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(Citation)
Bulletin of health sciences Kobe,41:39-59

(Issue Date)
2026-03-31

(Resource Type)
departmental bulletin paper

(Version)
Version of Record

(JaLCDOI)
https://doi.org/10.24546/0100503597

(URL)
https://hdl.handle.net/20.500.14094/0100503597

Micro-Ethnographic Study of Interdisciplinary Collaboration for Good Death Among Home-based End-stage Clients in Japan

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Abstract

Background: Aging and chronic illness increase demand for home-based end-of-life care, yet in Japan interdisciplinary collaboration for a good death remains underexplored as structure and cultural practice. This study aimed to clarify cultural norms embodied in interdisciplinary collaboration supporting a "good death" for clients receiving home-based end-of-life care. Methods: A micro-ethnographic design based on Roper and Shapira's framework was applied. Data came from fieldwork and interviews with 15 team members caring for three home-based end-stage clients. Results: Twelve embedded themes were identified across four culturally symbolic care phases. 1) Relational grounding: person-centered team formation and value recognition; family alignment and consensus building. 2) Cultural integration: living well in the present with anticipatory care; family-centered support and shared responsibility; resource use and professional collaboration. 3) Consensus and closure: individualized symptom relief and end-of-life education; shared decision-making and value-based care; family-centering of anticipatory grief care; preserving everyday life and personal identity; reflective team practices and rituals of closure. 4) Relational continuity: legacy recognition and affirmation of end-of-life experiences; grief support and professional reflection. Conclusions: Interdisciplinary collaboration enabling a good death harmonized with daily life, reflected individual life quality, and formed cultural community where clients and families shared concerns, learned, and lived together.

Keywords

Interdisciplinary collaboration, Good death, End-of-life care, Micro-ethnography, Home-based clients

Running title

Interdisciplinary Collaboration for Good death in Japan

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Introduction

Globally, aging and chronic illness heighten demand for holistic end-of-life (EOL) care. Many prefer home death[1,2], yet hospital deaths remain common[3,4], underscoring the need for stronger home-care systems. EOL care aims "to assist persons facing imminent or distant death to have the best possible quality of life (QOL) until the end, regardless of diagnosis, condition, or ages"[5]. In the context of home-based EOL care, the key goal is to support a good death for terminally ill individuals who wish to remain at home[6,7]. The notion of a good death is multifaceted and personal[8-11]. Despite known trajectories[12], prognoses remain uncertain, and suffering varies. A good death depends on condition, beliefs, values, and preferences, requiring interdisciplinary teams (ITs) in medicine, nursing, and social care to assume diverse, engaged roles. However, home-based interdisciplinary collaboration in Japan faces numerous challenges. Teams are client-specific, with members from different organizations; Japan's long-term care insurance system lacks a formal mechanism for shared care settings. These structural and systemic factors hinder collaboration and contribute to ongoing issues[13].

Most studies on IT focus on hospital settings[14-16]. One study explored strategies to improve EOL care from an IT perspective[17]; however, the settings differed from those in Japan. Cultural differences shape collaboration, as Japan's collectivist culture prioritizes respectful relationships and context-driven communication[18]. Previous Japanese studies on interdisciplinary EOL care focused on older adults and described fragmented care experiences[19-21]. In the case of clients with terminal illness who have discontinued active treatment, in-home IT collaboration is challenging because of medical dependency and the complex decision-making involved[22,23]. Specialized teams are formed to support these clients[24,25]. The culture embodied in IT members' actions is shaped by shared environments and behavioral norms, which cannot be fully understood through self-report studies[26,27]. Further research is needed to clarify what kinds of home-based IT collaboration, as culturally embedded practices, bring about a good death. While IT collaboration involves individual autonomy, cultural rules also influence team dynamics[19,28]. These underlying norms should be examined alongside actual interdisciplinary collaboration patterns. To address these gaps, this study uses a micro-ethnographic approach to examine what kinds of IT collaboration, as culturally embedded norms, bring about a good death in Japan's home-based EOL care. Interdisciplinary collaboration in EOL care is shaped not only by clinical protocols but also by culturally embedded values and relational ethics[29]. In Japan, where caregiving is often guided by implicit norms of harmony, modesty, and collective responsibility, healthcare professionals engage in nuanced practices that reflect these cultural dimensions. By interpreting interdisciplinary collaboration as a culturally meaningful practice, this study contributes to a more nuanced understanding of therapeutic communication and team dynamics in EOL care. It also offers practical implications for designing care models that honor cultural values while supporting professional coordination.

This study aimed to clarify the cultural norms embodied in interdisciplinary collaboration bringing about a good death in home-based end-of-life care in Japan.

Materials and Methods

This study followed the Consolidated Criteria for Reporting Qualitative Research (COREQ)$^{30)}$.

Design

This study used a micro-ethnographic design, guided by Roper and Shapira's framework$^{29)}$. Micro-ethnography is a qualitative research approach that describes specific subcultural groups within a holistic perspective and aims to uncover cultural beliefs and practices that generate observed behavior$^{26, 29)}$. Culture shapes behaviors, thoughts, and values, influencing daily practices often unconsciously$^{26,31)}$. These dimensions permeate healthcare systems and organizational structures, reflected in collaboration and care$^{32)}$. This study targeted interdisciplinary professional teams responsible for home-based end-stage clients and their families, focusing on their collaboration as a culturally embedded practice that supports a good death. These diverse teams differed markedly from institutional or hospital-based counterparts$^{33,34)}$.

Field and research participants

The study took place in urban Kansai (approximately 72,000 residents per ward, 7.72% growth, 20% aging). Healthcare resources included clinics, hospitals, home care-support clinics, and visiting pharmacies (Table 1). A home-visit nursing station was selected as the study site. It offers 24-hour emergency services and approximately 30 EOL cases annually, collaborating with clinics, hospitals, and hospices. The site was recommended by a home-care professional familiar with the study, ensuring alignment with research and ethical aims. Participants were IT members responsible for the care of three end-stage clients. Although the clients and their families provided consent for the study, they were not considered study participants. Prior to data collection, informed consent was obtained from each client and the IT members after a full explanation of the study. Eligible participants had end-of-life (EOL) care experience, were contractually employed at the facility, and provided informed consent. Those without contracts, facility permission, or client/family approval were excluded. Table 2 presents professional roles and experience. Most participants had over five years of experience, including several care managers and home-visiting nurses with more than a decade. This diversity enabled a multifaceted understanding of EOL care through micro-ethnographic fieldwork. The inclusion of both clinical and administrative staff highlights the interdisciplinary nature of home-based EOL care in Japan. Table 3 presents three illustrative EOL care cases from the research-collaboration facility. Though not formal participants, their trajectories contextualized interdisciplinary collaboration observed in micro-ethnographic fieldwork. End-stage clients and families were not study participants; however, their cooperation was ethically required to enable the description of interdisciplinary collaboration for good death among end-stage clients. For this reason, inclusion criteria specified clients aged 18+, who had ceased active treatment with a prognosis of less than six months, and who consented to home-based EOL care. Exclusion applied if cooperation was unclear or family consent was lacking. Among the researchers in this study, AA, a field researcher without prior home nursing experience, drew on her cross-cultural background in IT collaboration with end-stage home-care clients. She engaged emically (via empathetic interaction) and etically (through analytical observation).

Table 1. Survey area profile and research facility characteristics

Overview of the survey area (Kansai region) *1,*2	
Item	Value
Regional classification	Economic center (Kansai area)
Population (per ward)	Approx. 72,000
Population growth rate	7.72%
Aging rate	20.0%
General clinics	90
Hospitals	16
Home care support clinics	15
Home care support hospitals	0
Dental clinics	14
Visiting pharmacies	23
Home care support offices	20
Welfare environment offices	7
Home nursing stations	26
Status of research collaboration facility	
Item	Value
Emergency response	24 hours/day, 365 days/year
Annual end-of-life (EOL) care cases	Approx. 30
Collaboration partners	Home-support clinics, affiliated hospitals, hospices
Clients who died during survey period	11

*1 : RESAS (2025), https://resas.go.jp.   *2 : Japan Medical Association (2025), https://jmap.jp

Table 2. Participants' professional roles and duration of home care experience (n=15)

Duration of experience	Home doctors (HDs)	Home-visiting nurses (HNs)	Care managers (CMs)	Home therapists (HTs)	Office clerks (OCs)	Total
0–5 years	—	2	—	2	1	5
5–10 years	1	3	—	1	—	5
10+ years	—	2	3	—	—	5
Number of participants (n)	1	7	3	3	1	**15**

Table 3. The EOL clients' backgrounds *

Clients	Sex	Age (year)	Family caregiver	Family structure	Long-term care certification	Main disease	Final care location	Outcome	Days until death after transfer	Contract period
A	male	60 s	spouse	two households	level 4	cancer	general hospital	admission	1 d	3 months
B	male	70 s	spouse	per household	level 4	cancer	palliative care hospital	admission	5 d	1 months
C	female	90 s	spouse	per household	level 4	end-stage heart failure	home	death	0 d	4 years

* : These cases are illustrative and were referenced with informed consent for contextual analysis.

Study procedure

AA contacted the head nurse of the home-visit nursing station for study approval, following a home-care professional's recommendation. Upon approval, the head nurse, as gatekeeper, explained the study to staff, clients, and families, and obtained consent. The researcher then explained the study to IT members, who consented to participate.

Data collection

Over 50 days (393 hours) between April 2021 and December 2022, data were collected through 343 participant observations, 52 informal interviews, and 15 formal interviews with IT members (lasting 28–78 minutes each). These were documented in field notes and verbatim transcripts and supplemented by medical records and EOL-related documents from the research facility, ensuring data triangulation across these multiple sources. Daily observation explored interprofessional coordination during home visits, meetings, and informal conversations. The researcher accompanied IT members only when interdisciplinary interaction was expected, acting as a non-intervening observer and recording processes, interactions, and contextual factors. Observation focused on routine care activities as well as scenes in which professionals autonomously engaged with other disciplines, with particular attention to verbal and non-verbal exchanges, role negotiation, and the content and context of communication between disciplines, rather than on clients or families themselves. Before home visits, the researcher confirmed with IT members whether the researcher's presence might cause any psychological burden to clients or families.

Informal interviews were conducted after observed scenes. Interview topics first focused on understanding the initial situations at the beginning of fieldwork, and subsequently addressed team interactions, the client's condition, contemporaneous views on a "good death" for end-stage clients, and the cultural norms shaping collaboration. These interviews were carried out to verify the researcher's own interpretations, ensuring that the meanings attributed to observed practices were consistent with participants' perspectives. Formal interviews were conducted once data collection and analysis of participant observations had progressed and relationships with interdisciplinary team members had been established. The interview guide was created to include descriptive, structural, and contrastive questions, each serving a distinct purpose in relation to the research aim (Table 4).

Table 4. Interview guide

Descriptive questions	To elicit participants' experiences and concrete examples, adding depth to observational data
・Please describe a situation in which your team collaborated to support a client at the end of life. ・In home-based end-of-life care, what experiences do you consider important for achieving a "good death"? ・What do you think are the client's perspectives on a "good death" in home-based end-of-life care? ・Please describe a past case in which interdisciplinary collaboration contributed to a "good death." ・Please explain the meaning or interpretation of the clinical situation of the client and family you were in charge of.	
Structural questions	To explore implicit norms, shared values, and team arrangements, making visible the culturally embedded frameworks that shape collaboration
・What cultural norms or shared values guide collaboration in your team? ・How are roles and responsibilities typically negotiated among team members? ・What routines or practices are expected when caring for clients at the end of life? ・How do you express the uniqueness of your profession in collaboration? ・Please describe the content of collaboration using 5W1H (when, where, to whom, what shared goals, and how).	
Contrastive questions	To compare different situations and approaches, providing insights into cultural norms that guided collaboration and shaped perceptions of what was considered to support a "good death" and what was not
・In your experience, what kinds of collaboration contributed to a "good death," and what kinds did not? ・How does collaboration in home-based care differ from collaboration in hospital-based care? ・How did collaboration differ across phases such as the introduction of home care, stable periods, and the time of death? ・Please compare situations where interdisciplinary collaboration was successful and where it was unsuccessful.	

Descriptive questions invited participants to recount experiences and concrete examples, thereby eliciting their voices and adding depth to observational data. Structural questions explored implicit norms and team arrangements, helping to narrow cultural themes of collaboration. Contrastive questions encouraged participants to compare different situations and approaches, providing insights into the cultural norms that guided collaboration and shaped perceptions of what was considered to support a good death and what was not. This three-layered structure aligned the interview guide with the study's aim and addressed interdisciplinary collaboration as cultural norms in home-based EOL care. Specific interview questions were presented.

Data analysis

Data were inductively analyzed alongside collection, according to Roper and Shapira's framework[29]. Sources included field notes, interviews, memos, and records. First-level coding identified culturally meaningful micro-segments of action, interaction, and dialogue related to IT collaboration in supporting a good death. Descriptive codes captured nuances of collaboration and cultural practices, and were assigned across the four end-of-life (EOL) care phases described by Ichihashi et al.[35]: (a) Initial phase—home treatment begins and environment is prepared; (b) Reconstruction—stable home life with lifestyle support; (c) Actively dying—decline, symptom burden, and family strain; (d) Grief care—post-death reflection and emotional support.

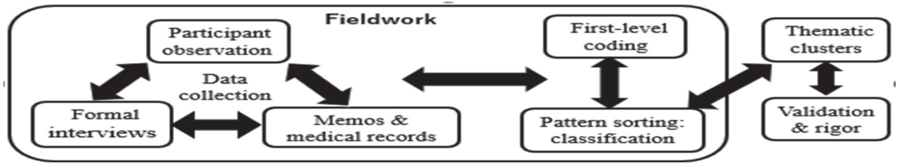

Fig1. Cyclical flowchart of the ethnographic data and analysis process

Similar codes were sorted into broader pattern categories, allowing recurrent regularities in behaviors and beliefs to emerge. This process facilitated the development of preliminary themes, providing a more global understanding of how collaboration unfolded and revealing connections across participants' experiences. Analytic memos documented coding decisions and supported reflection throughout, while iterative engagement led to the refinement of conceptual categories representing collaboration shaped by cultural norms and relational ethics. These categories were synthesized into thematic clusters highlighting key features of interdisciplinary EOL care in Japan, with cultural aspects of collaboration identified in each phase to show how shared understandings shaped care practices. To ensure rigor, the first author led the analytic process, co-authors conducted peer debriefing, and findings were validated through member checking. A qualitative research expert supervised the overall process, strengthening credibility and trustworthiness (Fig 1).

Ethical considerations

The study adhered to the Declaration of Helsinki and was approved by Kobe University's Health Sciences Ethics Committee (No. 979-2). The IT members responsible for the end-stage clients, together with the collaborating facility management, were informed verbally and in writing of the study's purpose and procedures and provided their consent. The three end-stage clients under their care and their families were also informed verbally and in writing of the study's purpose and voluntary cooperation, and consent was obtained. Families, like the clients themselves, were assured verbally and in writing of their right to refuse or withdraw cooperation at any stage, including after the client's death. These measures were taken to minimize the psychological burden on end- stage clients and their families, protect personal information, and respect their dignity, while collecting that data on IT members. Stakeholders received a verbal explanation and gave consent, though their data were not used.

Results

This study used a micro-ethnographic approach to examine interdisciplinary collaboration in Japanese home-based EOL care, focusing on how such collaboration supports a culturally meaningful good death. Through iterative coding and thematic analysis, four culturally symbolic phases and twelve embedded themes were identified (Table 5). Each phase name reflected both the temporal flow of care and the relational-professional dynamics observed in practice. These phases emerged inductively and represented distinct modes of collaboration shaped by shared values, implicit norms, and culturally grounded caregiving.

Table5. Culturally symbolic phases and embedded themes of interdisciplinary collaboration for a good death in Japanese home-based EOL care

Culturally symbolic phase *1	Embedded themes of interdisciplinary collaboration *2
Phase 1: Relational grounding phase	Person-centered team formation and value recognition Family alignment and consensus building
Phase 2: Cultural integration phase	Living well in the present with anticipatory care Family-centered support and shared responsibility Resource use and professional collaboration
Phase 3: Consensus and closure phase	Individualized symptom relief and end-of-life education Shared decision-making and value-based care Family-centering of anticipatory grief care Preserving everyday life and personal identity Reflective team practices and rituals of closure
Phase 4: Relational continuity phase	Legacy recognition and affirmation of end-of-life experiences Grief support and professional reflection

*1 : Phase names were inductively derived from fieldwork and reflect culturally symbolic patterns of collaboration.
*2 : Themes reflect care shaped by shared norms and values in Japanese EOL practice.

Phase 1: Relational grounding phase

In this initial phase, collaborative practices focused on forming person-centered teams by engaging with clients' life narratives, values, and self-care preferences. These interactions were shaped by cultural norms of humility, narrative respect, and anticipatory coordination, especially during early contact.

Theme 1.1: Person-centered team formation and value recognition

This theme illustrated how ITs prioritized relational harmony and client-centered understanding over formal role assertion. ITs that formed around the client emphasized understanding personal values, life narratives, and self-care preferences. Professionals refrained from asserting their roles initially, instead prioritizing relational harmony and shared understanding. These practices reflected Japanese cultural norms of humility, narrative respect, and anticipatory coordination observed during early team formation.

During intake, the visiting nurse asked, "What would you like to do at home?" highlighting the client's personal goals. Based on his response, she requested rehabilitation services. The physical therapist reflected (Case A), "I don't assert my role. What matters is what I bring. Their perception shapes how I explain. I mention I'm a physical therapist (PT) only if they're curious—like asking about therapist roles. I don't push recognition; they'll understand as we go." (Interview, 911)

This approach illustrated how professionals adapted their presence to client readiness, emphasizing mutual understanding over role clarity.

During a home visit, a care manager and nurse discussed a new client (Case B). The manager said, "There's no helper. I guess long-term care insurance and service setup weren't prioritized." The nurse replied, "We usually ask about EOL wishes early on, but if the client is terminal and asking feels invasive, *we wait and decide as a team. In such cases, we consider their "Kokorozumori." She then quietly called the home clinic to begin coordination. (Participant Observation, HN294)*

"Kokorozumori" refers to a culturally sensitive understanding of emotional readiness for EOL decisions. This exchange showed how professionals prioritize relational sensitivity and team-based coordination, especially when clients and families are emotionally vulnerable.

Theme 1.2: Family alignment and consensus building

This theme captured how ITs negotiated family perspectives and service expectations to maintain harmony and support clinical transitions. Collaboration involved aligning views, managing expectations, and building client-centered professional relationships. These practices reflected cultural values of harmony, relational negotiation, and collective responsibility.

After a home visit, a nurse updated a concerned therapist about Mr. B's condition (Case B): "He had a post-discharge fever of 38.8°C, but antibiotics are working—now 37.0°C. He still has a wet cough and is on preventive oral antibiotics. He drinks about 1500 ml daily. His wife says he's eating well, but he seems unmotivated. We arranged a dental visit for his dentures, but mouth ulcers appeared. I suggested early follow-up, but they prefer to wait. Dr. A will see him tomorrow. His right foot is swollen, and bruising remains around his eye. Since he and his family feel stable, we'll continue Monday, Wednesday, Friday visits—for now." (Participant Observation, 924)

This exchange illustrated how ITs align care with both the client's and family's perspectives, negotiating subtle differences in perception and adjusting services accordingly. Such negotiation reflected Japanese values of collective responsibility and relational sensitivity in care coordination.

Phase 2: Cultural integration phase

In this phase, ITs supported clients and families in reconstructing daily life by integrating medical care with personal rhythms, values, and social roles. These practices reflected cultural sensitivities to time, interdependence, and adaptive caregiving within the Japanese home care context.

Theme 2.1: Living well in the present with anticipatory care

This theme highlighted how teams balanced present-focused support with future planning, respecting clients' dignity and daily rhythms. Clients were supported in living meaningfully while anticipating change. Life events were celebrated, welfare equipment introduced in line with intentions, and everyday routines honored—reflecting norms of dignity, continuity, and temporal sensitivity.

After a home visit, the care manager spoke with a nurse and therapist (Case A), visibly affected. "He loves that bed his friend gave him—calls it an armored vehicle. When we introduced the low-resistance mattress, he muttered, 'So this is how I'll become immobile,'" (mimicking his posture). "He knows he's terminal but still feels strong and independent. Rather than pushing services, we'll act when needed." The therapist noted, "Given his wife's burden, earlier support may help." The nurse added, "He likes innovation—I'll approach it that way." (Participant Observation, 167)

The team's approach demonstrated a culturally attuned balance between honoring the client's current lifestyle and preparing for future care needs. Their sensitivity to emotional readiness and timing reflected Japanese values of dignity, continuity, and temporal awareness.

A clerk spoke to the nurse, who had skipped the dental visit (Case B): "It would've been a good chance to observe him during scheduled care." The nurse replied, "There were three people in the room, and with his low white blood cell count, I worried about infection. I checked briefly but didn't stay. He was very satisfied—said, 'I feel so refreshed!' The dentist's care seemed to improve his overall condition," she added, smiling at the therapist. The therapist said, "I'm glad we chose that dentist—he suited the case." Later, after a re-visit, the nurse told them, "No fever today. He was sitting up, had his upper teeth treated, used Excil, and said, 'My plaque is gone, I feel refreshed! I'll try brushing with Excil.' He was happy—he even ate tempura. The session lasted 90 minutes; they'll treat his lower teeth tomorrow. He said, 'Eating is fun.'" (Participant Observation, 901)

This vignette illustrated how the team aligned care with the client's lifestyle and personal values (Ikigai), integrating medical support into daily routines. Their flexible coordination and attention to emotional satisfaction—like the joy of eating and feeling refreshed—reflected Japanese norms of continuity, relational sensitivity, and the integration of everyday life with EOL care.

Theme 2.2: Family-centered support and shared responsibility

This theme highlighted how teams supported families in caregiving roles, adapting services to maintain harmony and emotional well-being. Support for families included shared caregiving, emotional assistance, and flexible visit coordination. Teams assessed caregiving capacity and adjusted care to maintain familial harmony. These practices reflected cultural values of interdependence, mutual respect, and adaptive caregiving.

During a home visit, the client's family member, working nearby, said, "I have an online meeting—please let me know later if anything comes up," and closed the door. The nurse replied, "Understood," and quietly continued care. At the end, she confirmed with the family the scheduled time and placement for the care bed, based on prior discussions (Case C). In a follow-up interview, the nurse reflected: "Time with family is precious. Care from loved ones brings comfort. I couldn't do much for my own father, so in EOL care, we should say and do what we can—regret comes otherwise. If the family is motivated, they may not need a helper. For harder tasks, we can bring support. If the client prefers not to receive help from someone, we adjust. We always find a way." (Interview, 553)

This vignette illustrated how the team respected the family's routines and caregiving roles, which reflected Japanese values of interdependence and shared responsibility. By supporting family-led care and offering flexible options, they upheld both comfort and dignity in EOL home care.

Theme 2.3: Resource use and professional collaboration

This theme explored how teams navigated resource constraints through creative collaboration and trust-based decision-making. Teams were engaged in mutual support, role-sharing, and cost-sensitive care planning. They built relationships with external professionals and coordinated responses to unexpected challenges. These practices reflected cultural norms of modesty, fairness, and relational trust.

After consulting with a care manager, a visiting nurse prepared a slip-in bedpan for the client (Case A). When asked about the term "trial," she explained: "Toileting-related equipment isn't available for rental—it must be purchased. But items like portable toilets or bedpans often go unused. So we offer an O-TA-ME-SHI (trial use), and if it's helpful, we ask the client to buy it." (Participant Observation, 348)

This vignette showed how the team addressed resource limitations through adaptive collaboration and client-sensitive decision-making. The use of "O-TA-ME-SHI" illustrated a culturally nuanced approach to resource management—emphasizing modesty, fairness, and relational trust. Such practices reflected the adaptive ethos observed in Japanese community-based care.

Phase 3: Consensus and closure phase

In this phase, collaborative efforts focused on shared decision-making, emotional preparation, and symbolic closure. These practices were guided by cultural scripts of harmony, relational negotiation, and dignified transitions in Japanese EOL care.

Theme 3.1: Individualized symptom relief and end-of-life education

This theme highlighted how teams addressed symptom management and emotional readiness through personalized care and collaborative education. Teams shared nuanced assessments of symptom relief, including emotional responses to opioids and non-pharmacological care. They also engaged in death education and prepared clients and families for transitions. These practices reflected cultural norms observed in Japanese home-based care, including personalized approaches to suffering and gradual preparation for EOL transitions.

A visiting nurse expressed concern about the client's symptom management, shaped by his beliefs about opioids (Case A). "The home doctor explained the protocol clearly with a diagram. His abdominal pain improved, but he still uses the toilet 7–8 times nightly. As a light sleeper, it doesn't bother him. He sees Oxynorm as only for severe pain, so he takes acetaminophen. I think Oxynorm at bedtime might help, but I'm unsure if he's unwilling or feels he shouldn't. "The therapist added, "His wife also thinks it might help him sleep." The nurse replied, "Let's ask the doctor to speak with him again. If we all explain from different angles, maybe his view of opioids will shift." (Participant Observation, 353)

This vignette showed how the team addressed the client's beliefs and hesitations around opioid use, aiming to improve symptom relief through collaborative education. Their culturally sensitive approach integrated medical guidance with emotional timing. By coordinating with the physician and family, and adapting communication, they offered individualized support and gentle persuasion—reflecting Japanese norms of emotional readiness and relational sensitivity in EOL care.

After a home visit, the nurse contacted the doctor about the client's worsening respiratory symptoms and the family's request for chest drainage and IV fluids (Case C). "Her husband noticed something was wrong. I explained IV fluids might be too burdensome and encouraged oral intake. Her urine was *concentrated, and I said afternoon vitals weren't needed. I treated her pressure sore. He wanted to read a picture book about dying but fell asleep—I told her to read just the last page. He feels he must act but isn't sure. Could you visit before your next scheduled appointment?" "She could deteriorate anytime, and the next visit is far off. Her husband had chest drainage himself and wonders if it might help her. In his case, it was curative; for her, it's unclear. I don't want him left with regret. He jokes, maybe to avoid the topic. Her birthday is coming, and I think he hopes she'll reach it. It's best if you speak with him directly." (Interview, 738)*

This vignette reflected culturally embedded practices of responding to individual suffering and preparing for death. Through sensitive coordination and EOL education, the team supported both symptom relief and emotional readiness, balancing clinical judgment with relational care in home-based settings.

Theme 3.2: Shared decision-making and value-based care

This theme illustrated how teams facilitated care decisions that aligned with clients' values, balancing clinical judgment with emotional and symbolic meaning. Clients and families were supported in making care choices aligned with their values. Teams unified their explanations and adjusted services to maintain dignity and emotional resonance. These practices reflected cultural scripts observed in Japanese home-based care, including relational negotiation and value transformation in shared decision-making.

During a team meeting, a visiting nurse expressed concern: "I think the infusion might worsen ascites or accelerate tumor growth—it could do more harm than good. "The care manager responded, "The doctor tends to avoid unnecessary medical interventions, but I feel he's open to considering treatments that hold personal meaning for clients, even if they lack medical necessity. "A clerk added, "We'd like the family to pick up the IV supplies from the pharmacy to avoid complications. "Another nurse shared, "The infusion was switched to Formula 2 on [date], but since the client has been eating well this week, we changed it back to Formula 1. I asked what she ate today—boiled eggs and scrambled eggs. She's adapting in her own way, and her abdomen was flat today. She even went out to vote. "The team agreed to consult the home doctor regarding the risks of ascites and tumor progression. For now, they decided to continue the infusion in accordance with the client's wishes (Participant Observation, 432).

This vignette illustrated culturally embedded shared decision-making in Japanese home-based EOL care. In a team meeting, concerns about high-calorie IV infusion—such as risks of ascites or tumor growth—were weighed against the client's emotional and symbolic needs. The discussion reflected relational negotiation, balancing medical necessity with personal meaning. The physician's openness to value-based choices enabled a care plan that honored dignity and emotional resonance. By aligning care with the client's wishes, the team demonstrated value transformation through coordinated support.

Theme 3.3: Family-centering of anticipatory grief care

This theme showed how teams supported families through emotional transitions, shared caregiving, and recognition of anticipatory grief. Support included emotional preparation and acknowledgment of inner struggles. Teams anticipated grief and adjusted care to ease burden. These practices reflected Japanese norms of familial devotion and collective mourning in home-based EOL care.

A visiting nurse spoke to the care manager about the client and his wife (Case A): "They went to the bank together—he said he's giving her a present. Today, she'll remove the IV needle herself. They said, 'We'll do it together.' She's still learning, but if there's no bleeding or infection, they'll manage. They'll call once it's done." Soon after, a clerk called out, "They've finished the IV!" The care manager reflected, "It's not just about treatment—it's about their time together. Even after illness, they talk about watching TV at 1 a.m., not as insomnia, but as sitting side by side in bed like a sofa. He said, 'It's such a silly show, but it makes us feel warm.' Maybe those silly moments help him feel free."
(Participant Observation, 651)

After an emergency night visit, the nurse returned visibly tired and spoke with the clerk, therapist, and care manager (Case B): "His wife fell in the bathroom and hurt her back. She said, 'My back hurts,' in a weak voice, clearly exhausted. I felt she'd reached her limit. It wasn't just about whether he should be hospitalized now—I thought even if things settled, it would recur. So I told the doctor, 'Please, just one more day—let's move toward hospitalization.' He said, 'Got it. I'll talk to them and ask them to hold on one more day.' I was so relieved. I can talk to him about anything." Later that day, the doctor called to confirm hospital arrangements had been made. (Participant Observation, 974)

These vignettes showed how everyday interactions—like shared routines and symbolic gestures—became sources of comfort and emotional resilience. The team's responsiveness to familial exhaustion and emotional thresholds reflected Japanese values of devotion, collective mourning, and relational continuity. By easing burdens and honoring daily moments, the team supported families through emotional preparation and shared caregiving, demonstrating culturally embedded anticipatory grief care in home-based settings.

Theme 3.4: Preserving everyday life and personal identity

This theme illustrated how teams supported clients in reclaiming ordinary routines and expressing personal identity, even during physical decline. Clients were supported in reclaiming ordinary moments and expressing life narratives. Teams recognized symbolic expressions of identity and continuity. These practices reflected cultural values of legacy, selfhood, and relational meaning.

A visiting nurse shared a family moment with the team (Case A): "On Sunday, the client had a meal with his family around a round table, including his grandchild. He was slowly eating liquid food with a teaspoon, and next to him, the grandchild was eating baby food with the same kind of spoon. When the client scooped a bite for himself, the child looked at him and opened his mouth, expecting to be fed." She smiled as she told the story. (Participant Observation, 562)

A visiting nurse shared a story with the team about a call from the client's husband requesting an urgent visit (Case C): "I asked him to wait for the home helper, since the purpose wasn't clear and we had to consider care units. During the regular visit, her breathing was shallow but stable. We started oxygen, and it rose to 97%. I explained everything and set up the meds. But guess what? Despite all the concern, *he was feeding her steak again." She smiled, relieved that everyday life was still intact. (Participant Observation, 616)*

These vignettes illustrated how nurses supported everyday life and personal identity by sharing stories of meals and routines. Such moments affirmed the client's self-hood and relational meaning, even in vulnerability. These vignettes showed how everyday gestures—such as shared meals and familiar routines—affirmed the client's sense of self and relational continuity. The team's recognition of symbolic moments reflected Japanese cultural values of legacy, selfhood, and emotional resonance in EOL care.

Theme 3.5: Reflective team practices and rituals of closure

This theme illustrated how teams engaged in reflective storytelling and closure rituals to honor the client's final moments and relational bonds. Teams engaged in reflective practices and closure rituals surrounding the client's final moments. They shared emotional responses and evaluated the quality of death. These acts reflected cultural norms of closure, respect, and continuity across caregiving experiences.

A visiting nurse shared with the team (Case C): "The husband called and calmly said, 'She's stopped breathing.' I arrived about an hour later. She must have passed peacefully—her face looked serene." A therapist joined in, mimicking the husband's voice: "He used to say, 'If I die first, who's going to take care of her?' He always cooked her meals." The nurse continued: "The helper came as usual, changed her diaper, and the husband was preparing dinner. When he touched her mouth, he noticed something was off—she had stopped breathing. Since the helper and husband were both present, the home doctor recorded that as the time of death." She smiled gently as she shared the story. Later, she relayed the same account to the care manager over the phone. (Participant Observation, 1079)

This vignette illustrated culturally embedded practices of closure and team reflection in Japanese home-based EOL care. Through shared storytelling, team members honored the client's peaceful passing and the husband's devotion, creating symbolic and emotional closure. These practices reflected Japanese norms of respect, continuity, and relational depth in EOL transitions.

Phase 4: Relational continuity phase

In this phase, post-death practices extended care through grief support, legacy recognition, and professional reflection. These acts reflected Japanese norms of collective mourning, relational continuity, and affirmation of caregiving.

Theme 4.1: Legacy recognition and affirmation of end-of-life experiences

This theme showed how teams supported families in affirming the EOL journey and recognizing the deceased's legacy. Emotional preparedness and personalized care were evaluated and shared. These practices reflected Japanese values of relational continuity and symbolic closure.

Early in the morning, a visiting nurse received a call from Mr. A's family—he had passed away in the hospital after emergency transport. She repeatedly said, "You really did your best," and "Thank you so much for calling." Later, she shared with the team: "The doctor had explained that his urine output was low and he might only have days left. Ultrasound showed intestinal tension, and a gastric tube would *require sedation—only possible in hospital. The family said, 'We'll think about it overnight.' The next morning, they called, and the doctor arranged transport. He passed away in hospital." Another nurse quietly said, "They made that decision in one day. That's strong." The reporting nurse added: "The family called in tears, saying, 'He passed peacefully.' I told them again, 'You really did your best,' and his wife replied, 'He was the one who tried the hardest.' She also said, 'There are some belongings left—will you come by to pick them up?'" The team honored the family's strength and care. (Participant Observation, 882)*

This vignette reflected culturally embedded practices of affirming the EOL journey and recognizing legacy. The nurse's affirmations and the team's emotional responses honored familial strength and the client's life story, reinforcing relational continuity and symbolic closure in Japanese home-based care.

Theme 4.2: Grief support and professional reflection

This theme illustrated how teams remained emotionally and practically engaged with bereaved families, offering compassionate support and reflecting on their caregiving roles. Grief care included practical adjustments, emotional understanding, and professional reflection. Teams shared post-death experiences and adapted responses to family needs. Such practices reflected cultural norms of compassion, discretion, and collective mourning.

Team members reflected on their support for the bereaved family—attending the funeral, responding to messages, and handling practical matters. A nurse said, "It's something we usually do, so I hadn't thought much about it. But when someone dies at home and we've been there until the end, it matters. We think about how the cohabiting friend feels, and how we feel too. It's part of grief care—even if the client dies in hospital, our care doesn't end." (Interview, 1056)

A clerk added, "The family left a thank-you message on Saturday. I wanted to save it so others could hear, but someone deleted it. I was disappointed—it said, 'Thank you so much for everything during that time.' It was thoughtful and would've meant a lot." (Interview, 1060)

A therapist said: "I was planning to go to the funeral during my lunch break. I took over the case from another nurse, and I feel I didn't get to connect deeply with the client or the family. That's why I really want to see them. I think the family probably has feelings about the sudden change too." (Interview, 1062)

A care manager coordinated practical follow-up: "She passed away, so we'll need to arrange for the bed pickup. It was a private rental, right? She had been approved for care level 4. Her wife asked when the pickup could happen. Should I contact her directly? Once we know the date, we'll follow up."(Participant Observation, 1023)

This vignette reflected culturally embedded grief care and professional reflection. Team members remained emotionally and practically engaged with the bereaved family, showing compassion and discretion. Their shared reflections embodied collective mourning and affirmed caregiving beyond death. These accounts showed how grief care extends past clinical boundaries, encompassing emotional resonance, coordination, and shared remembrance—reflecting Japanese values of discretion and relational depth.

Discussion

This discussion interprets the ethnographic findings in relation to the study's aim: clarifying cultural norms in interdisciplinary collaboration that support a "good death" in Japanese home-based end-of-life (EOL) care. Through practices shaped by shared values, relational ethics, and culturally embedded views of dying, ITs provided care that honored individual preferences and collective meaning.

Cultural interpretations of a good death in Japan

This section explores how Japanese cultural norms shape the understanding and enactment of a good death in home-based EOL care, emphasizing relational and symbolic dimensions. In Japan, a "good death" in home-based EOL care is not merely individual but a relational and symbolic process. It involves shared beliefs and meanings with emotional and moral significance for team members during daily collaboration36). While definitions of a good death vary across cultures, this study suggests that in Japan, a good death emphasizes dignity, continuity of family ties, reconstruction of daily life, and symbolic meaning-making after death. In Western contexts, a good death is often asserted through individual autonomy, whereas in Japan it is shaped through relational autonomy, emerging from narrative dialogue with family members and caregivers37). In a society where individuals often hold an "interdependent view of self"28), dying well entails relational interdependence with significant others, reflecting cultural models that value harmony and social embeddedness. In the field of this study, most clients regularly attended outpatient departments of large hospitals, often seeing multiple specialists for different conditions. As a result, there was no primary physician or dedicated team who holistically understood the client. IT members emphasized that this absence of a continuous, person-centered medical relationship made their role crucial: to support dying clients and their significant others in reconstructing daily life and affirming how the client wished to live until the end. IT members often described a good death not as a biological endpoint but as living fully until the soul departs. Rather than imposing value judgments, they centered care on the client's and family's perspectives regarding how life should be lived until the end—an approach consistent with a social model of dying that prioritizes meaning-making and relational continuity38). In the Relational Grounding Phase, person-centered collaboration was enacted through respectful exploration of clients' life narratives, values, and self-care preferences. Questions such as "How do you want to live at home?" and "What do you want to do?" were used to tailor care approaches. These inquiries reflect the dual importance of "how to live" and "how to face death," which IT members believed should be openly shared among clients, families, and diverse professionals39,40).

Negotiating medical expectations and emotional realities

This section examines how ITs navigate the tension between medical expectations and emotional realities, particularly in the context of persistent hope and culturally embedded beliefs about hospital care. Many Japanese clients, families, and professionals hold what can be termed a 'hospital belief'—the assumption that recovery is achievable only through hospital treatment, a view shaped by Japan's medical culture of institutional dependency and curative orientation. This belief often leads to viewing a good death as one that occurs in a medical setting, regardless of location. Unlike in countries where Advance Care Planning (ACP) is legally institutionalized, in Japan greater emphasis is placed on collaborative decision-making, where clients, families, and ITs jointly consider how to realize the best possible course of action, using the client's satisfaction as the measure37). IT members recognized that hope for recovery persists even in terminal stages. In the Consensus and Closure Phase, collaboration focused on helping clients, families, and team members understand acceptable treatment options for "inevitable death," thereby facilitating the realization of a good death. Here, the notion of "satisfactory choice" emphasizes the process ("how") over the outcome ("what"), allowing those involved to affirm that "this was the best approach"41,42), aligning with shared decision-making models that value relational negotiation and informed consent. IT members distinguished between reversible deterioration (e.g., infection, dehydration) and genuine near-death symptoms. These assessments were part of individualized symptom relief and EOL education (Theme 3.1), where communication was tailored to emotional hesitations and cultural sensitivities. Collaborative efforts also extended to anticipatory grief care (Theme 3.3), preservation of everyday life and personal identity (Theme 3.4), and reflective team practices and rituals of closure (Theme 3.5). These culturally embedded practices supported emotional preparation, relational meaning, and affirmation of the dying process.

Symbolic practices and everyday continuity

This section highlights how symbolic practices and the preservation of everyday life contribute to culturally meaningful EOL care, reinforcing the client's identity and relational continuity. Relationships among clients, caregivers, and professionals were central across all EOL care phases43). Japanese cultural norms emphasize relationality as a key component of a good death6). Ethnographic data revealed practices such as revisiting life stories with clients and families, affirming identity, and maintaining everyday rhythms. IT members aimed to ensure that EOL care remained true to the client's sense of self and desires until the very end. Importantly, the notion of a good death is unique to each individual and must address psycho-existential concerns rather than rely on standardized care models10,44). Because palliative care wards in Japan are limited to cancer and AIDS, home-based teams naturally and often unconsciously assume responsibility for standard care grounded in human rights and integrated care that combine daily life and medical support, thus unconsciously practicing palliative care37). In Japan, where hospital deaths are increasing and death is often disconnected from daily life, one emergent theme—restoring a sense of the ordinary—reflected the belief that death should be an extension of living, echoing findings on the cultural significance of everyday continuity in Japanese home-based EOL care45). Clients, families and professionals were encouraged to continue everyday life, envisioning death within a peaceful and familiar environment rather than as a dramatic or painful event46). IT members protected the client's individuality by realizing their preferences and hopes. Remembering the deceased with family and team members served as mutual affirmation of a good death and facilitated learning about death19), fostered ongoing relational bonds, allowing death to be integrated into shared narratives and everyday continuity47).

Interdisciplinary collaboration as relational practice

This section discusses interdisciplinary collaboration as a relational and culturally embedded practice, shaped by mutual understanding, emotional labor, and non-hierarchical team dynamics. The shift in Japanese home medical care from "medical care that cures" to "medical care that supports"48) necessitates collaboration across medical, health, and welfare fields, reflecting policy-level transitions toward integrated community care. IT collaboration must be grounded in awareness of how clients and families live while facing death. In Western contexts, a primary physician provides holistic and continuous total management of the client, whereas in Japan multiple professionals collaborate through IT to build care within relational practice. In Phase 1, professionals were linked to provide multifaceted views of clients' lives and care needs. To avoid dominance of any single professional perspective, ITs practiced mutual understanding and complementarity, aiming to support both the client's biological and biographical life49). Open communication allowed teams to share what was truly in the client's best interests, learning from clients and families20,50). Within the Consensus and Closure Phase, Theme 3.1 revealed that collaboration often occurred in relatively non-hierarchical styles, despite institutional hierarchies33). Emotional labor, however, was unevenly distributed. While some professionals openly addressed emotional matters, medical professionals often refrained from public emotional expression, viewing it as personal responsibility. This may reflect broader cultural norms such as emotional restraint and "shame culture," which discourage overt emotionality in professional settings51-53), where emotional expression is often internalized and regulated to maintain social harmony. Themes from Phase 2 and Phase 4 further emphasized the reconstruction of everyday life and relational continuity beyond death. Practices such as supporting clients' rhythms and affirming caregiving legacies reinforced the idea that interdisciplinary collaboration is not only clinical but also relational and symbolic.

Implications and future directions

This study contributes to the literature by theorizing interdisciplinary collaboration as a culturally embedded relational practice, extending existing models of EOL care through micro-ethnographic insights into symbolic continuity and emotional negotiation in Japanese home settings. This study shows that interdisciplinary collaboration in Japanese home-based EOL care is a culturally embedded, relational practice. It integrates diverse professional views while centering clients and families as co-constructors of meaning. The findings add to literature on relational ethics and culturally sensitive palliative care. Future research may examine how these practices adapt to demographic change, policy reform, and evolving family structures. The results may also inform IT education and training, emphasizing cultural competence, emotional sensitivity, and relational ethics in EOL care24,25).

Limitations

A limitation of this study is that it was based on an analysis of a few situations involving interdisciplinary collaboration at one facility during the COVID-19 pandemic.

Conclusion

This study explored culturally embedded practices that support a good death in Japanese home-based EOL care through IT collaboration. Employing a micro-ethnographic approach, the collaborative processes involved in caring for home-based end-stage clients were analyzed. The findings revealed four culturally distinct care phases and twelve embedded themes: (1) Relational grounding phase, (2) Cultural integration phase, (3) Consensus and closure phase, and (4) Relational continuity phase. In each phase, professionals engaged in culturally sensitive collaboration that honored the values and life perspectives of clients and families.

In Japan, a good death in home-based care is relational and symbolic, emphasizing dignity, family ties, daily life continuity, and meaningful choices. IT members supported clients in accepting death with agency and harmony, balancing hospital-centered beliefs with emotional realities through culturally embedded practices. IT collaboration sustained everyday rhythms, affirmed identity, and fostered non-hierarchical team dynamics, creating communities of shared concerns, learning, and living. This study demonstrates that interdisciplinary collaboration is not merely technical but cultural, relational, and symbolic, offering insights for strengthening education and training in home-based end-of-life care.

Acknowledgements

The authors want to thank all participants for dedicating their valuable time to this study.

Conflicts of interest

There is no potential conflict of interest to declare.

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