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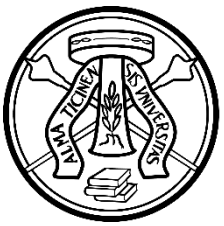

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Kalothanasia and Death with Dignity: Assisted Dying as a Relational and Moral Practice. A Qualitative Evidence Synthesis of Patients', Families', and Healthcare Professionals' Experiences

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Abstract

Assisted dying (AD), including physician-assisted suicide (PAS) and medical aid in dying (MAiD), is an increasingly prominent and contested end-of-life practice. This review examined whether and how AD is understood as kalothanasia, a "good death" aligned with dignity, autonomy, relational closure, and meaning-making. Guided by PRISMA and ENTREQ, we searched PubMed, Scopus, Web of Science, CINAHL, and PsycINFO. Sixteen studies (2018–2025) met inclusion criteria, predominantly from Canada (n=9; 56.3%), with additional studies from Australia and the USA (n=2 each) and single studies from the Netherlands, Switzerland, and New Zealand. Interviews were the sole data collection method, conducted in-person, virtually/telephone, or via mixed modes; thematic analytic approaches predominated. Six interrelated themes were identified: (1) autonomy and control over dying; (2) dignity and relief of suffering; (3) choreographing a "good death" through planning and presence; (4) ambivalence and moral conflict; (5) assisted suicide as care versus intentional ending of life; and (6) closure, bereavement, and continuing complexity. Overall, assisted suicide was experienced as a moral and relational process rather than a purely medical act, and the attainability of a "good death" was contingent on interpersonal dynamics and organizational context. Findings support integrating death education and structured ethical support to foster realistic expectations, reduce moral distress, and inform clinical practice, service design, and policy.

Keywords: Assisted dying; good death; assisted suicide; death with dignity; lived experiences.

Introduction

Assisted Dying (AD), also referred to as Physician-assisted suicide (PAS) or medical aid in dying (MAiD), describes the practice in which a physician provides a patient with the means to end their own life, typically through the prescription of a lethal dose of medication that the patient self-administers (De Lima et al., 2017). Over the past two decades, AD has moved from the margins of medical ethics into mainstream clinical and policy discourse, particularly as several jurisdictions have legalized or are actively debating its regulation. Across jurisdictions where assisted dying is regulated, access is typically subject to strict procedural and eligibility safeguards. For example, in Italy, recent Constitutional Court rulings and the 2025 Tuscan regional law require that requests for medically assisted suicide be assessed by public healthcare services, verified by a multidisciplinary commission, and approved by an ethics committee. Similarly, European countries such as the Netherlands and Belgium regulate assisted dying through detailed statutory frameworks that specify eligibility criteria, professional oversight, and mandatory consultation procedures, reflecting an effort to maintain patient autonomy with institutional and ethical safeguards (Seveso et al., 2025). Despite this growing institutional presence, AD remains a deeply contested practice, situated at the intersection of medicine, ethics, law, and personal values.

Much of the controversy surrounding AD reflects enduring tensions within medicine regarding the goals of care at the end of life. Supporters frequently frame AD as a compassionate response to intolerable suffering and as an extension of respect for patient autonomy, particularly in cases of terminal illness and irreversible decline. Opponents, by contrast, emphasize concerns related to professional integrity, the physician's duty to do no harm, and the potential normalization of death as a solution to suffering (Fontalis et al., 2018). Reviews of professional position statements demonstrate a lack of consensus across medical organizations, with arguments oscillating between commitments to autonomy and relief of suffering on one hand, and concerns about moral limits and the traditional healing role of medicine on the other (Emanuel et al., 2020).

Central to these debates is the broader question of what constitutes kalothanasia, also known as "good death." In palliative care and end-of-life research, a good death is

commonly associated with effective symptom control, preservation of dignity, a sense of autonomy, relational closure, and meaning-making at the end of life. (Kovács, 2014) While these dimensions are frequently invoked in policy and ethical discussions, they are neither universally defined nor uniformly valued. The concept of kalothanasia, understood as a good or dignified death, captures this normative ideal while simultaneously highlighting its moral and cultural contingency. Rather than referring to a single outcome, kalothanasia reflects an aspiration to align the circumstances of dying with personal values, relational needs, and perceptions of dignity (Kovács, 2014).

Assisted dying is often positioned as a means of achieving such an idealized death, particularly in the context of anticipated loss of bodily function, independence, or identity. Qualitative research with patients nearing the end of life suggests that support for AD is frequently grounded not only in physical pain, but also in fears of indignity, dependency, and loss of control (Fontalis et al., 2018). In one open-access qualitative study, participants emphasized that witnessing the prolonged deaths of others strongly shaped their desire for the option of assisted death, with many expressing a preference to die with medical support and in the presence of loved ones rather than endure an unpredictable or prolonged dying process (Seale et al., 2006). These findings suggest that AD is often understood less as an act of self-destruction and more as an attempt to preserve agency and relational meaning at the end of life.

At the same time, empirical studies highlight that the notion of a good death in AD contexts is far from straightforward. In particular, the role of existential suffering has emerged as a source of significant ethical and clinical uncertainty. Existential suffering has been described as a form of distress arising from a perceived loss of meaning, purpose, or coherence in one's life, rather than from physical symptoms alone. Research with healthcare professionals in AD contexts indicates that while many clinicians acknowledge the legitimacy of existential suffering, opinions remain deeply divided regarding whether such suffering should be sufficient grounds for accessing assisted death (Gaignard et al., 2023). This ambivalence underscores the difficulty of translating abstract ideals of dignity and autonomy into concrete clinical decision-making.

Importantly, perceptions of AD and its relationship to a good death vary across stakeholders. Patients, family members, caregivers, and healthcare professionals often

approach AD from distinct moral and relational positions, shaped by their roles, responsibilities, and emotional proximity to the dying person. Studies of families and caregivers describe AD as both a source of comfort (by enabling preparation, shared presence, and anticipatory closure) and a site of enduring moral tension, even when the death is retrospectively framed as peaceful or compassionate. Similarly, healthcare professionals report experiences ranging from moral affirmation to distress and ambivalence, particularly when assisted dying challenges established norms of care within palliative or hospice settings (Gaignard et al., 2023; Shapiro et al., 2021; White et al., 2023).

Despite a growing body of empirical literature on AD, several gaps remain. Much existing research has focused on legal frameworks, prevalence, and attitudinal surveys, often privileging abstract ethical arguments or population-level opinions. Fewer studies have systematically examined how AD is experienced and interpreted in relation to the concept of a good death across different stakeholder groups. While research on ethical positions on AD is well articulated, empirical qualitative research capturing lived experiences, moral reasoning, and meaning-making remains comparatively limited and fragmented. Moreover, there is a lack of integrative qualitative syntheses that explicitly situate AD within frameworks of kalothanasia and death with dignity.

While assisted dying has been widely debated in terms of legal regulation and professional positions (Emanuel et al., 2020; Fontalis et al., 2018), qualitative work has more often examined experiences and attitudes within single stakeholder groups or without an explicit interpretive lens of the "good death" (Gaignard et al., 2023; Seale et al., 2006). Moreover, although the good death has been theorized and discussed as a multidimensional ideal in end-of-life research (Kovács, 2014), prior syntheses have not systematically examined assisted dying through the lens of kalothanasia across patients, families/caregivers, and healthcare professionals, nor have they foregrounded how ideals of dignity, autonomy, and meaning-making are negotiated relationally and under institutional safeguards (De Lima et al., 2017; Seveso et al., 2025). By treating kalothanasia not as a fixed endpoint but as a socially situated and morally negotiated process (Cottrell & Duggleby, 2016; Kovács, 2014), this review offers a relational and

practice-relevant reframing of assisted dying that can better inform clinical guidance, education, and policy debates (Emanuel et al., 2020; Fontalis et al., 2018).

The present qualitative systematic review synthesizes qualitative evidence on how assisted dying is perceived, experienced, and understood by patients, families or caregivers, and healthcare professionals in relation to ideals of a good death, kalothanasia, and death with dignity. By examining both explicit references and implicit descriptions of autonomy, suffering, relational closure, and meaning-making (Kovács, 2014), this review clarifies how a "good death" is imagined, pursued, and contested in assisted dying contexts. In doing so, it provides a practice-relevant synthesis to inform clinical guidance, education, and policy debates (Emanuel et al., 2020; Fontalis et al., 2018).

Analysing AD through the lens of kalothanasia enables examination beyond legality and procedural ethics by foregrounding how a "good death" is socially and culturally constructed rather than fixed (Cottrell & Duggleby, 2016). In contemporary healthcare, particularly palliative care, this ideal is often linked to symptom control, dignity, autonomy, and relational closure. Treating kalothanasia as a dynamic, sensitizing concept allows AD to be understood as a morally and relationally negotiated process, marked by ambivalence and ethical tension across patients, families, and professionals. Using this lens, the present synthesis integrates diverse stakeholder perspectives while remaining attentive to lived meanings and the institutional contexts that shape whether AD is experienced as aligned with death with dignity.

Methods

This qualitative systematic review aimed to identify and synthesize qualitative evidence on how patients, families/caregivers, and healthcare professionals perceive assisted suicide with respect to kalothanasia, understood as good death, and death with dignity. Specifically, the review examined how assisted suicide is associated with features commonly linked to a good death, including symptom management, autonomy, preparedness, relational closure, and meaning-making. It further sought to compare patterns across stakeholders and clinical contexts and to derive practice-relevant implications for assisted dying contexts.

Research Questions

The review was guided by the following research questions:

Among patients eligible for or seeking assisted suicide, their families/caregivers, and healthcare professionals, how is assisted suicide perceived, experienced, and understood, in relation to the concepts of good death, kalothanasia, and death with dignity, including both explicit references and implicit descriptions of features commonly associated with a 'good death'?

Design

This review was guided by the qualitative systematic review methodology and was based on thematic analysis for synthesizing common themes across the studies (Fontalis et al., 2018). This review followed PRISMA guidelines (Page et al., 2021) and the ENTREQ (Supplementary material), to maintain transparency in qualitative research (Tong et al., 2012). A critical quality appraisal was conducted by two researchers following the JBI Critical Appraisal Checklist for Qualitative Research. This review protocol has been registered in the Open Science Framework (blinded for peer review). No ethical approval was required due to the nature of this study.

Information Source and Search Strategy

To identify proper keywords and relevant literature, one researcher (blinded for peer review) conducted an initial search in PubMed on 5 October 2025. Subsequently, two researchers (blinded for peer review) collaborated to develop the most suitable search string strategy for PubMed, which was adapted for other databases. A systematic search was conducted in five databases, such as PubMed, Scopus, Web of Science, CINAHL, and PsycINFO on October 8, 2025. An example of the search string can be seen in Table 1.

Table 1. Search string

Database	Search Strategy

PubMed	((("Suicide, Assisted"[Mesh] OR "Assisted Suicide"[tiab] OR "physician-assisted suicide"[tiab] OR "assisted dying"[tiab] OR "assisted death"[tiab] OR "medical aid in dying"[tiab] OR MAiD[tiab] OR "aid in dying"[tiab] OR "physician-assisted death"[tiab])) AND ((perception*[tiab] OR attitude*[tiab] OR experience*[tiab] OR perspective*[tiab] OR meaning*[tiab] OR view*[tiab] OR "lived experience"[tiab] OR belief*[tiab]))) AND ((qualitative[tiab] OR interview*[tiab] OR "focus group*"[tiab] OR ethnograph*[tiab] OR phenomenolog*[tiab] OR "grounded theory"[tiab] OR "thematic analysis"[tiab] OR "content analysis"[tiab]))

Eligibility Criteria

This study included only primary peer-reviewed studies that address assisted suicide, assisted dying, physician-assisted suicide, and medical aid in dying (MAiD). The population of interest was adult patients who were eligible for, seeking, assessed for, or who had undergone assisted suicide, family members or informal caregivers, and healthcare professionals involved in the assisted suicide process. It included studies conducted in different settings, including any country or legal context, hospital, or community setting. The included outcomes were limited to qualitative data on participant's perceptions, lived experiences, attitudes, meanings, moral reasoning, and values (e.g., autonomy, dignity, burden, suffering, control), hopes and fears, interpretations of a 'good death' (e.g., symptom control, relational closure, existential peace, and others), and perceived benefits, harms, or risks associated with assisted suicide. It was considered only studies published in English. It was excluded studies focusing exclusively on euthanasia and mixed methods.

Study Selection and Quality Assessment

Following the search string (Table 1), all identified references were downloaded in RIS format and uploaded into the Rayyan (Ouzzani et al., 2016), an online platform for systematic reviews. Duplicates were automatically removed. Two independent researchers (blinded for peer review) conducted the assessment of titles and abstracts in accordance with the predefined inclusion criteria. Potentially relevant articles were full text assessed by the same reviewers. Any discrepancies between reviewers during the assessment were resolved through a peer debriefing with a third reviewer (blinded for peer review). The search results and the studies eligible (and not) for this review are

comprehensively reported in the PRISMA flowchart (Figure 1). A critical appraisal of methodological quality was conducted independently by two researchers (blinded for peer review) using the JBI Critical Appraisal Checklist for Qualitative Research. Any disagreements were resolved through discussion and, when necessary, a third senior researcher (blinded for peer review) was involved. The JBI checklist comprises 10 items assessing methodological congruity, rigor, and transparency across the alignment of philosophical perspective, research design, data collection, analysis, interpretation, and ethical considerations in qualitative studies (Lockwood et al., 2024). The critical appraisal was answered with "yes", "no", "unclear", and "not applicable" formats.

Data Extraction and Analysis

The data extraction and synthesis were performed by two researchers to ensure methodological rigor. For data extraction, the researchers (blinded for peer review) developed an extraction table containing the study characteristics, including study title, authors' surname/year of publication/country, participants, context, methodology, data collection methods, phenomenon of interest, and main findings. The data synthesis was guided by Thomas and Harden's (2008) three-stage framework for qualitative thematic synthesis, comprising line-by-line inductive coding of study findings, the development of descriptive themes, and the generation of higher-order themes to address the review aim and research question while remaining grounded in the original data. Importantly, kalothanasia was not used as an a priori coding framework or deductive template. Instead, themes were generated inductively from the included studies, and only subsequently interpreted and discussed through the lens of kalothanasia as a sensitizing concept, to clarify how participants' accounts aligned with or complicated features of a "good death."

Reflexivity

The review team is trained in psychology, health psychology, and applied ethics, with prior research experience in patient engagement, end-of-life communication, and death education. This background informed a particular sensitivity to relational, moral, and meaning-making dimensions of assisted dying, as well as to experiences of ambivalence and ethical tension across stakeholder groups. To mitigate the risk of imposing normative assumptions about a "good death," themes were developed inductively from primary study findings and only subsequently interpreted through the sensitizing concept of kalothanasia.

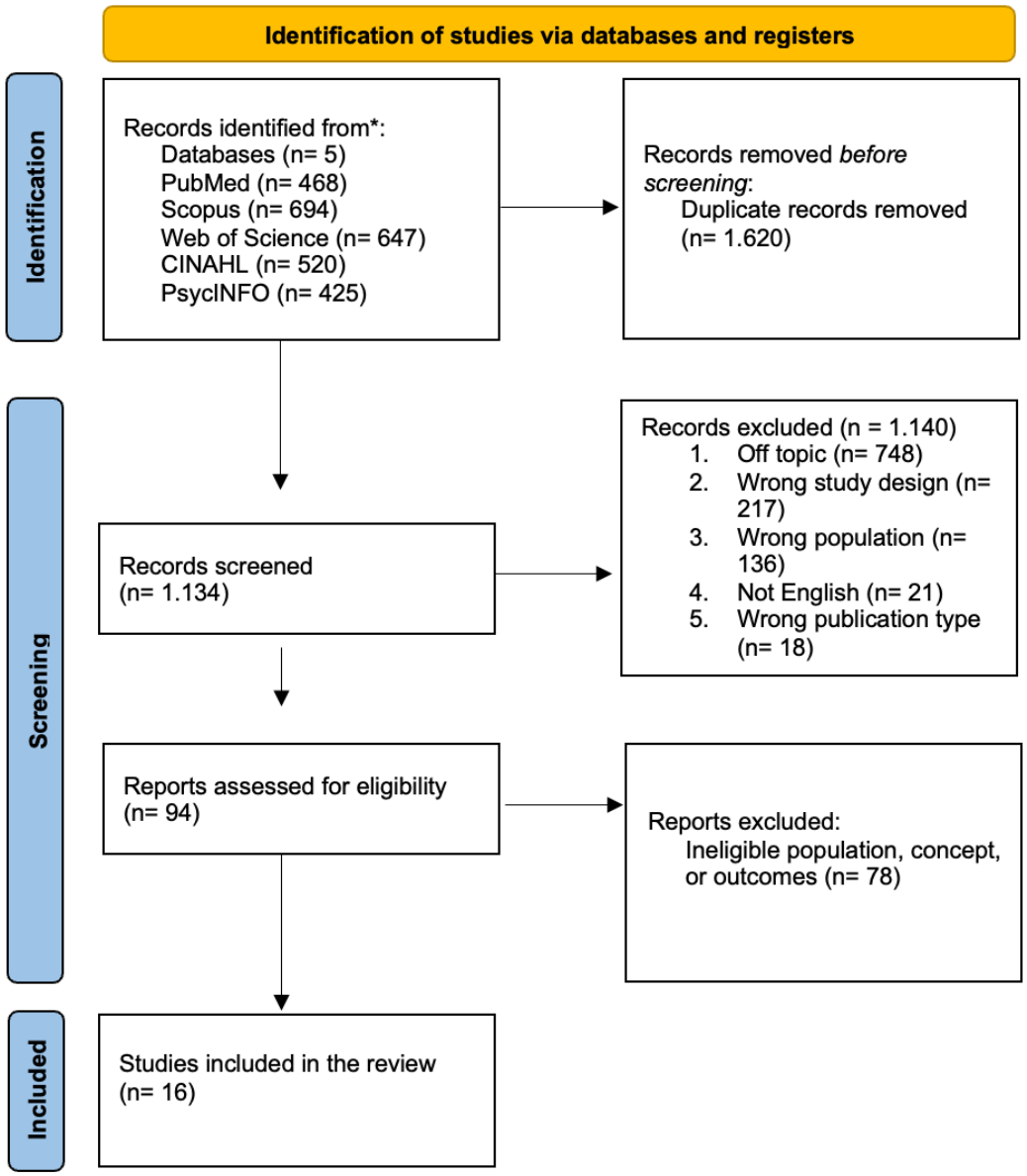

Figure 1. PRISMA flowchart of the assessment process.

Results

Study Characteristics

Overall, sixteen studies met the inclusion criteria for this qualitative systematic review. Published between 2018 and 2025, most studies were from Canada (n= 9; 56.3%), followed by Australia (n= 2; 12,5%), and the United States (n= 2; 12,5%), with single studies from the Netherlands, Switzerland, and New Zealand. The included studies

encompassed patients seeking or eligible for assisted suicide, family members, and caregivers (n= 9; 56,3%). Across all studies, the sample size ranged from 8 to 42 participants, with a cumulative of 332. All the 16 studies adopted the interview as the primary data collection method, in which 37,5% (n=6) adopted an in-person interview, 25% (n=4) virtually, and 37,5% (n=6) adopted mixed methods, such as in-person and virtual/phone call. Most of the studies employ thematic forms of qualitative analysis, with thematic analysis being the most frequently used (62.5%), followed by inductive (12,5%). Narrative, phenomenological, and others were used in a smaller proportion of the findings (6,3% each). The most common phenomena of interest were autonomy and control over dying, dignity and relief of suffering, moral reasoning surrounding assisted suicide, relational and caregiving processes, and bereaved experiences. For a comprehensive list of studies' characteristics, please refer to Table 2.

Critical Appraisal

The methodological quality of the included studies was high in accordance with the JBI Critical Appraisal Checklist for Qualitative Research, as seen in Table 3. All the studies included in the final version of this review demonstrated clear congruity between the research methodology and the research goal, data collection, data analysis, and interpretation of the findings. Participants' voices and lived experiences were adequately represented in all 16 studies, typically through rich and in-depth illustrative quotations, and the conclusions consistently flowed from the presented analysis. Ethical considerations were explicitly mentioned, with evidence of ethical approval reported in the majority. Only one study (Srinivasan, 2019) showed uncertainty regarding ethical reporting. The main methodological limitation across the evidence concerned researcher reflexivity. While most of the studies acknowledge the researcher's positionality at least implicitly, the influence of the researcher on the research process was inconsistently addressed, with several studies rated as "unclear" (D. T. Brown et al., 2024; Buchbinder et al., 2018; Haining et al., 2021; Lewis et al., 2024; Nuhn et al., 2018; Pronk et al., 2023; Serota et al., 2023) and one study rated as "no" in this criterion (Srinivasan, 2019). Notably, the first item was marked as "not applicable" across studies, reflecting the predominantly descriptive or pragmatic qualitative design, in which an explicit philosophical positioning was not articulated by the authors. Despite these limitations, no studies were excluded based on methodological quality, and all were deemed sufficiently rigorous to contribute meaningfully to this qualitative synthesis.

Table 2. Study Characteristics

Study Title	Author(S), Year, Country	Aim	Participants	Context	Methodology	Data Collection Method(S)	Phenomenon Of Interest	Main Findings
Physicians' moral distinctions between medical assistance in dying (MAiD) and withdrawing life-sustaining treatment in Canada: a qualitative descriptive study	Matthew et al., 2025; Canada	Explore physicians' experiences and bioethical distinctions in providing MAiD and WLT	Physicians (N = 21)	Physicians involved in providing either MAiD, WLT, or both practices	Qualitative descriptive approach (Thematic analysis)	Virtual, semi-structure interviews	Lived experiences and moral beliefs of physicians; bioethical and moral distinction between MAiD and Withdrawing Life Treatment (WLT)	Two significant conclusions emerged from the data: practitioners generally equate Medical Assistance in Dying (MAiD) and Withdrawal of Life Support (WLT) in moral permissibility, despite recognizing distinctions such as

								intent and participation. Both are seen as morally similar due to terminal illness contexts, with most physicians indicating relief of suffering as the primary intention, challenging existing bioethical views that categorize death negatively in the context of alleviating suffering.

What About Us? Experiences of Relatives Regarding Physician-Assisted Death for Patients Suffering from Mental Illness: A Qualitative Study	Pronk et al., 2021; Netherlands	Experiences of relatives with regard to a PAD request by patients suffering from mental illness	Relatives (N = 12)	Relatives from patients who had requested PAD because of their suffering from a mental illness. These relatives related to 12 unique PAD cases	Qualitative (Inductive analysis)	Interviews (Virtual and in-person)	Relatives' experience with PAD, and exploration of their ambivalence towards it (characterized by their understanding of the wish to die among others)	This study highlighted the ambivalence surrounding the process of requesting physician-assisted dying (PAD). This involves recognizing the desire to die while simultaneously hoping for an alternative choice from the patient. Key aspects of understanding this wish include compassion, respect for autonomy, shared

								experiences with the same mental illness, and concerns about potential gruesome suicides. Conversely, personal beliefs, such as religious convictions, or the optimism regarding the patient's recovery with different treatments create conflicts with the acceptance of PAD requests.

The discursive context of medical aid in dying: A paradox of control?	Young et al., 2021; New Zealand	Examines the discursive context of control as well as the participants' perception of control to offer insights into how paradoxically, a medical regime of assisted dying reinforces health professionals as in control of the circumstances of dying.	People who want/would consider PAS (N = 14)	Those with a terminal, incurable, degenerative or progressive illness	Qualitative (Thematic analysis)	Semi-structured interviews	PAS as a way to have control over death; dying with autonomy, agency and freedom	The choice of AD was seen as enabling more individual freedom and control. In desiring and advocating for the choice of an assisted death, participants were seeking to die in a manner that was consistent with their values and the way they lived their lives. The basis of their reasoning for wanting AD lay in determining

								what makes life good and worthwhile.

Choreographing a good death: Carers' experiences and practices of enacting assisted dying	Lewis et al., 2024; Australia	Caregivers' perspective and experience in providing a 'good death'	Caregivers (N = 42)	Caregivers of dying loved ones seeking VAD	Reflexive approach (Thematic analysis)	Interviews	Choreographing a good death for loved ones seeking VAD.	Assisted dying depends heavily on the work of family carers. Carers must plan, organise, and adapt to many challenges, often without clear guidance. Ideas about a "good death" can comfort carers, but they can also create pressure when things do not go as expected.

Unacknowledged Pain and Disenfranchised Grief: A Narrative Analysis of Physicaland Emotional Pain in Complex MAiD Bereavement Stories	Sarota et al., 2023; Canada	Explores the role of physical and emotional pain in the stories of family members with complex MAiD bereavement	Family members (N = 12)	Family members of terminally ill patients who chose MAiD	Narrative approach	Interviews (Virtual)	Family members justifying moral permissibility of MAiD or viewing MAiD as a compassionate choice due to the physical and emotional pain of the patient	Physical pain was a moralizing agent that was used to justify why MAiD was or was not morally acceptable. MAiD was seen as a compassionate choice for people who were in extreme physical pain.

A qualitative study exploring family caregivers' support needs in the context of medical assistance in dying	Smolej et al., 2023; Canada	Explore the experiences and support needs of family caregivers who are or who have provided care to individuals who are seeking or have sought MAID. [We'll focus on data regarding caregivers' thoughts and feelings about MAiD]	Caregivers (N = 11)	Caregivers (spouses, parents, and adult children) of patients seeking MAiD	Descriptive design (Thematic analysis)	Semi-structured telephone interviews and online surveys	Caregivers' perspective, thoughts, and feelings about MAiD as a way to end life.	The paper examines caregiver supports, services, and administrative procedures related to Medical Assistance in Dying (MAiD). It highlights caregivers' perspectives, with many expressing support for MAiD, citing reasons such as patient autonomy, empathy, relief for patients, and the chance for closure.

Hospice care providers experiences of grappling with medical assistance in dying in a hospice setting: a qualitative descriptive study	Freeman et al., 2021; Canada	Examining the perspective of hospice workers after legalization of MAiD	Hospice care staff (N = 8)	Hospice and palliative care	Descriptive design (Inductive and thematic analysis)	In-person interview	Hospice workers' perspective on MAiD and patients seeking MAiD	The initiation and provision of MAiD gave rise to a disrupted, distinct, and fragmented care pathway, one that excluded most of those at the frontline of hospice care. The different pathway for those who chose MAiD may lead some care providers to struggle with relational challenges and interpersonal unease.

Medical assistance in dying and the meaning of care: Perspectives of nurses, pharmacists, and social workers	Mills et al., 2021; Canada	(1) Characterize providers' views about the care they offer in general; (2) examine whether or not they consider MAiD a form of care; and (3) explore their reasons for viewing or not viewing MAiD as care.	Healthcare workers - Nurses (N = 10), Social workers (N = 8), Pharmacists (N = 3)	Healthcare workers with direct professional expereince with MAiD (defined as involvement when a patient was considering, requesting, or receiving MAiD)	Iterative approach (Inductive, thematic and template analysis)	Interviews	Explore HCP views on MAiD and it's relation to care and autonomy	Many participants perceived their participation in MAiD as care because they were supporting patient autonomy, while others described MAiD as palliation. Most participants articulated both logics at varying points in the interview. Similarly, participants repeatedly discussed MAiD as a better form of death—one that is

								kinder for patients and relatives.
Care Considerations in a Patient- and Family-Centered Medical Assistance in Dying Program	Brown et al., 2022; Canada	Assess opportunities to enhance patient-and family-centered care (PFCC) in MAiD	Patients (who requested assessment for MAiD) (N = 5) Family members (N = 11) Healthcare providers (N = 14)	People who have direct experience with MAiD (patients, families, and healthcare providers)	Interpretive/constructivist approach (Thematic analysis)	Sem-structured interviews	Patient-and family-centered care (PFCC) in MAiD (Emotional, physical, spiritual, and relational PFCC considerations)	The care considerations identified assist in conceptualizing the components of a quality PFCC MAID program.

Bereavement and the Oregon Death with Dignity Act: How does assisteddeath impact grief?	Srinivasan, 2019; USA	Explores bereavement experiences with an assisted death	Family members (mostly spouses) (N = 22)	Family members of patients who died through DWDA	Thematic Analysis	Interviews	Grief during the dying through DWDA process.	This study provides an in-depth qualitative explor-ation of bereavement experiences following anassisted death. The 'sense of control' theme describes personal experiences and views of loved ones regarding DWDA, and how it provided a sense of control, autonomy, dignity, peace, and closure.

Exploring the experience of supporting a loved one through a medically assisted death in Canada	Holmes et al.;,2018; Canada	To explore the experience of family and close friends of patients seeking medical assistance in dying (MAID) in Canada.	Caregivers/support system of patients seeking/have seeked MAiD (N = 18)	Experience of people whose loved ones sought out MAiD due to terminal/serious medical condition	Thematic Analysis	Virtual interviews	Focus on personal feelings when loved one wanted MAiD, preparation for MAiD, day of assisted death and reflections after, and comparing MAiD to natural death.	Participants in the study recounted their experiences supporting loved ones through the Medical Assistance in Dying (MAID) process in a context where assisted death has recently been legalized. They expressed full support for their loved ones' wishes after witnessing their suffering. The

								participants offered emotional and practical support in preparation for MAID, ultimately finding the process peaceful and noting advantages over natural death based on their loved ones' circumstances.

Experiences and perspectives of people who pursued medical assistance in dying	Nuhn et al., 2018; Canada	To explore the experiences, wishes, fears, and beliefs of people who requested and were eligible for medical assistance in dying (MAID) in Canada in the first year after legalization.	People requesting and eligible for MAID (suffering from long-term medical conditions) (N = 23) Family and friends who were identified as the patients' primary support people (N = 18)	Explore experience of people seeking MAiD, the first year after legalization	Descriptive design (Thematic analysis)	In-person interview	Explore reasons for choosing MAiD, and hopes/fears/wishes regarding MAiD.	The most prominent theme was that people believed it was important to have autonomy and control over their own lives. They wanted to decide for themselves when their suffering was too great and they wanted to have end-of-life options that included MAID.

Caregivers' Experiences With Medical Aid-In-Dying in Vermont: A Qualitative Study	Buchbinder et al., 2018; USA	To explore the experiences of lay caregivers involved with AID in the U.S., focusing on the day of death.	Caregivers of 11 patients (N = 19)	Caregivers' experience on the day of dying	Descriptive design (Inductive interpretative thematic analysis	In-person interview	Day of dying using MAiD	AID (Assistance in Dying) enables terminally ill patients to control the circumstances of their death, including timing, location, and attendees, thereby avoiding the suffering associated with the dying process. This approach often results in a more orderly death compared to natural ones. Patients seeking AID

								rely on social support from caregivers, significantly altering the end-of-life caregiving experience, making it more predictable and manageable.

Family Caregivers' Reflections on Experiences of Assisted Suicide in Switzerland: A Qualitative Interview Study	Gamondi et al., 2018; Switzerland	To explore family caregiver' reflections on experiences of assisted suicide in Switzerland.	Family caregivers (N = 28)	Caregivers of loved ones who chose assisted suicide as their form of dying/death	Deductive coding framework (Framework analysis)	Interviews (60-90 mins) in native language (French and Italian) and then translated to English	Experience of caregivers in phases.	Findings indicate that families played a critical role in allowing patients to obtain assisted suicide, and it appears likely that assisted suicide in some cases may not have been possible if families had not provided crucial help. It is possible that the Swiss civil model of assisted suicide allows patients and families

								greater autonomy in decision making and organization of assisted suicide.

Understanding the Reasons Behind Healthcare Providers' Conscientious Objection to Voluntary Assisted Dying in Victoria, Australia	Haining et al., 2021; Australia	To understand how conscientious objection (CO) operates in the context of VAD	Health professional (N = 17)	Health professionals who self-declared their CO to VAD prior to the legalization of VAD in 2019	Phenomenological (Thematic analysis)	Sem-structured interviews (In-person and virtual)	CO to VAD among health care workers	A key finding of this study is that, amongst these participants, religious reasons for objecting to VAD were seldom cited. Most participants' accounts of their CO referred to reasons that could be regarded as secular, humanist, or professional. This runs counter to what might be assumed: that as religious affiliations

								weaken and church attendance diminishes, that the need to accommodate doctors' CO to procedures like assisted dying might also recede. It also highlights the importance of having a better understanding of non-religious CO to VAD.

Patient experiences with requests for medical assistance in dying	Fruhstorfer, 2024; Canada	To explore experiences of patients who have complex chronic conditions (CCCs), such as fibromyalgia and chronic fatigue syndrome, when they request medical assistance in dying (MAID) in Canada.	People who have sought out MAiD (N = 16)	Patients who have complex chronic conditions (CCCs), who have sought out MAiD	Descriptive design (Thematic analysis and deductive analysis)	Virtual interviews	Exploring reasons behind seeking out MAiD	This report provided an opportunity for people with CCCs, such as chronic pain and CFS, to describe their suffering and their journeys toward applying for MAID.

Table 3. Critical appraisal based on JBI guidelines

Study Title	**Author(s), Year, Country**	**1. Is there congruity between the stated philosophical perspective and the research methodology?**	**2. Is there congruity between the research methodology and the research question or objectives?**	**3.Is there congruity between the research methodology and the methods used to collect data?**	**4. Is there congruity between the research methodology and the representation and analysis of data?**	**5. Is there congruity between the research methodology and the interpretation of results?**	**6. Is there a statement locating the researcher culturally or theoretically?**	**7. Is the influence of the researcher on the research, and vice-versa, addressed?**	**8. Are participants, and their voices, adequately represented?**	**9. Is the research ethical according to current criteria or, for recent studies, and is there evidence of ethical approval by an appropriate body?**	**10. Do the conclusions drawn in the research report flow from the analysis, or interpretation, of the data?**
Physicians' moral distinctions between medical assistance in dying (MAiD) and withdrawing life-	Matthew et al., 2025; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

sustaining treatment in Canada: a qualitative descriptive study											
What About Us? Experiences of Relatives Regarding Physician-Assisted Death for Patients Suffering from Mental Illness: A Qualitative Study	Pronk, et al., 2021; Netherlands	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
The discursive context of medical aid in dying: A paradox of control?	Young, et al., 2021; New Zealand	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Choreographing a good death: Carers' experiences and practices	Lewis, et al., 2024; Australia	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes

of enacting assisted dying											
Unacknowledged Pain and Disenfranchised Grief: A Narrative Analysis of Physicaland Emotional Pain in Complex MAiD Bereavement Stories	Sarota, et al., 2023; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
A qualitative study exploring family caregivers' support needs in the context of medical assistance in dying	Smolej, et al., 2023; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hospice care providers experiences of grappling with medical	Freeman, et al., 2021; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

assistance in dying in a hospice setting: a qualitative descriptive study											
Medical assistance in dying and the meaning of care: Perspectives of nurses, pharmacists, and social workers	Mills, et al., 2021; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Care Considerations in a Patient- and Family-Centered Medical Assistance in Dying Program	Brown, et al., 2022; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
Bereavement and the Oregon Death with Dignity Act: How does	Srinivasan, et al., 2019; USA	N/A	Yes	Yes	Yes	Yes	Yes	No	Yes	Unclear	Yes

assisteddeath impact grief?											
Exploring the experience of supporting a loved one through a medically assisted death in Canada	Holmes, et al., 2018; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Experiences and perspectives of people who pursued medical assistance in dying	Nuhn, et al., 2018; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
Caregivers' Experiences With Medical Aid-In-Dying in Vermont: A Qualitative Study	Buchbinder, et al., 2018; USA	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
Family Caregivers'	Gamondi, et al.,	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Reflections on Experiences of Assisted Suicide in Switzerland: A Qualitative Interview Study	2018; Switzerland										
Understanding the Reasons Behind Healthcare Providers' Conscientious Objection to Voluntary Assisted Dying in Victoria, Australia	Haining, et al., 2021; Australia	N/A	Yes	Yes	Yes	Yes	Yes	Unclear	Yes	Yes	Yes
Patient experiences with requests for medical assistance in dying	Fruhstorfer, 2024; Canada	N/A	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Main Findings

Six main themes emerged from the analysis, in which assisted suicide was consistently discussed in relation to ideals of kalothanasia, death with dignity, and moral acceptability. Themes revealed that assisted dying is not understood merely as a medical procedure, but as a deeply valued-laden process shaped by human autonomy, suffering, relational (and often complex) dynamics, and ethical tensions. The themes capture how patients, caregivers/family members, and healthcare professionals perceive and experience assisted suicide in relation to features of a 'good death'. Together, these themes represent interrelated implications of how assisted suicide is understood as a good death, while also revealing points of tension, ambivalence, and moral contestation across stakeholder groups. Table 4 contains a summary of the themes and illustrative quotations.

Table 4. Summary of the findings and quotations

Emerged themes	Theme's core	Stakeholders	Reference	Quotes
Autonomy and control over dying	Assisted suicide is framed as enabling control over timing, place, and conditions of death, often linked to identity, independence, and a fear of a "failed" death.	Patients; families/caregivers	Young et al., 2021; Nuhn et al., 2018; Buchbinder et al., 2018; Srinivasan, 2019; Holmes et al., 2018	"The control I want to have really is only in the event of…a failure of a good death." (Young et al., 2021)
Dignity and relief of suffering as justification	Assisted suicide is understood as a dignified and compassionate response to severe suffering (physical and/or psychological), where continued life is experienced as intolerable.	Patients; family members/caregivers; HCPs	Fruhstorfer, 2024; Sarota et al., 2023; Smolej et al., 2023; Mills et al., 2021; Matthew et al., 2025	"What I'm suffering from [the pain] is equal to that of stage 4 bone cancer." (Fruhstorfer, 2024)
Choreographing a 'good death' through planning and presence	A "good death" via assisted suicide is actively produced through planning, rituals, and relational coordination; when it goes well it is remembered as	Families/caregivers	Lewis et al., 2024; Holmes et al., 2018; Buchbinder et al., 2018; Gamondi et al., 2018;	"It was very peaceful and lovely…and we have lovely memories of that last day…"

	peaceful, but deviations can be distressing.		Brown et al., 2020	(Lewis et al., 2024)
Ambivalence and moral conflict around assisted suicide	Relatives and professionals often experience mixed emotions (support + discomfort), shaped by moral frameworks, religion/culture, hope for recovery, or professional identity.	Relatives; caregivers; HCPs	Pronk et al., 2021; Lewis et al., 2024; Freeman et al., 2021; Haining et al., 2021	"I understood her suffering… but I wanted to grow old with her." (Pronk et al., 2021)
Assisted suicide as 'care' versus 'killing'	Stakeholders negotiate whether assisted suicide is care, palliation, or killing, often resolving tension through emphasis on voluntariness, intention, and autonomy; clinicians also compare it with withdrawal of treatment.	HCPs; (sometimes families)	Mills et al., 2021; Matthew et al., 2025; Freeman et al., 2021	"The process is so incredibly smooth and peaceful…" (Mills et al., 2021)
Closure, bereavement, and continuing complexity	Assisted suicide can enable goodbye rituals and closure, but grief may remain complex, including guilt, distress, or disenfranchised grief—especially when the process is experienced as disrupted or morally contested.	Relatives; caregivers	Holmes et al., 2018; Srinivasan, 2019; Sarota et al., 2023; Gamondi et al., 2018; Lewis et al., 2024	"For us to spend all of that time before was such a privilege…" (Holmes et al., 2018)

Theme 1: Autonomy and control over dying

Assisted suicide was frequently associated and described as a means to preserve control over the circumstances of death, including timing, location, and who is present, often in response to feared loss of independence or identity (Nuhn et al., 2018; Young et al., 2021). In caregivers' accounts, control also involved practical management of the dying process

and the creation of an orderly, predictable death (Buchbinder et al., 2018), and in bereavement narratives, it was associated with comfort and reduced distress linked to uncertainty (Srinivasan, 2019). Support networks described planning and selecting the date as part of a death, understood to be "on one's own terms", contributing to the meaning of dignity and agency (Holmes et al., 2018). While patients primarily emphasized autonomy in relation to anticipated bodily decline, loss of identity, and self-determination (Nuhn et al., 2018; Young et al., 2021), caregivers and bereaved relatives framed control over relationally, as the ability to anticipate, organize, and emotionally prepare for death, thereby reducing uncertainty and distress (Buchbinder et al., 2018; Holmes et al., 2018; Srinivasan, 2019).

Theme 2: Dignity and relief of suffering

Across patient and family accounts, severe suffering, both physical and psychological, was central to the understanding of assisted suicide as a compassionate pathway to dignified death (Fruhstorfer et al., 2024; Serota et al., 2023). Caregivers frequently framed support for MAiD in terms of relieving unbearable suffering and avoiding prolonged deterioration, linking assisted suicide to humane and empathetic end-of-life care (Smolej et al., 2023). Healthcare professionals similarly emphasized relief of suffering as ethically salient, including in compassion between MAiD and withdrawal of life-sustaining treatment, where intention and context shaped moral permissibility (Matthew et al., 2025). Beyond symptom burden, dignity was also articulated in terms of remaining faithful to one's values, preserving identity, and determining when life no longer aligned with what participants considered meaningful living, in other words, a life that was worth living in accordance with the participants' preferences (Nuhn et al., 2018; Young et al., 2021).

Theme 3: Choreographing a 'good death' through planning and presence

Family members and caregivers described assisted suicide as requiring active organization and relational labour to produce a 'good death', including rituals, shared time, and careful management of the environment (Gamondi et al., 2018; Lewis et al., 2024). Caregivers also described structured preparation and a staged sequence of events on the day of the death (Buchbinder et al., 2018; Holmes et al., 2018). Where planning aligned with expectations, assisted death was remembered as peaceful and relationally meaningful; when procedures felt crowded, chaotic, or misaligned with needs,

experiences were distressing and challenged the ideal of 'good death' (Lewis et al., 2024). Patient and family-centered care elements, including emotional, physical, spiritual, and relational, were explicitly used to conceptualize quality of assisted dying provision (Brown et al., 2022).

Theme 4: Ambivalence and moral conflict around assisted suicide

Despite empathy and support, relatives often held ambivalent positions, simultaneously understanding suffering, struggling with moral frameworks, religious beliefs, or hope for alternatives (Pronk et al., 2023). Caregivers likewise reported mixed emotions even when describing assisted dying as the "best thing", indicating that participation could be both meaningful and confronting (Lewis et al., 2024). Among hospice staff and other professionals, assisted dying could produce interpersonal unease and guilt, including worries about normalization and desensitization (Freeman et al., 2021). Objection narratives highlighted objections grounded not only in religion but also in professional and secular moral reasoning, including concerns about transient suffering and the preservation of life ethos (Haining et al., 2021). Importantly, ambivalence was not experienced as indecision or lack of support, but as an enduring moral tension produced by competing values, such as care, hope, responsibility, and the meaning of death itself.

Theme 5: Assisted suicide as care vs 'killing'

Across studies, assisted suicide emerged as a morally contested practice, positioned at the boundary between care, palliation, and the intentional ending of life. Professionals and stakeholders negotiated whether assisted suicide should be conceptualized as care, palliation, or ending one's life. For some clinicians, participation was framed as care because it supported autonomy and resulted in a peaceful process (Mills et al., 2023). Physicians also drew distinctions between causation, intention, voluntariness, and the language of "ending someone's life", sometimes aligning assisted suicide with other end-of-life decisions such as withdrawing treatment (Matthew et al., 2025). In hospice contextst, assisted suicide could be experienced as a disrupted pathway that generated relational challenges and discomfort among frontline staff (Freeman et al., 2021).

Theme 6: Closure, bereavement, and continuing complexity

Assisted suicide was described as enabling anticipatory goodbyes, shared meaning-making, and closure often experienced as 'privilege' of time and intentional presence

(Holmes et al., 2018). Bereavement after assisted death included comfort and peace linked to autonomy and reduced uncertainty (Srinivasan, 2019), but grief could also be complex and morally charged, including experiences of unacknowledged pain or disenfranchised grief (Serota et al., 2023). Caregivers and family members suggested that the emotional consequences of assisted dying were shaped by how closely the experience matched expectations of a 'good death' and by the broader organizational and cultural framing of assisted suicide. In the study conducted by Lewis et al. (2024), carers described actively enacting a good death through careful planning, ritualization, and shared presence, with emotional outcomes ranging from peace and gratitude when the death unfolded as imagined to distress, guilt, and lingering ambivalence when the process deviated from expectations. By contrast, Gamondi et al. (2018) showed that in the Swiss context, where assisted suicide is embedded within a civil, non-medicalized model, carers' emotional experiences were shaped less by the immediate choreography of the dying moment and more by the prolonged process of contemplation, acceptance, and collective decision-making.

Across themes, assisted suicide was consistently framed as an attempt to align the circumstances of death with personal values, relational needs, and moral reasoning. However, the realization of a 'good death' was shown to be contingent, shaped by organizational contexts (in the case of healthcare experiences), interpersonal dynamics, and unresolved ethical dilemmas. Kalothanasia thus emerged not as a fixed outcome, but as a negotiated and sometimes fragile process.

Discussion

This qualitative systematic review synthesized how patients, family members/caregivers, and healthcare professionals perceive and experience assisted suicide in relation to kalothanasia. Across sixteen qualitative studies, assisted suicide consistently emerged as a deeply moral, relational, and value-based practice rather than a purely medical or legal intervention. This synthesis advances three higher-order contributions that move beyond reiterating single themes and instead clarify what the findings *mean* for how assisted dying is understood, organized, and supported in practice.

First, the findings position assisted dying as a relational moral practice rather than a procedure. Although autonomy and control were central across stakeholder groups, they were not expressed as an abstract individual right alone; instead, autonomy was enacted through decisions about timing, place, and social presence, and negotiated through relationships and care roles. Patients framed assisted suicide as preserving agency in the face of progressive illness, threatened identity, and anticipated loss of self-determination, aligning with accounts that connect dignity to authorship of one's life narrative (Frantz et al., 2025) and with broader arguments that autonomy, while foundational, is also relationally embedded in assisted dying contexts (Wittrock, 2025). This relational moral framing is also visible in caregivers' and families' experiences: assisted suicide was repeatedly described as requiring "choreography" (e.g., planning, environmental preparation, ritualization, and shared presence) so that dying could unfold in ways that felt orderly, meaningful, and ethically "right." In this sense, assisted dying appears less like a discrete clinical act than a temporally extended social practice, consistent with end-of-life ethics scholarship describing "good death" as socially situated rather than momentary or purely individual (Balducci, 2012; Kovács, 2014). The moral stakes were not confined to whether assisted dying is permissible, but to how it is carried out, with whom, and under what institutional conditions, an observation reinforced by reports of distress when procedures felt crowded, chaotic, or misaligned with the relational needs of those present (Kovács, 2014; Krikorian et al., 2020).

Second, this synthesis clarifies kalothanasia as a process rather than an endpoint. Across studies, the "good death" was not treated as a stable outcome that assisted suicide straightforwardly delivers; instead, it emerged as a negotiated and sometimes fragile process shaped by autonomy, suffering, relational closure, and moral reasoning. Relief of suffering (physical and psychological) was frequently invoked as a moral justification for assisted suicide, but participant accounts framed suffering not only as symptom burden; it was also described as existential erosion, loss of meaning, and threats to personhood and autonomy. These meanings resonate with literature emphasizing that dignity can be undermined when suffering becomes overwhelming or unresponsive to care (Meier et al., 2016; Pereira et al., 2025). Yet the synthesis also shows that the pursuit of kalothanasia often carries moral tension: relatives could be simultaneously compassionate and resistant, influenced by cultural, religious, or existential beliefs; professionals negotiated intention, proportionality, and the moral language surrounding assisted suicide in ways

that echo enduring ethical disputes (e.g., “killing” versus other end-of-life decisions). The key interpretive point is that assisted suicide was often understood as morally permissible not because death is desired per se, but because continued existence under certain conditions is perceived as incompatible with dignity or with a life considered worth living. In that respect, kalothanasia appears in these accounts as a moral Horizon, something pursued through choices and relationships, rather than a guaranteed endpoint, supporting the view that “good death” ideals can be both supportive and burdensome when treated as prescriptive norms (Kovács, 2014; Krikorian et al., 2020).

Third, the findings support reframing death education as an infrastructural response rather than an add-on. In the included studies, stakeholders repeatedly navigated ambivalence, ethical uncertainty, and emotionally complex relational dynamics; these challenges were not peripheral but structurally produced by the moral plurality surrounding assisted suicide and by the practical demands of organizing an intentional death. In this context, death education is best understood as a system-level capacity that can strengthen how patients, families, and professionals interpret suffering, articulate values, and negotiate expectations of a “good death.” Evidence from death education programs indicates that increasing death literacy can reduce fear, improve ethical dialogue, and foster more compassionate engagement with death-related attitudes across settings (Romão et al., 2025). Applied to assisted dying contexts, death education may help prevent the ideal of a “perfect” death from becoming a source of pressure or guilt, support more realistic preparation, and provide shared ethical language for navigating moral disagreement without escalating into relational rupture or professional moral distress (De Cock et al., 2024; Sutherland, 2019). Importantly, this framing extends beyond clinical training: at the policy level, the synthesis reinforces arguments that death with dignity should not be addressed solely through legal permissibility, but through broader public health and educational strategies that normalize conversations about death, dying, and moral pluralism (S. Richards, 2025; Romão et al., 2025). If death with dignity is treated as a human right, it also implies societal obligations to ensure access to information, dialogue, psychosocial care, and ethical support throughout the dying process, not only the availability of an assisted death (Wittrock, 2025).

Taken together, these three contributions situate assisted suicide within a broader ecology of meaning, care, and moral responsibility. They suggest that kalothanasia is not achieved solely through the availability of assisted dying, but through sustained cultural,

educational, and institutional efforts that enable individuals and communities to confront death openly, compassionately, and ethically.

Limitations and future directions

The review has two main limitations: (1) the qualitative evidence base is uneven and mostly comes from countries where assisted dying is already legal, so perspectives from restrictive or culturally contested settings are likely underrepresented; and (2) using *kalothanasia* ("good death") as the analytic lens is useful but normatively and culturally loaded, requiring interpretive judgment and potentially downplaying experiences that resist "good death" ideals. Future research should prioritize jurisdictions where assisted dying is new or ambiguous (e.g., Italy), broaden stakeholder groups beyond patients/families/clinicians (e.g., ethics committees, administrators, palliative care teams), and study the limits and tensions of the "good death" frame, especially cases of ambivalence, regret, or moral distress, using longitudinal qualitative designs to track how meanings change over time.

Conclusions

This qualitative systematic review synthesised empirical evidence on how AD is experienced and understood in relation to ideals of a good death, kalothanasia, and death with dignity. By foregrounding lived experiences and moral reasoning across patients, families or caregivers, and healthcare professionals, the review moves beyond polarized ethical debates to highlight the relational, emotional, and existential dimensions that shape AD practices. The findings underscore that AD is rarely understood as a purely technical or legal intervention, but rather as a deeply situated practice embedded in personal values, social relationships, and institutional norms. Taken together, the review suggests that analysing AD through the lens of kalothanasia offers a productive way to capture both its appeal and its ethical complexity. While AD is often framed as a means of achieving a good death, the synthesis reveals that such ideals are negotiated, contingent, and dynamic. Attending to these complexities is essential for clinicians, policymakers, and ethicists seeking to engage responsibly with AD as it becomes an increasingly prominent feature of end-of-life care.

References

Balducci, L. (2012). Death and dying: What the patient wants. *Annals of Oncology*, *23*, iii56–iii61. https://doi.org/10.1093/annonc/mds089

Brown, D. T., Frisby, H., & Prior, S. (2024). Grave communications: How an understanding of gravedigging practices informs post-medieval cemetery excavations and interpretations. *Post-Medieval Archaeology*, *58*(1), 100–120. https://doi.org/10.1080/00794236.2024.2356653

Brown, J., Goodridge, D., Harrison, A., Kemp, J., Thorpe, L., & Weiler, R. (2022). Care Considerations in a Patient- and Family-Centered Medical Assistance in Dying Program. *Journal of Palliative Care*, *37*(3), 341–351. https://doi.org/10.1177/0825859720951661

Buchbinder, M., Ojo, E., Knio, L., & Brassfield, E. R. (2018). Caregivers' Experiences With Medical Aid-In-Dying in Vermont: A Qualitative Study. *Journal of Pain and Symptom Management*, *56*(6), 936–943. https://doi.org/10.1016/j.jpainsymman.2018.08.010

Butler, A., Hall, H., & Copnell, B. (2016). A Guide to Writing a Qualitative Systematic Review Protocol to Enhance Evidence-Based Practice in Nursing and Health Care. *Worldviews on Evidence-Based Nursing*, *13*(3), 241–249. https://doi.org/10.1111/wvn.12134

Cottrell, L., & Duggleby, W. (2016). The "good death": An integrative literature review. *Palliative and Supportive Care*, *14*(6), 686–712. https://doi.org/10.1017/S1478951515001285

De Cock, C., Mathieu-Nicot, F., Trimaille, H., Giffard, M., & Chassagne, A. (2024). Requesting euthanasia or assisted suicide when it is illegal: A qualitative study

about relatives' experiences of patients hospitalized in French Palliative Care Units. *Palliative Care and Social Practice*, *18*, 26323524241308267. https://doi.org/10.1177/26323524241308267

De Lima, L., Woodruff, R., Pettus, K., Downing, J., Buitrago, R., Munyoro, E., Venkateswaran, C., Bhatnagar, S., & Radbruch, L. (2017). International Association for Hospice and Palliative Care Position Statement: Euthanasia and Physician-Assisted Suicide. *Journal of Palliative Medicine*, *20*(1), 8–14. https://doi.org/10.1089/jpm.2016.0290

Fontalis, A., Prousali, E., & Kulkarni, K. (2018). Euthanasia and assisted dying: What is the current position and what are the key arguments informing the debate? *Journal of the Royal Society of Medicine*, *111*(11), 407–413. https://doi.org/10.1177/0141076818803452

Frantz, P., Rego, F., & Barbas, S. (2025). Reclaiming human dignity: A critical review of contemporary theories in light of ontological foundations. *Medicine, Health Care, and Philosophy*, *28*(4), 791–797. https://doi.org/10.1007/s11019-025-10290-7

Freeman, S., Banner, D., & Ward, V. (2021). Hospice care providers experiences of grappling with medical assistance in dying in a hospice setting: A qualitative descriptive study. *BMC Palliative Care*, *20*(1), 55. https://doi.org/10.1186/s12904-021-00740-3

Fruhstorfer, C., Kelly, M., Spiegel, L., Baylis, P. J., Dembo, J., & Wiebe, E. (2024). Patient experiences with requests for medical assistance in dying: Perspectives of those with complex chronic conditions. *Canadian Family Physician Medecin De Famille Canadien*, *70*(1), 41–47. https://doi.org/10.46747/cfp.700141

Gaignard, M.-E., Pautex, S., & Hurst, S. (2023). Existential suffering as a motive for assisted suicide: Difficulties, acceptability, management and roles from the perspectives of Swiss professionals. *PLOS ONE*, *18*(4), e0284698. https://doi.org/10.1371/journal.pone.0284698

Gamondi, C., Pott, M., Preston, N., & Payne, S. (2018). Family Caregivers' Reflections on Experiences of Assisted Suicide in Switzerland: A Qualitative Interview Study. *Journal of Pain and Symptom Management*, *55*(4), 1085–1094. https://doi.org/10.1016/j.jpainsymman.2017.12.482

Haining, C. M., Keogh, L. A., & Gillam, L. H. (2021). Understanding the Reasons Behind Healthcare Providers' Conscientious Objection to Voluntary Assisted Dying in Victoria, Australia. *Journal of Bioethical Inquiry*, *18*(2), 277–289. https://doi.org/10.1007/s11673-021-10096-1

Holmes, S., Wiebe, E., Shaw, J., Nuhn, A., Just, A., & Kelly, M. (2018). Exploring the experience of supporting a loved one through a medically assisted death in Canada. *Canadian Family Physician*, *64*(9), e387–e393.

Kovács, M. J. (2014). A caminho da morte com dignidade no século XXI. *Revista Bioética*, *22*, 94–104.

Krikorian, A., Maldonado, C., & Pastrana, T. (2020). Patient's Perspectives on the Notion of a Good Death: A Systematic Review of the Literature. *Journal of Pain and Symptom Management*, *59*(1), 152–164. https://doi.org/10.1016/j.jpainsymman.2019.07.033

Lewis, S., La Brooy, C., Kerridge, I., Holmes, A., Olver, I., Hudson, P., Dooley, M., & Komesaroff, P. (2024). Choreographing a good death: Carers' experiences and practices of enacting assisted dying. *Sociology of Health & Illness*, *46*(7), 1345–1363. https://doi.org/10.1111/1467-9566.13761

Lockwood, C., Porritt, K., Munn, Z., Rittenmeyer, L., Salmond, S., Bjerrum, M., Loveday, H., Carrier, J., & Stannard, D. (2024). Systematic reviews of qualitative evidence. In E. Aromataris, C. Lockwood, K. Porritt, B. Pilla, & Z. Jordan (Eds.), *JBI Manual for Evidence Synthesis*. JBI. https://doi.org/10.46658/JBIMES-24-02

Matthew, M., Bonner, K., & Stumpf, A. (2025). Physicians' moral distinctions between medical assistance in dying (MAiD) and withdrawing life-sustaining treatment in Canada: A qualitative descriptive study. *BMC Medical Ethics*, *26*(1), 19. https://doi.org/10.1186/s12910-025-01176-7

Meier, E. A., Gallegos, J. V., Thomas, L. P. M., Depp, C. A., Irwin, S. A., & Jeste, D. V. (2016). Defining a Good Death (Successful Dying): Literature Review and a Call for Research and Public Dialogue. *The American Journal of Geriatric Psychiatry*, *24*(4), 261–271. https://doi.org/10.1016/j.jagp.2016.01.135

Mills, A., Bright, K., Wortzman, R., Bean, S., & Selby, D. (2023). Medical assistance in dying and the meaning of care: Perspectives of nurses, pharmacists, and social workers. *Health (London, England: 1997)*, *27*(1), 60–77. https://doi.org/10.1177/1363459321996774

Nuhn, A., Holmes, S., Kelly, M., Just, A., Shaw, J., & Wiebe, E. (2018). Experiences and perspectives of people who pursued medical assistance in dying. *Canadian Family Physician*, *64*(9), e380–e386.

Ouzzani, M., Hammady, H., Fedorowicz, Z., & Elmagarmid, A. (2016). Rayyan—A web and mobile app for systematic reviews. *Systematic Reviews*, *5*(1), 210. https://doi.org/10.1186/s13643-016-0384-4

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., Shamseer, L., Tetzlaff, J. M., Akl, E. A., Brennan, S. E., Chou, R., Glanville,

J., Grimshaw, J. M., Hróbjartsson, A., Lalu, M. M., Li, T., Loder, E. W., Mayo-Wilson, E., McDonald, S., … Moher, D. (2021). *The PRISMA 2020 statement: An updated guideline for reporting systematic reviews*. https://doi.org/10.1136/bmj.n71

Pereira, M., Ali, A. M., Fekih-Romdhane, F., Yıldırım, M., & Laranjeira, C. (2025). Fear of Death, Concept of a Good Death and Self-Compassion Among University Students in Portugal: A Cross-Sectional Study. *Healthcare*, *13*(18), 2382. https://doi.org/10.3390/healthcare13182382

Prado, E., Marcon, S., Kalinke, L., Da Silva, M., Barreto, M., Takemoto, A., Birolim, M., & Laranjeira, C. (2022). Meanings and Experiences of End-of-Life Patients and Their Family Caregivers in Hospital-to-Home Transitions: A Constructivist Grounded Theory Study. *International Journal of Environmental Research and Public Health*, *19*(20), 12987. https://doi.org/10.3390/ijerph192012987

Pronk, R., Willems, D. L., & van de Vathorst, S. (2023). What About Us? Experiences of Relatives Regarding Physician-Assisted Death for Patients Suffering from Mental Illness: A Qualitative Study. *Culture, Medicine and Psychiatry*, *47*(1), 237–251. https://doi.org/10.1007/s11013-021-09762-1

Richards, L., & Morse, J. M. (2013). *Readme First for a User's Guide to Qualitative Methods*. SAGE Publications, Inc. https://doi.org/10.4135/9781071909898

Richards, S. (2025). The Morality of Assisted Dying. -*The Journal of Medicine and Philosophy: A Forum for Bioethics and Philosophy of Medicine*, *50*(4), 262–284. https://doi.org/10.1093/jmp/jhaf003

Romão, M. E., Belli, G., Jumayeva, S., Visonà, S. D., Woodthorpe, K., Setti, I., & Barello, S. (2025). Death Education in Practice: A Scoping Review of

Interventions, Strategies, and Psychosocial Impact. *OMEGA - Journal of Death and Dying*, 00302228251338643. https://doi.org/10.1177/00302228251338643

Serota, K., Atkinson, M., & Buchman, D. Z. (2023). Unacknowledged Pain and Disenfranchised Grief: A Narrative Analysis of Physical and Emotional Pain in Complex MAiD Bereavement Stories. *Canadian Journal of Pain = Revue Canadienne De La Douleur*, *7*(2), 2231046. https://doi.org/10.1080/24740527.2023.2231046

Seveso, G., Romão, M. E., Barello, S., Visonà, S. D., Cecchetto, G., & Belli, G. (2025). Medically assisted suicide in Italy after regional law No. 16/2025: Perspectives, challenges, and the need for psychological support and specialized training for healthcare professionals. *Medicine, Science and the Law*, 00258024251380962. https://doi.org/10.1177/00258024251380962

Shapiro, G. K., Tong, E., Nissim, R., Zimmermann, C., Allin, S., Gibson, J., Li, M., & Rodin, G. (2021). Exploring key stakeholders' attitudes and opinions on medical assistance in dying and palliative care in Canada: A qualitative study protocol. *BMJ Open*, *11*(12), e055789. https://doi.org/10.1136/bmjopen-2021-055789

Smolej, E., Malozewski, M., McKendry, S., Diab, K., Daubert, C., Farnum, A., Orianna, S., Reel, K., & Cameron, J. I. (2023). A qualitative study exploring family caregivers' support needs in the context of medical assistance in dying. *Palliative & Supportive Care*, *21*(2), 254–260. https://doi.org/10.1017/S1478951522000116

Srinivasan, E. G. (2019). Bereavement and the Oregon Death with Dignity Act: How does assisted death impact grief? *Death Studies*, *43*(10), 647–655. https://doi.org/10.1080/07481187.2018.1511636

Sutherland, R. (2019). Dying Well-Informed: The Need for Better Clinical Education Surrounding Facilitating End-of-Life Conversations. *The Yale Journal of Biology and Medicine*, *92*(4), 757–764.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, *8*. https://doi.org/10.1186/1471-2288-8-45

Tong, A., Flemming, K., McInnes, E., Oliver, S., & Craig, J. (2012). Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology*, *12*(1), 181. https://doi.org/10.1186/1471-2288-12-181

White, B. P., Jeanneret, R., Close, E., & Willmott, L. (2023). The impact on patients of objections by institutions to assisted dying: A qualitative study of family caregivers' perceptions. *BMC Medical Ethics*, *24*(1), 22. https://doi.org/10.1186/s12910-023-00902-3

Wittrock, J. (2025). A human right to assisted dying? Autonomy, dignity, and exceptions to the right to life. *Nursing Ethics*, *32*(7), 2033–2043. https://doi.org/10.1177/09697330251328655

Young, J. E., Jaye, C., Egan, R., Winters, J., & Egan, T. (2021). The discursive context of medical aid in dying: A paradox of control? *Social Science & Medicine (1982)*, *291*, 114501. https://doi.org/10.1016/j.socscimed.2021.114501

Supplementary Material 1

ENTREQ: Kalothanasia and Death with Dignity: Assisted Dying as a Relational and Moral Practice. A Qualitative Evidence Synthesis of Patients', Families', and Healthcare Professionals' Experiences

ENTREQ item	What to report	Section	Page
1	Aim	Methods (opening paragraph)	5
2	Synthesis methodology	Design / Data extraction and analysis: qualitative systematic review +Thomas & Harden (2008) thematic synthesis	5 and 7
3	Approach to searching	Information source and search strategy: initial PubMed + 5 databases + Appendix A	6
4	Inclusion criteria	Eligibility criteria	6
5	Data sources	Information source and search strategy: PubMed, Scopus, Web of Science, CINAHL, PsycINFO	6
6	Electronic search strategy	Appendix A (explicitly referenced in "Information source and search strategy")	6
7	Study screening methods	Study selection and quality assessment: Rayyan, duplicates removed, dual screening, third reviewer	6 and 7
8	Study characteristics	Data extraction and analysis (extraction table fields) + Results: Study characteristics	7 and 8
9	Study selection results	PRISMA flowchart (Figure 1) is cited as reporting eligible/not eligible	8 and 9
10	Rationale for appraisal	Study selection and quality assessment: JBI checklist used; response options stated	9
11	Appraisal items/process	Study selection and quality assessment: JBI qualitative checklist + independent appraisal + disagreements resolved	9
12	Appraisal results	Results: Critical Appraisal + Table 2 placeholder	9 and 10
13	Data extraction	Data extraction and analysis: extraction table content listed	9 and
14	Software	Study selection and quality assessment: Rayyan (Ouzzani et al., 2016)	6

15	Coding	Data extraction and analysis: “line-by-line inductive coding…”	7
16	Derivation of themes	Data extraction and analysis: descriptive → higher-order themes (Thomas & Harden) And Main Findings (Figure 1)	7 and 10
17	Interpretation (lens/translation)	Data extraction and analysis + Reflexivity: kalothanasia not used a priori; themes inductive, then interpreted through sensitizing concept	7
18	Synthesis output	Main findings: six themes + Table 3	10-13
19	Context of included studies	Results: Study characteristics (countries, participants, modes of interview, analysis types)	9
20	Limitations of synthesis	Limitations and future directions	16
21	Conclusions/implications	Discussion (policy/death education implications) + Conclusions	13-16