searching for the keyword *good death*, it was decided not to search for related terms such as *quality of care at the end of life* or *quality of life at the end of life*. Inclusion of literature focusing on these related terms might add to the confusion between these concepts. The sample set for this study was also limited to articles that addressed the Western view of a good death. Since the concept of a good death is highly individual and variable, and since cultural practices, beliefs, and values play a large role in shaping one's expectations about death, it was decided to limit this analysis to a current, Western (North American/European/Australian) perspective.

Abstracts of all 154 articles with the keywords *good death* were reviewed for inclusion in the sample. Articles were excluded if they did not pertain to adults, were from a non-Western culture,[28,29] were historical reviews of the time prior to 1995, or dealt solely with euthanasia or assisted suicide. Abstracts of the 84 remaining articles were reviewed to determine the type of article, the perspective, and the year of publication. The type of articles were research,[3-5,31-37] case report,[30,38,39] review,[2,6,7,40] expert opinion,[10] clinical guideline,[41] letter,[42-47] essay, or editorial (see Table 1).[48] The perspectives included public, patient, family, health care provider, nurse, or physician. It is recognized that inclusion of popular books or articles might reveal a different perspective on the concept of good death, but these were not included because of the focus of the use of the concept of good death in professional health care literature. Articles were categorized according to 3 criteria: type of publication, perspective, and year of publication. Random sampling was done in each cell, which combined type, perspective, and year. Articles selected were obtained and used for analysis. Articles cited by 3 or more selected articles were purposefully reviewed for possible inclusion as classic references. A purposeful sample of these secondary references and of classic articles was undertaken. This sample included Steinhauser et al,[35] Singer et al,[8] and Ruland and Moore.[49] It should be noted that some references, such as Teno et al,[9] though frequently cited, were not chosen because they focused on quality of care at the end of life or quality of life at the end of life. A total of 42 references were chosen for analysis. This exceeds the 30 articles that Rodgers states is the minimum for a concept analysis and represented 50% of the total number of articles in the sampling pool.

Literature Retrieval and Data Collection

After article selection, literature was retrieved through online journals and the document delivery service of the University of Wisconsin–Madison libraries. Each item was initially read to discover the tone and mood of the articles and for data immersion. Then the articles were reread, and all references to the attributes, antecedents, consequences, surrogate, and related terms and opposite terms of good death were marked. Articles were read a third time, and information on these aspects of the concept of a good death was recorded in tabular form using Microsoft Excel. Information was color coded to indicate extraction from a review of the literature or extraction from original text by the author. Each row contained 1 article with the citation listed first, then the type of article, perspective, term used, surrogate terms, antecedents, consequences, references, attributes, opposites, related concepts, and comments. Each column was headed as indicated above. This method allowed for rereading of the original article if the information needed to be reviewed in context for clarity. Three articles,[50-52] all essays, had no information to offer on these aspects of the concept of a good death and were deleted from the sample. Another 3 of the 42 articles analyzed[8,41,49] were used for analysis of related concepts, but since their primary focus was a related concept such as quality of care at the end of life, they were not

Table 1. Articles Reviewed, by Type

Type of Article	Author(s)
Research	Bosek et al[5]
	Cohen et al[30]
	Hopkinson and Hallett[3]
	Kristjanson et al[31]
	Leichtentritt and Rettig[32]
	Low and Payne[33]
	Pierson et al[34]
	Schwartz et al[4]
	Steinhauser et al[35]
	Tong et al[37]
	Vig et al[36]
Case report	Cohen et al[30]
	Hayslip[38]
	Nenner[39]
Review	Emanuel and Emanuel[7]
	Mak and Clinton[2]
	Patrick et al[40]
	Steinhauser et al[6]
Expert opinion	Field and Cassel[10]
Clinical guideline	Ellershaw et al[41]
Letter	Curtis[43]
	El-Nimr et al[44]
	Grogono[45]
	Jones and Willis[47]
	Kittel[46]
	Smith[42]
Essay or editorial	Ayers et al[48]
	Erlen[56]
	Feinmann[57]
	Gazelle[59]
	Hart et al[54]
	McNeil[58]
	Neuberger[61]
	Winslow and Jacobson[55]

included in the analysis of antecedents, attributes, and consequences since inclusion would have further confused the concepts of interest.

Data Analysis

In each category (attributes, antecedents, consequences, surrogate terms, related terms, opposite terms), data were sorted alphabetically. Then the listing was reviewed, and words were grouped using affinity diagramming[53] (eg, dying at home, wanting to die in the hospital, and not wanting to die in a nursing home were grouped into "preferred location of death"). The character of the items in the group determined the name of the group. Items were named with words extracted from the literature when appropriate. These groups were reorganized and examined on at least 5 separate occasions to find the most cohesive, comprehensive, and relevant description of the data. The different perspectives and disciplines were analyzed together because of the interdisciplinary and interconnected nature of the different perspectives. Once the attributes were determined, counting of the number of times each element of the attribute was mentioned was used to determine the order of presentation of the attributes, with the first attribute being the one that was most often mentioned in the literature analyzed.

Some data (a total of 3 items in the attributes category, none in the antecedents category, none in the consequences category, 2 in the surrogate terms category, and 12 in the related terms) were not incorporated into the final analysis. These terms were not included as they provided little insight into the current use or state of knowledge regarding the concept of a good death. The need to delete items because they provide little insight is not uncommon in this type of analysis because the guideline in recording data is to initially record all terms, even if their application to the concept is questionable. The evolutionary method allows for these terms to be eliminated in the data analysis phase if they are irrelevant based on the emerging analysis.[1] Some of the data, particularly the items in the related terms category, were found to be remnants of earlier ideas about this concept, particularly the idea of good death being a deliberate and chosen death. These items contributed to the understanding of the evolution of the concept and were incorporated into the discussion of that evolution.

Results

The most obvious and notable finding of this study was that the concept of a good death is highly individual and dynamic. Numerous authors have emphasized these facts.[3,4,6,7,32,34,36,40,48] Pierson et al[34] even noted that there was both variability in the attributes of a good death and how those attributes were important. They found some participants who felt that death while sleeping was preferable, while others wished to be alert and aware at the time of death. This type of contrary finding was echoed in the work of other researchers.[33] This is an important, overarching idea in the concept of a good death.

What is a good death to one individual may not be to another. This means that clinicians and researchers must evaluate each individual's idea of a good death to assist that person in meeting this goal. Clinicians and researchers must also take care to ensure that their own perception of a good death does not unduly bias their care or their research.

In discussing a good death, one issue is whether death is considered a process or an event. Some authors[2,5-8,32,34,35,40,48,49,54] take the approach that death is a process, and the quality of dying may change over time during this process. Others[30,31,33,36,39,46,55] view death as an event. There is a subtle difference in the attributes or qualities of good death between these 2 views. Those who take the view that death is a process discuss issues such as closure and active decision making more than those who perceive death as an event do. Both groups largely agree, however, on the attributes of a good death and are therefore not separated in the results.

Attributes of a Good Death

There was the strong agreement that the concept of a good death was highly individual, changeable over time, and based on perspective and experience. There was considerable agreement about the attributes of a good death, although there was variation in opinion concerning how the attributes were important. The perspectives of physicians, nurses, and patients, as well as literature in sociology, agree on the following attributes of a good death: being in control, being comfortable, sense of closure, affirmation/value of the dying person recognized, trust in care providers, recognition of impending death, beliefs and values honored, burden minimized, relationships optimized, appropriateness of death, and leaving a legacy and family care.

Being in control. The attribute of being in control of the death is patient centered and multifaceted. The elements comprising the attribute of being in control were (1) choices/ wishes being honored including communication of wishes,[2-5,7,30,33,34,36,39,40,42,46,47,56-58] (2) clear decision making,[3,5,6,34,35,40] (3) option for suicide/euthanasia,[3,7,34,40] and (4) control over the death event including control of location, timing, and presence or absence of others.[2-5,31-34,36,37,39,40,42,45,46,55-57] Being in control was clearly the most important and most common attribute. There were more than 100 references to issues of control in the 39 articles in the final analysis. It is closely related to the antecedent of having wishes or preferences about dying.

Being comfortable. The attribute of being comfortable was also multidimensional. It included (1) lack of distress[10,30,32,45]; (2) symptom management including physical symptoms such as pain management and dyspnea management, emotional/psychosocial symptoms such as fear or anxiety, cognitive symptoms such as remaining mentally alert, and symptoms of spiritual distress[48]; (3) comforting, including physical measures such as hugging[40]; and (4) hope.[2,3,7] Patients and health care professionals usually listed being comfortable, and there was more agreement about this attribute than any other. Some authors referred to managing symptoms to the degree that the patient wished instead of to the degree of being comfortable because cultural or spiritual beliefs or practices might lead the patient to prefer not to have all pain relieved.[37]

Sense of closure. Sense of closure included the ideas of saying good-bye, completion of unfinished business, and preparation for death.[2,4-7,32,34,35,37,40,42] The type of unfinished business referred to included finishing work, attending upcoming family events, making funeral arrangements, getting financial affairs in order, and attending to wills and legal matters. Although there was some variation in the literature on what was included in this attribute, there was strong consensus that saying good-bye was a part of closure.

Affirmation/value of dying person recognized. Affirmation or recognizing the value of the dying person was multifaceted and encompassed (1) dignity[2, 3,31,33,35,38,40,42,45,48,54,56,59]; (2) wholeness or being a whole person,[5,31,34,35,40] including having physical, emotional, social, and spiritual aspects; (3) quality of life, which includes living fully[33,40,48,59]; and (4) individuality.[3,34,35,37] This attribute is attended to by holistic care on the part of care providers. One important element of the attribute of affirmation is the idea of living until one dies.

Trust in care providers. Trust in care providers was an important attribute of a good death.[34,56] The authors raised the issues of access to care,[34,42,47,59] good communication both between health care providers

and with the patient and family,[2,31,37] a good relationship with care providers or care providers being those who know the patient and family well,[31,34,35,57] that care providers should be strong patient advocates and should be non-judgmental concerning patient and family decisions.[37]

Recognition of impending death. Recognition of impending death included both awareness of the impending death and acceptance of the death.[2-4,6,31-36,40,42,54] This attribute was applicable only to anticipated deaths, not sudden deaths. There was also discussion about whether patients with Alzheimer's disease, who could not be aware or accept their deaths, could have a good death. Lack of awareness was felt to be a significant barrier to a good death in these patients.[5] Vig et al[36] also found some patients who said that not being aware would contribute to a good death.

Beliefs and values honored. Honoring of beliefs and values was another attribute that contained multiple elements. Authors cited the importance of honoring beliefs, values, and practices of a personal, cultural, and spiritual nature.[2-4,6,7,10,32-35,37,42,44,56] This was especially important in minority patients who might have desires different from the dominant culture.[37]

Burden minimized. Most discussions of a good death also addressed the importance of minimizing burden on the family, especially if the family was caring for the dying individual.[5,7,36,37,48,59] Other aspects of this attribute include freedom from financial burden or financial support for the dying person and his or her family,[7,40,48,59,60] and independence on the part of the patient.[4,32,36] Patients discussed being physically and financially independent as important to a good death.

Relationships optimized. The attribute of optimizing relationships appeared in many of the studies and in many ways. One of the important aspects of this attribute was the idea of having enough time with family members and friends.[5,40] Another aspect was having good communication with these important people.[4,31,37] The ideas of reconciliation and forgiveness were also mentioned as part of optimizing relationships.[40] The role of good social support for the dying person from family, friends, and the community was also seen as part of optimizing relationships.[2,30,31,58,61]

Appropriateness of death. The issues of the age of the dying person, appropriate use or nonuse of technology such as ventilators and dialysis, and aspects of the illness such as its being of a terminal nature, were all part of the aspect of appropriateness of the death.[4,5,7,32,34,42,45,54,62] While some articles proposed that a good death was a natural death, without the use of medical technology except to relieve suffering,[32,45,62] others[7,30,42] discussed the appropriate use of technology and avoidance of excessive use of dialysis or other life-prolonging measures.

Leaving a legacy. The attribute of leaving a legacy included being remembered and contributing to others.[6,32,35,36,62] This attribute was especially important in the perspectives of elders on a good death.[32,36] It included leaving behind an emotional, physical, financial, or social legacy. The issue of being remembered was also seen as very important, and the issue of how one was remembered by others was a component of this attribute.

Family care. The attribute of family care consists of family involvement in the death and in the care of the dying person as they choose, the family as well as the patient being the recipient of care, and family preparation for the death.[3,5,10,31,33,35,59] While family care is important to patients, families, and health care providers, the attribute of family care was mentioned least often in the literature.

Antecedents

While there was not universal agreement as to the antecedents of a good death, there was a general agreement that for a death to be good, the patient and/or family must have their wishes or preferences concerning the death honored.[36,39] Most health care professionals felt that the patient and/or family input, at least in terms of place of death,[33,34,40] level of consciousness at time of death,[40] or who should be present at the death,[34,40] was necessary for a good death to occur. There was also some indication that the ability to communicate such preferences was also an antecedent to a good death. Bosek et al[5] talked with family members of patients with Alzheimer's disease and concluded that most Alzheimer deaths in nursing homes were not good because the patient was not aware and could not communicate his or her preferences. This ability to communicate preferences is important since preferences

and wishes are likely to change as the patient's condition changes.[6] For example, death in the hospital can be a good death, even if home was the preferred site of death, if the patient's condition and family situation are such that the patient would no longer desire a home death if he or she were able to make or communicate such a change in decision.[58]

Another issue introduced in a few articles was having adequate care or adequate time to give care. This may be an antecedent in anticipated deaths but does not appear to be a universal antecedent.

Consequences

It was extremely difficult to find explicit discussion of the consequences of a good death in the literature. Only 1 article[31] directly addressed the consequences and then only specified the consequences for professionals, particularly nurses. These consequences are professional satisfaction, a sense of integration, learning from the experience, understanding self and others better, being more comfortable with their own mortality, being more connected to family and friends, and feeling privileged. Although not explicitly stated, it can be assumed that families would have similar consequences. Although it was expected, in this body of literature, no reference to a good death in terms of decreasing fear of death or easing grief was found.

Peaceful death was used as a consequence, surrogate term, related term, or attribute or consequence in more than 70% of the articles reviewed. After careful examination of the use of the term *peaceful death*, it seems to fit best as a consequence of a good death. The idea that the family's memories concerning the death affect the judgment of whether the death was good or bad was also discussed.[5,32,40,55] Therefore, if the family has peaceful memories as a consequence of the death, it may be considered a good death. The prevalence of the references to a peaceful death, even in situations in which the death was sudden or painful such as with a heart attack, supports the conclusion that peacefulness is a consequence rather than an attribute of a good death.

Surrogate Terms

One of the challenges in the discussion of a good death is that some terms are used alternately as attributes, surrogate terms, or related terms. For this analysis, a term was considered a surrogate term if it was used interchangeably with *a good death* and if there was not a definition given that was different from that of a good death. Terms that have been used as surrogates include *appropriate death*, *decent death*, *desirable death*, *dying well*, and *quality of dying*.

Related Concepts

Terms were considered related if they had a clear definition that differed from that of *good death* but were often used together or interchangeably. Some of these related concepts have been used interchangeably with the term *good death* but should be distinguished as separate from this concept. The most common related concepts were (1) quality of life, which is defined as the gap between the expectations and the present situation of the individual and includes quality of life at the end of life[6]; (2) quality of dying, which is defined as the quality of life for dying patients[6] or the personal evaluation of the dying experience as a whole[40]; (3) quality of care at the end of life, which is described as the process of care instead of the experience of the patient[6] or the care that is provided or the care that was received; and (4) quality of life for the dying person, which is said to differ from the quality of dying by virtue of focus and emphasis.[40] Other terms that were used as related terms include *needs of dying people*, *negotiated acceptable death*, *appropriate death*, *beautiful death*, *managed death*, *healthy death*, *correct death*, *happy death*, *peaceful death*, *dignified death*, *better death*, *tamed death*, *death with acceptance*, *gentle death*, *sacred death*, *medical death*, *natural death*, *good enough death*, *euthanasia*, and *meaningful life*.

Contrary Attributes

Although contrary attributes are not usual in Rodgers' style of evolutionary analysis of a concept, they were often found in the literature concerning a good death. However, in developing a picture of what a good death is, it is helpful to look at how a bad death is described. Bad deaths were frequently described in the literature and sometimes directly contrasted with a good death.[31,33,34,36] There was a high level of agreement between articles about what a bad death was. The attributes of a bad death include (1) its not being in accord with patient and/or family wishes, including

Table 2. Comparison of Attributes of a Good Death and the Attributes of a Bad Death

Attributes of a Good Death	Attributes of a Bad Death
In control	Not in accord with wishes
	Not location of choice
	Prolonged
	Dependent
	Traumatic
Comfortable	Suffering
	In pain or distress
	Cognitively impaired
	Fearful
	Angry
Sense of closure	Unprepared
Affirmation/value of dying person recognized	
Trust in care providers	Disorganized care
Recognition of impending death	Knowledge of impending death
Beliefs and values honored	
Burden minimized	Family burdened
Relationships optimized	Alone
Appropriateness of death	Young
Leaving a legacy	
Family care	

not being in the location of choice; (2) its being prolonged; (3) the patient's being dependent; (4) its being traumatic; (5) the patient's suffering, which included being in pain or distress, being cognitively impaired, and being angry or fearful; (6) a sense of unpreparedness; (7) having disorganized care; (8) having a knowledge of impending death; (9) the family's being burdened; (10) dying alone; and (11) the patient's being young. These attributes of a bad death are compared to the attributes of a good death in Table 2.

Implications

The concept of a good death is fluid and highly individual. It is affected by one's perspective, role, and experiences related to death. Because of the highly individualized nature of a good death, it is critical for health care professionals to assess the patient's and family's wishes and choices concerning death. Since patient and family preferences may not be the same, the patient's preferences should take precedence. If patients are not able to communicate their wishes, family may be asked to stand as a surrogate. Patient wishes or preferences being an antecedent to a good death emphasize the importance of advance care planning. According to the National Hospice and Palliative Care Organization,[63] 20% of Americans admit they have not thought about how they want to be cared for at the end of life, 15% have thought about their preferences but have not expressed them, and fewer than 25% have put their wishes into writing. So for more than 75% of patients, if they cannot communicate, health care providers cannot assist in meeting those wishes and preferences, and the individual's control of his or her death is greatly diminished.

The attributes of a good death—being in control, being comfortable, sense of closure, affirmation/value of the dying person recognized, trust in care providers, recognition of impending death, beliefs and values honored, burden minimized, relationships optimized, appropriateness of death, leaving a legacy, and family care—provide a basis for domains of clinical assessment at the end of life, as well as provide dimensions for measurement of the quality of dying. Some excellent work has been done[4,30,64] in developing instruments to measure the quality of dying. Application of the attributes of a good death should aid in the important task of further development of these and other instruments to measure a good death.

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