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Problems and Ingenuity of Nurses in Supporting Dialogue between Patients with Terminal Cancer and Their Families in the Post-COVID-19 Phase

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Abstract

Purpose: This study aimed to identify the challenges and strategies of nurses in facilitating dialogue between patients with terminal cancer and their families in the post-COVID-19 phase. **Methods:** An online questionnaire was administered to 839 nurses with at least two years of clinical experience. The questionnaire included items on challenges and strategies in supporting dialogue between patients with terminal cancer and their families, as well as free-response statements. All responses were subjected to inductive qualitative analysis. **Results:** A total of 193 responses were received and analyzed. The difficulties faced by nurses in supporting dialogue were classified into six categories: "environmental restrictions on visits and dialogue due to infection control" on the organizational side, "inability to be fully involved in dialogue support due to COVID-19," "influence of nurses' values regarding death and family," "insufficient skills of nurses in supporting dialogue," "lack of cooperation within the team," and "differences in how the patient and family perceive the disease, hindering dialogue" on the patient and family side. Conversely, five effective strategies for dialogue support were identified: "building trust by understanding the family daily," "facilitating dialogue between the patient and family despite visitation restrictions," "assessing the patient and family to guide dialogue," "encouraging the patient and family to share their thoughts," and "improving team quality in dialogue support." **Conclusion:** The findings suggest that when facing difficulties in dialogue support, a system enabling nurses to reflect on and learn from their practice is needed.

Keywords

Dialogue, End of Life, Patients with Cancer, Family Nursing

1. Introduction

In Japan, the number of deaths from cancer continues to increase as the population ages [1], necessitating high-quality nursing care for terminal cancer patients and their families in all care settings. Quality of life improves when cancer patients and their families communicate their thoughts and feelings, fostering deeper conversations [2]. Dialogue is crucial as a link between both parties. Families of terminally ill patients need time for dialogue [3], but they often experience challenges that make this difficult [4]. A survey of bereaved families of cancer patients reported regret over not being able to say goodbye or hear final words [5]-[7].

In Japan, patients and their families often cope with the terminal stage by denying the imminence of death [8], and there is a cultural tendency to assume mutual understanding without verbal communication [9]. Recently, the number of older people living alone in Japan has increased, and the nuclear family has become the norm. Additionally, the employment rate among women has risen, making it difficult for family members to always visit or accompany a terminally ill patient. Due to visitation restrictions and the social context of the post-COVID-19 era, terminally ill cancer patients and their families have specific needs for dialogue, which are challenging to meet. Given these unspoken and latent needs, nurses who facilitate dialogue as part of their nursing practice are expected to play an increasingly important role in the future.

One characteristic of families of terminally ill cancer patients is that they cherish the time spent together, strengthening family ties [10] [11]. The theory of family systems nursing emphasizes that nurses should approach families as the unit of care, as they are always impacted by illness [12]. Hudson [13] states that it is desirable to regard the patient and family as a single care unit, encourage interactions, and support the family in spending as much time as possible with the patient at the end of life. Thus, it is important for nurses to focus on the interactions between patients and their families and to intervene while coordinating family functions.

However, nurses involved in family care for terminally ill cancer patients face challenges in providing care as death approaches [14]. Additionally, during COVID-19, nurses under visitation restrictions reported various difficulties, particularly with non-face-to-face communication, observing patient-family relationships, understanding family thoughts, and promoting interventions, support, and multidisciplinary collaboration [15]. Although the COVID-19 pandemic has subsided and we are now in the post-COVID-19 period, nurses facilitating dialogue between terminally ill cancer patients and their families likely still encounter challenges in their daily work.

Given this background, this study aimed to identify the challenges and innovative solutions of nurses in facilitating dialogue between patients with terminal cancer and their families in the post-COVID-19 phase.

2. Methods

2.1. Subjects and Data Collection

Of 120 randomly selected hospitals with 100 or more beds registered in the Welfare and Health Information Network Project of the Japan Health and Welfare Organization, 54 facilities that had cooperated in a previous study [16] were selected as the target facilities. Representatives of the nursing departments were sent a request letter, a consent form, and a return envelope, asking whether they would cooperate in the study and, if so, how many subjects would be included. The nursing department representative was asked to select wards with opportunities to care for terminally ill cancer patients suitable for the study's purpose. As a result, 839 nurses with at least two years of practical nursing experience from the selected wards were chosen as study subjects. First-year nurses were excluded because their priority was to learn general nursing tasks and acclimate to the work environment. Managers at the head nurse level or above were also excluded from the study population.

Data were collected through an online survey, and a research description with a QR code was distributed to the subjects from April to June 2023 by a representative of the nursing department. Participation was voluntary, and responses were requested within two weeks of receiving the document.

2.2. Survey Items

The basic attributes included gender, age, years of experience as a nurse, and years of experience caring for terminally ill cancer patients.

In the written request to the subjects, dialogue support was described as "support that leads terminally ill patients with cancer and their families to exchange thoughts and feelings they have wanted to convey to each other to maintain and strengthen their relationship through mutual response." Regarding the challenges and innovations associated with dialogue support, we asked the respondents to fill in the free-response boxes for "please tell us what you usually have problems in supporting dialogue between terminally ill patients with cancer and their families" and "please tell us what you and the nurses around you do to support dialogue between patients with terminal cancer and their families with ingenuity." The respondents were asked to provide their answers in the free text box.

2.3. Analysis Method

After carefully reading the text, we focused on passages describing innovations or issues in dialogue support and analyzed them qualitatively and inductively. The procedure was as follows: First, the codes were separated into meaningful phrases, and then extracted for each device or issue as one meaning per sentence. Similar codes were grouped and named as subcategories. In naming the subcategories, we checked the context and accurately reflected the subject's narrative. Additionally, while reviewing the semantic content of the subcategories, similar codes were collected and categorized.

2.4. Reliability

After one researcher categorized the results, another researcher verified the analysis to ensure reliability. Supervision included both cancer and family nursing perspectives. The study aimed to clarify dialogue support between terminally ill cancer patients and their families. We received supervision from researchers specializing in family healthcare and cancer nursing who were familiar with qualitative research. To ensure accuracy, we continually returned to the raw data throughout the analysis process to review and refine interpretations.

2.5. Ethical Considerations

This study was approved by the Ethics Committee of Sendai Akamon College (No. 2022-5). We informed participants in writing that participation was voluntary, refusal would not result in any disadvantages, and results would be published in academic conferences and articles without identifying individuals, as the survey was anonymous. Participants were asked to check items to confirm their consent to participate in the online survey and their agreement with the research.

3. Results

3.1. Characteristics of the Subjects

Of the 296 questionnaires collected (collection rate: 35.3%), 193 subjects provided complete answers to the open-ended questions about the challenges and innovations associated with dialogue support. Among these subjects, 184 (95.3%) were female. The mean age was 39.8 ± 11.3 years, and the mean number of years of nursing experience was 16.5 ± 10.2 years.

3.2. Difficulties Perceived by Nurses in Supporting Dialogue between Terminally Ill Patients with Cancer and Their Families (Tables 1-3)

In total, 31 codes were extracted for problems perceived by the nurses. These codes were grouped into six categories and 13 subcategories. Difficulties in supporting dialogue between terminally ill cancer patients and their families, as perceived by the nurses, were broadly classified into three categories: the organization side, the nurse side, and the patient and family side.

3.2.1. Environmental Restrictions in Regard to Visits and Dialogue between Patients and Their Families Due to Infection Control (Table 1)

This category indicated that visitation restrictions related to infection control measures made it difficult to implement dialogue support for face-to-face communication between patients and their families. This category was generated from two subcategories: “restrictions on visits due to infection control” and “lack of an environment for dialogue between patients and their families”.

Table 1. Difficulties perceived by nurses in supporting dialogue between terminally ill cancer patients and their families (organizational side).

Category	Subcategory	Code
Environmental restrictions on patient-family visits and dialogue due to infection control	Restrictions on visits due to infection control	The facility has regulations prohibiting or restricting visitation to prevent infections.
	Lack of an environment for dialogue between patients and their families	No place in the facility for patients and their families to talk in a relaxed atmosphere. No online visitation system is available.

3.2.2. Inability to Be Fully Involved in Dialogue Support Because of COVID-19 (Table 2)

This category indicated trouble with visitation restrictions associated with COVID-19, which prevented nurses from building trust and having in-depth conversations with families. It also highlighted the difficulty of engaging in dialogue support under these restrictions due to limited time and more indirect forms of communication, such as via telephone and online. This category consisted of two subcategories: "unable to build trust and have deep conversations with family members" and "difficult to support dialogue in the face of restrictions due to COVID-19".

3.2.3. Influence of Nurses' Values Regarding Death and the Family (Table 2)

This category indicated that the nurses were uncomfortable with death, leading them to hesitate in engaging with dying patients and their families. The nurses were also troubled by imposing their own values on the family. This category consisted of two subcategories: "nurses are not good at dealing with death" and "nurses themselves struggle with their own values toward their families".

3.2.4. Insufficient Skills of Nurses Themselves in Supporting Dialogue (Table 2)

This category indicated that nurses had trouble determining the extent and timing of interventions to connect patients and their families. They also struggled to provide dialogue support due to a lack of experience. Additionally, they were hesitant to get involved in seemingly difficult cases and were troubled by the uncertainty in evaluating dialogue support after implementation. This category consisted of four subcategories: "struggling to determine the extent and timing of interventions to connect patients and families", "i don't know how to support dialogue that connects patients and their families", "hesitant to get involved in cases that are seemingly difficult to deal with", and "lack of certainty in evaluations after the implementation of dialogue support".

3.2.5. Insufficient Cooperation within the Team (Table 2)

This category indicated that the team lacked a culture of care or had issues with information sharing. It consisted of one subcategory: "insufficient cooperation within the team".

Table 2. Difficulties perceived by nurses in supporting dialogue between terminally ill cancer patients and their families (nurse perspective).

Category	Subcategory	Code
Inability to fully engage in dialogue support due to COVID-19	Unable to build trust and have deep conversations with family members	Difficulty in collecting information directly from family members due to COVID-19 and lack of knowledge about the family background. Unable to encourage visitation or engage closely with the family to build trusting relationships because of COVID-19. Sometimes, family members don't tell nurses how they really feel.
	Difficult to support dialogue in the face of restrictions due to COVID-19	The impact of COVID-19 on workloads has reduced the time available to talk with patients and families. There is difficulty in providing dialogue support within the time limits imposed by visitation restrictions. Infection control measures make it challenging to facilitate direct communication between patients and their families. It is also difficult to fully understand the thoughts and feelings of patients and families over the phone or online.
Influence of nurses' values regarding death and family	Nurses are not good at dealing with death	I struggle with being involved with dying patients and their families because it is difficult for me. It's hard for nurses to talk to patients and their families about what it feels like to die. Patients often resist accepting death because of how nurses communicate it to them.
	Nurses themselves struggle with their own values toward their families	Worried that nurses might be imposing their views of "this is how it should be" on patients and their families.
Insufficient skills of nurses in supporting dialogue	Struggling to determine the extent and timing of interventions to connect patients and families	When patients and family members do not express their true feelings out of concern, it is difficult to determine whether nurses should communicate these feelings to each other or to the patient. Nurses often struggle with knowing how far to go in the patient-family relationship and when to engage in dialogue with patients and families.
	I don't know how to facilitate dialogue that connects patients with their families	I don't know how to speak to my family thoughtfully and specifically. I don't know how to communicate with the patient and family to elicit mutual thoughts and feelings.
	Hesitant to get involved in cases that seem difficult to deal with	Adjustments are strained when there is a gap between the wishes of the patient and the family. It is difficult to get involved when family relationships are originally discordant or estranged. Estimating the thoughts and feelings of a patient whose condition has deteriorated makes it challenging to connect them with their family.
	Lack of certainty in evaluations after implementing dialogue support	After providing dialogue support, I wondered if it was the right thing to do. I am troubled by the lack of answers regarding whether the support I provided was appropriate.
Insufficient cooperation within the team	Insufficient teamwork	Not a culture of family care among all team members. Lack of ongoing information sharing among outpatients, wards, and teams.

Table 3. Difficulties perceived by nurses in supporting dialogue between terminally ill cancer patients and their families (patient and family side).

Category	Subcategory	Code
There is a gap in how the patient and family perceive the disease, and dialogue is not progressing	Consciousness of death makes dialogue between patient and family difficult	Family members encourage patients to be honest. However, they have difficulty accepting the patient's death, making dialogue with the patient challenging.
	There is a gap in the family's perception of the patient's medical condition	The patient's condition is not properly communicated among family members. Family members do not see the patient frequently enough to fully understand the condition and keep up with the disease's progression. If the patient is unaware of their imminent death, they remain optimistic and are not focused on what they want to communicate.

3.2.6. There Is a Gap in the Way the Patient and Family Perceive the Disease and Dialogue Is Not Progressing (Table 3)

This category indicated the difficulties experienced by the patient and family as perceived by the nurses. The nurses observed that awareness of death made dialogue between the patient and family difficult. They were also troubled by a gap in the family's perception of the patient's medical condition, which hindered dialogue. This category consisted of two subcategories: "consciousness of death makes dialogue between patient and family difficult" and "there is a gap in the family's perception of the patient's medical condition".

3.3. Characteristics of the Ingenuity of Dialogue Support by Nurses between Terminally Ill Patients with Cancer and Their Families (Table 4)

Thirty-six codes were extracted concerning the dialogue support devices used by nurses. These were aggregated into 10 subcategories and five categories.

3.3.1. Building a Relationship of Trust While Making Efforts to Understand the Family on a Daily Basis (Table 4)

This category indicates that nurses should routinely deepen their understanding of the patient and family as a prerequisite for dialogue support interventions and should consistently pay attention to and build trust with the family. This category consists of two subcategories: "deepening the understanding of patients and their families on a daily basis" and "building trust by regularly taking an interest in the family."

3.3.2. Preparing the Ground for Dialogue between the Patient and Family in the Presence of Visitation Restrictions (Table 4)

This category indicates that because the patient is in the terminal stage, the nurse should ask the physician to arrange for dialogue despite visiting instructions. The nurse should also arrange the time and environment so the patient and family can interact naturally. This category consists of two subcategories: "arranging for dialogue within visitation restrictions" and "creating the time and environment for patients and families to interact naturally with each other".

Table 4. Nurses' ingenuity in facilitating dialogue between terminally ill cancer patients and their families.

Category	Subcategory	Code
Building a relationship of trust while making efforts to understand the family daily	Deepening the understanding of patients and their families daily	Take a neutral position without siding with the patient or the family. Identify family relationships, key people, and daily interaction styles. Check on both family members who visit and those who cannot come to the hospital. Stay receptive to the diverse values and culture of the family.
	Building trust by regularly taking an interest in the family	Demonstrate interest in the family by having the nurse talk to them each time they visit the hospital. Offer words of encouragement during these visits. Avoid letting the patient and family know how busy you are, and allow extra time to talk. Create an atmosphere that encourages patients and their families to communicate from the earliest stages of the patient's care.
Preparing for dialogue between the patient and family amid visitation restrictions	Arranging dialogue within the visitation restrictions	Even if visitation is restricted, devise methods that allow family members to spend as much time as possible with the patient. Consult with the physician to proactively set up visitation times, as the patient is at the end of life.
	Creating the time and environment for patients and families to interact naturally with each other	Create an environment where patients and families can speak slowly and calmly. Provide opportunities for family members and patients to spend time alone outside the hospital room, such as going out or taking a walk. Perform care and treatment outside family visiting hours to prioritize time spent alone with the patient and family. Ensure privacy so patients and families can communicate freely.
Assessing the patient and family to guide dialogue	Making assessments to guide the dialogue between the patient and family	Assess what the patient and family want to communicate from each other's perspective. Determine which family members can connect better with the patient for communication. Understand why patients and families cannot share their true thoughts and feelings. Identify the best ways to reconcile the thoughts and feelings of the patient and family while recognizing the family's strengths. Explore why the patient and family choose not to disclose certain information.
Encouraging the patient and family to share their thoughts	Approaching each patient and family	Provide opportunities for individual listening and utilize communication skills, such as silence, to elicit thoughts and feelings before encouraging dialogue between the patient and family. Keep the family informed about the patient's daily condition and the topics discussed with them in mind. Notify family members promptly when a patient's medical condition changes to ensure timely dialogue. Identify changes in the feelings of each patient and family member before and after the visit.
	Engaging the patient and family as intermediaries	Speak to the patient and family according to their level of acceptance and understanding. Involve the family in the patient's care and elicit their thoughts and feelings. Intervene between patients and their families when necessary and express

		their thoughts and feelings. Listen carefully to both patients and family members, and communicate clearly. Introduce easy topics, and when the atmosphere is relaxed, encourage the patient and family to express what they want to say. Never miss the moment when the patient and family are ready to speak for themselves.
	Effectively connecting with patients and families without meeting in person	Never miss the opportunity to hear from family members when they receive packages. Use LINE, a communication app offering free voice and video calls, and videophones.
Improving the quality of dialogue support on the team	Acting proactively to improve the quality of dialogue support	Learn how to support dialogue by observing how senior nurses handle situations. Speak up and ask for help to make the conference more fulfilling.
	Collaboration among multiple professions with timely information sharing	Listen to each patient's family's thoughts and feelings, and share the information with other professionals at daily conferences and in records. Consult specialty teams and certified nurses early for collaboration.

3.3.3. Assessing the Patient and Family to Guide Dialogue (Table 4)

This category indicated that the nurses analyzed the background regarding the lack of dialogue between the patient and the family to determine the extent of intervention needed to support dialogue. This category consisted of one subcategory: "making assessments to guide the dialogue between the patient and family".

3.3.4. Encouraging the Patient and Family to Share Their Thoughts (Table 4)

This category indicated that nurses approach each patient and family member according to the situation or are involved in a way that brings the patient and family together. It also highlighted the effective use of methods to connect the patient and family without a face-to-face meeting during visitation restrictions. This category consisted of three subcategories: "approaching each patient and family", "engaging the patient and family as a go-between", and "effectively utilizing means of connecting patients/families without meeting in person".

3.3.5. Improving the Quality of Dialogue Support on the Team (Table 4)

This category indicated that nurses should take the initiative to improve the quality of dialogue support and work together on a multidisciplinary team with timely information sharing. This category consisted of two subcategories: "acting proactively to improve the quality of dialogue support" and "collaboration among multiple professions with timely information sharing".

4. Discussion

4.1. Characteristics of Difficulties in Supporting Dialogue between Terminally Ill Cancer Patients and Their Families as Perceived by Nurses

The study revealed six categories of difficulties in supporting dialogue between

terminally ill cancer patients and their families, as perceived by nurses. These difficulties were divided into those directly affected by COVID-19 and those related to the nurses' lack of skills, irrespective of COVID-19's effects.

Those affected by COVID-19 included (Environmental restrictions on visits and communication between patients and their families due to infection control), and (The inability to fully engage in dialogue support because of COVID-19). Matsumoto *et al.* [15] noted that although both the patient and family should be considered the focus of nursing care, visitation restrictions biased care towards the patient, making it challenging to support the entire family. In this study, nurses were unable to meet directly with family members, which hindered their ability to build trust or have in-depth discussions with both the patient and family due to limited opportunities to interact.

On the other hand, factors not related to the influence of COVID-19 included (The influence of nurses' values regarding death and the family), (Insufficient skills of nurses in supporting dialogue), and (Insufficient cooperation within the team). It is important for patients and families to discuss their concerns and anxieties. Prior research has shown that nurses who find death and dying very difficult may feel helpless, inadequate, distressed, and defensive, and may also employ coping mechanisms such as prevention, distancing, and avoidance [17]. Therefore, if nurses feel anxious about the topic of death, it is important for them to acknowledge this anxiety. If a nurse becomes distressed by a serious topic, it is crucial to consider how to respond as a team, such as consulting with senior nurses. Dialogue support is not a special kind of support but rather a daily routine. It is important for nurses to develop their own views on life and death through dialogue support for patients and their families. In addition, a previous survey [18] revealed nurses' difficulties with end-of-life cancer nursing and reported insufficient information sharing among nurses, suggesting issues similar to those in previous studies. It has been shown that those who report their cases at conferences implement dialogue support significantly better and more frequently [19]. Therefore, we believe it is important to provide a forum for teams to discuss their thoughts on dialogue support in practice and to raise awareness of dialogue support daily. Furthermore, we believe that (The insufficient skills of nurses in supporting dialogue) reflect their lack of experience in providing support. It is inferred that, due to the influence of COVID-19, opportunities for support were scarce, and chances to improve practical skills for dialogue support were limited. Considering that visitations will eventually become possible, capacity building is an urgent issue.

The nurses perceived that (There was a gap in how the patient and family understood the disease, hindering dialogue). Patients and families found it difficult to communicate due to their emotions. Additionally, some had an overly optimistic view due to a lack of understanding of the patient's condition, while others struggled to grasp the situation because of visitation restrictions, preventing families from fully accepting the patient's condition. Shiraishi *et al.* [20] highlighted the impact of visitation restrictions on cancer patients and their families, noting

that "it is difficult to communicate and share medical information with family members" due to these restrictions during the COVID-19 pandemic. The reduced opportunities for family members to obtain information may lead to anxiety about the patient's condition. To promote family preparedness, information of appropriate quality and quantity should be provided [21]. Such information should include expected physical changes, psychological changes, and the specific time period left for the patient while developing dialogue support that connects the patient and family.

4.2. Characteristics of the Ingenuity with Which Nurses Support Dialogue between Terminally Ill Patients with Cancer and Their Families

The results of this study revealed five categories regarding innovations by nurses in supporting dialogue between terminally ill cancer patients and their families.

Due to visitation restrictions imposed during COVID-19, nurses had fewer opportunities to engage directly with families. In the limited opportunities available, nurses were trying to support dialogue by (Building a relationship of trust and making efforts to understand the family daily) and (Preparing the ground for dialogue between the patient and family despite visitation restrictions). To improve interactions between patients and families, creating an environment based on family participation that builds trust and strengthens communication is essential [22]. The results of this study corroborate previous research and emphasize the importance of building trust and creating an environment conducive to dialogue with patients and their families as a precondition for dialogue support in the post-COVID-19 era.

Steele and Davies [23] state that the patterns of behavior and emotional expression of families in end-of-life situations can vary considerably. The nurses in the present study also encountered situations where family members were sad, in denial, and unable to communicate their feelings to the patient. The nurses considered the background of the event, even if it appeared problematic, by "assessing why the patient and family could not share their true feelings" and "assessing why the patient and family behaved the way they did when they chose not to communicate". Next, they considered measures to promote dialogue, including "assess what the patient and family really want to communicate to each other from their own perspectives," "identify which family members can be better connected to the patient for improved communication," and "evaluate how the patient and family can reconcile their thoughts while considering the strengths of the family members." The present study clarified specific assessment perspectives regarding (Assessing the patient and family to guide dialogue). Care for families should include providing support to help family members bond. Such care must consider family dynamics, including preparedness, communication patterns, relationships, and values [24]. Nakazato *et al.* [25] found that family members were more likely

to verbalize their thoughts to patients at the end of life if they regularly expressed their thoughts. The more they verbalized, the better they could articulate their thoughts. Those who valued "understanding each other without talking" were less likely to express their thoughts verbally compared to those who did not hold this value as strongly. This finding highlights the importance of developing personalized support rather than a one-size-fits-all approach. Nurses are expected to provide more flexible support by incorporating the assessment perspectives clarified in this study, thereby broadening their perceptions.

In this study, nurses provided many negative comments about being troubled by the discrepancy between the thoughts of patients and their families. In response to this problem, nurses should not directly connect patients and their families to encourage dialogue. Instead, they should focus on "approaching each patient and family", "engaging the patient and family as a go-between", and "effectively utilizing means of connecting patients/families without meeting in person". It is significant that we clarified ways of (Encouraging the patient and family to share their thoughts) depending on the situation. Sharing visual information during online visits helps prevent complicated grief during bereavement [26]. However, digital solutions to enhance connections over the phone and in person can aid in sharing details about the patient's status, trajectory, and care. These solutions require technical and emotional preparation and support [27]. It is expected that online visits will continue in the future. Therefore, improving the quality of dialogue support during online visits is a challenge to ensure patient and family satisfaction.

In this study, nurses did not provide dialogue support alone but shared information with multiple professions in daily conferences and records. This is considered a method for (Improving the quality of dialogue support within the team). The dialogue style and values between patients and their families over the years can be observed in their daily interactions. We believe that involving multiple staff members, rather than a single nurse, in interactions with the patient and family aligns better with their viewpoints. The study results emphasized that, due to various dialogue styles and values, it is important for multiple staff members to share information from different perspectives. This involves understanding the background and personalities of the patient and family. This approach allows multidisciplinary staff to complement each other's information, leading to in-depth discussions on how best to relate to the patients and their families. Additionally, nurses often handle the family's emotional reactions during dialogue support. Unaddressed psychological stressors experienced by nurses ultimately impact the quality of patient care [28], which extends to the care of the family. Enhancing opportunities for the team to reflect and devise new perspectives can help make sense of experiences and ease the psychological burden associated with dialogue support. We believe these innovations are effective measures that can provide positive feedback in general dialogue support, connecting terminally ill cancer patients with their families.

4.3. Suggestions for Nurses to Provide High-Quality Interactive Support to Terminally Ill Patients with Cancer and Their Families

In recent years, many facilities have maintained visitation restrictions due to the ongoing COVID-19 pandemic. Although nurses recognize the importance of supporting end-of-life dialogue for patients with cancer, they have been unable to provide sufficient support to connect patients and their families because of these restrictions. Additionally, there have been few opportunities to improve their support skills.

In this study, we distinguished two major types of problems: those caused by the COVID-19 pandemic and those that nurses were originally uncomfortable with, regardless of the pandemic. Rather than treating these as a single problem, it is necessary to address the pre-existing issues. Recently, the COVID-19 pandemic has subsided, and there has been a shift to new lifestyles and values; however, challenges for families and family nursing remain diverse. To maintain connections between patients and their families through dialogue, we believe it is necessary to develop and implement interventions appropriate for the post-COVID-19 era based on the innovations identified in this study. It is important for nurses to be flexible in their views of life, death, and family. Nurses with limited experience can learn from the reflections of practicing nurses to gain confidence. Multiple staff members should contribute their perspectives to understand the values of the patient and family, as support is not provided by one person. Our findings suggest understanding these values by incorporating multiple staff perspectives. We recommend that the organization ensure the time and environment for implementing dialogue support as routine care. Educational involvement is necessary to enable young nurses to speak up at conferences and expand their assessments.

5. Limitations of the Study

The low response rate (23%) raises concerns about possible response bias and limits the representativeness of the sample. However, it is significant that we were able to identify ways to support dialogue and propose concrete guidance. This study provides basic data for nurses on high-quality dialogue support for terminally ill cancer patients and their families.

6. Conclusion

This study aimed to identify the challenges and ingenuity of nurses in facilitating dialogue between terminally ill cancer patients and their families in the post-COVID-19 era. The difficulties faced by nurses in supporting dialogue were classified into six categories: “environmental restrictions on visits and dialogue between patients and their families due to infection control” on the organizational side; “inability to be fully involved in dialogue support because of COVID-19,” “influence of nurses’ values regarding death and the family,” “insufficient skills of

nurses in supporting dialogue," and "insufficient cooperation within the team" on the nurses' side; and "a gap in how the patient and family perceive the disease, hindering dialogue" on the patient and family side. On the other hand, five categories were identified as essential for dialogue support: "building a relationship of trust while making efforts to understand the family daily," "preparing the ground for dialogue between the patient and family despite visitation restrictions," "assessing the patient and family to guide dialogue," "encouraging the patient and family to share their thoughts," and "improving the quality of dialogue support within the team." Therefore, a support system that enables nurses to reflect on and learn from their practice when experiencing difficulties in dialogue support is needed.

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Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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