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A Better Understanding of the Concept "A Good Death": How Do Healthcare Providers Define a Good Death?

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ABSTRACT

Objective: *The goal of palliative care is to improve quality of life when recovery is no longer possible. The study's objective was to widen our vision of potential (unspoken) needs at the end of life with patients, close relatives, nurses, and general practitioners to aim at more versatile but personal care. The question asked was how important patients, close relatives, and healthcare providers considered the 11 core themes in defining a good death, as described in the 2016 article "Defining a good death" by Meier et al.* ***Methods:*** *Specific questionnaires for general practitioners, nurses, patients, and family members were distributed in the working area of the regional palliative care network, Aalst-Dendermonde-Ninove, with the cooperation of five local quality groups, two nursing homes, and two groups of home care nurses, and data were analyzed.* ***Results:*** *Questionnaires were completed by 67 nurses, 57 general practitioners, 16 patients, and 8 family members. Although the 34 subthemes were generally considered important for classifying a death as a good one, there were still significant differences between general practitioners and nurses, men and women, and different age groups. Nurses found 9 of the 34 themes significantly more important than general practitioners. All groups believed a pain-free death was most important. General practitioners, nurses, patients, and close relatives found the following themes important: support of family, respect for patient as an individual, being able to say goodbye, and euthanasia in case of unbearable suffering.* ***Conclusion:*** *In agreement with the patient, medical care should focus on a pain-free situation during the last phase of life and not on exhausting possible treatments to prolong life unnecessarily. Appropriate care at the end of life can be broader, and all 34 subthemes can be important in early healthcare planning. Significant differences between general practitioners and*

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nurses deserve attention because patients and family members expect that healthcare providers will work together as a team. (Am J Geriatr Psychiatry 2019; 27:463−471)

INTRODUCTION

Dying is inextricably tied to life, yet we still notice a reluctance to speak about death. However, a good death is an important goal in palliative care. We know this can go further than being pain-free. One of the pioneers in this area, Cicely Saunders, spoke in the 1950s of the "total pain concept."[1] We can find this in the definition of palliative care, prepared in 2002 by the World Health Organization.[2] The general practitioner should prevent and relieve suffering on a physical, psychological, emotional, social, and spiritual level. Open communication is important for successful guidance/care of terminally ill patients and their close relatives.

According to the American Institute of Medicine's definition, a good death is free from avoidable distress and suffering for patients, family members, and healthcare providers; in general accord with patient and family member wishes; and reasonably consistent with clinical, cultural, and ethical standards.[3] Meier et al.[4] researched in 2015 which themes were previously addressed in the literature in order to know what was really important. Eleven core themes were identified as able to define a good death, specifically preferences related to the dying process, a pain-free situation, emotional well-being, family, dignity, completion of life, religiosity-spirituality, preferences in regard to treatment, quality of life, and relationships with healthcare providers and others, each with two to four subthemes.[4] There is a consensus between patients, family members, and healthcare providers about the importance of the themes in speaking of a good death. There are still differences, depending on who is asked. From the perspective of family members, the following themes are mentioned more frequently in the literature: "life completion," "quality of life," "dignity," and "presence of family." On the other hand, from the perspective of patients, "religiosity and spirituality" are mentioned more often as part of a good death.

Other research highlights how important we find "control" in the West: control over time and place of dying (often with a preference for the home environment) and control over unwanted symptoms, planning, and preparation on different levels.[5] In Belgium, we frequently read or hear editorials about dying in which the euthanasia debate has acquired a very important role. We live in one of the few countries where euthanasia is regulated by law, and this is often considered obvious by patients. Is this about having control, as mentioned above? Other factors are also discussed regarding why euthanasia plays an important role, including the denial of the natural dying process because of existential uncertainty and the increased medicalization of the terminal phase of life.[5,6] Patients attach more importance to the integration of spiritual care as the end of life approaches.[7] General practitioners also acknowledge the importance of the spiritual well-being of their patients, but applying this in practice seems to be more difficult for various reasons, such as lack of time and uncertainty or lack of vocabulary to engage in these conversations. Referrals to other professionals may be necessary when spiritual needs are identified and the general practitioner feels uncomfortable taking this role upon themselves. Therefore, interdisciplinary cooperation is important in palliative care.[8] The goal is to broaden our view of possible (unspoken) end-of-life needs with patients, close relatives, nurses, and general practitioners. On one hand, this is necessary to strive for versatile but personal care at the end of life. On the other, this is needed to integrate information in discussions about early care planning. We want to know how important the 11 core themes for defining a good death are to patients, close relatives, and healthcare providers, as described in the 2016 article "Defining a good death" by Meier et al.[4]

METHODS

- The 11 core themes and 34 subthemes in the article by Meier et al.[4] were translated and poured into a query for the four groups: patients, close relatives,

nurses, and general practitioners. On a symmetric Likert scale of 0−10, depicted as a visual analog scale, each participant scored their answer to the following question: "How important do you find the below themes to speak of 'a good death' (for your family member/close relative) (for your patient)?"

The questionnaires were distributed over the scope of the regional palliative care network in Aalst-Dendermonde-Ninove (Flanders, Belgium) after a pilot study with each target group. To do so, there was a collaboration with the palliative care network itself, five local quality groups of general practitioners (LOK), two nursing homes, and two groups of home care nurses. The general practitioners were included through the LOKs, and they were also asked to include legally capable patients older than 18 with a Global Medical File as patient or close relative. Nurses were included through the residential care center, the palliative care network, and home nursing groups.

Data were analyzed with Excel 2016 (Microsoft Corporation, Redmond, WA) and the statistical software program SAS (SAS Institute, Cary, NC). The GLM procedure with analysis of variance was applied to the latter. Independent variables included group (general practitioner/nurse), sex, and age. The dependent variables were the 34 subthemes identified by Meier et al.[4] Scores from 0 to 10 were continuously divided.

RESULTS

A total of 67 nurses, 57 general practitioners, 16 patients, and 8 family members took part in the study. The main characteristics of the participants are summarized in Table 1. The percentages specify the share in relation to the total group.

The demographics of the participants were compared with the overall population of healthcare providers in Flanders.[9] Younger healthcare providers were more represented in comparison with older general practitioners, and especially older nurses, as can be seen in Table 2.

Results From Healthcare Providers

Significant differences between general practitioners and nurses can be found in Table 3. The highest scores in both groups are given on the core theme a pain-free situation (no suffering and pain and symptom management).

The differences between male and female healthcare providers (general practitioners and nurses) are displayed in Table 4. Male healthcare providers do not find any themes significantly more important than female healthcare providers when speaking of a good death. In terms of age, based on non-normal distribution, there was no statistically significant difference in the degree of importance of themes when speaking of a good death for their patient.

Results From Patients and Close Relatives

No significant differences can be calculated because of the limited scale of these groups, and only Excel was used for further analysis (Figure 1 and 2). The main differences are seen in the following themes: being with pets, patient not being a burden to their close relatives in their final phase of life, spiritual beliefs can be discussed with their healthcare provider, recognition of cultural background, religious or spiritual comfort, and patient independence.

DISCUSSION

Patients as well as close relatives and healthcare providers generally gave a high score to the 34 covered subthemes. This indicates that all themes can play an important role in appropriate care in the last phase of life. A pain-free situation was unanimously presented by all groups as the most important core theme, and this is in line with the article by Meier et al.,[4] which supported this research. Results show that medical treatments should focus on a pain-free final stage of life and not on exhausting all possible treatments to (needlessly) prolong life, and that patients should keep control of their own treatment. In addition, general practitioners, nurses, patients, and close relatives also considered the following themes very important: support by family, respect for the patient as an individual, being able to say goodbye, and euthanasia in case of unbearable suffering. Since the law regarding euthanasia was promulgated on May 28, 2002, euthanasia seems more and more accepted based on these results. However, there is a

TABLE 1. Characteristics of Participants

Characteristics	General Practitioners n = 57 (%)	Nurses n = 67 (%)	Patients n = 16 (%)	Close Relatives n = 8 (%)
Sex				
Male	37 (65)	6 (9)	6 (38)	0 (0)
Female	20 (35)	61 (91)	10 (62)	8 (100)
Age				
<25	0 (0)	3 (5)	2 (13)	1 (13)
25–34	7 (12)	14 (21)	2 (13)	0 (0)
35–44	4 (7)	31 (46)	0 (0)	1 (13)
45–54	15 (26)	11 (16)	3 (19)	2 (25)
55–64	24 (42)	5 (8)	4 (25)	2 (25)
≥65	5 (9)	0 (0)	5 (31)	2 (25)
Reflection on a good death?				
Yes	51 (89)	63 (94)	14 (88)	7 (88)
No	6 (11)	3 (5)	2 (12)	1 (12)
Terminal care frequency				
Occasional	17 (30)	9 (13)		
Monthly	22 (39)	23 (34)		
Weekly	14 (25)	14 (21)		
Daily	3 (5)	20 (30)		
In practice				
Solo	26 (46)			
Duo	7 (12)			
Group	23 (40)			
Home care nurse		46 (69)		
Palliative network		5 (7)		
Nursing home		16 (28)		
Education				
Basic			0 (0)	0 (0)
Secondary			8 (50)	1 (13)
Higher			5 (31)	4 (50)
Academic			3 (19)	3 (37)

Notes: Percentages are rounded to the nearest integer. Invalid answers are not displayed.

TABLE 2. Demographics of Participants and Overall Population of Healthcare Providers in Flanders

Characteristics	Age	Percentage of Participants	Percentage of Healthcare Providers in Flanders
General practitioners			
Female	25–44	45	52
	45–64	55	44
	>64	0	4
Male	25–44	6	14
	45–64	80	51
	>64	14	35
Nurses			
Female	<25–44	76	41
	45–64	24	46
	>64	0	13
Male	<25–44	60	43
	45–64	40	48
	>64	0	9

big difference between finding the possibility of euthanasia important in the face of unbearable suffering and actually requesting or performing it. This results of this subtheme cannot be generalized to other countries that have not legalized euthanasia. Nevertheless, it may be important worldwide because the universal principles of medical bioethics can be discussed far beyond the borders of the Benelux.

Experience with terminal care by general practitioners and nurses was considered important by both the healthcare providers themselves and the family members. A healthcare provider who is well aware of what palliative care can mean will see the needs more rapidly and will provide the necessary additional care at the end of life. This is also important to keep in mind with regard to a good education in family medicine.

Religiosity and spirituality were considered less important by all parties compared with other themes

TABLE 3. Comparison of Results Between General Practitioners and Nurses

Characteristics	General Practitioners Mean ± SD	Nurses Mean ± SD	df	p value
Preferences for dying process				
Death scene (where, how, etc.)	8.44 ± 1.52	8.76 ± 1.21	2	0.4900
Dying during sleep	6.52 ± 2.05	7.79 ± 1.87	2	0.0184[a]
Preparations for death (last will and testament, etc.)	7.71 ± 1.78	8.23 ± 1.57	2	0.3615
Pain-free status				
Pain and symptom management	9.48 ± 0.70	9.53 ± 0.83	2	0.1050
Not suffering	9.26 ± 0.85	9.63 ± 0.73	2	0.6009
Emotional well-being				
Emotional support	8.58 ± 1.49	9.03 ± 1.21	2	0.3407
Psychological comfort	8.56 ± 1.34	9.08 ± 1.04	2	0.6047
Chance to discuss meaning of death	7.61 ± 1.73	8.22 ± 1.46	2	0.9618
Family/close relatives				
Family support	8.70 ± 0.99	8.94 ± 1.17	2	0.5734
Family acceptance of death	8.01 ± 1.48	8.43 ± 1.54	3	0.4965
Family prepared for death	8.16 ± 1.32	8.81 ± 1.15	2	0.7521
Not being a burden to close relatives	5.37 ± 2.25	7.51 ± 2.04	2	0.0007[a]
Dignity				
Respect for patient as a unique individual	8.69 ± 1.47	8.94 ± 1.03	2	0.4489
Patient independency	6.95 ± 2.11	7.38 ± 1.94	3	0.2729
Completion in life				
Saying goodbye	8.54 ± 1.36	9.12 ± 1.07	2	0.6530
Life well lived	5.57 ± 2.43	7.37 ± 2.00	2	0.0022[a]
Acceptance of death	7.66 ± 1.55	8.10 ± 1.58	2	0.6839
Religiosity and spirituality				
Religious or spiritual comfort	6.93 ± 1.82	7.30 ± 2.00	2	0.9706
Faith	6.15 ± 2.15	7.52 ± 2.10	2	0.0049[a]
Spiritual or layman consultant	6.49 ± 2.14	7.27 ± 2.06	2	0.0907
Preferences in terms of treatments				
Not prolonging life (unnecessarily)	8.99 ± 1.15	8.75 ± 1.44	2	0.5247
All available treatments	5.74 ± 2.33	7.60 ± 2.49	2	0.0025[a]
Control over treatment	8.25 ± 1.66	8.90 ± 1.17	2	0.5051
Euthanasia in case of unbearable suffering	8.96 ± 1.33	9.09 ± 1.18	2	0.5344
Quality of life				
Living as usual	7.02 ± 1.87	8.22 ± 1.36	3	0.0025[a]
Maintaining hope, pleasure, and gratitude	8.23 ± 1.44	8.74 ± 1.15	3	0.2116
Life worth living	7.04 ± 2.01	8.40 ± 1.34	2	0.0122[a]
Relationship with healthcare providers				
Support from healthcare provider	8.87 ± 1.08	9.03 ± 1.06	2	0.5561
Experience with terminal care	8.45 ± 1.34	8.90 ± 1.20	2	0.6122
Discuss spiritual beliefs with healthcare provider	7.75 ± 1.80	8.46 ± 1.28	2	0.0350[a]
Other				
Recognition of cultural background	7.32 ± 2.01	7.94 ± 1.51	2	0.3311
Physical touch when dying	7.12 ± 2.05	8.04 ± 1.64	2	0.0826
Being with pets	6.02 ± 2.94	8.27 ± 1.66	3	<0.0001[a]
Healthcare costs	5.05 ± 2.45	7.35 ± 2.38	2	0.0001[a]

Notes: SD: standard deviation.
[a] $p < 0.05$.

and were scored low by both patients and family members. After reading the literature, this was rather surprising. A possible explanation for this could be that the participants did not have much understanding of the broader concept of spirituality, as *spirituality* was translated into Dutch as *spiritualiteit*, which most people associate with religiosity. Furthermore, we see a large distribution in all groups, which means that religion and spirituality are being experienced individually (i.e., irrelevant for one person and necessary for another when speaking of a good death). Recently, an article by the Catholic Church in Belgium reported that in 2018, only 9.42% of Belgians considered themselves practicing Catholics; in 2016, this figure was still 20%.[10] This may explain why religiosity scored so low compared with other themes.

TABLE 4. Comparison of Results Between Male and Female Healthcare Providers

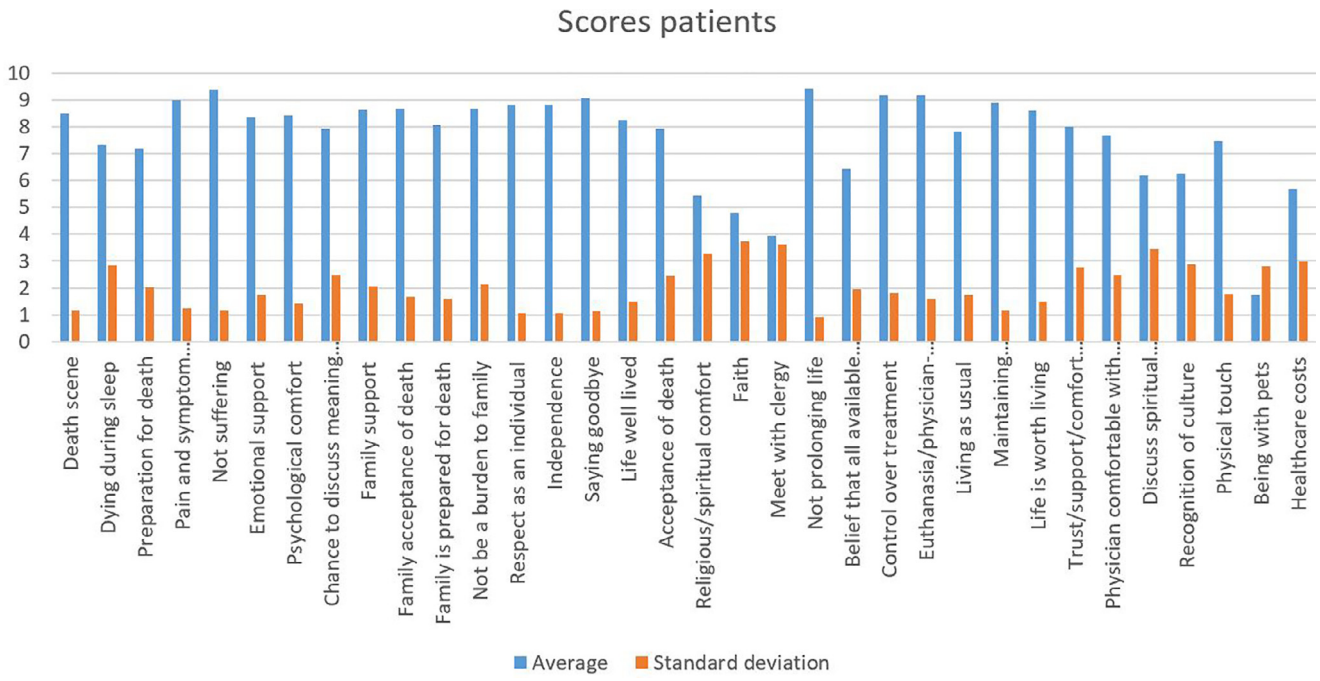
Characteristics	Male Mean ± SD	Female Mean ± SD	df	p value
Preferences for dying process				
Death scene (where, how, etc.)	8.09 ± 1.49	8.89 ± 1.22	2	0.0065[a]
Dying during sleep	6.55 ± 2.13	7.56 ± 1.93	2	0.2194
Preparations for death	7.65 ± 1.96	8.17 ± 1.50	2	0.4491
Pain-free situation				
Pain and symptom management	9.24 ± 0.80	9.65 ± 0.72	2	0.0084[a]
Not suffering	8.95 ± 0.94	9.73 ± 0.57	2	<0.0001[a]
Emotional well-being				
Emotional support	8.14 ± 1.55	9.19 ± 1.09	2	0.0012[a]
Psychological well-being	8.16 ± 1.36	9.20 ± 0.95	2	0.0002[a]
Chance to discuss meaning of death	7.21 ± 1.73	8.33 ± 1.41	2	0.0096[a]
Family/close relatives				
Family support	8.70 ± 0.93	8.90 ± 1.17	2	0.5735
Family acceptance of death	7.61 ± 2.10	8.57 ± 1.26	3	0.0045[a]
Family prepared for death	7.86 ± 1.41	8.85 ± 1.04	2	0.0039[a]
Not being a burden to close relatives	5.37 ± 2.48	7.14 ± 2.10	2	0.0696
Dignity				
Respect for patient as a unique individual	8.43 ± 1.54	9.04 ± 1.02	2	0.0670
Patient independency	7.02 ± 2.35	7.27 ± 1.97	3	0.9319
Completion in life				
Saying goodbye	8.30 ± 1.42	9.15 ± 1.03	2	0.0183[a]
Life well lived	5.78 ± 2.55	6.95 ± 2.18	2	0.7905
Acceptance of death	7.27 ± 1.76	8.23 ± 1.36	2	0.0315[a]
Religiosity and spirituality				
Religious and spiritual comfort	6.63 ± 1.94	7.40 ± 1.87	2	0.0318[a]
Faith	6.22 ± 2.33	7.25 ± 2.09	2	0.1893
Spiritual or layman consultant	6.53 ± 2.34	7.11 ± 1.99	2	0.2388
Preferences in terms of treatments				
Not prolonging life (unnecessarily)	8.90 ± 1.23	8.84 ± 1.36	2	0.5380
All available treatments	5.90 ± 2.21	7.19 ± 2.66	2	0.5198
Control over treatment	8.07 ± 1.74	8.88 ± 1.77	2	0.3267
Euthanasia in case of unbearable suffering	8.81 ± 1.42	9.14 ± 1.14	2	0.5666
Quality of life				
Living as usual	7.12 ± 1.80	7.96 ± 1.76	3	0.9822
Maintaining hope, pleasure, and gratitude	8.21 ± 1.78	8.66 ± 1.30	3	0.4467
Life worth living	6.97 ± 2.02	8.20 ± 1.53	2	0.1740
Relationship with healthcare providers				
Support from healthcare provider	8.62 ± 1.14	9.14 ± 0.99	2	0.1706
Experience with terminal care	8.23 ± 1.36	8.93 ± 1.17	2	0.0234[a]
Discuss spiritual beliefs with healthcare provider	7.81 ± 1.67	8.30 ± 1.50	2	0.4836
Other				
Recognition of cultural background	7.23 ± 2.02	7.88 ± 1.60	2	0.2399
Physical touch when dying	7.02 ± 1.93	7.93 ± 1.80	2	0.1144
Being with pets	6.36 ± 2.77	7.70 ± 2.44	3	0.9246
Healthcare costs	5.37 ± 2.53	6.78 ± 2.61	2	0.8971

Notes: SD: standard deviation.
[a] $p < 0.05$.

Professionals as well as patients and close relatives gave the lowest scores to healthcare expenses. Does this indicate that it is difficult for those directly involved to integrate a general concern such as healthcare costs into the individual care of the patient at the end of life? The Belgian health system is a universal insurance system covering more than 95% of the population, with a fee-for-service system for physicians, nurses, hospitals, etc.[11]

In general, nurses gave the themes for a good death higher scores than did general practitioners. A possible reason could be that these healthcare providers often have a much closer and intimate relationship with the patient (and their close relatives). Significant differences were also found. Nurses considered it more important than general practitioners that all available treatments be used. This is important to reflect on in practice because patients can receive conflicting messages

FIGURE 1. Scores by patient.



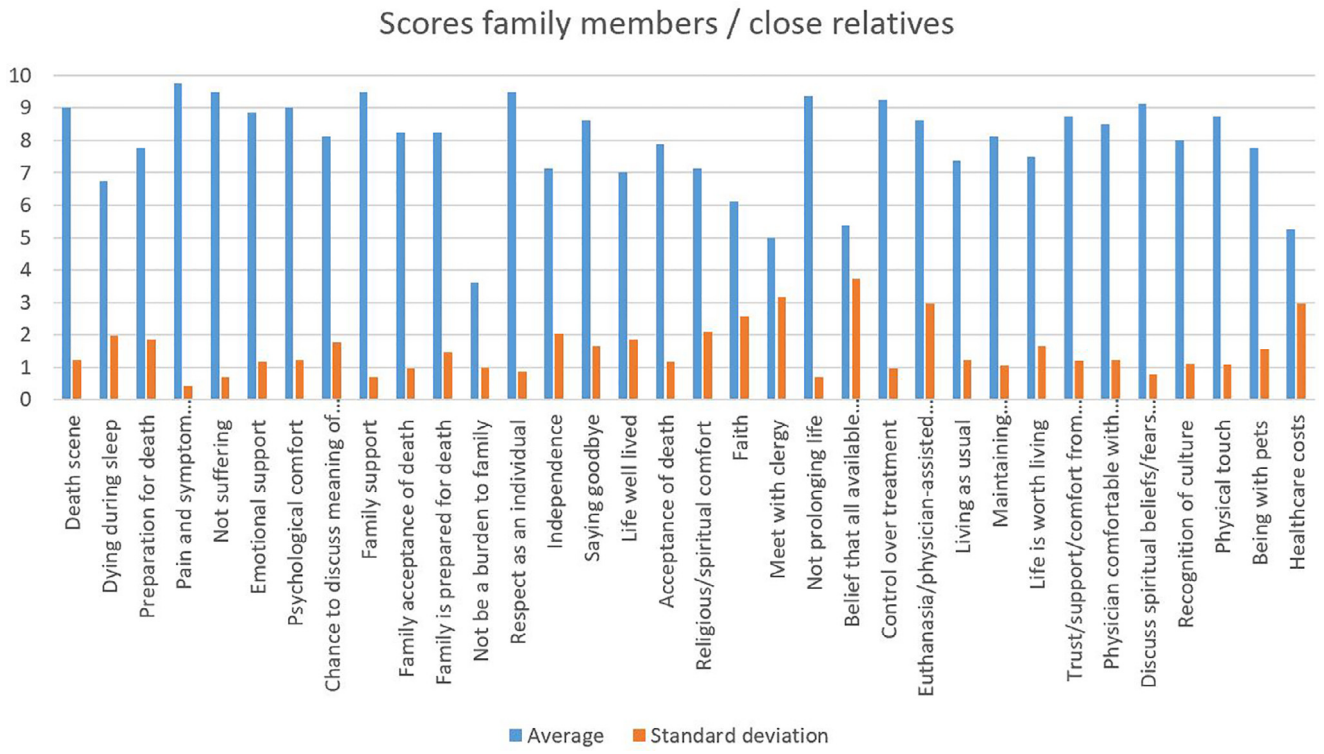
about whether to undergo, for example, an additional (invasive) examination or third-line chemotherapy. Another explanation could be that general practitioners have a more comprehensive picture of possible treatments in comparison with nurses in home care and nursing homes. Moreover, it is possible the question "all available treatments" leaves too much space for interpretation.

Another important difference is that general practitioners considered the healthcare costs for good terminal care less important than nurses. Could this difference of opinion have an influence on the predetermined care by the involved healthcare provider? The importance of the patient not being a burden to close relatives at the end of life is another significant difference between general practitioners and nurses. Presumably, the nurse who takes care of the patient and their environment daily in the nursing home or at home finds this more important because the nurse is confronted daily with the consequences of increasing care needs in all areas (physical, psychological, spiritual, etc.). It is also very striking that participating family members found the possibility of a close relative becoming a burden in their last phase of life less important. However, to be able to speak of a good death, patients themselves found it important not to be a burden to their relatives. This is reflected in the theme of independence, which was scored high by patients and rather low by family members. A possible explanation is that family members perceive caring for terminal close relatives as less of a burden than the patients themselves. Although this care can be tough, it gives some purpose and meaning, which in turn gives family members strength. Misunderstandings and tensions can be avoided with open communication. This is particularly important because healthcare providers unanimously consider support from family members very important.

It is also striking that female healthcare providers often gave higher scores than their male colleagues. For example, they found the emotional and spiritual or religious comfort of the patient significantly more important than did their male counterparts. This could mean that less attention will be paid to a patient who happens to have a male nurse and general practitioner.

Of participants, 88% or more said they had thought about what constitutes a good death. Nevertheless, it

FIGURE 2. Scores by family member/close relative.



is clear from literature that it is difficult to discuss impending death for patients as well as close relatives and caregivers. Being able to have this conversation can be a great relief for patients and their close relatives, and it is very important for healthcare providers to offer customized care for patients.

The Federal Resource Centre for Healthcare in Belgium published in December 2017 an important report about appropriate care at the end of life. Nine aspects are mentioned in the definition of appropriate end-of-life care as showed in Table 5.[12]

Even though this study was conducted in a very different way (along with the use of open questions), a comparison is interesting. All nine aspects are implicitly or explicitly addressed in the 34 surveyed subthemes. The first aspect corresponds with the high scores of the core themes a pain-free situation and emotional well-being. The second and third criteria could be compared with the core themes preferences related to the dying process and preferences related to treatments. The fourth condition shows the importance of family and close relatives. This emerges in the research regarding the core theme of family (support by family, family can accept the death, family is prepared for the death, and patient is no burden to their close relatives). The last five conditions are about the healthcare providers or caregivers, and this is defined more extensively in the core theme of relationship with healthcare providers.

In the subthemes, we see that experience and spiritual beliefs can be discussed with healthcare providers (in which an empathetic attitude is necessary), and support by healthcare providers is mentioned as well. Taking time to openly communicate with all involved parties is not literally questioned in the research but is a necessary condition if you want to discuss all 34 subthemes. The Belgian Health Care Knowledge Center report also assigns cooperation in a multidisciplinary team, which is missing in the themes of Meier et al.[4]

TABLE 5. Appropriate Care at End of Life

Appropriate care at end of life	1	relieves the patient's physical pain and ensures their well-being and comfort
	2	corresponds with the patient's vision, wishes, and choices
	3	is personalized and complete care, adapted to the patient's situation and needs
	4	supports both patients and their close relatives
	5	is given by trained and experienced healthcare providers
	6	is given by healthcare providers with empathetic and respectful attitude
	7	is given by healthcare providers who take their time to listen to the patient and their family
	8	is given by healthcare providers who work together in a multidisciplinary team
	9	is given by healthcare providers who openly communicate with all those involved, including the patient and their family

Notes: Belgian Health Care Knowledge Center report 296.

Study Limitations

Certain limitations of this study must be acknowledged. The limited amount of data for patients and close relatives—as well as not having a total sample from which these participants came—results in nonrepresentative conclusions for these groups. Second, the younger healthcare providers were more represented in comparison with older general practitioners, and especially older nurses.

CONCLUSION

Patients, family members, nurses, and general practitioners generally gave high scores to the 34 subthemes regarding a good death, which indicates that all of these themes can play an important role in appropriate care at the end of life and should thus be addressed in a discussion about early care planning. Medical treatments should focus on a pain-free last phase of life and not on exhausting possible treatments to prolong life unnecessarily. This should always be done in agreement with the patient. Significant differences between general practitioners and nurses deserve attention in clinical practice because patients and family members expect healthcare providers to work as a team....

The authors confirm there is no conflict of interest. The study was approved by the program-specific ethics advisory committees of masters in family medicine education of Katholieke Universiteit Leuven and others March 30, 2017 (mp18475). The project was completed with their own finances as a thesis for the degree of master of medicine by the first author.

References

1. Saunders C: The Management of Terminal Disease. London, Edward Arnold, 1978
2. World Health Organization: WHO definition of palliative care. (online). Available at: http://www.who.int/cancer/palliative/definition/en/. Accessed 08/2017.
3. Field MJ, Cassel CK: Approaching Death: Improving Care at the End of Life. Washington, DC, National Academies Press, 1997
4. Meier EA, Gallegos JV, Montross-Thomas LP, et al: Defining a good death (successful dying): literature review and a call for research and public dialogue. Am J Geriatr Psychiatry 2016;24(4):261–271
5. Cottrell L, Duggleby W: The "good death": an integrative literature review. Palliat Support Care 2016;14(6):686–712
6. Eggermont E, Renaer M: The doctor with the patient at their end of life. J Med 2002;58(12):793–805
7. Vermandere M, De Lepeleire J, Van Mechelen W, et al: Spiritual care at the end of life. J Med 2013;69(11):535–538
8. Menten J: Principles of palliative care and terminal care. J Med 2001;57(14−15):990–994
9. Federale Overheidsdienst Volksgezondheid: HWF STATAN 2016. (online). Available at: http://overlegorganen.gezondheid.belgie.be/nl/documenten/hwf-statan-2016-details. Accessed 09/2017.
10. Bisschoppenconferentie van België. Jaarrapport 2018 van de katholieke Kerk in België. Licap Halewijn, 2018. Available at: https://www.kerknet.be/sites/default/files/2018_Jaarraport%20Bisschoppenconferentie%20-%20light.pdf. Accessed 11/2018
11. Gerkens S, Farfan MI, Desomer A, et al: Het Belgische Gezondheidssysteem in 2010. Health services research (HSR). Brussels, Federaal Kenniscentrum voor de Gezondheidszorg (KCE). 2010. KCE Reports 138A. D/2010/10.273/59. Available at https://kce.fgov.be/en/all-reports
12. Van den Broeck K, Schmitz O, Aujoulat I, et al: Appropriate care at the end of life. Health services research (HSR). Brussels: Belgian health care knowledge centre (KCE). 2017. KCE reports 296. D/2017/10.273/90