

Thinking about the patient's wishes: practical wisdom of discharge planning nurses in assisting surrogate decision-making

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Abstract

Background:

The accelerating trend toward shorter hospital stays in Japan has made modes of decision-making essential for effective patient transition from the hospital to recuperation in the regional community, and the aging of the population has brought a rise in surrogate decision-making by the families of patients lacking decision-making (“self-decision”) capacity.

Aim:

To verbalise and elucidate the practical wisdom of discharge planning nurses by focusing on the perceptions and judgements they apply in practice and describing their methodology in concrete terms.

Research method:

Participants were six discharge planning nurses and one person with previous experience as a discharge planning nurse, all working at discharge planning departments of acute care hospitals. Separate, semi-structured, interactive interviews were conducted with each participant. The study design was qualitative descriptive in form with qualitative content analysis. All participants provided written informed consent to participate in the study, which was approved by the study institution.

Results:

Three concepts were extracted as the basis for discharge planning nurses’ perception and judgement at acute care hospitals: working for mutual envisionment of the available postdischarge options; helping the family act as spokesperson(s) for the patient’s wishes; and understanding the family inclusive of the patient as a relationship of strongly interaffecting interests.

Conclusion:

The practical wisdom of the nurse, working in mutual envisionment with the family, and collaborative decision-making through discussion with those who know the patient, leads to rational discharge assistance.

Keywords: discharge planning, discharge planning nurse, family, surrogate, decision-making, practical wisdom

INTRODUCTION

National medical care expenditures in Japan are mounting year by year (1). In 2025 the baby-boom generation will be at least 75 years old, and the generation that has always supported government expenditures will by then be the recipients. There is growing concern that this could lead to a collapse in the financial balance of the social security system. As one measure to resolve the crisis of the increasing elderly population, the national government is developing an integrated, community care system targeted for completion by 2025 (2-4). The system is designed to spur differentiation of medical care functions in close collaboration with regional communities.

Rational, effective patient transition is essential to the operation of this system. For patients lacking self-decision capacity it will be necessary to provide a new post-transition environment that will be conducive to their safe recuperation following discharge from an acute care hospital. Since 2008 in Japan,

the establishment of discharge planning departments (DPDs) has been directly linked to the medical fee system and has proceeded quickly, with assignment of discharge planning nurses (DPNs) as key staff members (5). Since fiscal year 2012, the standard for recognition as a DPD facility under the medical fee system has required that DPNs be assigned to the facility, and also includes an outcome assessment with stepwise scoring of medical fee points depending on the length of hospitalisation (6).

At present, decision-making for patients lacking self-decision capacity is generally performed by their families; however, this is not without complexities. According to the 2013 Comprehensive Survey of Living Conditions, the average number of household members in Japan at that time had declined to 2.51 (7). Approximately 30% of households with persons aged 65 years and over were households comprising couples only, which was the highest among other types of households, and these along with one-person households already accounted for more than half of all households (7), with a corresponding rise in the number of households having no available surrogate family members living nearby. Complexities also arise for nurses in such cases.

According to Popejoy et al.'s (8) review on discharge planning for elderly patients from 1990 to 2008, the effectiveness of discharge planning by hospitals had been noted in several studies but almost none focused on the establishment of partnerships between the patient, family, and medical care professionals. In a subsequent study, Popejoy (9) interviewed elderly patients, their families, and DPNs or social workers involved in their discharge planning, and elucidated the complexities of discharge planning. None of these studies included instances of family conflicts with the patient or with a DPN or social worker (9).

Various studies have focused on surrogate decision-making families involved in withdrawing or withholding life-sustaining treatment (10-12). Meeker and Jezewski (13) performed a metasynthesis of studies on family experiences in withdrawal of life-sustaining treatment. Bauer et al. (14) conducted a study on the experience of families in the discharge planning process for hospitalised elderly dementia patients, and reported on the perceptions of the family caregivers concerning discharge planning and preparation. The studies focused on families as surrogate decision makers, but gave no detailed description of the practices of the nurses engaging the families, their perceptions of the families, or the judgements they form. In their review on the perceptions of nurses relating to ethical problems in elderly patient care, Rees et al. (15) showed ageism as one of the main reasons for the problem. The literature included in their review, however, concerned studies performed only in Europe and Israel, and they noted the need for study in other countries that may differ in healthcare systems, cultural values, and other aspects.

The aim of the present study was to verbalise and elucidate the practical wisdom of DPNs by focusing on their perceptions and judgements in their practice and deriving a description of the specific means they employ in following their practice. The research question was two-fold: how do DPNs view families as surrogate decision makers, and what type of judgements do they form when conducting the nursing practice of discharge assistance? We centred on surrogate decision-making by the families of patients lacking self-decision capacity in actual cases of hospital discharge transition, and particularly on those cases in which the DPN sensed discord with the family and achieved a resolution in performing discharge assistance.

RESEARCH METHOD

Study design

This study was designed to provide a reference point for theoretical investigation through case-bound generalisation (16), and not as an empirical study designed for nomothetic generalisation. In this light, primary importance was placed on gaining an understanding of the individual nursing practices applied by each participant in multiple cases, rather than the total number of participants.

As the theoretical framework, we used the architecture of illness beliefs relating to family nursing, which attaches importance to interaction and circularity with others and with the environment (17). We defined decision-making as the thought process of selecting a logical choice from the available opinions (18). In regard to the basis of the mode of thought applied in decision-making in the complex circumstances of nursing care and in view of the limits inherent to application of traditional ethical principles to nursing, we took as reference a well-known guidebook on the performance of ethical decisions (19).

Participants

The participants of this study were six DPNs and one person with experience as a DPN. All were female veteran nurses with 20 or more years of nursing experience. Six participants had approximately 3 to 5 years' experience as a DPN while one participant had more than 10 years of DPN experience. The 2010 nationwide survey of DPNs by the Japan Visiting Nursing Foundation indicated the average length of experience of DPNs was 23.9 years as a nurse and 3.3 years as a DPN (20).

Participants were initially recruited by purposive sampling, in which DPNs were chosen at random from among those found by searching the Internet for acute care hospitals with DPDs having assigned DPNs in the category of general bed hospitals in the Tokai region of Japan, and asked to participate. The number was thereafter increased by snowball sampling via DPN networks to add participants with similar experience and engagement in problems and a capacity for clear expression (21, 22). One participant with experience as a DPN but not currently working in that capacity was asked to join the study because she had been transferred to another department only 1 month prior.

Data collection

The DPN practice of engaging with families to achieve a resolution is not a static or fragmentary process, but a dynamic process in an environment of circumstances and relationships of the people involved. In this practice, the DPN forms various perceptions and judgements in a manner which, as noted by Polanyi (23) and Schön (24), is tacit, unconscious, and difficult to verbalise.

In the present study, we therefore used a semi-structured interactive individual interview mode with interview guidelines, in which the study participant recalled and described cases in which she had been responsible for assisting surrogate decision-making by patients' families. The interactive mode of interviewing was deemed important particularly in view of the inherent difficulty of verbalising DPN experiences, and in this light the researcher was herself a nurse who proceeded with the interview as though working in collaboration with the participant to verbalise those experiences (25). Among the cases, we focused particularly on those in which the participant had sensed discord with the family and for those

cases interviewed the participant two to four times, paying close attention to the details of the practical experience. The interviews varied in length from 46 to 131 minutes.

Data saturation was deemed to be reached and data collection was accordingly ended when repetition of similar data among the participants was observed, a data pattern had emerged, and little new data were forthcoming (21, 22). Factors determining the scope of this study and the nature of the topic were the hospital limitations, the focus on the DPN perspective, and the conditions affecting actual cases. The objective in the interviews was not to increase the number of reported experiences but to obtain information on each reported experience and the practices applied, and the emphasis throughout was on sample quality rather than sample quantity (22).

The interviews were recorded on a digital voice recorder with the consent of the participants, and notes were taken simultaneously. Two participants withheld consent to voice recording, so their interviews were recorded with note taking only. After each interview, a verbatim transcript was produced from the voice recording and in its absence a story line was promptly composed from the notes taken during the interview. The contents of the verbatim transcripts and story lines were confirmed jointly in interviews with each of the participants. All data collection was performed by the lead author.

Samples

The samples in this study were accordingly the practical experiences of the participants in the cases they encountered, rather than the number of participants (26). In total, 17 experiences were analysed (see Table 1).

Analysis procedures

The present study consisted of bringing to light the practical wisdom embedded in nursing practice through verbalisation of that practice and its modes by means of an interview. For this purpose it was essential to derive a straightforward description with interpretation that did not depart from the interview data and with a minimal level of inference, and the study design was therefore qualitative descriptive in form with qualitative content analysis (27).

Following Morse and Field (28), Sandelowski (29), and Polit and Beck (21), the analysis began with extraction and organisation of each individual case in the multiple cases described by each DPN in the verbatim transcripts and story lines. We next extracted the resolution achieved by the study participant with the family performing surrogate decision-making, even where the participant sensed discord with the family. We then listened to the recordings while writing down in more detail what elements comprised those scenes and what sort of DPN perceptions and judgements constituted the practice. While listening, we noted similarities in DPN practices and categorised them. The abstraction level of the classified data was increased by descriptive summarisation, and interpretation and conceptualisation of universal or intrinsic parts of the various practices applied in each case were then performed. In the final step, we considered the relationships among the concepts and identified them as elements of DPN practical wisdom.

This type of study, as noted by Sandelowski (27), is characterised in part by simultaneous data collection and analysis with one thus influencing the other, and includes reflexive, interactive data refinement and revision. In this study, in addition to the process of joint confirmation performed during

the interview in the interaction between participant and researcher in regard to consistency in the description of the practical experience and interpretation of the data, supervision and peer review were performed to ensure descriptive and interpretative validity (27).

Ethical considerations

The study participants were informed that information obtained in the course of this study would not be used for any purpose other than the study objectives, that the anonymity of both the interviewed participants and the cases that emerged in the interviews would be protected, that no individuals would be identified, that the study was not an evaluation or judgement of the value of the participant's practice, and that the participant could, without any disadvantage, cancel participation and collaboration in the study at any time. All participants provided written informed consent to participate in the study, which was approved by the study institution.

RESULTS

At the centre of perception and judgement by the DPNs in their practice of assisting families acting as surrogate decision makers for patients was considering "what are the thoughts of the patient?" Three concepts were extracted as the basis for DPN perception and judgement at acute care hospitals: working for mutual envisionment of the available postdischarge options; helping the family act as spokesperson(s) for the patient's wishes; and understanding the family inclusive of the patient as a relationship of strongly interaffecting interests. These concepts are evident in the DPN interactions in the following three characteristic cases.

Working for mutual envisionment of the available postdischarge options

With regard to DPN assistance in surrogate decision-making by the family of a patient who is to be discharged, the subjects spoke of the importance of DPN engagement that enables the family to envision the life of the patient following discharge. To have the family do so, however, the DPN must also envision the daily lives of the patient and the family to present, as it would otherwise be difficult or impossible for the DPN to consider what kind of postdischarge daily life the patient would prefer after a shorter hospitalisation.

In Case 1, the patient's son told the DPN that she had always looked forward to her visits to the day service before she suffered her fracture, and expressed the wish that she be transferred to a facility where she could enjoy recreational activities. The DPN described this case as follows:

You know, the son really understood how she felt. But with her femoral neck fracture and her swollen condition due to the cardiac failure, her state altogether worsened. You know, her physical condition just changed considerably, and her son really had a hard time accepting it. (DPN A-2nd interview)

The DPN therefore advised him to consider her transfer to a medical long-term care sanatorium providing full medical care. In looking back on the son's thoughts, the DPN provided a further observation:

As medical professionals, as long as we have the information we can predict what's ahead for the patient pretty well. But the families – you know, they assume the patient will get better. (A-3)

Simply on the basis of discussion with a DPN, it is difficult for a family to envision the kind of facility that will be provided for a patient following discharge from an acute care hospital. In Case 1, at the recommendation of the DPN the son actually went to see the long-term care sanatorium. All of the DPNs who participated in these interviews recommended that the families go and see the facilities. The DPNs said that actually seeing the facility, rather than just hearing about it, helped the family to envision the circumstances and led to understanding and agreement.

For the family, seeing is believing. After they see the facility their reaction is "Ahh, now I understand". (E-2)

To close the gap with the family, as in Case 1, the DPNs also provide an explanation to the family. For that purpose, as well, they described a need to closely approximate the family's own understanding.

Even though (the family) has heard the attending physician's explanation, their interpretation may differ from the expressed content, so I make sure what the family got from the explanation. If you can't bring your own perception close to that of the family, then you can't really talk with them about it. (D-1)

Helping the family act as spokesperson(s) for the patient's wishes

In situations where the patient lacks self-decision capacity, the DPNs engaged with the family to envision the prior life of the patient and the family. In performing this work the DPNs helped the family act as spokesperson(s) for the patient's wishes, and the DPN practices became part of the family's progress toward their decision-making.

In Case 2, the DPN told the family that she wondered whether they were considering "*what he (the patient) himself wants to do,*" and the family responded as spokesperson(s) with a deep understanding of his thoughts and feelings based on his longstanding way of life. In recounting the family and their response, the DPN made the following observation:

Looking at his way of life up to that time, he'd done various things, he'd decided various things for himself, and it was his own wish from the beginning to stay away from the hospital.... And probably thought he just didn't want this kind of treatment. (G-2)

Medical decision-making often involves life and death, and making the decision for the patient places a heavy burden on the family. Inferring the patient's wishes and voicing that inference might in effect shorten the patient's life. The DPN in Case 2 spoke of supporting the decision-making family in the following way.

When (the family) is, you know, considering what to do, you might feel an urge to provide a final nudge.... But then I think, you know, is it really providing support?... The thing is not to manipulate the choice making process, but to provide expert knowledge to the family as a gentle nudge, so they can decide on the basis of a close understanding based on that expertise. (G-2)

Another DPN spoke in the following terms.

Families are essentially making a decision on how long the patient will live. So, you know it weighs heavily on them.... I would probably tell them, "I don't think there's a wrong choice." You see, families want someone to nudge them toward a decision. (E-2)

Understanding the family inclusive of the patient as a relationship of strongly interaffecting interests

The words of the family are sometimes conveyed to the DPN as thoughts and feelings experienced by the family in thinking about the patient, as well as representations of the patient's own wishes. In Case 3, the

DPN said the first daughter had strongly expressed the following wish.

She (the first daughter) said, "I just can't give up, no matter what, so I've got to get her to eat." (E-1)

As recounted by the DPN, the first daughter wanted oral ingestion performed despite the patient's condition and the patient's own wishes could not be ascertained from that daughter's description, and in contrast, the second daughter told the DPN that the patient had gradually become unable to take food. The DPN nevertheless could not simply deny or ignore the wishes of the first daughter and proceeded on that basis. She recounted further that:

In talking more with the first daughter, my remarks became more in the vein of "Ahh, yes, I see. That's how it was," "Yes, I understand. She was a wonderful mother, I can see that...". It was as though my role became providing an understanding ear for her feelings. (E-2)

In this way, the DPN became a sympathetic "ear" and tried to understand the first daughter's desire not to give up on somehow enabling oral ingestion. For a frail, dependent patient, postdischarge family care strongly links the interests of the patient and family members involved, so that the interests of each strongly affect those of the others. The DPN, while respecting the thoughts of the first daughter, helped to forge a relationship that the first daughter could accept.

In regard to finding a resolution when the family's hopes and the medical professional's opinion seem to conflict, the DPN in Case 3 said the following.

The daughter's wish was for oral ingestion by the patient, but there was a medical risk. What shall I call it, uhh, a gap, perhaps. How, where, what kind of good common ground can you find? You know that's not easy. (E-1)

Another DPN was involved in a case similar to Case 3, in which the family of an elderly patient would not relinquish the hope of oral ingestion. The DPN provided the following observations.

A common ground, something that the family will accept and the hospital will, too. You've got to find someplace like that, yes.... It might be a time, or a place, or something else. Looking everywhere and anywhere, finding something that "seems right to these people", that's what it is. (B-1)

Thinking about the wishes of a patient that cannot be confirmed—three interrelated concepts

In assisting surrogate decision-making by a family, each DPN helped the family to envision the postdischarge daily life of the patient and the family, through engagement that was interactive rather than one-way. In this practice, the DPN envisioned the pre-admission daily life of the patient and the family, shared her vision with the family, and effectively linked it to decision-making assistance. In the words of one DPN:

If we didn't know anything about the patient, it would be useless, no matter how much experience we have.... After all, we look after the patient, listen to doctors talk about the patient, form a mental image of the person, bear in mind how that person will fare, listen to the family about what the patient wants to do and what the family wants to do. That's our job; to work toward a resolution, you know, one that says O.K., let's do this. (A-2)

In the course of thinking about the wishes of a patient who cannot confirm what they want, the DPN in each case engaged with the patient's family in mutual envisionment while also viewing the family as the spokesperson for the patient's wishes and considering the nature of the relationship as one of mutually affecting interests. From her vantage point from outside the family, the nurse viewed the patient as an individual within the family and provided information and assistance based on her own interpretation of the situation of the patient and of the family, an interpretation that was itself based on information

obtained from the family.

When the patient's wishes are all gone, then if the decision is supposed to be made on this side it means deciding in a place where the patient's wishes are actually not present. In that situation, all anyone can do is decide on some solution that is good given the context, isn't it?... It seems to me that in a situation where the person's own wishes are just not there, then no matter how much you talk things over, or how much you debate and talk to each other, even though you think the decision is the best one, the person's own wishes are just not there, so nobody can be absolutely sure it's really the best. (G-2)

Thinking about the wishes of a patient that cannot be confirmed is a heavy burden for family surrogates and DPNs. Furthermore, the length of hospitalisation is also an issue. The DPNs indicated that with knowledge of these circumstances they worked toward smooth and effective achievement of early discharge by engaging the family with care and consideration rather than simply leaving the family to make the decision on their own. Though it may seem paradoxical, the DPNs indicated that they gained this wisdom in their day-to-day experiences with the families, and thus as practical wisdom developed in the course of practicing their profession.

DISCUSSION

The three concepts that informed the perception and judgement of the DPNs in their support of the families serving as surrogate decision makers clearly show that their practice consisted of engaging with the families to gain a timely understanding of the patient and working with them in a collaborative process of decision-making, rather than simply leaving them to make the decision on their own.

In engaging with the patient's family, the DPN forms a mental image of the patient's life and values. In forming this image, the DPN moves closer to the thoughts of the patient and the family. The purpose is to "know" other people—the patient and the family—who are naturally different from the DPN and would never have met if the patient had not entered the hospital. With regard to knowing a patient, Takemura and Kanda (30) described cases in which, "Not only could the nurses understand the patient's subjective world, but they could also add their own assessments and judgement and appraise the patient holistically from their own perspectives". In the present study, similarly, the DPNs consistently spoke not of simple one-sided information gathering but mutual interaction with the family through which they were able to develop their own interpretations of a patient's and a family's circumstances, and of sharing with the family in envisionment that enabled her to assist in decision-making.

Prior reports have also noted the tendency of nurses to gain an understanding of the patients by listening to stories relayed by their families and to engage with the family surrogates throughout the course of decisions on patient care, and concluded that the practice of narratives was more pertinent than principle-based ethical discussion (31, 32). The term "patient's needs" is part of a principle-based terminology that tends to focus on insufficiencies and deficiencies. In this study, in contrast to principle-based studies, "patient's wishes" is more pertinent term as reflected in patients feelings, thoughts, wants, hopes, interests, and other manifestations, as seen from the observations and descriptions provided by DPNs concerning their experiences in active implementation of their practice.

Tanner et al. (33) described the importance of family presence in coming to know the patient as a person and not just a clinical entity. For the nurse, it is important to know the patient not just as an

individual but as a member of a group—the family. Doi (34) described the concept of “*amae*” (commonly translated as “dependence”) and its singular importance for interpersonal relationships in Japan, and noted that people in Japan are adept at “identifying” with others. The prevalence of the adage “be guided by your children when you are old” suggests a particularly strong tendency for people in Japan to identify with their group, and thus with their family. In this context, it is difficult to view the patient as an individual, distinct from family membership and dependence. This is by no means limited to Japan. Family paternalism and family-centred care have elsewhere been noted as characteristic veins of Confucian societies (35-37). In this light, the present study may well serve as a reference for consideration of the modes of decision-making at medical sites of other Confucian societies in which projected aging of the population emerges and proceeds.

Minooka (38) noted that, in contrast to the focus on the individual’s “self-determination” in Europe and the United States, in Japan this often becomes a matter of “self-determination within the family relationship” and in cases where the family relationship is poor or involves conflicting interests, the family itself may not necessarily speak for the patient’s own best interests and it becomes essential to consider very carefully whether “the surrogate judgement given by the family is actually appropriate”. In some cases, family members may say things, such as “*I just can’t give up, no matter what; I’ve got to get her to eat*”, that represent not an inference of the patient’s thoughts but an indication of the family’s own thoughts in regard to the patient. In such cases, the focus on the patient’s wishes may easily end up blurred or lost if the patient and the family are taken as inseparable or one and the same rather than “others” as they actually are, or if the family is permitted to view the patient as its appropriation.

Wondering “what does the patient want to do” means seeing things as they really are, without somehow allowing the patient, who is an “other”, to turn into anyone’s appropriation. In deliberating on what the patient wants to do, people often try to make their own thoughts equal to those of the patient. As noted by Stonestreet (39), however, surrogate decision-making must not focus on acting *as* the patient but remain patient-centred, and the decision need not be exactly the same as the decision that the patient would probably desire.

No matter how close a family may be, even if it is said to be a relationship of mutual understanding in all matters, all members except the patient differ from the patient as “others” vis a vis the patient. As the DPNs related, for those who are “other” than the patient “*all anyone can do is decide on some solution that is good given the context*” and in a situation where the person’s own wishes are not there, then “*no matter how much you talk things over, or how much you debate and talk to each other, even though you think the decision is the best one, the person’s own wishes are just not there, so nobody can be absolutely sure it’s really the best*”. For this very reason, for a decision to be made for a patient whose wishes cannot be obtained it is essential for others who know that patient to “*debate*” and “*talk to each other*” about the question. Studies on the collaborative experiences of DPNs and families of frail elderly patients in the busy clinical environment of acute care hospitals have shown that nurses sometimes tend to avoid families as people who make difficult requests or think of them as a “side issue” (40). The increasing need, however, is for close, effective interaction. With the adoption of the outcome evaluation system in which medical fees depend on the length of hospitalisation and the corresponding continuous rise in the trend toward further shortening of hospital stays, rational, effective discharge assistance is becoming all the more desirable.

It may be held that surrogate decision-making as a private and autonomous process by family members alone, who best know the patient, without including any “other” except them, is preferable as a rational mode of decision-making that respects the family’s wishes. It may seem, in contrast, that working with the family in mutual envisionment and discussion with those who know the patient is threatening to the family’s autonomy. It may also seem to be simply an added time-consuming burden on medical professionals. In any event, the approach to discharge assistance is strongly affected by the laws and regulations of the country in which it is implemented. The wisdom of the nurses described in the present study may be regarded as a response to their environment, in which they developed their collaborative decision-making approach in the course of their cumulative experience in their practice as DPNs for an effective response to the need for shorter hospital stays while contributing to smoother, more effective patient transitions.

LIMITATIONS

The participants interviewed in this study were all DPNs and the aspects of DPN practical wisdom revealed are accordingly those noted by these participants, and the small sample size may have created a research gap. Practical wisdom not apparent to the DPNs themselves may well be brought to light by interviewing the families that receive their assistance. In addition, regional differences between the quantity of care facilities and care services for the elderly and patients with chronic diseases as well as people’s sense of family values should be considered.

CONCLUSION

The work of the DPN in assisting surrogate decision-making by families, as found in this study, consists not only of helping the family to envision the postdischarge daily life of the patient and the family but also of the DPN’s own envisionment of their daily life before admission and sharing of that vision with the family. This study showed that in considering together with the family the question “what are the wishes of the patient”, the DPN views the patient as a single individual in the family group, performs assessment and judgement based on the information provided by the family while adding the DPN’s own interpretation of the situation of the patient and the family, provides relevant information and assistance to the family, and links all of this to achieve collaborative decision-making. Given the pervasive shortening of hospital stays, this practice and its effective advancement of rationally assisting patient discharge must not be neglected. In conclusion, this practice represents the practical wisdom of the DPN, nurtured and developed daily in practical experience.

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Author contributions

Yoko Kageyama designed the study, carried out the interviews and analysis, and prepared the manuscript. Midori Asano was involved in critical revisions for important intellectual content and supervised the study.

Ethical approval

This study was performed with the written approval of the Department of Ethics Review Committee of Nagoya University Graduate School of Medicine (No. 13-147).

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Table 1. Study Samples

Participant	Number of interviews	No. of analysed DPN experiences	Type of analysed DPN experience
A	3	2	Choice of facility in transfer Decision on gavage introduction
B	3	3	Decision on continuing ingestion Decision on life-support treatment Choice of postdischarge place of care
C	2	1	Economic problems
D	2	2	Choice of postdischarge place of care Choice of facility in transfer
E	4	3	Decision on continuing ingestion Choice of facility in transfer
F	3	3	Decision on life-support treatment Choice of needed postdischarge care Arrangements for posthumous care of bones and settlement of affairs
G	3	3	Decision on treatment discontinuation Choice of postdischarge place of care