A Comparison of Nursing Ethical Dilemmas in Geriatric Palliative Care Between Japan and Finland

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Laurea University of Applied Sciences **Abstract**
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A purpose of the thesis was to describe the differences and similarities in ethical challenges encountered by nurses in geriatric palliative care between Finland and Japan. The study aimed to deepen the knowledge of ethical challenges in palliative care and improve expertise in the care between the two different cultures, and to provide nurses more opportunities to tackle the problems. A research question was what differences and similarities are in nurses' ethical challenges in a practice of geriatric palliative care between the two countries.

Although there are growing number of literatures concerning the topic, there is no comparative studies of Finnish and Japanese nurses. The thesis was conducted by a literature review with 14 articles, and an inductive content analysis method was applied.
Four categories were detected; "Truth-telling", "responsibility and uncertainty", "environment", and "interactions".
Japanese nurses emphasised on a sense of guilt as a reason for ethical dilemmas, whereas Finnish nurses experienced the distress as infringing on patients' rights. The findings indicated that those differences had a great impact on palliative care and ethical issues to both nurses and patients' way of behaviour and thoughts. Further research is required to explore the ethical issues regarding geriatric palliative patients with dementia, and can be done by an empirical methodology to understand the further implication of the findings.

Keywords: Palliative care, Geriatric, Nurse, Finland, Japan, Ethical dilemmas

Contents

1 Introduction

Palliative care has seen a rapid develop and been becoming an interested field in medicines and nursing due to a high degree of awareness of its need for even non-cancer patients (World Health Organization 2002). Although the history of palliative care is fairly new as first recognised in 1987, the care is now inevitable as a part of dying patients' holistic care (Dunn & Milch 2001). Consequently, palliative care began to be advanced more with an influence of idea by Professor Patrick Wall, "The old methods of care and caring had to be rediscovered and the best of modern medicine had to be turned to the task of new study and therapy specifically directed at pain" (Finegan & McGurk 2007), which led to modern dimensions of palliative care, physical, psychosocial and spiritual care as well as pain alleviation instead of prolonging the patient's life by curative treatment in the end-of-life situation (WHO 2002).

An earlier perception of palliative care might be meant only for patients with incurable diseases, such as cancer due to its historical background. Yet, the modern definition of palliative care is much broader, and the care ought to be provided not only based upon the diagnosis of the patient, but also their needs. Therefore, end-of-life patients without incurable disorders are also entitled to the palliative care, which is actually becoming more common and an accepted conception of palliative care. (Traue & Ross 2005; O'Brien 2013.)

Today our life expectancy is greatly extending. The current average lifespan of the global population in 2020 is 73.2 years, which is remarkably longer than the length of 66.5 years in 20 years ago, in 2000 (Worldometer 2020; WHO 2016). As the number of elderly population increases, a need of palliative care for them also grows. Hence, an influence of aging society on demands for palliative care is rising, and the care should be improved and developed more for those who need the mentioned care for their quality of life and human dignity until the last moment of their life. (Voumard, Truchard, Benaroyo, Borasio, Büla, & Jox 2018.)

However, there are innumerable complex ethical problems arisen in a practice of palliative care (Barker 2017). There is a trend of increasing awareness of ethical issues confronted by nurses in palliative care settings, which is seen from the fact of growing numbers of international studies on the subject of ethical issues or dilemmas in geriatric palliative care from nurses' point of view (Hermsen & Have 2001). However, there are no comparison studies of Japan and Finland on the subject matter. As a nursing student, the author focused on ethical dilemmas in the geriatric palliative care encountered by the nurses. Moreover, the research has been implemented in order to compare the differences and similarities of the subject in the two countries. This study brought a new sight of nurses' ethical issues by contrasting

those components. The thesis described the theoretical background of palliative care, contemporary situations in the studied countries, nursing ethics and principles, as well as particular ethical dilemmas arisen in palliative care settings. The research has been conducted by a literature review methodology in order to answer its research question.

2 Background

Both Finland and Japan are leading aging society in the world. According to Finnish Institute for Health and Welfare (2019), Finland is seeing a rapid change in the number of ageing population and the percentage of over 65-year-olds were 20 percent while the percentage of elderly population in Japan was also 27.7 per cent of total population (Chino 2018). Death is a part of our life, which no one can avoid. Therefore, a palliative care plays a significant role in the patients' care in healthcare settings, especially, in ageing society. Inevitably, a palliative care is needed more in a situation where the population is becoming ageing. This is because naturally, the more elderly patients tend to face with death than those who are younger in the developed countries. A good palliative care should be practiced in patients' holistic care so that the patients can retain the high quality of life until their end of life (Finnish institute for health and welfare 2019). (Voumard et al. 2018.)

Today, the world is getting closer and more similar in various ways including medical care practices, which was yielded from a modern concept of evidence-based practice. For instance, when new discovery of the cranial nerve connections is revealed by a medical team and scientifically approved, this news will immediately spread all over the world so that many countries will apply the new knowledge in a practice. Or when a research team publishes a major breakthrough of cancer medication, other countries would also introduce it as soon as the safety of the medication is confirmed. We share the scientific information, which results in improving and developing our medicinal practice so that gaps of practices in medicine among countries are becoming invisible. For another instance, the current guideline of treatment of acute lymphocytic leukaemia in paediatric patients in many countries may not show great differentiations among nations. These apply to palliative and end-of-life care as well. (University of Canberra library 2019.)

However, there are still some differences included in an area of medicines in both countries. Chinese natural herbs are used officially as pharmacotherapy in Japan, whereas in Finland there are no such drugs legally prescribed from hospitals. Although both countries have a concrete concept and practice of palliative care as a part of treatment, there are ethical differences in the care among the healthcare professionals between these countries. (Watanabe, Matsuura, Gao, Hottenbacher, Tokunaga, Nishimura, Imazu, Reissenweber & Witt 2011; Fimea 2018.)

Moreover, a cultural diversity is widening in Finland due to an increase of immigrants. There are not many elderly patients with foreign background who need a palliative care currently yet. However, the number of those elderly immigrants who need a palliative care will rise in the future, which means we as healthcare professionals are required to possess the knowledge and understanding of their culture as well as ethical issues in the palliative care occurring in the circumstances. (Finnish institute for health and welfare 2019.)

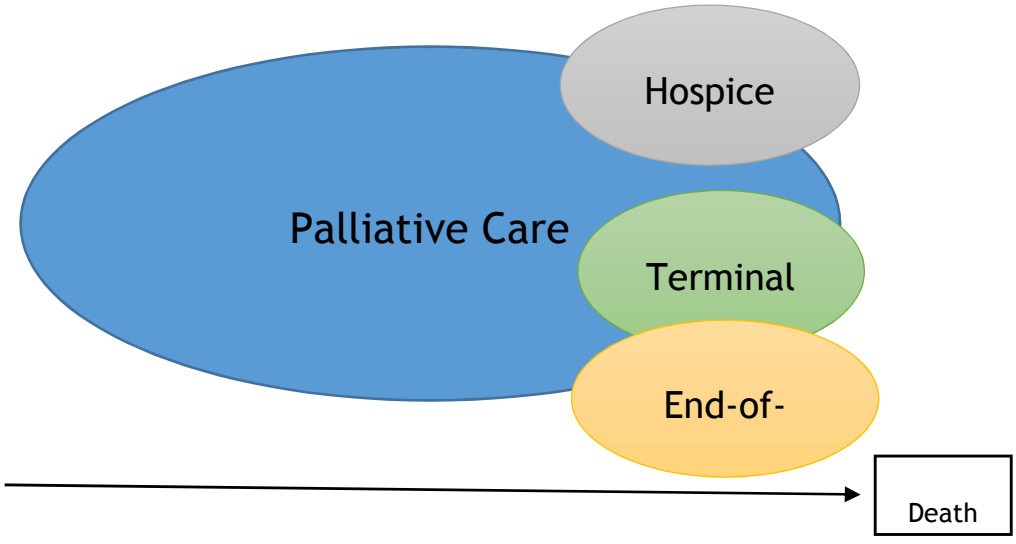
2.1 Definition

2.1.1 Palliative, end-of-life, terminal and hospice care

The World Health Organization (2002) defines that palliative care is an approach for patients and their significant others who are facing an issue correlated with life-threatening disease in order to enhance their quality of life by preventing and relieving suffers, identifying, assessing, and treating pain, and other issues of physical, psychosocial and spiritual.

The Finnish institute for health and welfare (2019) stated that end-of-life care related palliative care refers to medical treatment that relieves symptoms as the illness is not curable and life extension is not only the goal of treatment. Palliative care can last for years and is aimed at the well-being of the patients and their significant others. Krau (2016) discussed that end-of-life care is implemented only to the patients whose life is close to end, whereas palliative care embraces the end-of-life care. Finnish Ministry of Social Affairs and Health (2017) defined that the end-of-life means for the last few weeks or days of life.

Hospice care originated initially in 1967 in England and Ireland (National Hospice and Palliative Care Organization 2019) is a synonym of end-of-life care (NHS 2018) whereas terminal care is provided to the patients whose curative treatment has been terminated (Cancer Society of Finland no date).



In this thesis, the author discussed principally palliative care, yet in order to widen the scope of the research study, hospice care, terminal care as well as end-of-life care were encompassed and utilised the three terms as synonyms.

2.1.2 Ethics, moral and value

Oxford dictionary provides a definition of ethics as “moral principles that govern a person's behaviour or the conducting of an activity”. Rich & Butts (2013) stated that ethics is a discipline of ideal behaviour of human-beings, and also a methodical approach to perceive, resolving, and differentiating issues of right and wrong, and good and bad. In other words, ethics appertain to options of beneficial or harmful (Husted, Husted, Scotto & Wolf 2014).

In contrast with ethics, morals were characterised as certain belief and behaviours originated from personnel ethical judgement (Rich & Butts 2013). Every person has his or her own values. Oxford dictionary defines a value as “one's judgement of what is important in life”. In addition to it, values can be reformed and improved over time, and they are constantly influenced by various elements, such as environments (Carvalho, Reeves & Orford 2011). Since the concepts of ethics, morals and values are correlated strongly as Carvalho et al. (2011) stated, both morals and ethics can be also developed as a change in values occurs. That is to say, “values are starting points for morality and ethics” (Carvalho et al. 2011).

2.1.3 Nursing ethics and morality

Nursing ethics simply can be said as nurses’ actions for good nursing. Ethics is a continuous process of moral considerations how to take an action for good in a particular situation. There are four principles in nursing ethics; beneficence, non-maleficence, autonomy and justice. (Bhanji 2013; Robichaux 2016, 4.)

“Mature ethical sensitivities are critical to professional nursing practice” (Rich & Butts 2013). We as a healthcare professional have to develop more advanced ethical sensitivities in order to perform nursing practice. Particularly, ethics in healthcare is concerned as bioethics (Rich & Butts 2013). Thus, the “mature ethical sensitivities” are required in bioethics. One explanation of it is that an environment where bioethics is taken place has vulnerable persons involved (Husted, Husted, Scotto & Wolf 2014). In other words, healthcare professionals are treating patients or clients who are considered as vulnerable. Moreover, the phenomenon makes us remarkably challenging to resolve the ethical dilemmas arisen (Husted et al. 2014).

In Finland, the National Advisory Board on Social Welfare and Health Care Ethics from the ministry of social affairs and health (2012) stated in a broad sense that “all the work has to be done in social and health care sectors based on human dignity and respect for individuals, which includes human right, the right of determination and the right of choice”.

In particular, the Finnish Nurses Association published in 2014 the ethical guidelines of nursing which brings us more concrete support in decision-making process regarding ethical problems in nursing, consisting of six categories; “I. The mission of nurses, II. Nurses and patients, III. The work and professional competence of nurses, IV. Nurses and their colleagues, V. Nurses and society, and ultimately, VI. Nurses and the nursing profession”. The mission of nurses is to promote and maintain the well-being of populations, prevent diseases, and reduce suffering. The nurses have high regard for the autonomy and self-determination of the patients and offer an opportunity to take part in decision-making in his or her own care. The interdependence of nurses and patients is based upon open relation and reciprocal faith. We have to treat all the patients equally without any discriminations. The nurses are in charge of their work. And the nurses perform their work actively for enhancing people with health issues. (The Finnish Nurses Association 2014.)

Japanese Nursing Association (2003) also provides ethical principles for Japanese nurses. Nursing is aimed at supporting various individuals, families, groups, and communities by promoting and recuperating health, preventing diseases, and alleviating suffers so that a person can live with his or her personhood valued till the end of life. There are 4 main components in ethical guidelines for nurses; “advocacy, obligation, cooperation, and caring” (Japanese Nursing Association 2003). Nurses ought to assist the patients as their advocator, and encourage the patients to make their own decisions for their benefits. The nurses have two dimensions of legal and moral obligations. The legal obligations are based upon the law of Act on Public Health Nurses, Midwives and Nurses, and moral obligations are originated from nursing ethical principles (2003) and standards of nursing duties (2016). Cooperation is described as working together with other multi-disciplinary professionals, patients and their significant others in order to fulfil high quality and safe care to individuals, families, groups or communities who need nursing care. Lastly, caring is a concept of “1. Mutual relation with targeted persons, 2. Ideal and ethical attitude of nursing to value the dignity of the intended persons, and 3. Thoughtfulness and considerations” are shown in nurses’ attitudes so that the intended persons can benefit for their health.

Furthermore, ethical principles are utilised in health care including nursing practice, which are obtained from the idea of morality. The four principles of beneficence, non-maleficence, autonomy and justice are meant to be used in order to encourage moral behaviour and decision-making action by bringing us a framework in practice. (Rich & Butts 2013.)

As those codes and guidelines of ethics in healthcare are maturely developed, it gives us a framework for what is pertinent for motivations and value-centred performance, and how these interact to human condition (Husted et al. 2014).

2.2 Distinctive ethical issues in palliative care

Moral or ethical issues or dilemmas are frequently experienced in nursing despite the codes and guidelines of ethics. There is no concrete correct answer that applies to all the patients in terms of ethics and morality. There are guidelines and principles as well as the laws that provide a framework of ethics or what we should do to patients for good or right professionally. Yet, every patient has unique values. Since the concepts of values, ethics, and morals have deep connections each other, they are inconstant as values vary. (Carvalho et al. 2011.)

In addition, values in nursing contain respecting not only what is significant for the patients, but also what is significant for both nurses and profession (Rich & Butts 2013). Furthermore, values are influenced by numerous factors including environment (Carvalho et al. 2011). Cultural differences are also vast phenomena as considered them as circumstance that affects personal values and ethical practice. Although nurses try to conserve their integrity in order to work consistency with both personnel and professional values, there are obstacles or restrictions that impose the nurses on pressure and incongruity between their values and the undesirable situations. Hence, the nurses face ethical or moral dilemma recurrently. (Carvalho et al. 2011; Rich & Butts 2013.)

Ethical principles are not to get rid of ethical issues and futile without professional enthusiasms in a moral manner (Rich & Butts 2013). Benjamin & Curtis (1992) also stated that it is a misconception that all nurses require is merely the code of ethics when managing the moral dilemmas because there are limitations in the ethical framework. As indicated earlier, nursing professional ethics involve with patients, nurses, other professionals, as well as the patients' significant others, and there is no specific correct solutions. Thereby, the dilemmas and issues in ethics and morals experienced by nurses are very complicated. (Rich & Butts 2013; Carvalho et al. 2011.)

When healthcare professionals take an action towards patients for a purpose of caring them, healthcare professionals must consider and follow the ethical codes in order to achieve the optimal outcome for the cared persons based upon their values in any stage of care (Finnish institute for health and welfare 2019). Caring patients does not always mean that the treatment cures their illnesses completely. Although the patient suffers from incurable disorder or terminal illness without a hope of long life expectancy, the care should be continued by alle-

viating a pain or any discomfort that the patient is experiencing as well as his or her significant ones, and provide a psychological and spiritual care in order to improve the patient's quality of life with dignity in a practice of palliative care. (WHO 2018.)

Hermsen & Have (2001) discussed that palliative care is particularly correlated with moral issues concerning traits of healthcare professionals, care quality, and high esteem for the patients' and their significant others' autonomy. In particular, the ethical concerns in palliative care frequently appear due to arguments, such as what and what degree of care should be carried out for the end-of-life patients. In the situation, various collisions happen among medical professionals, patients, and their significant ones regarding what is appropriate care for the specific individual who is ending his or her life. Moreover, palliative care or end-of-life care is very sensitive because the cared populations are extremely vulnerable. There are also various persons, such as multi-professionals, patients, and their family members involving in the care, and the care itself is complex due to the main dimensions of the care, spiritual, psychosocial, and physical care. Because of these mentioned traits of the palliative care, challenges arise frequently, which require ethical decision-making skills. Therefore, ethics in palliative care plays significant role in palliative care. (Fromme 2018; Mamiya 2016.)

2.3 Contemporary situations of palliative & terminal care

2.3.1 Palliative and terminal care in Finland

Although palliative care has seen a development in recent years, there is still a need to be enhanced (European Observatory on Health Systems and Policies 2019). Terminal care recommendation by Finnish ministry of social affairs and health (2010) emphasised on the dignity, humanity and self-determination of a dying person.

In Finland, there is an organisational model describing three-tier palliative care services to secure need-based and also equal access. Its premise is that all the individuals are equally entitled to receive the palliative care at home or in social and health care facilities. There are three levels (A-C) in the mentioned model besides the basic level of all the social and healthcare facilities where patients in the terminal stage are to be cared or the patients who do not belong to any other levels are cared. Level A is formed by health care units, such as wards of health centres and hospitals where the palliative and terminal care has been developed as one of the basic duties. Level B comprised of units specialized in palliative and end-of-life care in hospital areas. Ultimately, level C composes centres for palliative care in university hospitals, including outpatient clinics for palliative care, teams for counselling, home hospitals as well as mental support facilities. (Sosiaali- ja terveysministeriö 2019, 15-17.)

However, accessibility to palliative and end-of-life care is regionally diverse since the care is not actually accommodated into the current health care system (Sosiaali- ja terveysministeriö 2019, 14). Moreover, sosiaali- ja terveysministeriö (2019) addressed that there were no Finnish university hospital districts (HYKS, KYS, OYS, TAYS, and TYKS), which achieved the level of C. Their operation was targeted more for the university hospitals, and inclusive consultation assists for the palliative patients were not performed. The regional variations in the operations for palliative and terminal care were also seen in other ward hospitals and health care facilities in Finland. The majority of Finnish patients die in hospitals despite their desire to spend the end-of-life at home. In fact, there are merely 3090 patients annually who receive terminal care whereas the estimated number of patients who require the care is 30,000 yearly in Finland. (Sosiaali- ja terveysministeriö 2017, 7; Sosiaali- ja terveysministeriö 2019, 37-45; The National Advisory Board on Social Welfare and Health Care Ethics 2012.)

In a study by Palliative Care for Older People in Care and Nursing Homes in Europe, PACE (2019) revealed that palliative care knowledge in nursing in Finland was 0.49 from the scale from 0 to 1. environmFinland was also categorised as a country where hospice and palliative care services at the introductory level of integration into mainstream service provision, graded as 5th in 6 levels (WHO 2014).

2.3.2 Palliative and terminal care in Japan

There are multi-forms of palliative care facilities in Japan, such as “in-hospital independent style, in-hospital floor style, in-hospital segmented style, and home care” (Ferrell & Coyle 2010). According to a publication of number of hospice palliative facilities in Japan (Hospice Palliative Care Japan 2019), there were 424 in total in 2019. Japan was categorised as a country with advanced integration in palliative and hospice care services, with having comprehensive palliative care and knowledge, graded as the highest level of 6 (WHO 2014).

Although the care has been developing in Japan in consequence of a revised version of national schemes of the Cancer Control Act (Japanese Ministry of Health, Labour and Welfare no date), still the percentage of terminal cancer patients died in hospice or specialised palliative units was merely 12.5 in 2016. Furthermore, the number of beds in hospice or palliative care facilities in Japan varies dependent upon the areas, and they were not equally allocated. Therefore, the improvement of specialised trained staff and facilities still need to be performed. (Igarashi & Miyashita 2017.)

Despite the progress and efforts for improving palliative care by both governments and medical professionals, we face challenges contributed by Japanese general populations’ perceptions of palliative care. Japanese people do not fully accept the concepts of palliative care in

a positive way or even their knowledge of the care is rather poor. Their typical view of opioid use is vicious, and palliative care is only for people who have abandoned the hope of living. (Ferrell et al. 2010.)

2.4 A description of the phenomenon to be studied

Both Finland and Japan should develop higher level of palliative care (European Observatory on Health Systems and Policies 2019; Igarashi & Miyashita 2017). One of the key portions of palliative care is ethics (Hermsen & Have 2001). Although there are research articles and studies in palliative care from nursing ethical perspectives both in Finland and Japan, most of the relative scholarly articles are written in languages either Finnish or Japanese. Moreover, there was no comparative studies focused on those two mentioned countries regarding the subject. Therefore, the thesis was implemented for the new study on the subject in the countries.

3 Purpose, aim and research question

A purpose of the thesis was to describe the differences and similarities in ethical challenges experienced by nurses in geriatric palliative care between Finland and Japan. Aims of the study were to deepen the knowledge of ethical challenges arisen in palliative care in both countries and develop higher expertise in the care by knowing ethical issues between the two different cultures, and to provide nurses more possibilities to tackle the problems. A research question of this thesis was what are differences and similarities in nurses' ethical challenges in a practice of geriatric palliative care between Finland and Japan.

4 Methodology

A form of the thesis is a theoretical study conducted by using a literature review method. Literature review is a comprehensive research methodology and interpretation of articles that correlates to a certain topic. After generating a research question, research articles should be searched and analysed in order to answer the question by conducting systematic methods. Literature review approach therefore, provides us a new perspicacity of the subject which we can see only when the each piece of relevant information is collected. (Aveyard 2010, 5-6.)

Williamson & Whittaker (2017) discussed that literature review demonstrates what is already known in the field and identifies traditional and modern arguments in addition to gaps in the field. Furthermore, a process of literature review is continuous so that it begins in the very

early stage of planning until the end of the process. The method is not just a summary, yet, it is a synthesis of the elements collected. A use of designed concepts, such as PICOT is recommended to utilise in order to structure a search of literature explicitly, which yields constructive and systematic search strategies. (Boswell & Cannon 2017.)

The author has found earlier studies concerning ethical dilemmas arisen in palliative care both in Finland and Japan. A methodology of literature review was the most suitable for the research since there were research materials for the specific phenomenon, and it was hardly achievable to conduct an empirical study in both countries. In addition, the method provided newer perspectives of the targeted subject. Earlier studies concerning the issue in both countries yield the best opportunity for the author to compare the subject.

4.1 Search Method

The key point of searching the literatures is a systematic search. This systematic search is comprised of identifying the literature that answer the research question by utilising logical search terms as well as inclusion and exclusion criteria. (Aveyard 2010, 69.)

Table 1 describes all the inclusion and exclusion criteria for the literature search. The relevant articles ought to involve ethical issues, either Finnish or Japanese background as well as palliative care, the end-of-life care or similar care. The focused populations were elderly or aged, not paediatric or younger patients. The publication restriction was over the last 15 years, during the period of 2004-2019 in order to perform the up-to-date study, yet, avoiding too little findings. The language in the texts should be either English, Finnish or Japanese. In addition to those, the author limited the literature level as academic journals, the PhD dissertations or the corresponded levels. Those criteria were carefully considered in order to achieve the systematic search for the study and remove irrelevant information. Bachelor level or lower level of research was excluded since the articles can be less trustworthy compared to the higher academic materials. Because the author focused on elderly palliative care in the study, paediatric patients, young adults, and middle aged populations was excluded. As mentioned in the background, the author studied terminal care and end-of-life care as well as hospice care as synonyms as palliative care, those terms were included. Yet, articles without ethical or moral issues or other than Finnish or Japanese background were excluded to answer the research question precisely and appropriately.

Table 1: Inclusion and Exclusion Criteria

Inclusion	Exclusion
Palliative care, terminal care, end-of-life care, or hospice care with ethical or moral issues as well as either Finnish or Japanese background.	Palliative care, terminal care, end-of-life care, or hospice care without ethical or moral issues and other than Finnish or Japanese background.
Published last 15 years, 2004-2019.	Published over 15 years ago, before 2004.
Written in either English, Finnish or Japanese	Not published in one of the three languages
Academic or scholarly journal level	Non-academic articles
Aged, older adults, over 65 years old	Paediatric, young adults, middle aged

Firstly, the author searched relevant scholarly articles based upon the subject and the research question by using six electronic databases suitable for the subject, which are Finna.fi, Ebsco/Cinahl, Proquest, PubMed, Julkari, and J-stage. The search terms, restrictions in the search, and results are described below in table 2. The words used in the search varied slightly dependent upon the database since some electronic engines are specified in Finland or Japan such as Finna.fi, Julkari, and J-stage. In addition, the advanced search function in a few databases had limitations to use multiple words for literature search. Therefore, for instance, in julkari, search term was merely “palliative” as shown in table 2. Similarly, the terms used to search in Japanese database of J-stage were only “palliative” and “ethic*”.

The restriction section shows exclusions and limitations used in the search. This is described more precisely in table 1, inclusion and exclusion criteria. In the result part, the total number of hits after using the search terms and limitations is seen. Since the study required two countries’ materials, the search was taken place twice for each country besides julkari and J-stage. A letter of “FI” in the table means Finland, and “JP” is for Japan. The number of accepted literatures after reading abstract is shown in “Accepted by abstract”. Finally, the total accepted number of articles after critical reading of literatures is described in the “Accepted” part.

Table 2: Literature Search

DATABASES	Search Terms	Restrictions	Results	Accepted by Abstract	Final acceptions
FINNA.FI	FI. Finland AND palliative	Last 15 years Research level aged	FI. 15	FI. 0	FI. 0
	JP. Japan AND palliative		JP. 6	JP. 1	JP. 0
EBSCO/CINAHL	FI. palliative OR end-of-life OR terminal OR hospice AND ethic* OR moral* OR spiritual* AND Finland or Finnish	Last 15 Years Academic journals Aged 65+	FI. 3	FI. 1	FI.0
	JP. palliative OR end-of-life OR terminal OR hospice AND ethic* OR moral* OR spiritual* AND Japan OR Japanese		JP. 30	JP. 1	JP.1

PROQUEST	FI. (palliative OR end-of-life OR terminal OR hospice) AND (ethic* OR moral* OR spiritual*) AND (Finland OR Finnish)	Last 15 Years Scholarly Journals Full text	FI. 31	FI. 2	FI.0
	JP. (palliative OR end-of-life OR terminal OR hospice) AND (ethic* OR moral* OR spiritual*) AND (Japan OR Japanese)		JP. 63	JP. 1	JP.0
PubMed	FI. (palliative OR end-of-life OR terminal OR hospice) AND (ethic* OR moral* OR spiritual*) AND (Finland or Finnish)	Last 15 Years Aged 65+ years	FI. 26	FI. 5	FI.1

	JP. (palliative OR end-of-life OR terminal OR hospice) AND (ethic* OR moral* OR spiritual*) AND (Japan OR Japanese)		JP. 76	JP. 8	JP.1
Julkari	Palliative	Last 15 years	101	2	1
J-STAGE	palliative AND ethic*	Last 15 years	29	4	3

Total number of selected articles including manual search method	
Japan: 7	Finland: 7

Aveyard (2010, 82) argued that highly relevant literature can remain to be unidentified despite the use of well-planned search terms on the first search. This opinion is supported by a study conducted by Montori, Wilczynski, Morgan & Haynes (2004), in which they showed the high frequency of literature findings encountered by chance in electronic databases regardless of their broad-ranging well-designed searching strategies. Hence, Aveyard (2010, 82) stated that wider searching strategies in information retrieval can be a portion of systematic manner if the method is well-structured and its relevancy is justified on the subject. For that reason, the author carried out the manual search for the literature derivation in addition to the methods mentioned above. The manual search included a search from reference lists from relevant articles. As a result, seven studies were chosen by the manual method.

The review was ultimately conducted with 14 articles, Japanese articles (n=7) and Finnish (n=5) and European (Belgium, Denmark, England, Finland, Italy, the Netherland, Poland, and Sweden) papers (n=2), selected accordance with the inclusion and exclusion criteria. The descriptions including setting, purpose and aim, method and sample, main findings, limitation of the each study are shown in appendix 1.

4.2 Critical Appraisal

In a process of critical appraisal, the author prudently read the selected articles by abstracts to assess whether the articles answered for the research question, and their quality was adequately high and reliable with a help of The Critical Appraisal Skills Programme (CASP) checklist. The score of each article is written in table 3. For each CASP question, the article obtained 1 point when the answer was "Yes" in the checklist, 0.5 point for "can't tell" answer, and 0 point for "No" answer. The max score was 10. The highest score of the studied articles was 9.5, whereas the lowest score was 6. The selected materials were read repeatedly to detect the purpose and aim, methods, main findings and limitations to develop a chart of those which is shown in appendix 1.

Table 3: CASP Score

Authors & (Year)	CASP score
Izumi, S. (2007)	8
Yoshida, M. (2010)	6
Tanaka, M & Okamitsu, K. (2013)	8
Eguchi, H. (2017)	9
Izumi, S. (2010)	8.5
Yanagisawa, E., Kaneo, S. & Kamiyama, Y. (2012)	8.5
Schreiner, A., Hara, N., Terakado, T. & Ikegami, N. (2004)	9
Hemberg, J & Bergdahl, E. (2019)	9
Godskesen, T., Petri, S., Eriksson, S., Halkoaho, A., Mangrete, M., Pirinen, M. & Nielsen, Z. (2018)	8.5
Anttonen, M. (2016)	9

Grönroos, M. & Hirvonen, A. (2012)	9
National Advisory Board on Health Care Ethics. (ETENE) (2004)	7
Koppel, M., Pasman, H., van der Steen, j., van Hout, H., Kylänen, M., Van den Block, L., Smets, T., Deliens, L., Gambassi, G., Frogatt, K., Szczerbińska, K., Onwuteaka-Philipsen, B., & PACE. (2019)	9.5
Seppelvirta, T. (2014)	8

4.3 Analysis

In this thesis, inductive content analysis was performed in order to compare the literatures. Inductive content analysis is a methodology of research analysis utilised to detect the concepts, idea or messages from data collected (Columbia University Mailman School of Public Health 2019). The thesis applied this analysis methodology since the data was extracted from literatures, and the methodology was well suited for both qualitative and quantitative studies (Columbia University Mailman School of Public Health 2019). Also the author intended to collect the messages of nurses' voices from the words within the texts, and compare the contents in order to obtain the deeper understanding and interpret them for new insight of the subject. Therefore, this approach was perfectly suitable for this thesis.

The selected articles were read recurrently, and relevant elements were firstly highlighted in the original papers and extracted into a notebook by hand. Thereafter, two mind maps were generated for each perspective of Finland and Japan. Based upon the mind maps, categories were created in accordance with connections of each element. As having completed the categorising process by analysing the chosen materials, the author compared the contents within the categories to address the research question. In addition to the mind maps, a table to compare the subjects was also created. The descriptions and main body of the thesis were then built in a logical order. The relationships of categories and the contents are shown in appendix 2.

5 Findings

There were in total 14 papers studied, six articles were implemented as a qualitative study, three systematic reviews, two quantitative studies, a seminar discussion paper, and two mixed studies (intervention, quantitative and qualitative). The setting of Japanese studies was in Japanese hospitals, cancer care hospitals and palliative care units, whereas there were Finnish homecare settings (n=1), oncology and haematology unit in Denmark, Finland and Sweden (n=1), home hospitals and hospices (n=1), municipal healthcare services (n=1), and long-term care facilities (n=1) on Finnish side. Although two articles were involved in other European countries besides Finland, only Finnish related contents were extracted for this study.

Four main categories identified by the analysis were “truth-telling”, “responsibility and uncertainty”, “environment”, and “interactions”. The correlation of the number of articles and the four categories of each country are shown in Figure 1 and Figure 2 below. Figure 1 describe the prevalence of the four themes in the selected Japanese research papers, whereas figure 2 explains the Finnish side.

Figure 1: Japanese Articles

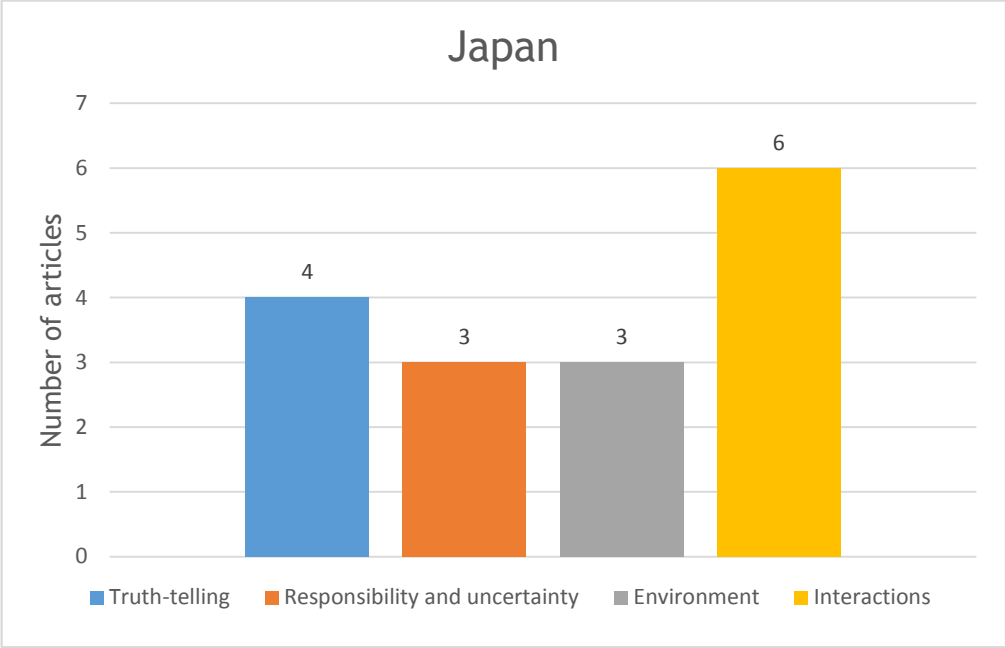
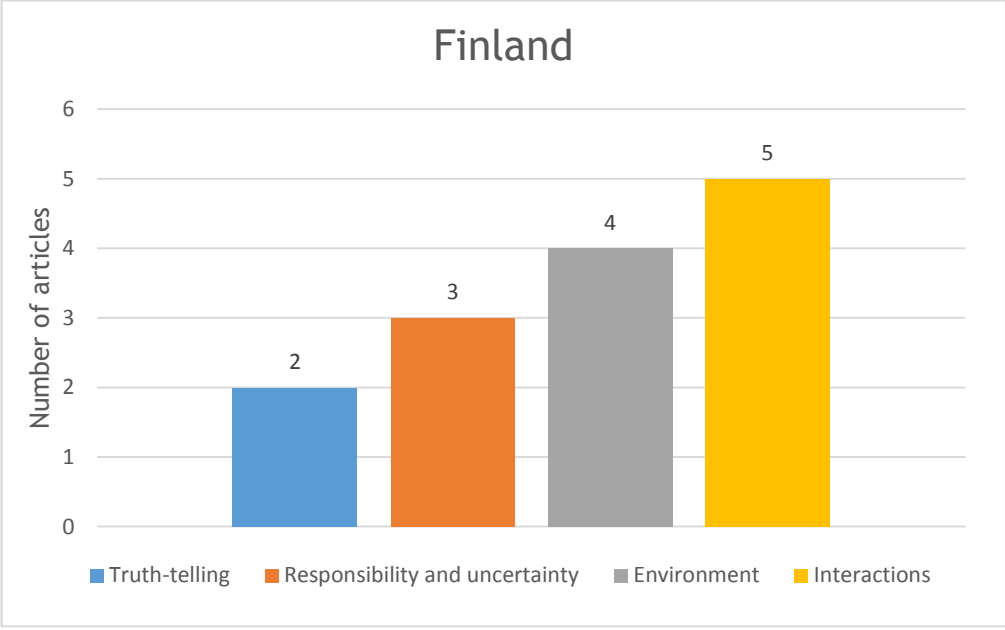


Figure 2: Finnish Articles



Nurses from both countries experienced ethical challenges as they collided with either systematic ethical principles or their own values. Although there were many similarities in ethical dilemmas that nurses felt in both countries, a genesis underlying moral dilemmas and process of forming ethical challenges had distinctions. Japanese nurses emphasised more on a sense of guilt for the patients as a reason for feeling ethical dilemmas, while Finnish nurses experienced ethical challenges due to infringing on patients' rights. Moreover, from the ethical dilemmas experienced in the mentioned countries, variations of culture and healthcare systems were revealed. The contents of the similarities and differences in ethical dilemmas in each category are shown in table 4 below. The "Similarities" sections describes the contents of similar findings in the each category detected from both countries, while the "Differences" are indicated the unique contents identified from one of the countries. The name of the country in the table is indicated as "JP" or "FI".

Table 4: Similarities & Differences

Category	Similarities	Differences
Truth-telling	-Patient's unrealistic hopes. -Should nurse disclose the truth? -To what extent nurses should tell the truth?	(JP) -Sense of guilt and fear of breaking the patient's hope. -Avoid telling truth to prevent the patient from further hurting. -Information disclosure only to family members. -Being rude to patients. -Acting sincerely.
		(FI) -Staying truth to nurses' duty. -Patients should obtain the information, but difficult to achieve it.

Responsibility & Uncertainty	-Inadequate experience & knowledge. -Uncertainty in care. -Insufficient skills & training. -Conflicts between nurses' responsibility and patient safety or will. -Patient safety against patient autonomy.	(JP) -Conflicts between patient's hope and own defensiveness.
		(FI) -Uncertainty in right place for treatment.
Environment	-Insufficient time. -Lack of resource. -Excessive workload.	(JP) -Inadequate medical equipment. -Inappropriate ward arrangement.
		(FI) -Work pressure. -Constant disruptions. -Limited information access. -Complexity & inflexibility of service use. -Frequent changes in workplace. -Inconstancy in computer system & personnel. -Homecare associated issues.

Interactions	-Conflict between other healthcare professionals. -Unnecessary medical interventions. -Inappropriate interactions with doctors. -Hierarchy in hospitals. -Conflicts within family members. -Unmotivated patients. -Patient is left behind. -Insufficient communication with patients. -patient's difficulty in accepting the situation.	(JP) -Widened psychological and physical distance from patients. -A culture of admiring a doctor. -Family is a decision-maker. (FI) -Inappropriate attitude towards patients and significant ones. -Demanding family members. -Cooperation with family Pressure from family to disclose the information.

5.1 Truth-telling

Nurses in both countries commonly confronted ethical challenges in a situation where they inform the truth of diagnosis or prognosis to the terminally ill patients or their significant ones. Ethical dilemmas arisen from truth-telling situations were detected by Japanese articles (n=4) and Finnish papers (n=2). (Anttonen 2016; Godskesen, Petri, Eriksson, Halkoaho, Mangset & Nielsen 2018; Eguchi 2017; Izumi 2007; Yanagisawa, Kaneko & Kamiyama 2012; Yoshida 2010.)

This case was particularly seen in Japan when the terminally ill patients had an unrealistic hope or expectation for their future or prognosis as the patients did not know regarding their diagnosis or prognosis (Izumi 2007; Eguchi 2017). A palliative patient suffered from several cancers had a hope for his prognosis so that he desired to participate in a rehabilitative pro-

gramme to improve his physical problems. However, the nurse considered that the rehabilitation might only deteriorate his condition without providing any benefits to the patient. The nurse had a fear of breaking his hope for life by telling the truth. (Yoshida 2010.)

Japanese nurses' other concerns leaded to psychological distress was hurting the patients further both psychologically and physically by telling the truth although they already have been suffering enough from the terminal stage illnesses. Therefore, they would rather avoid it by not operating truth-telling. This dishonest attitude towards the patients made them feel an intense sense of guilt because this action was against their values. In other words, nurses regarded it as even being rude to the patients. Thereby, the nurses felt regrettable for the patients which resulted in broadening both the physical and psychological distance between patients and nurses. (Izumi 2007.)

Finnish nurses also experienced the dilemmas in the similar context of telling truth to the patients. A qualitative study with semi-structured interviews from Nordic nurses (n=39) from Denmark, Finland and Sweden (Godskesen et al. 2018) revealed that Finnish nurses had a concern whether they ought to inform the truth to the patients and to what extent they should disclose it because they also desired the patients to keep their hope to live. This is because improving or maintaining the quality of life of the terminal patients with their hope was essential from nurses' point of view. However, as its solution, several nurses brought up an opinion of "staying truth to their roles as decisional support" (Godskesen et al. 2018). This can be originated from a concept of significance for patients to obtain the true information of their condition, and patients also wished it for a purpose of decision-making (Anttonen 2016).

Nurses in Japan felt ethical difficulties in a situation where the patient's information disclosure was fulfilled only to their significant ones. They suffered from ethical dilemmas especially, when the family members or doctors prohibited nurses from informing the truth to the patients. In this setting, the nurses conflicted with their untruthful behaviour to the patients despite their value of trustfulness to them. (Yanagisawa et al. 2012.)

In contrast, the corresponded case was not detected from Finnish articles. Instead, Finnish nurses concerned the situation as endangering patient's confidentiality if the family members hope to obtain the information against patient's will (Hamberg & Bergdahl 2019). The patients have right of self-determination to decide a role of other persons involving in the end-of-life care (Anttonen 2016). In addition, the patients are to decide the treatment based on their will, but not the significant one's hope (Seppelvirta 2014, 65).

While Finnish nurses viewed the solution to be truth to their duty for the patients (Godskesen et al. 2018), Japanese nurses considered that acting with sincerity to the patients would be

the resolution. Being honest to patients does not necessarily mean that telling a true prognosis. Instead, having nurses' honest wishes that the patients improve their condition was more emphasised in Japan. (Izumi 2007.)

5.2 Responsibility and uncertainty

Ethical dilemmas caused by uncertainty in the care and conflicts with nurses' responsibility was also discussed in both countries in seven articles (Anttonen 2016; Eguchi 2017; Godskesen et al. 2018; Grönroos & Hirvonen 2012; Izumi 2010; Schreiner, Hara, Terakado & Ikegami 2004).

Japanese nurses had ethical dilemmas when they did not know how to achieve their responsibility of doing ethically good for the palliative patients. This was caused by an inadequate experience in the ethically complex situation. Their desire was to achieve the optimal outcome for the patients. Yet, this was not very simple because of their inability or a lack of practical knowledge. An enormous gap between nurses' knowledge of ethical principles and how to actually implement it in practice was addressed. (Izumi 2010.)

Similarly, Finnish nurses described moral challenges in the indistinguishable context. Some had not been trained adequately for the care, therefore, they were not capable of providing an answer to questions asked by the significant others (Godskesen et al. 2018).

Besides inadequate experience, lack of skills and clinical knowledge caused Japanese nurses moral dilemmas (Schreiner et al. 2004; Eguchi 2016). Some nurses were not confident in implementing terminal care due to the grounds. For instance, they had inadequate knowledge of opioids and their adverse effects, which might be resulting in jeopardizing the patient's safety and bringing the nurses about ambiguous in their care. However, they were fully aware of their own responsibility as a caregiver who is meant to do good for patients. Therefore, they were distressed by the dilemmas. (Eguchi 2017.)

End-of-life care itself is very complicated. According to a quantitative study participated by 622 Finnish nurses (Grönroos et al. 2012, 23-24), 4.3 percent of Finnish nurses and practical nurses (n=14) gave their answers as having experienced ethical dilemma, which was grouped as A-type dilemma in their study, where nurses not knowing how to act appropriately in providing end-of-life care. From the same study, 13.1 percent of nurses (n=43) answered that their uncertainty in treatment method and right treatment place caused ethical dilemmas. The subjectivity in quality of life also complicated to actualise ideal care (Anttonen 2016).

Moreover, Japanese nurses distressed in a situation where they had uncertainty which to prioritise more, either nurses' own defensiveness, patient's safety, or patient's wish. The case

was described as the patient desired to go to the toilet with considerably deteriorated physical condition, the nurses would like to respect his or her autonomy and will. However, nurses simultaneously considered the risk of falls. If the patient had an accident, this might become nurses' responsibility. (Tanaka & Okamitsu 2013.)

When nurses in Japan conflicted with their responsibility against patient's autonomy, they tended to feel ethical dilemmas. This was because they could not fulfil their ideal nursing care by focusing more on their responsibility for patient's safety and nurses' own safeguarding rather than patient's wish or autonomy. As a consequence, the patient autonomy was severely restricted. Likewise, the nurses in a research studied by Yanagisawa et al. (2012) revealed that they could not actualise terminally ill patient's hope of going home due to the patient's circumstances and health condition despite the nurses' own values of prioritising patient's desire and patient's will. As the patient's condition was too bad to go home, fulfilling the patient's wish became challenging. (Eguchi 2017; Yanagisawa et al. 2012.)

Similar contexts were detected from Finnish articles. Finnish nurses felt dilemmas from uncertainty of which to place more emphasis on their own values of good for the patients or their duty and responsibility. They brought a case of a smoker patient who suffered from lung cancer. Although nurses was taking care of the patients for the cancer, the patient hurt or deteriorated the condition by himself or herself from the action of smoking. Nevertheless, this is a patients' choice, and they have legal right to choose for their desire. This issue caused nurses enormous ethical distress because they felt their ethically good action for the patients was wasted. (Hemberg et al. 2019, 3; Seppelvirta 2014.)

5.3 Environment

Environmental issues which contributed to nurses' ethical challenges were identified from literatures from both countries. More precisely, heavy workload, inadequacy of time and resource, and organisation correlated issues were identified. However, Japanese nurses focused more on moral issues caused by facility related problems, whereas Finnish nurses had ethical issues associated with healthcare systems and organisations. (Anttonen 2016; ETENE 2004, 12,40; Godskesen et al. 2018; Grönroos et al. 2012; Schreiner et al. 2004; Tanaka et al. 2013; Yanagisawa et al. 2012.)

Japanese nurses experienced the moral difficulties when the time limitation did not allow them to provide a good care to the patients. This was one of the largest reasons for moral dilemmas for Japanese nurses. Some nurses stated that although they would like to have a discussion more with the patients, it was hardly achievable because of insufficient time and re-

source, and overtasked. Managing time is one of the most important tasks for nurses as a professional. Therefore, their ideal patient care, which embodies adequate time to discuss with the patients, was hardly fulfilled despite their value, which resulted in ethical dilemmas. Likewise, a mixed approach study by Schreiner et al. (2004), where Nurses (n=106) and physicians (n=8) took part in, detected that the second most influenced obstacles (28 percent) in the research to provide a palliative care was too little time and insufficient number of caregivers. (Tanaka et al. 2013; Yanagisawa et al. 2012; Schreiner et al. 2004.)

Finnish nurses also responded as their time at work was not sufficient. Nurses had difficulty in implementing their duty in the very limited time. Moreover, they felt a considerable work pressure and experienced constant interruptions at work. In fact, there was a limitation in number of Finnish nurses informants in the research because of their excessive workloads. (Godskesen et al. 2018.)

Furthermore, a research revealed the largest reason (37.5 percent) for Finnish nurses feeling the moral dilemma in general was because of lack of resource and being busy at work. Due to the time and resource deficiency, they experienced disruptions in their duty and inability of implementing the care that they desired to provide. (Grönroos & Hirvonen 2012.)

A Finnish nurse shared her experienced of doing excessive work for "good" for patients voluntarily although the care plan did not encompass it. Although they would like to provide a good care and a good service to meet client's demand, the workload became too heavy for nurses. (Grönroos & Hirvonen 2012.)

Issues caused by inappropriate facility made Japanese nurses felt ethical conflicts. For instance, the patients wished to take a bath, yet, the limitations in the environment did not allow it. Restrictions of medical equipment in elderly care homes also leaded to ethical conflicts because the restrictions caused the difficulty in achieving nurses' desire to provide necessary and appropriate care for dying persons. Other example shown was that despite the patient's hope to be in a single room for his or her peace, it was not possible due to the insufficient hospital rooms. As a consequence, the care staff could not concentrate on providing the special care for terminally ill patients and their significant ones since there was intermingle-ment of patients in various stages of disease in the same unit. This phenomenon made more challenging for the nurses to implement the suitable care for palliative and terminally ill patients. (Tanaka et al. 2013; Yanagisawa et al. 2012.)

In contrast, Finnish nurses expressed their ethical dilemmas arisen from organisational and systematic perspectives, which were not identified from Japanese articles (Grönroos et al. 2012; ETENE 2004; Anttonen 2016; Grönroos et al. 2012). Inconstancy in the care was highlighted in the Finnish studies. For instance, when they had frequent changes in workplaces and in each unit has unique regulations to follow or patients to take care of vary constantly,

the nurses felt ethical difficulties as they became confused. Otherwise, when the workplaces often altered their operational models, the nurses had a similar feeling as above. Some nurses even answered that the care in home care environments was complex and caused ethical dilemmas. (Grönroos & Hirvonen 2012.)

The organisational issue in home care that had limitations in information access, or operational problems leaded to ethically challenging situations to nurses. Some home care may have very comprehensive guidelines for the care, whereas others do not. As other issue, the travel distances between each home for care can very wide. As a result, this can increase the financial pressure as well as workload of care staff. Moreover, limitations in information access due to different computer systems used in Finnish healthcare facilities also caused nurses ethical difficulties. Without obtaining precise information on the patients, providing the optimal care was unachievable. (Anttonen 2016, 61; ETENE 2004, 36.)

Other contributor to ethical distress experienced by Finnish nurses was inflexibility and complexity of the services. Finnish hospice nurses expressed Finnish service's trait as "bureaucracy" (Anttonen 2016, 88). In the case, despite the patient's need of borrowing a care equipment from an assisting instrument unit, it imposed the patient and significant ones on additional work as well as unnecessary costs to pick it up because the unit was only in the different city, and either terminal patient or the family member had to go there to collect the aids by taxi. (Anttonen 2016, 88; Grönroos et al. 2012, 28.)

5.4 Interactions

Ethical dilemmas arisen from a circumstance where problematic interactions with other persons involving in the care were detected from six Japanese articles and five Finnish literatures. Conflicts between other healthcare professionals, patients and relatives were seen in both countries. Nevertheless, the ethical issues arisen by family becoming a sole decision-maker in the care, and patients' incapability of interacting with doctors were detected only from Japan, whereas Finnish nurses had distinctive issues of family's demandingness and jeopardised patient's confidentiality by their significant ones. (Anttonen 2016, Eguchi 2017; Godskesen et al. 2018; Grönroos et al. 2012; Hemberg et al. 2019; Izumi 2007; Izumi 2010; Schreiner et al. 2004; Seppelvirta 2014; Tanaka et al. 2013; Yoshida 2010.)

Different opinions from doctors and colleagues and inappropriate communication with them brought Japanese nurses moral difficulties. These ethical dilemmas occurred in Japan particularly, when their dissimilar decisions resulted in hurting the patients. For instance, aggressive treatment prioritised more than palliative care due to physician's decision. The amount of opioids and sedatives prescribed by doctor were too little for a dying patient, which resulting

in nurses having to watch the patient suffering. The inappropriate communication manner with physicians also made challenging the nurses to acknowledge the precise information on the patient. As a consequence, they were unable to create a proper nursing care plan. Nevertheless, they had a strong desire of relying on consulting with other professionals for their uncertainty in care and difficulty in making a decision solely, lack of communications brought them about ethical issues. (Schreiner et al. 2004; Tanaka et al. 2013; Yoshida 2010.)

Similarly, Finnish nurses also encountered ethically challenging situations where they had different opinions from other professionals, such as co-workers and physicians, and their unsuitable attitude. Finnish nurses (n=43) provided an answer of having ethical dilemmas as they saw inappropriate behaviour towards the patients (Grönroos et al. 2012). Improper medical procedures ordered by the doctor, such as PEG tubing treatment for the patient in the end-of-life care against the patient's wish was one of the contents. More focused sustaining the dying patient's life by unnecessary medical interventions brought the nurses ethical dilemmas because this was against nurses' value of securing the patient's autonomy and quality of life. Lack of communication with the physicians evoked moral dilemmas to Finnish nurses because nurses could not ensure how to support the patients. The inadequate interactions between doctor and patients and their significant ones also brought Finnish nurses moral issues. The inappropriate way of communication made the patients and their family insecure, and the nurses who have seen them most closely ended up with having moral difficulty. As a consequence of the insufficient interactions between healthcare professionals and the patients and their family members, the patient's dignity was not taken into consideration accordingly. (Anttonen 2016, 61,62; Godskesen et al. 2018; Grönroos et al. 2012; Hemberg et al. 2019.)

Yet, discussing ethical problems with physicians for Finnish nurses was challenging and needed a courageousness particularly, when their opinions conflicted. Some Finnish nurses expressed that they had an intense moral dilemmas due to a nurses' subordinate position. (Godskesen et al. 2018.)

Furthermore, hierarchy of their positions contributed Japanese nurses to ethical dilemmas as well. The higher position of doctors became a barrier for nurses to provide their opinions. It was also revealed that some Japanese nurses considered that physicians did not accept or listen to nurses' opinions due to the culture. Many Japanese nurses (close to 50 percent) answered that they had ethical conflicts due to the doctors in a study (Schreiner et al. 2004). The hierarchy in hospitals had an impact on the patients and family members as well. The patients and their significant ones could not give their opinions to the physician due to a culture of admiring persons who are in high position. Moreover, doctors' inadequate interactions with the terminally ill patients and their significant ones caused them more suffers by not providing adequate explanations and information. Even when the informed consent was generated, there were cases that the contents were based upon more physician's interest. The nurses

felt that the physicians did not grant opportunities for the patients and family members to make a decision (Schreiner et al. 2004). Inadequate communications between healthcare professionals and the patients' side left the patients and family behind in the care. As a result, healthcare professionals missed to disclose the information at the right time, and their dignity and patient-centredness in the care as well as their will were neglected, which caused nurses ethical conflicts because the nurses were fully aware of unethical practice in the situations. (Izumi 2007; Eguchi 2017; Yanagisawa et al. 2012.)

Another interaction problem that caused Japanese nurses' moral issues was patient and family related issues. When the palliative patients had a different value from their significant ones, especially in Japan, when only family knew the poor prognosis of the patients, nurses experienced the ethical distress. Although in a case where the patient was informed about his or her very limited time to live and poor condition, the significant others would like to prolong the life against the patient's will of receiving the palliative care. Japanese nurses also conflicted ethically as the palliative patients were too passive to discuss or interact with nurses or physicians. In addition, the patients' inability of understanding their circumstances caused ethical difficulties since the patient was left behind as its consequence. Due to the dishonest attitude towards patients caused by not being able to disclose the truth, Japanese nurses concerned the widened psychological distance between the patients and nurses. This was because nurses attempted to hide the truth by not interacting with the patients. Moreover, inadequate communication made the nurses challenging to identify the patient's will, which resulted in nurses' ethical dilemmas. (Eguchi 2017; Izumi 2007, Izumi 2010; Yanagisawa et al. 2012.)

Finnish nurses also had similar types of ethical dilemmas yielded by patient related issues, such as patients' incapability of understanding the situations, the patients' unconcerned attitude towards their own conditions and treatment, or their difficulty in accepting the deteriorated situation. Relatives associated contributors were also detected from Finnish articles. When the communications between the family members did not act well, the nurses felt moral conflicts. In addition, as the family members could not accept the poor health status of the patients or lack of understanding the circumstances emerged moral difficulty to the nurses. Unique family issue identified only from Finnish perspectives was high demands for care from the significant ones. Finnish nurses (n=12) answered that the cooperation with the significant ones caused them ethical dilemmas (Grönroos et al. 2012, 24). Some significant ones claimed the very last minute transfer of the dying patients to the hospital, which nurses considered as being more risky to the patients. Intense pressure from the significant others to disclose the patient's information without a patient's consent also leaded to nurses' dilemmas because this would infringe the patient's confidentiality. (Anttonen 2016, 62, 72, 97; Godskesen et al. 2018; Grönroos et al. 2012, 24; Hemberg et al. 2019; Seppelvirta 2014, 59.)

6 Discussion

A purpose of the study was to describe the differences and similarities in ethical challenges experienced by nurses in geriatric palliative care between Finland and Japan. This thesis provided those differences and similarities of Japanese and Finnish nurses' ethical dilemmas in palliative care or similar contexts with the four generated themes by analysing 14 articles selected. Interestingly, there were a great number of similarities in the subjects across the two countries. Yet, the cultural and healthcare environmental differences strongly affected the ethical dilemmas experienced by the nurses. The nurses tended to encounter moral issues when the ethical principles, their responsibility, or their own value of doing good for the patients were conflicted with problematic situations, which are shown as categories in this thesis. (Izumi 2007; Izumi 2010; Yoshida 2010; Tanaka et al. 2013; Anttonen 2016; ETENE 2004; Godskesen et al. 2018; Grönroos et al. 2012; Schreiner et al. 2004; Yanagisawa et al. 2012; Hemberg et al. 2019; Eguchi 2017; Koppel et al. 2019; Seppelvirta 2014.)

6.1 Nurses' values

The nurses' values were seen differently in the two countries. The ethical concerns of Japanese nurses which were corresponded as their own values (Izumi 2007). This emphasised on the nurses' consideration of the patients on emotional level rather than actual harm to them. For instance, they cared more not hurting the patients psychologically by not being rude or dishonest to the patients. In a situation where they had to tell a lie to the patients or they could not tell the truth, the nurses suffered from intense sense of guilt because they felt as they deceived the patients. (Izumi 2007; Yanagisawa et al. 2012.)

Patient's personhood is valued greatly in Japan. Personhood is a unique Japanese expression, which was influenced by Japanese culture. The term was defined as unique characteristic of basis of individuals with their dignity maintained (Kuroda, Funahashi & Nakagaki 2017). In other words, the patients should live with dignity remained in a way of how they are until the last moment of their life. The nurses also would like to provide a meaningful and pleasant time to the patients with their personhood respected. However, when this was not fulfilled, they experienced heavy ethical dilemmas. These considerations seem to be originated from nurses' sympathy and compassion in Japanese culture. (Kuroda et al. 2017; Izumi 2007, Tanaka et al. 2013; Yanagisawa et al. 2012.)

In contrast, Finnish nurses emphasised more on patient's right and autonomy. For instance, when the patient's right of self-determination was neglected or nurses had to act against the

patient's will and leading to actual harm to the patients, it caused the nurses ethical dilemmas. These concerns seem to be derived from the ethical principle of non-maleficence and human right. (Grönroos et al. 2012, 23; Hemberg et al. 2019.)

6.2 Truth-telling from patient's perspective

Japanese nurses faced ethical issues when only significant ones know the true prognosis or diagnosis of the patients. In fact, it has been intentionally avoided telling the true diagnosis to the patients in many cases since the intense shock caused by the action may deprive the palliative patient's hope for life (Japan Hospice Palliative Care Foundation no date). However, this may be only from the perspective of healthcare professionals. According to an attitude survey (Japanese hospice palliative foundation 2018), around 70 percent of the total participants answered that they would like to know the true diagnosis and prognosis. Interestingly, from the same survey, in terms of disclosing the true diagnosis to a family member who was diagnosed with a cancer, 53.6 percent of Japanese informants answered that they as other family members follow the cancer patient's intention if he or she has, whereas only 21.5 percent said that they disclose it regardless of the cancer patient's desire. Therefore, as the patients, they prefer to know the truth. Yet, when someone close, such as a family member is the patient, other family members are not willing to disclose it if there is no particular intention from the cancer patient.

From the perspective of patients in Finland, some participants in a study (Raisio, Vartiainen & Jekunen 2015) debated that the significant ones should be eliminated from a discourse of death with the patient since their values might be completely different from the patient's ones which should be respected the most. Although family members should be close to the dying patients for supporting, they are not entitled to be a decision-maker. Discussing the truth with the terminally ill patients is not easy for Finnish nurses as well (Anttonen 2016, 64, 65). Some patients may not have desire to hear about the true prognosis. However, the issues are hardly processed without discussing it. In Finnish contexts, obtaining the true information as a patient is significant in order to make a decision. Protecting the patient's right of self-determination is seen from this context as well. (Anttonen 2016, 59.)

6.3 Practical training need and problematic environment

The significance of having knowledge and well-trained in the complex palliative care is clear. However, if there is no opportunity for the nurses to learn and experience the specific examples in a practical setting, nurses' duty can be hardly achievable. In fact, a study (Izumi 2010)

revealed that the nurses were fully aware of ethical principles and codes. Therefore, the uncertainty could be originated from both insufficient practical experience and a lack of clinical knowledge. They should be trained practically so that they can identify what is ethically wrong and good in order to find a solution. (Izumi 2010.)

The same matter was seen from theories as well. A question concerning a demand for terminal care training for healthcare professionals was brought up by ETENE (2004, 36). Especially, in smaller communities in Finland, the need of care staff training is more emphasised because the same personnel has to manage to cover various specialities. Similarly, PACE (2019) suggested that Finnish nurses should be educated more in this particular environment. Ethical principles in healthcare provide nurses only a direction to do good for the patients (Carvalho et al. 2011).

Reserving adequate time is very important in the terminal care for cared persons too because haste diminishes the nurses' opportunities for discussion with patients and their family members, which require time to assimilate the sensitive subjects. Moreover, adequate resources enable the nurses to care the dying persons and their family members serenely and more safely. (ETENE 2004, 12, 40; Anttonen 2016.)

The ideal end-of-life care suggested by ETENE (2004, 35) is a care with personal nurses. The patients at the terminal stage ought to have a few personal nurses who consistently provide a care. By achieving this, the relationship of the patients and nurses enhances, and nurses are able to become acquainted with the patients more. Japanese ministry of health, labour and welfare also proposed the similar principle as ETENE that palliative patients should have their exclusive nurses and doctors in the care. (Japanese Ministry of Health, labour and Welfare 2018.)

On the other hand, in reality, Japanese nurses answered that traits of Japanese palliative care unit in hospitals had problems. Due to the mixed patients with various stages of illnesses in the same unit brought them challenges in care. Also because of the busyness, they did not have sufficient time to educate themselves. Nurses were being pressed only by daily duty. (Hirose, Nakanishi, Kamimiya & Nito 2017; Yanagisawa et al. 2012.)

An environment issue caused ethical dilemmas to the Finnish nurses was various computer systems used in healthcare settings. This can yield a sense of insecurity not only to care staff, but also to patients and their significant others. A family member of a cancer patient experienced confusion by discovering that the university hospital did not have access to patient's information from municipality healthcare centre from which the patient came. Furthermore, inconsistency in care can endanger the patient's safety and nurses' trustworthiness. For instance, patients and their significant others complained about the inconstancy in care in Finn-

ish home care environment as different nurses visited them without perceiving their situations, which resulted from either information access restrictions or constant alternations in nurses' workplace. The negative psychological effects on the patients and their significant others are immense although they are already in a challenging situation with the severe illnesses. The relationship that they can build in a sole home visit is very shallow. The carelessness attitude towards both patient and family members make them feel insecurity. (Anttonen 2016, 61, 65.)

For all the patients, their family members and the healthcare professionals, the healthcare organisations should secure resources who can provide the constant care to the same patients so that time also can be reserved more.

6.4 Cultural differences and communication issues

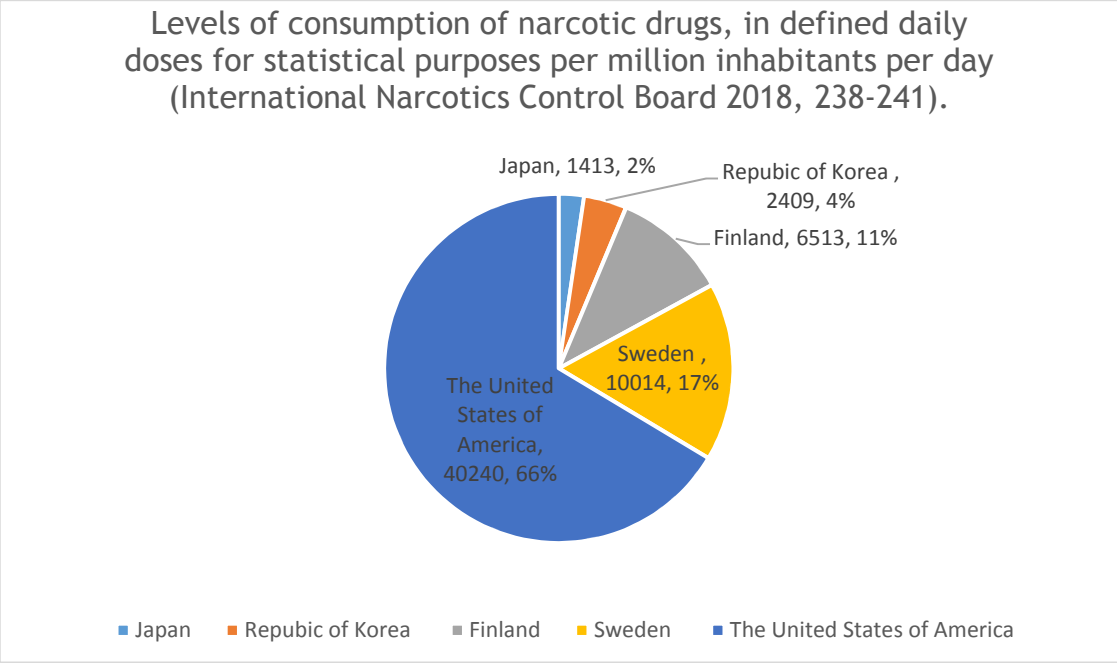
Some cultural differences were seen from the issues of communications. A research (Schreiner et al. 2004) identified Japanese nurses' further need of communication with doctors, patients and also their significant others. 84.4 percent of nurse informants assented that nurses ought to take part in a decision-making discussion. Japanese nurses were evidently aware of the need of more communication with doctors, patients and family members. Healthcare professionals' appropriate communication with the patients facilitates their difficult feelings emerged from the end-of-life setting (Umekawa 2016, 94). A data also suggested that the existence of end-of-life discussion with family members caused them less psychological difficulties after the patient's death (Japan Hospice Palliative Foundation 2016, 50-52). The decisive benefit of communication with the patients and family is seen from them.

Nevertheless, Japanese nurses participated in a study (Schreiner et al. 2004) constantly insisted that physicians did not provide the opportunities for the patients and family to make a decision in terminal care. Moreover, merely a few (11.7 %) agreed that physicians spent adequate time with patients and family in the same research. Generally speaking, asking questions or telling wills to doctors was difficult from the patient's perspective in Japan (Umekawa 2016, 94). This may be originated from the authoritative image of doctors in Japan. In fact, Japanese nurses shared one of their ethical dilemmas caused by a public view of the superiority of doctors in Japanese culture (Eguchi 2017). Furthermore, nurses had moral dilemmas due to the doctor's manipulative attitude towards the patients and family to choose the aggressive treatment (Eguchi 2017).

Another cultural contribution to the communication issues is that the patients do not prefer to talk about death. Death has been deemed impure from a Japanese cultural standpoint (Horie 2014, 11). In other words, the death is seen as a taboo. Japanese nurses conflicted

ethically with the patients who were not willing to discuss the death in practical settings (Izumi 2010). Moreover, Japanese tend to see enduring suffering as a virtue from a cultural perception. A public survey (Pfizer Inc. 2017) revealed that close to 70 percent of Japanese (n= 5,943) answered that they should endure a pain. In addition, more than a half (n=4,830) stated that they should not tell about having a pain to others easily. Thus, even as a patient, Japanese people tend to hesitate to discuss their suffering openly, which can result in inappropriate communication with the healthcare professionals in even end-of-life contexts. A level of medical opioids consumption may show it as a proof of the subject described in Figure 3 (International Narcotics Control Board 2018, 238-241). The use of opioids in medical ground in Japan was significantly lower compared to any other countries including Finland. The figure contains other neighbour countries of Japan and Finland for a comparative purpose. The phenomenon might be resulted from the cultural concept of enduring a pain, and patient's hesitation to communicate regarding their pains and suffers.

Figure 3: Level of Narcotic Drugs Consumption



Likewise, many issues in Finnish palliative or terminal care were also related to lack of discussion and information process with the patients and family members. Discussing it together with healthcare professionals will bring about more possibilities to success in the terminal

care. Moreover, the patient's view plays a significant role in the care because of the subjective characteristics of quality of life (ETENE 2004, 12). Seppelvirta (2014, 65) also agreed that end-of-life care ought to be chosen based upon the patients' preference. In order to achieve it, good communication manner is inevitable. Negative impacts of inappropriate communication with healthcare professionals are also immense on the significant others as well, since communication failure can abandon the family's psychological preparation for the death (Anttonen 2016, 99). This unpreparedness of the death makes it difficult for the family members to handle the future concerns. (ETENE 2004, 34.)

Finnish relatives were not satisfied with a level of consensus with healthcare professionals in end-of-life care settings. A study (Koppel et al. 2019) revealed that the degree of consensus in Finland from the family's perspective was considerably lower compared to the other researched countries. Similarly, from the view of Finnish healthcare professionals, the level of full consensus was the lowest of 59.5 % among six studied countries. This gap could be arisen from a family's intense demand of "all can be done should be done" in Finland (Seppelvirta 2014, 59). Their expectation for healthcare professionals might be too high so that they are not satisfied with the current situation. Due to the strong demands from the family, the physicians may have to focus on the aggressive treatment instead of palliative care so that the significant others may not complain about it (Seppelvirta 2014, 59). Finland also has a view of the death as taboo (ETENE 2014, 41), and it is a difficult subject to talk about (Anttonen 2014, 51). This culture also can be one of the reasons why some Finnish patients with terminally ill also did not desire to discuss with others.

7 Conclusion

The purpose of this thesis was to identify and report the differences and similarities in ethical dilemmas from the nurses' perspective in the set of geriatric palliative care by comparing Finland and Japan. This was conducted by a literature review methodology in order to answer the research question of what differences and similarities are in nurses' ethical challenges in a practice of geriatric palliative care between Finland and Japan. The research was also done to mature the expertise the subject in the aging society of the studies countries for the future work as its purpose. The findings indicated that there were rather many similarities of the circumstances when the nurses conflicted with their moral dilemmas in the two countries. However, the reasons and the process of shaping the dilemmas were seen differently in addition to culture and systematic distinctions.

By implementing the well-planned approach of literature review, explicit differences in the subject were detected as well as similar contents. There was no similar comparative studies of the matter in the researched countries in the past. Therefore, this thesis provided a new

insight into the nurses' experiences of the subject in the palliative and end-of-life care in Finland and Japan. In a process of this research, unexpected sight of healthcare system related issues arose from both countries. Although the challenges caused by organisational problems were slightly different in both countries, the nurses in both countries experienced the ethical dilemmas intensely generated by those extrinsic factors. The cultural differences were also identified in the context, which had a great impact on palliative care and ethical issues to both healthcare professionals and patients' way of behaviour and thoughts. By knowing the issues arisen, we can improve the care, and reduce the frequency or level of moral conflicts.

7.1 Limitation

There was limitations in number of Finnish articles on the subject at the searching stage. It was challenging to detect as numerous Finnish literatures as Japanese ones despite the widened scope of language criteria for this thesis, Finnish, Japanese and English. This leaded to be widened the scope of the literature for 15 years in order to collect the adequate number of materials for the analysis. Moreover, since the study has been researched by 14 articles, it cannot be said that the findings detected are generalised. Although the thesis is a comparative study, the researched articles did not have the exact same grounds in the two countries. Therefore, there is also a limitation in accuracy in the comparison.

7.2 Ethical issues, validity & reliability

The academic journals selected for the study are reliable since merely high level of articles were chosen. Using high quality papers ensures higher reliability in literature review. Furthermore, combining the systematic approach of search with review enhanced reliability and validity. This study applied the structured searching strategy with a use of various reliable databases, critical appraisal using a CASP checklist for selected articles, as well as the systematic review process. Those methodological strategies leaded to higher consistency and validity of the research. (Aveyard 2010, 9-11, 14.)

Since this thesis was conducted by a method of literature review, it did not require to obtain a research permit from the Advisory Board on Ethics. After reading responsible conduct of research and procedures for handling allegations of misconduct in Finland (Finnish Advisory Board on Research Integrity 2012), the author ensured not violating professional ethics while conducting the study by being transparent throughout the research process. In addition, the ethical observations were taken place for each section of the study (Laurea 2017). The author

has followed the rules of referencing and citations strictly throughout the work in order to avoid the violations of the responsible conduct of research.

When conducting the review approach, objectivity is significant in order not to encompass the author's own bias (Jones, R 2019). Hence, systematic approach and well-structured strategy are crucial for literature review. The work has been done with faithful and legitimated manner by utilising only data extracted from the literatures. Nevertheless, this thesis was conducted by an individual student and due to the nature of qualitative study, objectivity in the thesis had limitations. (Aveyard 2010, 57-58.)

7.3 Recommendation

This thesis focused on "elderly" populations in the palliative care excluding for populations of aged people who have dementia or deteriorated cognitive ability. When taking care of those with cognitive issues, the results will turn out differently from the one studied by this thesis. The nurses will face different ethical problems, and the communication and care methods may also not be the same as for the populations focused in this study. Further research can be required to describe the ethical issues caused by taking care of elderly palliative patients with cognitive challenges. In addition, to understand the further implication of the findings, future studies could be done by empirical methodology. By collecting the data from current voices of nurses, the findings can be different from the ones from this thesis study.

References

Printed

Boswell, C. & Cannon, S. 2017. INTRODUCTION TO NURSING RESAERCH Incorporating Evidence-Based Practice. 4th edition. Burlington: Jones & Bartlett Learning.

Robichaux, C. 2017. Ethical competence in nursing practice: competences, skills, decision making. 1st edition. New York: Springer Publishing Company, LLC.

Grace, P. 2018. Nursing ethics and professional responsibility in advanced practice. 3rd edition. Massachusetts: Jones & Bartlett Learning.

Williamson, G. Whittaker, A. 2017. Succeeding in Literature Reviews and Research Project Plans for Nursing Students. 3rd edition. London: SAGE Publications Ltd.

Electronic

Anttonen, M. 2016. Kuoleman vaikeuden lievittäminen kuoleman todellisuuden kohtaavassaja ohittavassa saattohoidossa. Accessed 28 November 2019. https://trepo.tuni.fi/bitstream/handle/10024/98745/978-952-03-0066-1.pdf?sequence=1&isAllowed=y

Aveyard, H. 2010. *Doing A Literature Review In Health And Social Care: A Practical Guide*, McGraw-Hill Education. 2nd Edition. Glasgow: Bell and Bain Ltd. Book from ProQuest. Accessed 1 October 2019. http://ebookcentral.proquest.com/lib/laurea/detail.action?docID=771406.

Barker, P. 2017. Ethical dilemmas in palliative care. Accessed 16 April 2020. https://journals-sagepub-com.nelli.laurea.fi/doi/full/10.1177/1755738017712536

Bhanji, S. 2013. Health Care Ethics. Accessed 31 March 2020. https://www.longdom.org/open-access/health-care-ethics-2155-9627.1000142.pdf

Benjamin, M. & Curtis, J. 1992. Ethics in Nursing. 3rd edition. New York: Oxford University Press, Incorporated. Book from ProQuest. Accessed 9 October 2019. http://ebookcentral.proquest.com/lib/laurea/detail.action?docID=3051930.

Cancer Society of Finland. No Date. Terminal Care. Accessed 27 September 2019. https://www.allaboutcancer.fi/treatment-and-rehabilitation/terminal-care/

Carvalho, S., Reeves, M., & Orford, J. 2011. Fundamental Aspects of Legal, Ethical and Professional Issues in Nursing 2nd Edition. London: Andrews UK Ltd. Book from ProQuest. Accessed 28 September 2019. https://ebookcentral.proquest.com/lib/laurea/reader.action?https://ebookcentral.proquest.com/lib/laurea/reader.action?docID=1043059&query=moral%2Bor%2Bethics%2BAND%2Bnursing

Columbia University Mailman School of Public Health. 2019. Content Analysis. Accessed 6 May 2020. https://www.mailman.columbia.edu/research/population-health-methods/content-analysis

Critical Appraisal Skills Programme. 2018. CASP Qualitative Research Checklist. Accessed 6 October 2019. https://casp-uk.net/casp-tools-checklists/

Dunn, G. & Milch, R. 2001. Introduction and historical background of palliative care: where does the surgeon fit in? Accessed 10 October 2019. https://www.journalacs.org/article/S1072-7515(01)01019-5/fulltext

Eguchi, H. 2017. Development of an Ethical Dilemma Scale in Nursing Practice for End-of-Life Cancer Patients and an Examination of its Reliability and Validity. Accessed 24 October 2019. https://www.jstage.jst.go.jp/article/jjsnr/40/4/40_20170124001/_pdf/-char/ja

Ferrell, B. & Coyle, N. 2010. Oxford Textbook of Palliative Nursing. 3rd edition. New York: Oxford University Press, Incorporated. Book from ProQuest. Accessed 11 October 2019. http://ebookcentral.proquest.com/lib/laurea/detail.action?docID=510308.

Fimea. 2018. Traditional herbal medical products. Accessed 31 March 2020. https://www.fimea.fi/web/en/marketing_authorisations/herbal_medicinal_products/traditional_herbal_medicinal_products

Finegan, W. & McGurk, A. 2007. CARE OF THE CANCER PATIENT. Oxon: Radcliffe Publishing Ltd. Book from Google books. Accessed 10 October 2019. https://books.google.fi/books?id=YSJWDwAAQBAJ&pg=PT75&dq=The+old+methods+of+care+and+caring+had+to+be+rediscovered+and+the+best+of+modern+medicine+had+to+be+turned+to+the+task+of+new+study+and+therapy+specifically+directed+at+pain&hl=en&sa=X&ved=0ahUKEwjjjrufyZHlAhVh1qYKHUpAB_gQ6AEIMjAB#v=onepage&q=The%20old%20methods%20of%20care%20and%20caring%20had%20to%20be%20rediscov-

ered%20and%20the%20best%20of%20modern%20medicine%20had%20to%20be%20turned%20to%20the%20task%20of%20new%20study%20and%20therapy%20specifically%20directed%20at%20pain&f=false

FINNISH ADVISORY BOARDON RESEARCH INTEGRITY. 2012. Guidelines of the Finnish Advisory Board on Research Integrity 2012. Accessed 6 October 2019. https://www.tenk.fi/sites/tenk.fi/files/HTK_ohje_2012.pdf

Finnish institute for health and welfare. 2019. Elderly immigrants. Accessed 31 March 2020. https://thl.fi/en/web/migration-and-cultural-diversity/immigrants-health-and-wellbeing/elderly-immigrants

Finnish institute for health and welfare. 2019. Quality of end-of-life care. Accessed 31 March 2020. https://thl.fi/en/web/ageing/focus-on-the-quality-of-care/quality-of-end-of-life-care

Finnish institute for health and welfare. 2019. Study on end-of-life care: more training needed not only in Finland but also in many other countries. Accessed 11 October 2019. https://thl.fi/en/web/thlfi-en/-/study-on-end-of-life-care-more-training-needed-not-only-in-finland-but-also-in-many-other-countries

Fromme, E. 2018. Ethical issues in palliative care. Accessed 11 October 2019. https://www.uptodate.com/contents/ethical-issues-in-palliative-care#H30036538

Godskesen, T., Petri, S., Eriksson, S., Halkoaho, A., Mangrete, M., Pirinen, M. & Nielsen, Z. 2018. When Nursing Care and Clinical Trials Coincide: A Qualitative Study of the Views of Nordic Oncology and Hematology Nurses on Ethical Work Challenges. Accessed 12 October 2019. https://journals-sagepub-com.nelli.laurea.fi/doi/full/10.1177/1556264618783555

Grönroos, M. & Hirvonen, A. 2012. Eettinen kuormittuneisuus ja eettisten dilemmojen sisällöt kunta-alan hoitohenkilöstöllä. Accessed 12 October 2019. http://urn.fi/URN:NBN:fi:jyu-201205181680

Hemberg, J. & Bergdahl, E. 2019. Dealing with ethical and existential issues at end of life through co-creation. Accessed 12 October 2019. https://journals-sagepub-com.nelli.laurea.fi/doi/full/10.1177/0969733019874496

Hermsen, M. & Have, H. 2001. Moral problems in palliative care journal. Accessed 4 October 2019. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1191/026921601680419483

Hirose, K., Nakanishi, Y., Kamimiya, A. & Nito, T. 2017. Study on problems of nurses engaged in palliative care ward for the first time; Interview survey at three times from the opening of

the palliative care ward to one and a half years later. Accessed 25 April 2020. https://www.jstage.jst.go.jp/article/jspm/12/4/12_771/_pdf/-char/ja

Horie, T. 2014. Study on Japanese view of life and death with quantitative approach. Accessed 23 February 2020. https://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=11&cad=rja&uact=8&ved=2ahUKEwjnhtS0wefnAhXy0qYKHfcQBxo4ChAWMAB6BAgEEAE&url=https%3A%2F%2Frepository.dl.itc.u-tokyo.ac.jp%2F%3Faction%3Drepository_action_common_download%26item_id%3D41863%26item_no%3D1%26attribute_id%3D19%26file_no%3D1&usg=AOvVaw1ujvhDOOvLw-LzEATY-NWs

Hospice Palliative Care Japan. 2019. The number of hospital charge notification accepted Palliative care ward. Accessed 11 October 2019. https://www.hpcj.org/what/pcu_tdfk.html

Husted, J., Husted, G., Scotto, C. & Wolf, K. 2014. Bioethical Decision Making in Nursing, 5th Edition. New York: Springer Publishing Company. Book from ProQuest. Accessed 28 September 2019. https://ebookcentral.proquest.com/lib/laurea/detail.action?docID=1876347&query=moral%2B

Igarashi, N. & Miyashita, M. 2017. A current situation of Japanese palliative care through data. Accessed 24 October 2019. https://www.hospat.org/assets/templates/hospat/pdf/hakusyo_2018/2018-3-1.pdf

International Narcotics Control Board. 2018. REPORT 2018. Estimated World Requirements for 2019 - Statistics for 2017. Accessed 5 April 2020. https://www.incb.org/incb/en/narcotic-drugs/Technical_Reports/2018/narcotic-drugs-technical-report-2018.html

Izumi, S.2007. Nursing Ethical Concerns in End of Life Care, Using Hermeneutics Approach. Accessed 11 October 2019. https://www.jstage.jst.go.jp/article/jans/27/4/27_4_4_72/_pdf/-char/ja

Izumi, S. 2010. Ethical practice in end-of-life care in Japan. Accessed 12 October 2019. https://journals-sagepub-com.nelli.laurea.fi/doi/pdf/10.1177/0969733010364584

Janssesns, R., Zbigniew, Z. & Have, H. 1999. Articulating the concept of palliative care: Philosophical and theological perspectives. Accessed 10 October 2019. https://search-proquest-com.nelli.laurea.fi/central/docview/214203484/fulltextPDF/38E57C6C8A064612PQ/1?accountid=12003

Japan Hospice Palliative Care Foundation. No date. A manual for concerning cancer palliative care. Accessed 24 January 2020. https://www.hospat.org/practice_manual-3.html

Japan Hospice Palliative Care Foundation. 2018. Attitude survey on hospice and palliative care. Accessed 22 February 2020. https://www.hospat.org/assets/templates/hospat/pdf/ishikichousa-2018.pdf

Japan Hospice Palliative Care Foundation. 2016. Research on the quality evaluation of hospice and palliative care from bereaved family's view 3. Accessed 23 February 2020. https://www.hospat.org/assets/templates/hospat/pdf/j-hope/J-HOPE3/J-HOPE3_all.pdf

Japanese Ministry of Health, Labour and Welfare. 2018. Measures to improve the quality of palliative care. Accessed 25 April 2020. https://www.mhlw.go.jp/content/10901000/000488421.pdf

Japanese Ministry of Health, Labour and Welfare. No date. Regarding palliative care. Translated by Misa Myller. Accessed 12 October 2019. https://www.mhlw.go.jp/stf/seisakunitsuite/bunya/kenkou_iryou/kenkou/gan/gan_kanwa.html

Japanese Nursing Association. 2003. Code of Ethical Practice for Nurses. Accessed 31 March 2020. https://www.nurse.or.jp/nursing/practice/rinri/rinri.html

Jones, R. 2019. Doctoral Research: The Importance of Objectivity. Accessed 10 April 2020. http://refractivethinker.com/articles/doctoral-research-the-importance-of-objectivity/

Keskimäki, I., Tynkkynen, L., Reissell, E., Koivusalo, M., Syrjä, V., Vuorenkoski, L., Rechel, B., & Karanikolos, M. 2019. Health Systems in Transition. Finland Health System Review 2019. Accessed 27 September 2019. https://apps.who.int/iris/bitstream/handle/10665/327538/18176127-eng.pdf?sequence=1&isAllowed=y

Koppel, M., Pasman, H., van der Steen, j., van Hout, H., Kylänen, M., Van den Block, L., Smets, T., Deliens, L., Gambassi, G., Frogatt, K., Szczerbińska, K., Onwuteaka-Philipsen, B., & PACE. 2019. Consensus on treatment for residents in long-term care facilities: perspectives from relatives and care staff in the PACE cross-sectional study in 6 European countries. Accessed 2 December 2019. https://bmcpalliatcare.biomedcentral.com/track/pdf/10.1186/s12904-019-0459-9

Krau, S. 2016. The Difference Between Palliative Care and End of Life Care: More than Semantics. Accessed 27 September 2019. https://www.nursing.theclinics.com/article/S0029-6465(16)30027-5/pdf

Kuroda, S., Funahashi, M. & Nakagai, K. 2017. Concept Analysis of Personality in Nursing: U sing Rodgers' Model. Accessed 22 February 2020. https://www.jstage.jst.go.jp/article/jjsnr/40/2/40_20161207005/_pdf

Laurea. 2017. Laurea's thesis guidelines. Accessed 7 October 2019. https://laureauas.sharepoint.com/sites/linken/Documents/Laurea's%20thesis%20guidelines.pdf

Mamiya, K. 2016. Palliative Care and Health Care Ethics. Accessed 31 March 2020. http://s-igaku.umin.jp/DATA/64_01/64_01_04.pdf

Ministry of Social Affairs and Health. 2017. Providing palliative treatment and end-of-life care. Accessed 27 September 2019. https://stm.fi/documents/1271139/5933711/VERKKOON_RAPORTTI_Palliatiivisen%20hoidon%20ja%20saattohoidon%20j%C3%A4rjest%C3%A4minen.pdf/06538389-4b02-43d6-af77-a3eae6173bd3

Ministry of Social Affairs and Health, Finland. 2010. Terminal care recommendations based on expert consulting. Accessed 12 October 2019. https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/71949/URN%3ANBN%3Afi-fe201504225791.pdf?sequence=1

Montori V, Wilczynski N, Morgan D, & Haynes R. 2004. Optimal search strategies for retrieving systematic reviews from Medline: an analytic survey. Accessed 6 October 2019. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC543864/

National Hospice and Palliative Care Organization. 2019. History of Hospice. Accessed 9 October 2019. https://www.nhpco.org/hospice-care-overview/history-of-hospice/

NHS. 2018. Hospice care - End of life care. Accessed 27 September 2019. https://www.nhs.uk/conditions/end-of-life-care/hospice-care/

O'Brien, T. 2013. The impact of an aging population on palliative care. Accessed 16 April 2020. https://www.ncbi.nlm.nih.gov/pubmed/24303834

Pfizer Inc. 2017. Field study on chronic pain. Accessed 23 February 2020. https://www.pfizer.co.jp/pfizer/company/press/2017/2017_08_23.html#q2

Quill, T. & Miller, F. 2014. Palliative Care and Ethics. New York: Oxford University Press, Incorporated. Book from ProQuest. Accessed 9 October 2019. https://ebookcentral.proquest.com/lib/laurea/reader.action?docID=1665576

Raisio, H., Vartiainen, P. & Jekunen, A. 2015. Defining a Good Death: A deliberative democratic view. Accessed 14 October 2019. https://search-proquest-com.nelli.laurea.fi/central/docview/1707815553/fulltextPDF/1137E2C0704B4A0APQ/5?accountid=12003

Schreiner, A., Hara, N., Terakado, T. & Ikegami, N. 2004. Attitude towards end-of-life care in a geriatric hospital in Japan. Accessed 12 October 2019. http://web.b.ebsco-host.com.nelli.laurea.fi/ehost/pdfviewer/pdfviewer?vid=4&sid=6d33f027-f58a-4902-bdac-af0849990c97%40pdc-v-sessmgr04

Seppelvirta, T. 2014. Ammatillisen etiikan dilemmat -kirjallisuuskatsaus hyvän saattohoidon eettisiin tekijöihin. Accessed 9 January 2020. https://osuva.uwasa.fi/handle/10024/5259

Sosiaali- ja terveysministeriö. 2010. Hyvä Saattohoito Suomessa. Accessed 27 September 2019. https://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/71949/URN%3ANBN%3Afi-fe201504225791.pdf?sequence=1

Sosiaali- ja terveysministeriö. 2017. Palliatiivisen hoidon ja saattohoidonjärjestäminen. Accessed 1 April 2020. http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/160392/Palliatiivisen%20hoidon%20ja%20saattohoidon%20j%c3%a4rjest%c3%a4minen.pdf?sequence=1&isAllowed=y

Sosiaali- ja terveysministeriö. 2019. Palliatiivisen hoidon ja saattohoidon tila Suomessa. Accessed 12 October 2019. http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161396/R_14_19_Palliatiivisen_hoidonjasaattohoidon_tila.pdf?sequence=1&isAllowed=y

Sosiaali- ja terveysministeriö. 2019. Suositus palliatiivisen hoidon palveluiden tuottamisesta ja laadun parantamisesta Suomessa: Palliatiivisen hoidon asiantuntijaryhmän loppuraportti. Accessed 1 April 2020. http://julkaisut.valtioneuvosto.fi/bitstream/handle/10024/161946/STM_2019_68_Rap.pdf?sequence=1&isAllowed=y

Tanaka, M. & Okamitsu, K. 2013. A study on the factors affecting solving ethical problems of nurses that arise when assisting in autonomous activities of daily living/life of cancer patients in the end-of-life period. Accessed 24 October 2019. http://jnea.net/journal_item/journal/0501/img/010.pdf

The Finnish Nurses Association. 2014. Ethical Guidelines of Nursing. Accessed 4 October 2019. https://sairaanhoitajat.fi/artikkeli/ethical-guidelines-nursing/

Traue D. & Ross J. 2005. Palliative care in non-malignant diseases. Accessed 14 April 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1275998/

Umekawa, N. 2016. The essential nature of nursing care for the terminally ill. Accessed 23 February 2020. https://archives.bukkyo-u.ac.jp/rp-contents/KK/0015/KK00150L089.pdf

University of Canberra library. 2019. Evidence-Based Practice in Health. Accessed 31 March 2020. https://canberra.libguides.com/c.php?g=599346&p=4149261

Valtakunnallinen terveydenhuollon eettinen neuvottelukunta (ETENE) SOSIAALI- JA TERVEYSMINISTERIÖ. 2004. Kuolemaan liittyvät eettiset kysymykset terveydenhuollossa. Accessed 12 October 2019. https://etene.fi/documents/1429646/1559098/ETENE-julkaisuja+4+Kuolemaan+liittyv%C3%A4t+eettiset+kysymykset+terveydenhuollossa.pdf/6a1cd043-354c-486d-b554-e9f37159924e/ETENE-julkaisuja+4+Kuolemaan+liittyv%C3%A4t+eettiset+kysymykset+terveydenhuollossa.pdf

Voumard, R., Truchard, E., Benaroyo, Borasio, L., Büla, C & Jox, R. 2018. Geriatric palliative care: a view of its concept, challenges and strategies. Accessed 16 April 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6148954/

Watanabe, K., Matsuura, K., Gao, P., Hottenbacher, L., Tokunaga, H., Nishimura, K., Imazu, Y., Reissenweber, H. & Witt, C. 2011. Traditional Japanese Kambo Medicine: Clinical Research between Mordernity and Traditional Medicine- The State of Research and Methodological Suggestions for the Future. Accessed 31 March 2020. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3114407/

World Health Organization. 2014. Global Atlas of Palliative Care at the End of Life. Accessed 11 October 2019. https://www.who.int/nmh/Global_Atlas_of_Palliative_Care.pdf

World Health Organization. 2018. Palliative Care. Accessed 31 March 2020. https://www.who.int/news-room/fact-sheets/detail/palliative-care

World Health Organization. 2016. Global Health Observatory data. Accessed 16 April 2020. https://www.who.int/gho/mortality_burden_disease/life_tables/situation_trends_text/en/

Worldometer. 2020. Life Expectancy of the World Population. Accessed 16 April 2020. https://www.worldometers.info/demographics/life-expectancy/

Yanagisawa, E., Kaneo, S. & Kamiyama, Y. 2012. Conflict for Nurses Regarding Terminal Patients and Their Families: Literature Review. Accessed 31 October 2019. https://kki.repo.nii.ac.jp/index.php?action=repository_action_common_download&item_id=44&item_no=1&attribute_id=22&file_no=1&page_id=13&block_id=21

Yoshida, M. 2010. Ethical Issues in End of Life Care and Cancer Nursing. Accessed 24 October 2019. https://www.jstage.jst.go.jp/article/itetsu/28/0/28_KJ00008960593/_pdf/-char/ja

Figures

Tables

Appendices

Appendix 1: Articles

Authors (Year)	Setting	Purpose/Aim	Method/ Sample	Main findings	Limitations	CASP score
Izumi, S. (2007)	Japanese hospitals	To investigate and describe the nurses' ethical values and concerns in Japanese end-of-life care settings.	Qualitative, Hermeneutics. Japanese RNs (n=32) with end-of-life care experience.	Japanese nurses emphasised on "not hurting the patient", "honesty", "concerns for isolation or loneliness", "regard for the patient's personhood", "respect for the wishes", "relief from suffering" and "meaningful time for the patient" in the subject.	Non-generalizable results due to the number of participants.	8
Yoshida, M. (2010)	Japan	To describe ethical issues in end-of-life care in cancer nursing.	Literature review, content analysis.	Ethical issues arose when nurses experienced situations of having different opinions from the patient's wish, having fear of depriving the patient's hope, telling	Not mentioned.	6

				the truth about the patient's condition, and patient's wish for meaningless treatment or rehabilitations.		
Tanaka, M & Okamitsu, K. (2013)	Japanese hospitals	To detect the factors affecting when solving nursing ethical challenges in assisting terminal cancer patients' autonomy. To study the process of ethical judgement in the subject.	Qualitative, Induction content analysis. Japanese RNs (n=9) with at least 6 years of end-of-life care experience.	Seven themes of factors affecting solving moral issues; nursing principles and values, assessing risk and anticipated results from clinical experience, care environment, nurses' circumstances, medical team judgement, and nurses' responsibility were detected.	Non-generalizable due to the number of informants and facilities.	8
Eguchi, H. (2017)	Japanese cancer care hospitals and palliative care units	To develop a scale to measure nursing ethical dilemmas in terminal cancer care settings.	Quantitative, correlational analysis & factor analysis.	Seven factors of nursing ethical dilemmas; 1) insufficient level of informed consents for both patients and the significant others,	Need further studies to examine the correlations with the factors affecting	9

		To examine the validity and reliability of the scale.	Japanese RNs (n=1,337) with cancer or palliative care experience in 450 facilities The response rate was 29.7%.	2) inadequate degree of assist for decision-making in nursing, 3) nurses' inability to provide care in compliance with patient's need, 4) mismatched opinions from doctors, prioritised life-prolonging treatment against the patient's condition, 5) proceeding a care as the patient is left behind, 6) the different opinions between patient and 7) family members were detected.	nursing dilemmas and different care facilities for terminal cancer patients.	
Izumi, S. (2010)	3 large Japanese hospitals	To describe Japanese nurses' ethical practice in end-of-life care. To detect how ethical practices disclose in practice.	Qualitative, phenomenological approach. Japanese nurses (n=32) with end-of-life care experience.	Four degree of nurses' ethical actions; "ethical", "distressed", "uncertain" and "unethical" were analysed.	The findings apply to only nurses' views, but not from patients' ideal nursing care. Interactions with other healthcare	8.5

				Having a capability of judging the good and right leaded to the different level of ethical implementation.	professionals were not affected the findings. The voluntary informants were more sensitive and interested in the subject compared with other nurses.	
Yanagisawa, E., Kaneo, S. & Kamiyama, Y. (2012)	Japan	To identify the nursing conflicts in end-of-life care environments, and to detect their solutions.	Systematic review, inductive content analysis. 24-Japanese medical research articles published by The Japan Medical Abstract Society for the 20-	The nurses experienced ethical conflicts due to a lack of experience, insufficient communications, and inadequate care environments, which were opposed to their ideal care. As solutions for the issue, initiative actions, such as having a conference, communicating directly to patients and significant others, doing research,	Not mentioned.	8.5

			year period of 1991 to 2011.	and gaining experiences were detected.		
Schreiner, A., Hara, N., Terakado, T. & Ikegami, N. (2004)	A private 180-bed non-commercial geriatric hospital in Japan	To detect nurses' and physicians' approach towards terminal care and discerned obstacles to the improvement of palliative care programme in the hospital.	Mixed methodology of intervention research, qualitative and quantitative study with a use of survey and open-end question. Content analysis for qualitative results and SPSS version 10 was used for quantitative study analysis. Nurses (n=106) and physicians (n=8) participated.	Majority of nurses agreed that the palliative care curriculum would ameliorate the terminal care and addressed the physician's treatment-oriented attitude and insufficient communication skills were hindrances to improve the palliative care. The doctors stated that the limited medical approaches and legal issues as their main barriers.	Generalisability was the merely limitation because the study was conducted only in a hospital.	9
Hemberg, J & Bergdahl, E.	Finnish homecare organisations	To investigate nurses' experiences of ethical and existential concerns in	Qualitative study, hermeneutical approach, thematic analysis.	Great co-creative connections and trustful caring were required to tackle with ethical and existed issues in end-of-life care.	The results may have limitations in generalizability and comparability.	9

(2019)		co-creation in palliative home care.	Finnish homecare nurses (n=12)			
Godskesen, T., Petri, S., Eriksson, S., Halkoaho, A., Mangrete, M., Pirinen, M. & Nielsen, Z. (2018)	In oncology and haematology units in Sweden, Denmark and Finland	To explore the types of ethical difficulties experienced by oncological and haematological nurses as nursing care and research overlap in clinical trials, and the solutions for the challenges.	Qualitative study with semi-structured interviews, inductive content analysis. Nurses (n=39) in oncology or haematology in the three countries.	There were two main challenges detected from the study; patient-related and workplace-related. Solutions were individual responses, assists from co-workers and using inclusion/exclusion criteria to deal with the issues.	Not mentioned.	8.5

Anttonen, M. (2016)	Home hospitals and hospices in Finland	To establish a substantive theory of palliative care. To improve patient and family oriented palliative care based upon the created substantive theory.	Qualitative study, the Grounded theory method. Nurses (n=15), patients (n=16), and family members (n=14) in home hospitals (n=5) and hospices (n=3) in Finland.	The main category of "alleviating the severity of death by confronting or passing the reality of death during end-of-life care", which was described by patients', families' and nurses' perspectives was detected.	The joint interview may have brought limitations in interviewees' expressions.	9
Grönroos, M. & Hirvonen, A. (2012)	Municipal health care services in Finland.	To investigate the ethical strain including prevalence of ethical dilemmas and consequent stress experienced by municipal health care workers and the details of more rep-	Quantitative study with a use of electronic questionnaire, analysed by IBM SPSS Statistics 19.	More than half (53%) of the informants had type A (situations in which nurses did not know what the right actions to take) ethical dilemmas a small number times a week at least. The greater number (62%) experienced fairly little distress in these dilemmas.	The subjects were asked only the most general dilemmas either types A or B, which could not provide an inclusive view of the framework of the ethical dilemmas.	9

		resentative ethical dilemmas they have experienced in their work. To detect -to what extent do municipal health care professionals experience distress at work. - Is ethical stress related to background factors (e.g. gender, age) - What are the contents of the most general moral dilemmas on the subject. - Do the contents of the most representative ethi-	Nurses (n=622) in health care services; basic nurses (17%), practical nurses (53%) and registered nurses (30%) in Finland.	Most participants (63%) experienced type B dilemmas (situations in which nurses were forced to act against the regulations or own values) several times a year or a few times a month. More than half (53%) experienced rather little distress by dilemmas categorised in B. In both type A and B dilemmas, the largest contributor was lack of resource and haste.	The research had a deficiency of not being able to determinate the degree of existence of differences between answered nurses and non-responded ones.	

		cal dilemmas vary dependent upon the background factors.				
National Advisory Board on Health Care Ethics. (ETENE) (2004)	Finland.	To enhance the dying persons' right for an optimal care in Finland. To introduce the subject and to provide a foundation for a public debate on the matter.	A report paper for a seminar organised by the Finnish organisation (ETENE) on ethical and legal questions in end-of-life care with researchers and representatives of family members. Number of participants were not mentioned.	More demanding ethical and legitimate requirements for dying persons was addressed by both healthcare professionals and the patients' significant others.	Not mentioned.	7
Koppel, M., Pasman, H., van der	Long-term care facilities	To illustrate and contrast the levels of consensus among persons involving	Cross-sectional study with a use of structured ques-	Finland saw the lowest full consensus degree from both family	There was recall bias. The partici-	9.5

Steen, j., van Hout, H., Kylänen, M., Van den Block, L., Smets, T., Deliens, L., Gambassi, G., Frogatt, K., Szczerbińska, K., Onwuteaka-Philipsen, B., & PACE. (2019)	in six European countries of Belgium, England, Finland, Italy, the Netherland and Poland.	in end-of-life care decisions from the view of family and care professionals in the mentioned countries. To evaluate the contents of factors that are correlated with reporting a full consensus from the perspectives of both significant others and care staff.	tionnaires, analysed by logistic Generalised Estimating Equations (GEE) with an exchangeable correlation structure. Residents in the selected facilities (n=790), and healthcare professionals (n=1284) in the care homes in those countries.	members' and caregivers' perspectives. Family members reported full consensus more as the residents had more comfort or discussed care preferences, a caregiver gave an explanation of palliative care, good communication with physician, they are not residents' children, or living in Poland or Belgium compared to Finland.	pated family members may not be completely representative. There was no identifications of decisions based upon which full consensus and when it was not reached. There was no specification in the persons involving in the care in the study.	
Seppelvirta, T. (2014)	Finland	To explore what ethical and professional ethical	Systematic review with articles (n=24) of years between 200-2014 from	The ethical problems appeared in terminal care were categorised	Not mentioned.	8

		codes are pertinent to the end-of-life care. To examine what kind of ethical dilemmas as well as their contents identified from palliative and terminal care related articles.	which seven articles were Finnish.	into four divisions of the physician's personal circumstances, ethical framework, moral decision-making, and work-related influences. Overlapped ethical problems and dilemmas made treatment decisions more complicated. The requirements of good ethical conducts, particularly, the prominent pressure for respect for patient's autonomy at the end of life were not simplistic at all in practice.		

Appendix 2: Analysis

Category	Sub categories	Examples of contents
Truth-telling		-Patients are having unrealistic hopes and expectations for their condition. (FI & JP) -Not sure whether nurse disclose the truth to the patients. (FI & JP) -Not sure to what extent nurses should tell the truth. (FI & JP) -Feeling a sense of guilt and fear of breaking the patient's hope if I tell the truth. (JP) -Would like to avoid telling truth to prevent the patient from further hurting. (JP) -Doctors or family members prohibit nurses from telling the truth to the patients. (JP) -Not sure if information disclosure only to family members is right thing to do. (JP) -Feeling rude or dishonest to patients if I tell a lie about their prognosis or diagnosis. (JP) -Would like to act sincerely to the patients, but it is difficult. (JP) -Would like to be staying truth to nurses' duty to support the patients. (FI)

		-Patients should obtain the information, but difficult to achieve it. (FI) -Patient's confidentiality can be endangered if disclosing the information to the significant ones despite the patient's will. (FI)
Responsibility & Uncertainty	Responsibility	-Conflicts between patient' hope and own defensiveness. (JP) -Lung cancer patient's desire to smoke. (FI) -Not sure which to prioritise nurses' responsibility, patient's safety or will. (FI & JP) -Should I let the patient with high risk of falls go to bathroom as desired? (JP) -Letting the dying patient go home as desired despite his or her deteriorated condition? (JP)
	Uncertainty	-Inadequate experience in the terminal care. (FI & JP) -Not being confident about the knowledge opioids, care and appropriate response to the patients. (FI & JP)

		-Not knowing what to do for a care or how to implement it. (FI & JP) -Not having sufficient skills or training in palliative or terminal care. (FI & JP) -Not knowing which to emphasise more, patient safety or patient autonomy. (FI & JP) -Uncertainty in right place for treatment. (FI)
Environment	Time deficiency, excessive tasks & poor resources	-Not having adequate time at work. (FI & JP) -Resources are insufficient. (FI & JP) -Excessive amount of work to do. (FI & JP) -Would like to have more time for discussion with patients, but inadequate time does not allow it. (JP)
	Facility and system issues	-Medical equipment is not sufficiently facilitated for palliative care in elderly nursing homes. (JP) -Patients with different stages of diseases are mixed in the ward. (JP) -The hospital does not have enough single rooms to provide despite the patient's hope. (JP) -Work pressure is immense. (FI)

		-Experienced disruptions constantly at work. (FI) -Not be able to access to patients' information. (FI) -Very difficult to access to service that the patient needs. (FI) -The patients have to sacrifice to use the service. (FI) -Nurses work in various places instead of a particular workplace. (FI) -Different computer systems are used. (FI) -Complexity of homecare environment. (FI) -Travel distance between clients' homes are wide in home care. (FI) -Operational models in unit change frequently. (FI) -Many different nurses treat the patients. (FI) -There are not enough doctors available. (FI) -Not be able to make a proper care plan due to the limitation in information access. (FI)

Interactions	Issues in multidisciplinary team	-Different thoughts and opinions from the doctors. (FI & JP) -Unnecessary medical interventions are taken place by doctors. (FI & JP) -Not having adequate interactions with doctors. (FI & JP) -Hierarchy in hospitals. (FI & JP) -Nurses' position is too low. (JP) -A culture of admiring a doctor. (JP) -Doctors opinions are too strong. (JP) -Doctors explained unwell to the nurses. (JP) -Need a courage to disagree with the doctors. (FI) - Physician's decision on PEG tubing care for terminally ill patients despite the patient's wish. (FI)

	Patients & family	-Different opinions from the patients and the significant others. (FI & JP) -Patients are not willing to discuss with nurses. (FI & JP) -Patient is left behind in the care. (FI & JP) -Patient's difficulty in accepting the situation. (FI & JP) -Doctors are having issues in communication with patients. (FI & JP) -Family members would like to prolong the patient's life despite the patient's will. (Fi & JP) -Insufficient communication with patients. (FI & JP) -Patient's and family members' right for choice of treatment is not ensured. (JP) -Psychological and physical distance are widening from patients. (JP) -Family is a decision-maker. (JP) -Informed consents are not respected. (JP) -Family members and the patients do not support each other. (FI) -Patients are not interested in the care. (FI)

		-Family does not accept the poor prognosis. (FI) -When seeing inappropriate behaviour towards the patients (FI) -Strong demands from family members for the care. (FI) -Pressure from family to disclose the information. (FI)