

Perspectives of a “Good Death” among Patients who have Recovered from Severe COVID-19, Immediate Family Members of Patients who have Died from COVID-19, and Health Care Providers who Took Care of Patients who have Died from COVID-19 in a Tertiary Hospital in the Philippines

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ABSTRACT

Background. The premise of a “good death” is vital in delivering proper care of terminally-ill patients but the COVID-19 pandemic has brought about new challenges and necessary protocols. There is a need to explore this gap in knowledge and understand perspectives of various stakeholders in COVID-19-related deaths.

Objectives. To describe the perception, barriers, and facilitators of a “good death” from COVID-19 survivors, relatives, and healthcare providers in the setting of a COVID-19 tertiary hospital.

Methods. The study was done in a COVID-19 tertiary hospital in Metro Manila from September to December 2021. Three groups of target respondents were invited to participate in the study: 8 survivors of severe/critical COVID-19, 9 close relatives of COVID-19 patients who had died, and 9 healthcare providers who directly cared for COVID-19 patients who had died. Semi-structured in-depth interviews were conducted by video calls which explored themes on good death. Thematic analysis was also done.

Results. A total of 26 respondents were included in the study: 8 COVID-19 survivors, 9 relatives, and 9 healthcare providers. The definition of “Good Death” among the participants focused on “being at peace” and having “everything in order”. The experience with COVID-19 were influenced by the fear of the infection and isolation restrictions during hospitalization. Recurring themes across all groups were the fear of COVID-19 and death, importance of family in the healthcare process, difficulty in communication, and cremation viewed as necessary but not preferred.

Conclusion. A “good death” is perceived as a peaceful, prepared experience. The main barriers of a “good death” were the strict restrictions on physically comforting and communicating with patients. Video/voice calls and compassionate health care providers facilitated a better hospitalization experience. Careful study and focus on these factors can improve interventions for terminally ill patients to achieve a “good death” in the Filipino socio-cultural context.

Keywords: death, COVID-19, perception

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INTRODUCTION

The description of a "good death" in the time of COVID-19 has been difficult and diverse. Testoni conducted in-depth interviews with priests on COVID-19-related deaths and came up with 3 common themes: the prevailing (negative) early emotions, social distancing and the perceived inadequacy of the funeral rituality, and religion and prayer as sources of resilience.¹ For health care providers dealing with loved ones who passed away, issues of mental health, loss of sleep, post-traumatic stress, inability to attend funerals, cremation, and not being able to say their last goodbyes were the prevailing issues.² In Italy, people who had lost loved ones noted four major themes in their loss: 1. Abandonment: Anger and Guilt, 2. Dehumanization, 3. Derealization and Constant rumination, and 4. Social support and the importance of sharing photos on social media.³

The overwhelming negative aspect of "death" due to COVID-19 has led some authors to argue that all COVID-19 deaths are "bad deaths", with patients marred

with "physical discomfort, difficulty of breathing, social isolation, psychological distress, lack of preparation, being treated without respect or dignity, and the receipt of unwanted medical interventions or being deprived of treatments one desires."⁴ Attempts to establish a set criteria, as well as set a standard script, have been met with contrasting belief of individualizing the criteria due to studies showing how different groups of people, such as patients, nurses or physicians, define a "good death".⁵

This study aims to explore the themes prevalent in a Philippine COVID-19 tertiary health facility during the pandemic, and to find out which are common among patients who recovered from severe COVID-19, relatives of patients who died of COVID-19, as well as health care providers (HCPs) who attended to COVID-19 patients.

Conceptual Framework

The conceptual framework adopted by this study is based on the Commonwealth-Cummings Project (Figure 1).⁶ The framework is based on the assumption that the overall

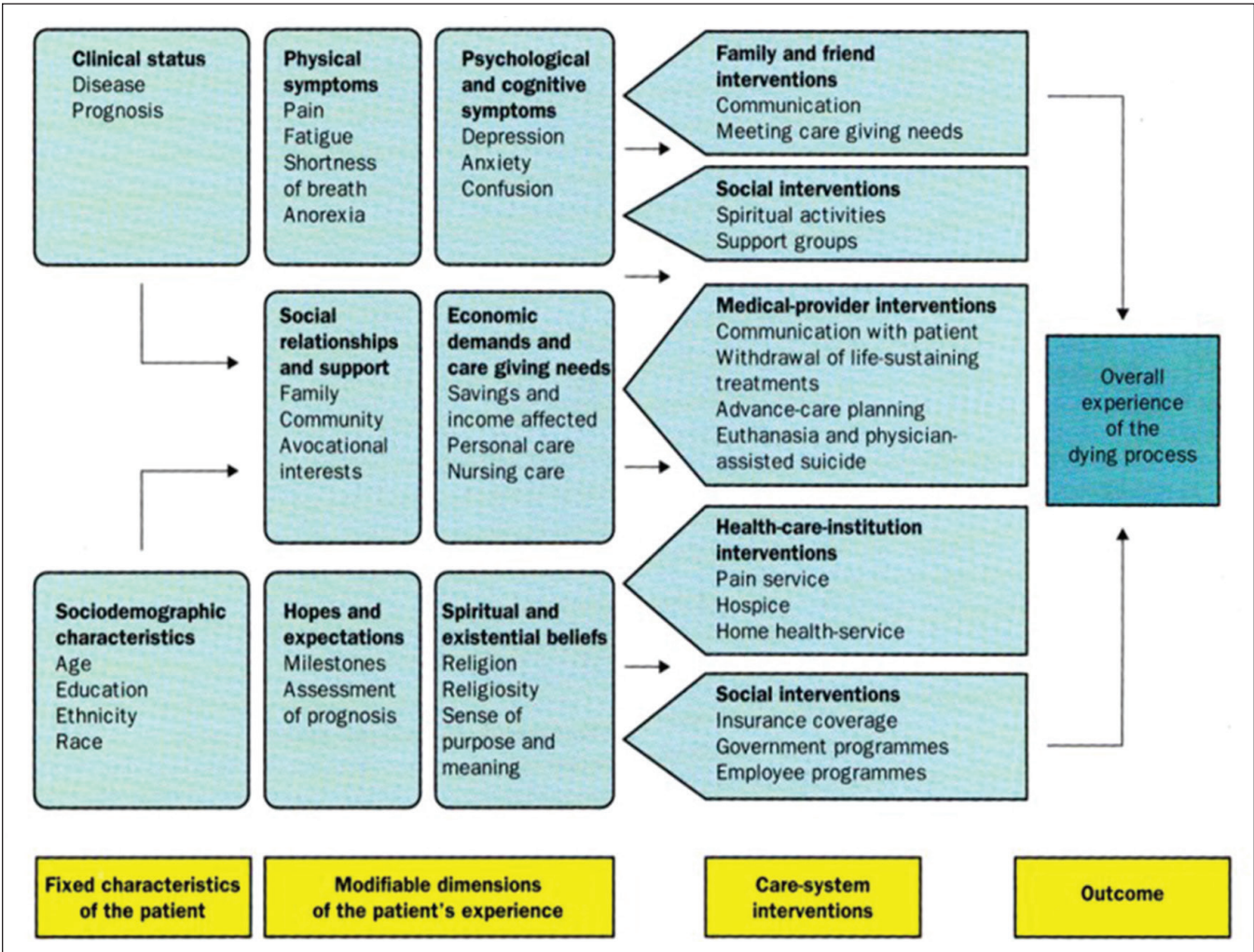


Figure 1. Framework for a Good Death.

experience of the dying process is affected by multi-dimensional qualities, where there are fixed variables as well as modifiable variables. The four characteristics that influence the dying experience are outlined in Figure 1. The purpose of this framework is to systematically evaluate different components as well as show that physical and psychological aspects are interlinked. It also shows that dying is not a medical experience but also a social and psychological one. A "good death" in this conceptual framework is achieved when the modifiable dimensions of the patient's experience have favorable outcomes.

This framework characterizes dying as primarily a multi-dimensional experience based on evolving insights in the end-of-life field. The framework states the dying experience can be divided into four critical components.

1. The fixed characteristics of the patient
2. The modifiable dimensions of the patient's experience, or elements that may respond to events or interventions
3. The potential interventions available to family, friends, health-care providers, and others
4. The overall outcome

MATERIALS AND METHODS

Study Setting

The study was conducted among participants from the Philippine General Hospital (PGH), a tertiary government hospital. It is a 1,500 bed capacity hospital taking care of 600,000 patients annually. During the pandemic, PGH was designated as a "National Referral Center for COVID-19". PGH was treating 150-240 COVID-19 patients daily during the pandemic of April 2020 to December 2021. PGH had 7,508 confirmed COVID-19 cases managed from April 2020 to December 2021. During that period, there were 1,714 COVID-19-related deaths.

Study Design and Duration

The study was a cross-sectional qualitative study employing interviewer-directed semi-structured in-depth interviews via video calls. The study was conducted from September 2021 to December 2021.

Materials: Development of interview guide

In-depth interview questions were developed based on similar studies on "good death" with focus on their major concerns in relation to death, hospitalization, and mourning.⁷ Validation of the guide questions were done using forward and back-translations and pre-testing for face validity to ensure that the questions would rate highly on the following criteria:

1. Relevance to the study objectives
2. Clarity of questionnaire item/ sentences
3. Appropriateness to target respondent (HCP/ COVID survivor/ relative)

Three sets of questions were prepared, one for COVID-19 survivors, another for relatives who experienced loss of a loved one through COVID-19-related death, and another for HCPs who took care of patients in COVID-19 wards with subsequent death of patients (Appendices 1A, 1B and 1C).

Selection and Recruitment of participants

The investigators used purposive sampling method based on existing personal or professional networks in PGH patterned after the rapid ethnographical research done by Simpson.⁸ To respect participants' bereavement period, there was at least 2 weeks interval from the Index Event (death of patient/loved one or recovery from COVID-19). Informed consent was secured, carefully explaining details of the interview as well as risks and benefits. The participants were informed that if they feel any anxiety or any negative emotions during the course of the interview, they would be offered psychiatric counselling arranged by the investigators.

Data Collection

Interviewers, who were Anesthesiology Pain Fellows, were initially trained by the investigators on how to conduct the interview prior to contacting participants, taking into consideration the sensitive topic of death. Study interviewers set up appointments with potential respondents through voice call or message in order to explain the study and the written informed consent.

After the respondent signed the consent form, the interview proper was done through video call so that behaviors and non-verbal cues could be better observed. Online telecommunication applications such as Zoom, Viber, and Messenger, were used. Interviews were conducted remotely in a quiet and safe room for both parties to ensure privacy. The interviews were recorded using either the video call platform or through a digital audio recorder.

Data Analysis

Interviewers transcribed and summarized the interviews independently and sent them to investigators. Investigators then organized them into coded transcripts according to agreed themes. Investigators analyzed these reports and compared common themes within different stakeholders as well as their differences. Perspectives and themes were then presented and expounded upon as narratives and quotes from the interviews. Study procedure flow diagram is shown in Figure 2.

Ethical Considerations

This study was approved by the PGH Department of Anesthesiology Technical Review and the University of the Philippines Manila Research Ethics Board (UPMREB No. 2021-413-01).

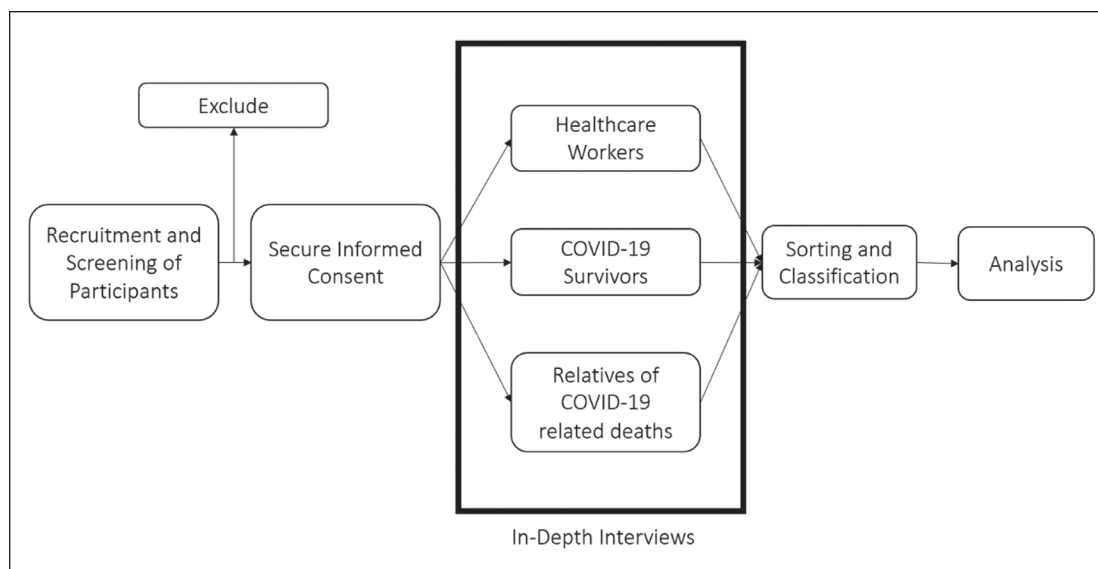


Figure 2. Study Procedure Flow Diagram.

RESULTS

Participants

A total of 26 participants were interviewed. There was a difference in age between the 3 participant groups (Table 1). The Patients group had a mean age of 50 ± 18 years, compared to the Relatives group which had a mean age of 39 ± 11 years, and the HCP group which had a mean age of 30 ± 3 years. Majority were female in all of the groups. For the Patients group, mean hospital stay was 19 ± 10 days, with their interviews 220 ± 158 days after recovery. For the Relatives group, mean hospital stay of their loved one was 15 ± 11 days, with their interviews done 185 ± 120 days after their loved one passed away. For HCPs, 5 Nurses (55.5%) and 4 Physicians (44.5%) were interviewed. The mean duration of respondent's patient encounter was 20 ± 27 days, with the interview being conducted 283 ± 128 days after the patient's death.

Common Themes on the COVID-19 Hospitalization Experiences

Fear of COVID-19

Respondents, especially patients and relatives of patients that passed away due to COVID-19, mentioned about many fears surrounding COVID-19. One would be the "unknown" factor, in which they didn't know what to expect, especially during the first parts of the pandemic, where not much was known of the virus. There was also the general fear of dying from the disease, as patients knew there was potential for death, some even being in the Intensive Care Unit for a time. Relatives were scared for their loved ones until they did meet their eventual demise. HCPs were also scared for their patients, especially due to the helplessness of the situation. All groups mentioned the fear of infecting other people as

well. General quotes such as "I felt sad and scared" were also mentioned by some participants.

Emphasis on Family

A great deal of discussion during the interviews revolved around the role of the COVID-19 patient's family. Patients lamented the fact that they could not be with their relatives, or wanted at least a family member to stay with them during their confinement. Relatives emphasized their role as the decision maker as well as coordinator for the rest of the clan. HCPs stressed the importance of constant communication with the family member and problems arose because of technical difficulties in contacting relatives. Most participants in the Patient group noted that messages from friends and family through video call, voice call, and messages helped them cope with the stressful and scary stay at the hospital. "Video calls and texts with family and loved ones" were directly mentioned by a participant as a way of coping.

Difficulty in Communication

All groups of participants reported communication as a main difficulty during the pandemic. Patients complained on the lack of ways to communicate. Although virtual means were available most of the time, patients yearned for the personal care of their relatives and HCPs. Relatives needed more information day to day, as they noted lack of updates from HCPs on their patient's condition. Relatives also wanted to be beside their loved one and to care for them, but strict isolation protocols only permitted some patients to have a relative in the hospital room. HCPs commented on the severe difficulty in communicating through the layers of PPEs, and that it was more difficult to explain things to relatives who wanted to know more about their loved one's condition.

Table 1. Participant Demographic and Clinical Characteristics by Group (n = 26)**Patient Survivors (n = 9)**

Patient Characteristic	Description
Age in years (Mean Average \pm SD)	50.3 \pm 18.7
Sex	Male 3 (33.3%) Female 6 (66.6%)
Duration of hospitalization (number of days \pm SD)	19.2 \pm 10.3
Interval between COVID onset and date of interview (number of days \pm SD)	220.8 \pm 158.9
Brief description of respondent (over-all appearance & behavior ex. calm/tearful)	Calm (100%)

Relatives (n = 8)

Patient Characteristic	Description
Age in years (Mean Average \pm SD)	39.3 \pm 11.1
Sex	Male 2 (25%) Female 6 (75%)
Duration of patient hospitalization (number of days \pm SD)	15.6 \pm 11.1
Interval between COVID onset and date of interview (number of days \pm SD)	185 \pm 120.4
Brief description of respondent (over-all appearance & behavior ex. calm/tearful)	Calm 5 (62.5%) Cried during interview 3 (37.5%)

Healthcare Providers (n = 9)

Patient Characteristic	Description
Age in years (Mean Average \pm SD)	30.1 \pm 3.5
Sex	Male 3 (33.3%) Female 6 (66.6%)
Role in patient care (ex. Attending MD, Nurse)	Nurse 5 (55.5%) Physician 4 (44.5%)
Duration of respondent's patient encounter (number of days \pm SD)	20.5 \pm 27.6
Interval between COVID death and date of interview (number of days \pm SD)	283.3 \pm 128.7
Brief description of respondent (over-all appearance & behavior ex. calm/tearful)	Calm (100%)

Most participants noted that communicating virtually was convenient and safe, but for most, it was by no means a perfect substitute for direct face to face communication.

Cremation as necessary but not preferred

All groups of participants noted the importance of adhering to COVID-19 protocols on disposing the body through cremation. They considered it a necessary step in ensuring that no one gets infected. Even though most of the participants agree, they still had very negative feelings towards cremation because they perceive viewing the body and mourning during the wake as part of standard rituals for the deceased. Some even commented that they hope there is a compromise in the future.

Religious Concerns

Some participants in all groups touched upon religious issues surrounding COVID-19. One participant noted that their religious denomination did not allow for cremation, and, thus, a more expensive method (steel casket) was used. Others mentioned the need for a priest or religious/spiritual guidance during the ordeal.

Life is Short

All groups had participants that mentioned this concept. The pandemic, to them, has brought about a heightened awareness of their own mortality as well as the morality of the people around them. Comments such as "Live life to the fullest", "Wake up call to us". This could also be tied to a feeling of gratefulness – usually "thanking God you are alive".

Differences in themes per participant group

The Patient group heavily emphasized their own personal experiences during their admission, highlighting their loneliness and helplessness, more focused on the day-to-day difficulties like food that tastes bad, or lack of personal interaction with HCPs. Relatives, on the other hand, were more concerned on being updated with the status of their loved ones and the medical aspect of their treatment. HCPs were more concerned about helplessness due to lack of supplies and equipment which led to more human suffering.

The Perceptions of a "Good Death"

The general themes presented when participants were asked this question was:

Everything in order

Participants' notion of a good death revolved around having all the post-mortem plans ready. This meant having a burial plan after cremation, having a last will and testament, all loose ends or issues with friends have been resolved, and a general notion of peace and calm before passing on.

A 30-year-old male patient said a "good death" is "Ready. Prepare yung family for burol o libing. No regrets." ("Ready. Prepare the family for the wake and funeral. No regrets." - Translated)

Relatives/Family Members have accepted it and can survive without them

Another recurring or crucial theme is the involvement of loved ones, as most of the participants always want to include them in the equation. Patients had fears of leaving their loved ones which revolved around the financial or emotional troubles they will face when they possibly die. They noted that they would be happy and at peace if they know that their relatives can move on and would be well taken care of.

A 25-year-old male patient said "Ang good death ng isang tao is yung nakahanda ka kung dumating ung pagkakataon. Nakahingi ka ng tawad sa Diyos. Kaya na nang family kabiti wala ka na. Nabigay ko

ung best ko" ("A good death is a person who is ready when the time comes. You have asked forgiveness from God. Your family can cope even if you are gone. I gave my best." - Translated)

Burial and Mourning practices

Almost all participants noted that as much as cremation is a safety protocol, it is still not the ideal way to handle the patients who. Majority of the participants in the Relative group and HCP group still prefer a mourning phase and ability to view the body of the deceased as the proper way to send off their loved one. Final religious rites, such as anointing of the sick, were also preferred.

The themes and descriptions are summarized in Table 2.

DISCUSSION

This is the first qualitative study on the perception of "good death" and the hospitalization experience among COVID-19 patients in the Philippines. The common perception of a "good death" reported in our study were the feeling of being at peace for the patient and feeling prepared, that is, having everything taken cared of (burial, financial, emotional aspects).

Definitions and concepts revolving around "good death" have been explored in the past. The London School of Economics and Political Science Anthropology interviewed 58 cross-community key contacts and concluded that, across all social groups, a "good enough death" is possible as long as the deceased can die with company (either with a relative

Table 2. Major Themes and Subthemes Per Group

Patient Survivors

Theme	Description	Exemplar Quote
Hospitalization and Support		
Fear, Isolation, and Loneliness	Most patients felt that they were scared and lonely, and usually had no watcher with them. Even the nurses and doctors spent limited time with them.	"I felt sad and scared." "Hindi ako sanay mag-isa."
Support from Family, Friends, and Healthcare Workers	Most patients had relatives who would check up on them from time to time through virtual means, even some 3-5x a day.	"Video calls and texts with family and loved ones."
Appreciation of communication technology	Most patients are grateful they have access to cellphones etc., where they can communicate with the outside world.	"I had emotional support from social media, talked with sisters online, had videocalls."
Feeling of disgust from others	Some patients "felt" that the HCPs were scared or disgusted with them, only had limited interaction or none at all.	"Naka-level 4 ang mga tao. Feeling mo ang dumi dumi mo, You're so infected. Mag-iwan ng food, kakatok lang."
Death and Dying		
Fear of Dying	Most patients were scared of dying. They were anticipating possible events that could happen to them.	"Pag nawala ako, ano na ang mangyayari. Natakot ako."
Regret	Patients noted that getting COVID-19 was too sudden and had a lot of unfulfilled wishes. Some regretted their lives and asked for apology from friends and relatives.	"Yes actually! I did call my classmates, I said sorry for all the wrong things that I have done."
How sudden death can be	Most patients noted that it took them by surprise, that their life is fast and fleeting.	"Life is short." "The suddenness – the illness can just take you anytime."
A good death is being prepared and being "at peace"	Most patients noted that being ready for death meant all the burial plans are ready, the relatives have already accepted the patient's fate and are ready to live on comfortably afterwards, filled with no regrets.	"Ang good death ng isang tao is yung nakahanda ka kung dumating ung pagkakataon. Nakahingi ka ng tawad sa Diyos. Kaya na nang family kahit wala ka na. Nabigay ko ung best ko."
Mourning and Funeral		
Mixed opinions regarding cremation	Patients were divided with their views on cremation. Most of them knew that cremation was more of a safety protocol rather than a preference. They would still prefer that the body be viewed by relatives, but understood why it was not allowed in the pandemic.	"Yung mga taong namatay sa COVID, hindi natutupad yung wishes ng namatay na andun sana yung family and friends nila sa burol." "We need to put things in the proper perspective! I agree with that. They should be cremated so they cannot infect other people."
Agree with social distancing protocols	Most patients had no problem doing online congregations.	"I am okay with that. It is for our safety."
Acceptance of pandemic situation	Patients are accepting the harsh reality of the pandemic, and are focusing their energies elsewhere.	"I need to accept that life before pandemic will never come back any time soon. I just make myself busy."
Feeling of gratefulness	Some patients noted that they were grateful for the care they received from HCPs.	"Grateful for all doctors and nurses who took care of me during my admission in the covid ward of PGH."

Relatives

Theme	Description	Exemplar Quote
Hospitalization and Support		
Relatives as coordinators	Most relatives were relegated the task of being coordinators and were busy during the whole process.	"I was the one who coordinated with my family."
Patients had a fear of being admitted / Fear of COVID-19	Some relatives noted that delays in admission or no admission at all was due to the patient being scared of the admission process and restrictions once admitted, also noted there is stigma to being diagnosed with COVID-19 such that they hide their diagnosis and just treat at home.	"Nalaman ko na maysakit talaga siya the night before. They hid it from me."
Difficulty in accompanying patient	It was hard to actually accompany patients due to the protocols in place as noted by the relatives.	"For our other family members and relatives, they didn't get to visit my dad due to restrictions and health protocols."
Support from family and friends	Most relatives noted that there was overwhelming support from family, friends, and also the Church.	"Messages from family, video calls, prayer warriors."
Death and Dying		
Physical access to a dying loved one	Relatives noted difficulty in being with their loved one, some had access, some did not.	"I was able to be with my mom, and I am contented with it." "Access to my mother physically, but it was not granted."
Suddenness of Cremation process	Relatives were shocked that hospital protocols required the body to be cremated immediately.	"He passed away before midnight. The next day, cremation na. Nafeel ko na he was snatched from me."
Mourning and Funeral		
Acceptance of Health Protocols regarding handling of the body	Most relatives accepted the fact that there was no mourning/funeral period, though generally they are against it but see it as a "necessary" rule.	"It is for everyone's safety"

Healthcare Providers

Theme	Description	Exemplar Quote
Hospitalization and Support		
Difficulty in communication	HCPs had a hard time communicating with the relatives due to wearing of PPEs and also having restrictions on accompanying watchers. This also sometimes led to delay in treatment or giving of treatment without fully explaining to the relatives due to emergency situations.	"Hard to communicate with the family since nakaseparate. Rapport with family is difficult if via phone call only. Hirap mag-explain when using PPE and stuff."
Emphasis on involvement of family members of the patient	Most of the HCPs emphasized that the pandemic hampered their ways to communicate with relatives. Most HCPs noted the importance of relatives in treating the patient. Also emphasized desire of relatives to physically visit the patient.	"Because they only allow one watcher. Some of them die without a relative by their side."
Mixed feelings on Virtual Solutions	HCPs are not as convinced regarding virtual solutions for communication due to difficulty in explaining things as well as technical limitations like internet speed etc. Some HCPs noted that it did benefit patients and relatives, but did not elaborate further.	"It is sad, but then again better than nothing."
Death and Dying		
Lack of personnel and equipment	HCPs noted severe lack of personnel and equipment.	"Kulang sa bed, nung mga nakaraan na severe ung symptoms. Nagkaubusan ng oxygen. Wala silang nagawa. Pinanood na lang patient nila na mamamatay."
Lack of Last Rites	Common theme was that patients died abruptly, relatives were not beside them, religious rituals such as "anointing of the sick" could not be done.	"Proper resources for those who are dying. Maybe a unified protocol because different hospitals have their own protocols."
Mourning and Funeral		
Agreement on Cremation	Most HCPs agree with cremation as a medical precaution, but still note the sadness it brings. There are also some religious conflicts that do not allow cremation.	"We do not know how contagious the patients can be, so they need to be cremated right away."
Coping with death through "making ourselves busy"	HCPs note that there is still a lot of work to be done and they cope by simply working.	"This is emotional torture for me but I try to be professional."

or a spiritual advisor) and undergoes appropriate ritual procedures modified for the pandemic without due delay. "Not dying alone" seems to be the prevailing theme.⁸ Another study investigated the impact of communication among 328 bereaved family members using open ended questions, and identified contextual factors perceived to impact communication quality: allowing family at the bedside when death is imminent, and fears that the patient died alone.⁹

These interesting aspects, focusing on not dying alone, are quite different from the standard conceptual framework of death and dying. One of the well-cited works are from the Commonwealth-Cummings Project in the late 1990s process with four critical components: 1) the fixed characteristics of the patient; 2) the modifiable dimensions of the patient's experience, or elements that may respond to events or interventions; 3) the potential interventions available to family, friends, health-care providers, and others; and 4) the overall outcome.⁷ Though the main elements of the framework are unchanged, some of its subthemes and elements are not applicable to the PGH situation. Factors such as Euthanasia and Physician-assisted suicide is not legal in the Philippines would be the most direct example.

In the Philippines, there are still no published studies exploring a "good death" during the pandemic. Local practices and beliefs, as well as socio-cultural norms have also not been explored. The closest study available would be the one done by Lanaban et al. in 2016 exploring perspectives of good death among patients in Southern Philippines Medical Center. Lanaban's conclusions on the focused interview sessions on HCPs, patients, and relatives involved in end-of-life care. Three main themes were predominant in the interviews: 1. Recognition of an external locus of control; 2. A good death is something that one is ready for; 3. It is ideal for one to die comfortably.¹⁰

Our study tackles the concept of a good death in the Philippine setting, in the backdrop of the COVID-19 Pandemic. Firstly, it is interesting to note that traditional international definitions have some commonality as well as differences with how participants of our study view death. Pain control, patient care, terminal sedation, and other themes were rarely mentioned by the participants, but were prevalent themes in other overseas studies. Most participants in our study place a large emphasis on the role of relatives, which is a common theme in other papers, but not of this magnitude. Our Filipino respondents rank the interaction with their loved ones as very high in their priorities as a source of comfort, as a companion in the hospital room, and also to have a degree of control in the healthcare of their relatives who are confined with COVID-19. This Filipino trait centered around family ties is highlighted in this study.

Another difference to consider is that the pandemic has put a strain on communication lines between physicians, patients, and relatives. Wearing PPEs, which usually involve wearing medical grade masks and face shields, severely limit talking, as HCPs sound muffled and faint when they talk.

This newfound difficulty in communication resulted in delayed management, frustration, fear, and overall sadness in the whole hospital stay.

Judging from our initial framework of the study, we see that there is more of an emphasis on "Family and Friend Interventions" as well as "Medical Provider Interventions" for our participants. Figure 3 is a visual representation of the comparison of the initial framework when superimposed with our findings, as we grayed out other care-system interventions that were hardly not mentioned during the interviews, namely – Social Interventions, Health-care Institution Interventions, and Social Interventions.

It seems that, for the COVID-19 pandemic, the overall experience of the dying process heavily relies on good communication, preferably face to face, but is not allowed due to infection protocols. As much as relatives have also talked about how their loved ones passed away, there was still a knowledge gap since they did not know how the deceased patient truly experienced the dying process. For example, they were not aware if there was pain control, if the patient was sedated, how the body was handled in the hospital, and if there were any religious rites performed. This limitation was due to the lack of communication and inability of relatives to be beside the patient in his or her final moments most of the time.

CONCLUSION AND RECOMMENDATIONS

COVID-19 is a sudden and merciless killer that forces patients, relatives, and HCPs to compromise on their ideal notions of a "Good Death". Inability to congregate and be with their loved ones due to quarantine and isolation protocols result in fear and loneliness for the patient, as well as forced cremation due to health policies, take away options for burial.

For this study, a "Good Death" was perceived as having a sense of peace and calm, with a reassurance that the finer details are already in order, such as, post-mortem care, funeral and burial plans, and future of relatives are secured. The strict restrictions on physical distancing and communication were distressful barriers for all the participants during the pandemic. Video/voice calls with loved ones and compassionate HCPs facilitated a better hospitalization experience. Severely ill COVID-19 patients, and Filipino patients in general, would benefit from the development of new technologies and better hospitalization protocols such as Family and Friend interventions and Medical Provider interventions to improve the over-all experience during hospitalization and the dying process.

The strength of the study is that it highlights certain aspects of Filipino culture and their perception of what is a "Good Death" in the light of the COVID-19 pandemic. This could be a starting point for more extensive studies on this topic, which could be a basis for concrete changes in public policy in the future. The weakness of the study was that since

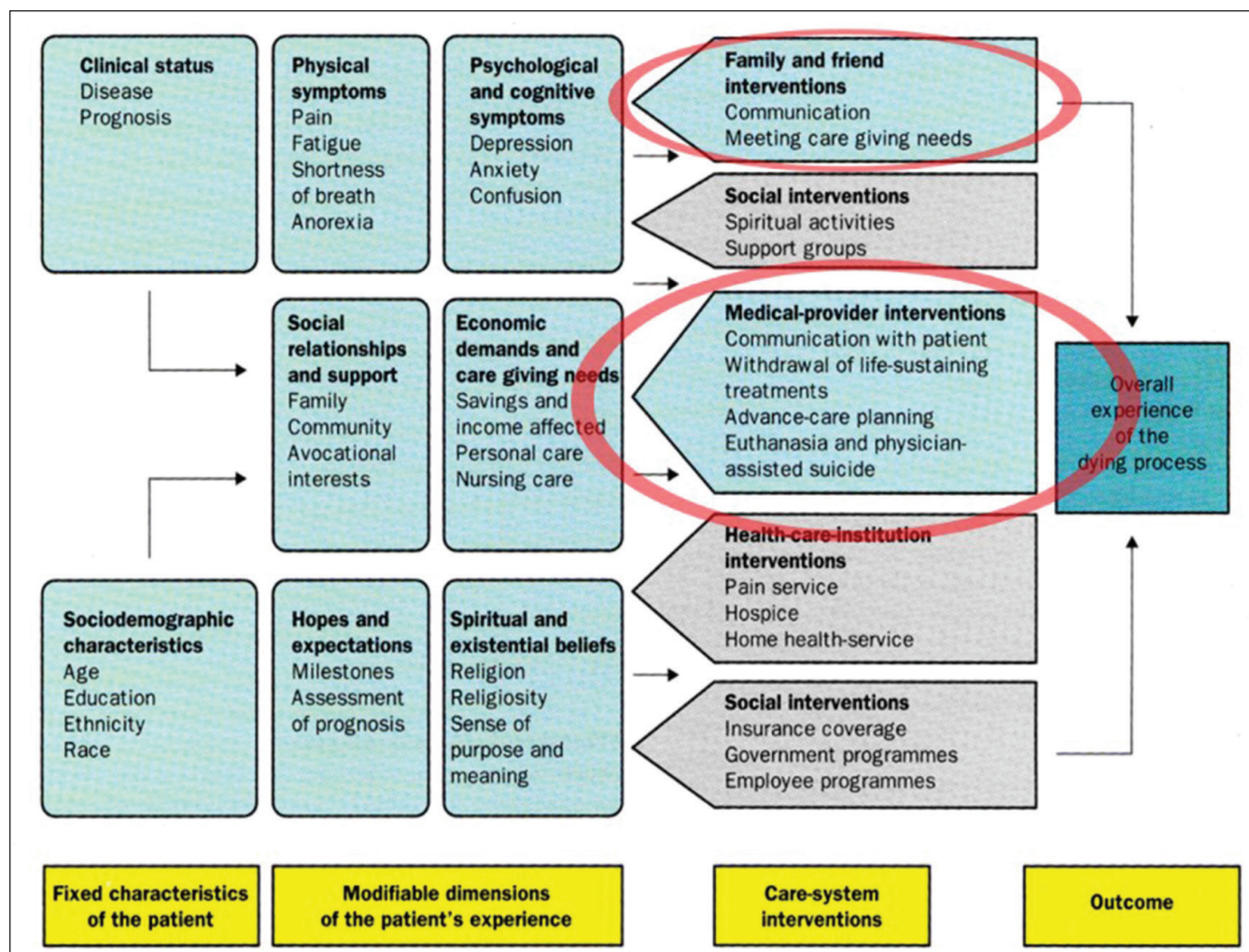


Figure 3. Framework for a Good Death with Emphasis on Family and Friend Interventions and Medical-Provider Interventions.

this was an initial study, sample size was limited. Getting a larger number of respondents might open up newer factors or emphasize other aspects of perceptions of a “Good Death” that have not been given enough attention. Possibly a more objective and directed survey, with more correspondents would be a next step in studying this topic more.

Statement of Authorship

LKC, CBD and BLD participated in writing the protocol, and the original and final manuscripts. CBD conducted and supervised the data collection.

Author Disclosure

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APPENDICES

Appendix 1A: Interview Guide for COVID-19 Survivors

1. Can you describe your stay in the COVID-19 wards?
2. What wishes were implemented to comfort you and your family? What aspects were virtually assisted that would have traditionally been in-person?
3. What emotional support did you need? What about other kinds of support (e.g., messages from family, spiritual support, etc?) Probe: refer back to virtual aspects if they are relevant here. How did the virtual nature of this support affect the experience of the patient?
4. Did you have thoughts on your own death during your stay?
5. What would you describe as a "good death"?
6. What is your opinion regarding body handling of the deceased as well as cremation?
7. What is your opinion regarding inability to congregate at funerals? How have communities adapted to the social distancing guidelines for funerals?
8. How are you coping during this pandemic?
9. Given the pandemic circumstances, was there anything about your hospital care that could have been improved?
10. Has anything surprised you about the concept of death during the pandemic?
11. Is there anything else you'd like to share with me?

Appendix 1B: Interview Guide for Relatives with COVID-19-Related Death of a Loved One

1. Can you describe the last few weeks of [patient's name] and how you were involved?
2. Did the pandemic circumstances have an influence on end-of-life care for [patient's name] and their family members? If yes, please explain.
3. What wishes were implemented to honour [patient's name] and comfort their family? What aspects were virtually assisted that would have traditionally been in-person?
4. What emotional support did [patient's name] need? What about other kinds of support (e.g., messages from family, spiritual support, etc?) Probe: refer back to virtual aspects if they are relevant here. How did the virtual nature of this support affect your experience of it? How do you think it affected [patient's name] experience of it?
5. What emotional support did the family need? What about other kinds of support (e.g., more detailed information about the final moments, reassurances etc?) Probe: refer back to virtual aspects if they are relevant here. How did the virtual nature of this support affect your experience of it? How do you think it affected the family's experience of it?
6. Are you aware of the procedure regarding the disposal and release of the body? What is your opinion on government restrictions on handling the body as well as mandated cremation?
7. What is your opinion regarding inability to congregate at funerals? How have communities adapted to the social distancing guidelines for funerals?
8. How are you coping with bereavement during this pandemic?
9. Given the pandemic circumstances, was there anything about the end-of-life experience that could have been improved? (Probe: Any resources you would have liked to offer or wish you had access to?)
10. Has anything surprised you about dying during the pandemic?
11. Is there anything else you'd like to tell us?

Appendix 1C: Interview Guide for Healthcare Providers

1. Can you describe the last few weeks of [patient's name] and how you were involved?
2. Did the pandemic circumstances have an influence on end-of-life care for [patient's name] and their family members? If yes, please explain.
3. What wishes were implemented to honour [patient's name] and comfort their family? What aspects were virtually assisted that would have traditionally been in-person?
4. What emotional support did [patient's name] need? What about other kinds of support (e.g., messages from family, spiritual support, etc?) Probe: refer back to virtual aspects if they are relevant here. How did the virtual nature of this support affect your experience of it? How do you think it affected [patient's name] experience of it?
5. What emotional support did the family need? What about other kinds of support (e.g., more detailed information about the final moments, reassurances etc?) Probe: refer back to virtual aspects if they are relevant here. How did the virtual nature of this support affect your experience of it? How do you think it affected the family's experience of it?
6. Are you aware of the procedure regarding the disposal and release of the body? What is your opinion on government restrictions on handling the body as well as mandated cremation?
7. What is your opinion regarding inability to congregate at funerals? How have communities adapted to the social distancing guidelines for funerals?
8. How are you coping with bereavement during this pandemic?
9. Given the pandemic circumstances, was there anything about the end-of-life experience that could have been improved? (Probe: Any resources you would have liked to offer or wish you had access to?)
10. Has anything surprised you about dying during the pandemic?
11. Is there anything else you'd like to tell us?