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Motivations for choosing “home” as one’s preferred place of death: A scoping review

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Review Article

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Abstract

Objectives. While dying at home is often described as desirable, to our knowledge, no reviews have focused specifically on people’s reasons for wanting to die at home. This review describes the breadth of what is known about motivations, attitudes, ideas, and reasons underlying the decision to choose “home” as one’s preferred placed of death.

Methods. This review was guided by a scoping review methodology following a five-stage approach including: (1) identify the research question, (2) identify relevant studies, (3) select studies based on inclusion/exclusion criteria, (4) chart the data, and (5) summarize and report the results.

Results. Seventeen articles were identified that met inclusion/exclusion criteria and discussed motivations underlying people’s desires to die at home. Thirty-five percent of studies were from Canada ($n = 6/17$), 29% were from Europe ($n = 5/17$), and 29% were from Asia ($n = 5/17$). Most studies ($n = 11/17$) used methods that involved collecting and/or analyzing interview data from participants, while the remaining studies ($n = 6/17$) used methods that involved administering and analyzing surveys or questionnaires. Characteristics of participants varied, but most commonly, studies included people with advanced illnesses who were nearing death (35% of studies, $n = 6/17$). Motivations for choosing a home death included desires to preserve a sense of self, factors relating to interpersonal relationships, and topics such as culture, religion, socioeconomic status, living situation, and lived experience.

Significance of results. The many interconnected reasons that lead people to choose a home death vary, as individuals have a range of motivations for choosing to die at home, which are highly influenced by contextual and cultural factors. Ultimately, this review will provide a comprehensive description of factors which may inform end-of-life planning, highlighting needs to be considered when planning the preferred location of a death.

Introduction

Many people assume that a death at home is more desirable than a death in other locations (Funk et al. 2023, 2022). While not everyone wants a home death, literature shows that when participants are asked where they want to die, “at home” is the majority answer (e.g. Malhotra et al. 2022; Pinto et al. 2024; Volberg et al. 2024). In Canada, achieving a home death has been established as a marker of a high-quality death experience, and as a quality indicator for Canadian health care systems (Canadian Institute for Health Information 2022; Funk et al. 2023, 2022; Pollock 2015). However, the acceptance of a home death as an indicator of a high-quality death experience has been criticized. Pollock (2015) argues that focusing on the place of death as an indicator of death quality causes people to overlook how dying is experienced uniquely by patients and their families, and notes that evidence suggests place of death may not be the biggest priority in determining the quality of a death experience. Pollock et al. (2024) further argue that home death is an ethnocentric and middle-class ideal which has been adopted by health policy as an indicator of death quality. It is crucial to understand this idealization through discovering what causes people to choose a home death. To do this, we explore the underlying motivations, attitudes, and contextual factors surrounding this dominant preference. By investigating what “home” represents for those who wish to die at home, we can start to understand what makes the idea of home death desirable, and how patients’ expectations and plans can be met.

To understand what motivates people to choose a home death, we must first understand what “home” means. The Canadian Oxford Dictionary defines home as “the place where one lives; the fixed residence of a family or household” (Barber 2004). However, this definition fails to incorporate contextual elements which contribute to the complexity of the word. Zharani and Selim (2023) explain that the notion of “home” synthesises physical, social, and personal aspects, and that a home can be conceptualized both as a physical shelter as well as an abstract concept which incorporates aspects of community and spirituality. O’Mahony (2013) discusses five “clusters” of meaning associated with home, including home as a financial investment, a

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physical structure, a territory, an identity and self-identity, and as a social and cultural signifier. It is essential to recognize that the definition of home is not universal, and when considering how people come to the decision of wanting a home death, we must remember that individuals will have unique understandings of what home means to them.

The objective of this scoping review is to explore and map what is known about motivations, attitudes, ideas, and reasons underlying the decision to name "home" as one's preferred place of death. This review focuses on these motivations from the perspectives of people who want to die at home. It is also important to note that for the purposes of this review, the idea of dying at home encompasses more than just the moment of death, but also the process of dying that precedes it.

Methods

This review was guided by a scoping review methodology to identify, synthesize, and describe the breadth of available literature on underexplored topics. We began with a broad research question, so we chose a review method that would allow us to identify the volume and content of available information (Munn et al. 2018; Peterson et al. 2017). Methodology for the present scoping review was based on the framework proposed by Arksey and O'Malley (2005), which includes five stages: (1) identify the research question, (2) identify relevant studies, (3) select studies based on inclusion/exclusion criteria, (4) chart the data, and (5) summarize and report the results.

Search strategy

We searched three electronic databases in May 2024, including PubMed (MedLine), CINAHL (Ebsco), and PsychInfo (Ebsco). A research librarian at the University of Northern British Columbia assisted in identifying relevant databases and creating search terms. The following key search terms were used in various combinations as appropriate to locate relevant literature available on this topic: "Home Death" ("death at home," "dying at home," "place of death") and Motivation* (factor*, attitude*, reason*, desir*, prefer*, perception*, opinion*, thought*, feeling*, belief*). A detailed article search chart outlining inclusion and exclusion criteria can be found in Figure 1.

Inclusion and exclusion criteria

Several inclusion criteria defined the literature search process. First, included articles must have focused on discussing factors and motivations behind people wanting to die at home. Due to limited language abilities of the research team, only articles written in the English language were included. This review only focused on the perspectives of persons over age 18, so articles including participants under age 18 were excluded. Finally, our search was limited to only include articles written from 2020 to 2024. We made this decision because of how the COVID-19 pandemic has had rapid and potentially lasting effects on place-of-death preferences and the way home care and death are perceived (Cherba et al. 2023; Funk et al. 2023; Pollock et al. 2024).

Search outcomes

Our initial search resulted in the retrieval of 665 articles. After removing 246 duplicates, 419 articles were screened. All titles and abstracts were reviewed. Full-text review was performed on 39 articles, with 17 articles found to meet inclusion criteria for inclusion in the review.

Data analysis

Microsoft Excel was used to prepare a data extraction matrix, which aided in summarizing and thematically analyzing the studies we selected. We extracted key points from the studies in this data extraction matrix. After identifying recurring ideas throughout the literature, the data was further analyzed by mapping relationships between these ideas, and we ultimately established a series of overarching themes which were present in the data. Included in the data extraction matrix are characteristics of the included studies, which are summarized in Table 1. Table 1 contains information about each article, such as the methodology and characteristics of participants.

Results

Studies we reviewed were conducted in multiple countries. Six studies were conducted in Canada (Cai et al. 2021; Chan et al. 2024; Cherba et al. 2023; Funk et al. 2022, 2023; Stajduhar et al. 2024). Five were conducted in Europe, including one in Germany (Volberg et al. 2024), two in Norway (Aurén-Møkleby et al. 2023; Nysæter et al. 2022), and two in the United Kingdom, one of which was exclusively performed in Wales (Pollock et al. 2024; Pottle et al. 2020). Five studies were conducted in Asia, including one in China (Cheng et al. 2021), three in Japan (Ishikawa et al. 2021; Kawaguchi et al. 2022; Tsuchida et al. 2022), and one in Singapore (Malhotra et al. 2022). Finally, one study was conducted in Colombia (Moreno et al. 2023). Most of the included studies ($n = 11/17$) used qualitative or mixed methods that involved collecting and/or analyzing interview data from participants (Aurén-Møkleby et al. 2023; Cai et al. 2021; Chan et al. 2024; Cherba et al. 2023; Funk et al. 2023; Moreno et al. 2023; Nysæter et al. 2022; Pollock et al. 2024; Pottle et al. 2020; Stajduhar et al. 2024; Tsuchida et al. 2022). The remainder of the studies ($n = 6/17$) used methods that involved administering and/or analyzing surveys or questionnaires (Cheng et al. 2021; Funk et al. 2022; Ishikawa et al. 2021; Kawaguchi et al. 2022; Malhotra et al. 2022; Volberg et al. 2024).

There was diversity in participant characteristics across the studies reviewed, which included various populations, such as persons with advanced illness who were nearing death ($n = 6/17$), community members with various roles and perspectives ($n = 5/17$), health care professionals ($n = 5/17$), and bereaved family caregivers ($n = 4/17$). One study interviewed couples together where one partner was seriously ill and the other was not (Aurén-Møkleby et al. 2023). Other studies included patients with cancer that were not close to death (Cheng et al. 2021) and people over age 65 who were also not expected to die soon (Ishikawa et al. 2021; Kawaguchi et al. 2022; Tsuchida et al. 2022). One article included health care professionals who were directly involved in the care of a deceased person referred to in the study (Pottle et al. 2020). Another article included family caregivers of living cancer patients (Cai et al. 2021).

Themes from review on motivations for home death

The articles we reviewed suggested reasons for choosing home death which were often interconnected. For the purposes of this review, themes were identified which seemed to convey unique components that contribute to a desire to die at home. Throughout

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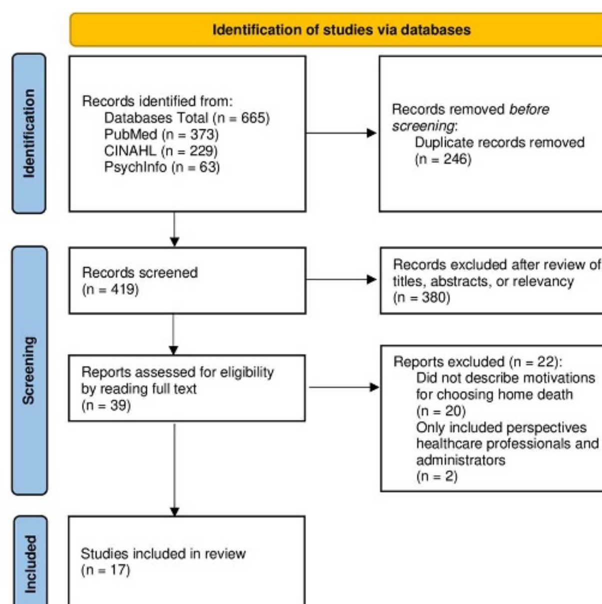

Figure 1. PRISMA flow diagram outlining database search process and outcomes.

the review on motivations for choosing home deaths, three themes emerged as strong motivators for choosing home deaths. These themes were (1) preservation of identity, (2) interpersonal themes, and (3) other motivations.

Preservation of identity (intrapersonal motivations)

The idea that a home death supports a sense of selfhood was described throughout the literature and was supported by three subthemes: (1) feelings of comfort, calmness, and familiarity, (2) feelings of safety, and (3) maintenance of normality, autonomy, and control.

(1) Feelings of comfort, calmness, and familiarity

Participants frequently spoke about home being a place of peace, quiet, and calmness, where someone might find the most comfort in their surroundings (Aurén-Møkleby et al. 2023; Funk et al. 2023; Moreno et al. 2023; Pottle et al. 2020). The comfort that home provided was deeply connected to how a home can protect and nurture one's identity through the proximity of familiar objects and surroundings (Aurén-Møkleby et al. 2023; Funk et al. 2023; Pottle et al. 2020). The protection of identity was a source of comfort (Funk et al. 2023). Cheng et al. (2021) found that one of the most common reasons for choosing home death is that home is the most familiar place. Some participants noted that to protect the authenticity of their home, it was important that changes to their space due to illness or other factors related to the dying process remained limited (Aurén-Møkleby et al. 2023; Pottle et al. 2020). One article that included structurally vulnerable participants noted that even for those without access to traditional or stable housing, participants wished to stay in place at the end of their lives, with support from familiar environments and people (Stajduhar et al. 2024). Funk et al. (2023) further discussed how being in a familiar environment may be very important to some in the unfamiliar context of the dying process. In sum, feelings of comfort and familiarity were an important motivator for choosing a home death.

(2) Feelings of safety

People with a preference to die at home tended to be motivated by previous good experiences with home as a safe place, or by viewing home as safe when compared to other options. For example, one participant in a study by Funk et al. (2023) talked about how growing up as an only child shaped their perspective of home as a place of refuge and nourishment. Home may represent a safe place for people who have had negative experiences in public and health care settings (Chan et al. 2024; Funk et al. 2023). Chan et al. (2024) further noted that preferring home death due to fear of harm elsewhere removes the sense of choice, as dying at home becomes a need. Additionally, people belonging to marginalized groups may require the safety of home to protect their identities (Funk et al. 2023). Safety remained a powerful motivator for choosing a home death.

(3) Maintenance of normality, autonomy, and control

The preference for a home death was often associated with the ability to maintain normality, autonomy, and control. For many participants, home represented a place where one could continue to make small decisions for oneself, continue daily rituals, and maintain their sense of a normal life, despite illness (Aurén-Møkleby et al. 2023; Funk et al. 2023; Nysæter et al. 2022; Pottle et al. 2020). Maintaining agency over one's lifestyle may help to preserve one's identity; indeed, Funk et al. (2023) found that participants identified control as something that helped them feel more like themselves. Aurén-Møkleby et al. (2023) described how home deaths are associated with independence and self-determination, which are valued in Western societies. Interestingly, all four articles that discussed autonomy as a reason for wanting to die at home (Aurén-Møkleby et al. 2023; Funk et al. 2023; Nysæter et al. 2022; Pottle et al. 2020) were conducted in Western countries, specifically Canada, Norway, and Wales. Normality and autonomy are important considerations for patients planning home deaths.

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Table 1. Excerpt from the data extraction matrix showing characteristics of studies included in the scoping review

Author(s), year, country	Methodology	Sample	% Female	Age in years
Aurén-Møkleby et al. 2023, Norway	A qualitative interview research design with a narrative approach was used	5 couples (interviewed together), in which one of the partners is seriously ill with cancer and prefers home death	Partner with cancer: 60%	Partner with cancer: 59–79
			Other partner: 40%	Other partner: 62–76
Cai et al. 2021, Canada	Prospective cohort study based on telephone interview data	303 family caregivers of cancer patients	67.99%	Mean age 59.5
Chan et al. 2024, Canada	Qualitative semi-structured interviews as a component of a larger mixed/multi-method study	24 compassionate community advocates, palliative care professionals, volunteers, bereaved family caregivers, residents of rural and remote regions, service providers working with structurally vulnerable populations, and members of francophone, immigrant, and 2SLGBTQ+ communities	Not noted	Not noted
Cheng et al. 2021, China	Cross-sectional study using data from questionnaires	239 patients with cancer who were hospitalized between December 2019 and January 2020	56.49%	Mean age 49.63
Cherba et al. 2023, Canada	Analysis of virtual interviews was conducted as part of a larger mixed-methods study	29 key informants (professionals, volunteers, and community advocates with expertise in the policy and practice context related to dying at home and end-of-life care) in three Canadian provinces: British Columbia, Manitoba, and Québec	Not noted	Not noted
Funk et al. 2022, Canada	Analysis of survey data collected online	2500 people from the general population with roughly equal numbers of men and women. The majority of respondents were white, English-speaking, married, well-educated, religious and urban dwelling. Most participants had past or current experiences with death and dying	48.76%	Range 18–99
				Mean age 52.3
Funk et al. 2023, Canada	Qualitative study based on semi-structured virtual interviews	24 community and practitioner representatives and advocates across Canada during the Covid-19 pandemic. This included compassionate community advocates, palliative care professionals and volunteers, bereaved carers, and members of queer, rural, and immigrant communities	Not noted	Not noted
Ishikawa et al. 2021, Japan	Logistic regression analyses were conducted based on cross-sectional survey data collected in 2016 as part of the Japan Gerontological Evaluation Study	20204 people ≥65 years who were not recipients of benefits from public long-term care insurance	54.15%	11433 people age 65–74
				7401 people age 75–84
				1370 people age ≥85
Kawaguchi et al. 2022, Japan	Longitudinal study using questionnaire data from years 2016–2019 of the Japan Gerontological Evaluation Study	1200 noninstitutionalized adults aged over 65 years who are independent in activities of daily living	52.50%	Mean age 72.9

(*Continued*)

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Table 1. (*Continued.*)

Author(s), year, country	Methodology	Sample	% Female	Age in years
Malhotra et al. 2022, Singapore	Prospective cohort study based on face-to-face survey data	466 people. Eligibility criteria included diagnosis of stage IV solid malignancy, age ≥21 years, Singapore citizenship or permanent residence, cognitive ability to self-report (determined through medical records or Abbreviated Mental Test administered to participants aged ≥60 years), and ECOG performance status ≤2 (to allow a period of follow-up before death or the end of the study period)	54.72%	Median age 61
Moreno et al. 2023, Colombia	Qualitative study based on face-to-face in-depth interviews following an unstructured interview script	27 patients receiving treatment at two academic hospitals and the National Cancer Institute. Patients were ≥18 years of age with an advanced non-curable cancer diagnosis with a life expectancy between 6 and 12 months who understood and accepted their illness and imminent death	74.07%	Range 28–78
				Median age 53
Nysæter et al. 2022, Norway	A qualitative study based on in-person interviews	9 adults with cancer in the late palliative phase (expected survival 6–12 weeks) were informed and aware of their state of illness and prognosis, had no cognitive impairment, could understand and speak Norwegian, were living in their own home alone or with relative(s), had an expressed wish to die at home documented in the patient record	22.22%	Range 47–90
				Median age 71
Pollock et al. 2024, United Kingdom	Analysis of qualitative interview data which formed part of a mixed methods study	12 patients, aware of the terminal nature of their illness and limited prognosis, and willing to talk about, and reflect on, this experience and their goals and values for future care	Patients: 58.33%	Patients: 50–88
		34 bereaved family caregivers	Bereaved family caregivers: 70.59%	Bereaved family caregivers: 19–82
Pottle et al. 2020, Wales	Qualitative study based on face-to-face semi-structured interviews with family carers and telephone interviews with health care professionals	15 bereaved main family carers	Family carers: 80%	Family carers were age 18 and over
		13 health care professionals that had been involved in supporting the patient to stay at home	Health care professionals: Not noted	
Stajduhar et al. 2024, Canada	Longitudinal qualitative analysis drawing from data collected during two studies that took place from May 2014 to December 2019. Data includes observational fieldnotes, focus group and interviews transcripts. Interpretive thematic analytic techniques were employed	1st study: 139 participants experiencing structural vulnerability, informal support persons, formal service providers, and key informants	Not noted	Not noted
		2nd study: 18 community service workers who had been engaged in the first study and were identified as playing critical roles in the provision of care for structurally vulnerable populations at the end of life		

(*Continued*)

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Table 1. (*Continued.*)

Author(s), year, country	Methodology	Sample	% Female	Age in years
Tsuchida et al. 2022, Japan	Qualitative cross-sectional study based on semi-structured in-depth interviews	20 long-term care users and their families (from 16 households) with the cognitive capacity to comprehend and discuss the study topic	45%	Female: 70–90 (average 81)
				Male: 70–100 (average 86)
Volberg et al. 2024, Germany	Explorative survey study	88 urological tumor patients visiting a German university hospital. Inclusion criteria were metastatic or irresectable prostate cancer, urothelial carcinoma, or renal cell carcinoma.	13.63%	Range 47–87
				Mean age 70.2

Interpersonal motivations

There were many reasons for preferring a home death that fell under a broad theme of interpersonal motivations. Four subthemes were identified that relate to interpersonal motivations, including: (1) being near friends and family and/or a supportive community, while avoiding neglect and isolation, (2) preference as shaped by experience and perceptions of other settings, including those shaped by COVID-19, (3) marital status, and (4) ability to adhere to one's own customs and traditions.

(1) Being near friends and family and/or a supportive community, while avoiding neglect and isolation

Being around friends and family during the process of dying was one of the most important and frequently mentioned reasons that participants wanted to die at home (Aurén-Møkleby et al. 2023; Chan et al. 2024; Cheng et al. 2021; Funk et al. 2023; Moreno et al. 2023; Pottle et al. 2020; Tsuchida et al. 2022). It was suggested that home facilitates informal family gathering while maintaining privacy and feelings of normality (Aurén-Møkleby et al. 2023; Funk et al. 2023; Pottle et al. 2020). One participant in a study by Pottle et al. (2020) described how conversations at home can occur more naturally than conversations in the hospital. The perceived access to loved ones that home provides was complimented by some participants' desires to avoid neglect and isolation, although this was untrue in situations where home was perceived as isolating, such as with people who lived alone (Funk et al. 2023; Volberg et al. 2024). Residing within a supportive community was another motivation for wanting a home death. A participant in a study by Tsuchida et al. (2022) described how positive relationships with neighbors and other community members contributed to wanting to stay at home. Immigrant populations in Canada discussed returning to their country of origin for a home death, where they would have greater access to social networks and extended community (Chan et al. 2024; Funk et al. 2023). In sum, patients may prefer a home death because of support from family and community.

(2) Preference as shaped by experience and perceptions of other settings, including those shaped by COVID-19

Participants often defined their preference for a home death by juxtaposing it with undesirable alternatives or previous good experiences with home death (Aurén-Møkleby et al. 2023; Cherba et al. 2023; Funk et al. 2023; Malhotra et al. 2022; Pollock et al. 2024; Stajduhar et al. 2024; Tsuchida et al. 2022). Often, participants compared home with hospital environments. Hospitals were described as impersonal and unfamiliar, and hospitals were perceived as lacking proper care for the process of dying (Aurén-Møkleby et al. 2023; Funk et al. 2023). Stajduhar et al. (2024) note that stigmatized populations may believe hospitals are symbolic of oppressive systems of control, and they may pursue home deaths to avoid negative experiences. Indeed, negative experiences in hospitals, and experiences of recent hospitalization, may cause patients to prefer home deaths (Malhotra et al. 2022; Tsuchida et al. 2022).

Conversely, positive experiences with home care or home death were motivators for wanting to die at home. Positive experiences with family members dying at home may shape desires for home death and reduce resistance to incorporating home care services (Aurén-Møkleby et al. 2023; Ishikawa et al. 2021). Tsuchida et al. (2022) found that positive experiences with medical care in the home environment enhanced desires for home death.

The COVID-19 pandemic further sculpted preferences for home death. COVID-19 was associated with an increased desire to die at home for reasons such as visitor restrictions and thus fear of isolation from loved ones, negative media coverage of institutional settings, and fear of contracting COVID-19 (Cherba et al. 2023; Funk et al. 2023; Pollock et al. 2024). Cherba et al. (2023) note that it is unclear whether shifts in attitudes toward home death because of COVID-19 are transient or will prove long-lasting. External factors including a desire to avoid the hospital environment, positive experiences with home care and home deaths, and the presence of COVID-19 contribute to patients' desires for home death.

(3) Marital status

Three studies found that marital status influenced desires for home death. Volberg et al. (2024) found that being in a civil partnership or marriage contributed to desires to die at home. Further, Tsuchida et al. (2022) showed that having a positive relationship with a spouse enhanced desires for home death. Cai et al. (2021) found that patients who were divorced, separated, widowed, or never married were less likely than married patients to pursue a home death, possibly due to the absence of a partner who can serve as an informal caregiver and provide emotional support. In sum, marital factors are relevant considerations in determining attitudes towards home death.

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(4) Ability to adhere to one's own customs and traditions

Religious and cultural customs and traditions discussed in the articles included Muslim (Funk et al. 2023; Malhotra et al. 2022), Colombian (Moreno et al. 2023), and Chinese (Cheng et al. 2021) populations and described unique reasons for preferring to die at home. Two studies shared the perspectives of individuals who are Muslim, one in the context of Canada and the other in Singapore, with all the Singaporean Muslims being Malay. In both studies, a home death was important for accommodating a customary large number of visitors for an extended period – something that is not always possible in environments such as hospitals (Funk et al. 2023; Malhotra et al. 2022). For some Colombians, home deaths may be preferred to avoid difficulties such as the need to return the body back to their village after death, as many participants desire to be buried in cemeteries close to their families and often in their hometown (Moreno et al. 2023). Cheng et al. (2021) described that in mainland China, dying at home holds cultural significance for patients and their families. Finally, Chan et al. (2024) discussed how immigrants may wish to return to their country of origin to die, where they can be assured that religious rites and rituals will occur appropriately. Cultural and religious factors have important roles in determining attitudes towards home deaths.

Other motivations

Several other motivations for preferring home death were identified, including (1) qualities of illness, (2) home as an idealized place to die, (3) gender-linked motivations, (4) education, and (5) cost.

(1) Qualities of illness

Seven articles discussed the role that one's illness has in wanting to die at home. It was a common finding throughout these studies that people with lower needs, continued independence, and fewer or more manageable symptoms had an increased propensity to prefer a home death (Cai et al. 2021; Funk et al. 2022, 2023; Moreno et al. 2023; Pollock et al. 2024; Tsuchida et al. 2022; Volberg et al. 2024). Underlying this finding, there was a worry that if illness were to advance, proper management of needs could not be attained at home. Further, some people worried about the extra burden that would be put on family members (Cai et al. 2021; Funk et al. 2022, 2023; Moreno et al. 2023; Pollock et al. 2024; Tsuchida et al. 2022; Volberg et al. 2024). Funk et al. (2023) noted that in the context of frightening symptoms, home may actually become a place of anxiety if those symptoms cannot be properly managed.

(2) Home as an idealized place to die

Some participants were motivated to die at home because of how it is idealized in society. Aurén-Møkleby et al. (2023) discussed a participant who did not have personal experience with home death, but had watched documentaries on it, which helped guide their decision to die at home. Chan et al. (2024) found that participants speculated that people may assume that others want to die at home, and this may influence their attitudes towards home deaths.

(3) Gender-linked motivations

Two studies, done in Germany and Japan, found that men wanted to die at home more often than women, while women wanted to die in hospital more often than men (Kawaguchi et al. 2022; Volberg et al. 2024). Volberg et al. (2024) speculated that reasons for this could include men's expectations to receive care from their family, and in particular their wife, while women may not expect to receive care from their husband/life partner and may be more aware of a potential need for professional care. Further, Volberg et al. (2024) discuss how men are more likely to die of serious illnesses, while women live longer with chronic illnesses. If women are aware that they will potentially be dependent on care in the future, they may choose to consider hospital or hospice options rather than staying at home (Volberg et al. 2024).

(4) Education

One study explored education's role in shaping motivations for home death. Cai et al. (2021) found that patients with postgraduate education tended to prefer home death. However, the authors noted that other studies had found that people with lower education levels also preferred home deaths, and some studies had found no correlation between education and home death preference (e.g. Gu et al. 2015; Schou-Andersen et al. 2016).

(5) Cost

Three studies mentioned financial reasons for preferring a home death. In Singapore, home hospice care is the only palliative care service provided free of charge, which may motivate patients to choose a home death (Malhotra et al. 2022). Tsuchida et al. (2022) found that patients' concerns about hospital and long-term care costs may lead them to choose home deaths. Similarly, hospital and nursing home stays in China can be costly, causing some patients to favor home deaths (Cheng et al. 2021). Of note, all articles that mentioned home death as an inexpensive option were conducted in Asian countries.

Discussion

Dying at home allowed patients to maintain as normal of a life as possible when faced with changing circumstances. Participants associated home with feelings of comfort, calmness, and familiarity through quiet surroundings and familiar objects (Aurén-Møkleby et al. 2023; Funk et al. 2023; Moreno et al. 2023; Pottle et al. 2020). Participants were motivated by the perception of home as a safe place, through previous positive experiences or by seeking to avoid negative aspects of other locations (Chan et al. 2024; Funk et al. 2023). This was a particularly powerful motivator for participants who had experienced stigmatizing events in health care and public settings. Home was also seen as a place where participants could maintain autonomy and control, and could continue to lead a normal and meaningful life (Aurén-Møkleby et al. 2023; Funk et al. 2023; Nysæter et al. 2022; Pottle et al. 2020). Home was described as a place where one's sense of identity could be preserved.

Further motivations for preferring a home death included those related to interpersonal relationships. We found that being near friends and family was an important and frequently mentioned motivator for wanting to die at home. Additionally, participants thought that home better facilitated access to loved ones while maintaining the authenticity of interactions (Aurén-Møkleby et al. 2023; Chan et al. 2024; Cheng et al. 2021; Funk et al. 2023; Moreno et al. 2023; Pottle et al. 2020; Tsuchida et al. 2022). People were motivated to die at home if they felt their community was caring and supportive, and for immigrant populations, dying at "home" sometimes meant returning to their country of origin where they

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could access extended community connections (Chan et al. 2024; Funk et al. 2023; Tsuchida et al. 2022).

Participants were motivated to die at home to avoid negative experiences they thought would be associated with dying in an institutional setting like a hospital; these beliefs stemmed from perceptions, opinions, and personal experiences (Aurén-Møkleby et al. 2023; Cherba et al. 2023; Funk et al. 2023; Malhotra et al. 2022; Pollock et al. 2024; Stajduhar et al. 2024; Tsuchida et al. 2022). The COVID-19 pandemic increased desire for home death for reasons such as visitor restrictions, negative media coverage of institutions, and fear of contracting COVID-19 (Cherba et al. 2023; Funk et al. 2023; Pollock et al. 2024). Conversely, positive experiences with home death and dying were motivators for choosing a home death for oneself (Aurén-Møkleby et al. 2023; Ishikawa et al. 2021; Tsuchida et al. 2022). We also found that positive relationships with spouses enhanced the desire for home death, possibly for reasons related to care and emotional support (Cai et al. 2021; Tsuchida et al. 2022). For immigrants, home was also described as a place where they could adhere to their own customs and traditions at the end of life without the limiting factors of an institutional setting, or unfit cultural context (Chan et al. 2024; Cheng et al. 2021; Funk et al. 2023; Malhotra et al. 2022; Moreno et al. 2023).

Participants were more motivated to die at home if they remained relatively independent and experienced few or manageable symptoms (Cai et al. 2021; Funk et al. 2023, 2022; Moreno et al. 2023; Pollock et al. 2024; Tsuchida et al. 2022; Volberg et al. 2024). In some cases, the idealized portrayal of home death in society was enough of a reason for people to choose home death as their preferred option (Aurén-Møkleby et al. 2023; Chan et al. 2024). Additionally, it was found that men wanted to die at home more often than women, possibly for reasons relating to traditional gender norms (Kawaguchi et al. 2022; Volberg et al. 2024). The association between home death preferences and education levels is unclear (see Cai et al. 2021, for a discussion). We also found that financial burden could motivate people to choose a home death over a death in hospital or long-term care (Cheng et al. 2021; Malhotra et al. 2022; Tsuchida et al. 2022). Aurén-Møkleby et al. (2023) describes how a home death incorporates elements of self-maintenance, autonomy, and independence, in addition to location. In sum, motivations for preferring a home death were found to be context-dependent and individualized, and incorporated considerations related to culture, religion, socioeconomic status, living situation, relationships, and lived experience.

Further considerations

For some populations, it can be difficult to discuss opinions about preferred places of death due to cultural norms discouraging conversations about death (Malhotra et al. 2022; Moreno et al. 2023). Malhotra et al. (2022) described how in the Asian context of Singapore, survey questions could not directly ask about preferred place of death. Instead, they asked about where patients "would prefer to spend their last days of life." A Colombian study found that some participants refused to think or talk about death, which limited engaging conversations (Moreno et al. 2023).

Cultural differences in decision-making around end of life also create a barrier in understanding why people prefer home deaths. Indeed, in China and Japan, much of the care and decisions made at end of life are entrusted to others, including family and medical care providers, which may limit the consideration of individual preferences around dying (Cheng et al. 2021; Kawaguchi et al. 2022). Furthermore, Chinese patients are sometimes the last to learn about the prognosis of their illness, with the decision to tell patients about their illness resting with their family (Cheng et al. 2021). If patients are unaware of their prognosis, they may be unlikely to be considering decisions related to end of life. Moreno et al. (2023) further note that in Colombia, family member preferences often influence decisions made about a patient's place of death.

Conclusion

There are a wide range of motivations that may lead someone to choose home as their preferred place of death. These reasons are heavily context-dependent and individualized, ranging from motivations related to preserving a sense of self, to motivations relating to interpersonal relationships, and marital and financial motivations. Although a variety of motivations were identified throughout the included studies, very few studies had a principal focus on attitudes and reasons behind wanting to die at home. Further research is needed to study these motivations in different contexts, validate existing findings, and identify other potential reasons for preferring a home death. Future studies may also consider exploration of how socioeconomic status and housing differences affect motivations for, and likelihood of, choosing home death. Understanding the factors underlying home death preferences may be critical in ensuring fulfillment of patients' end of life wishes.

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