Decision-Making about the Place of Death for Cancer Patients: A Concept Analysis

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Objective: The objective of the study was to conduct a concept analysis of “decision-making about the place of death for cancer patients” to develop a theoretical definition of the concept and identify its attributes, antecedents, and outcomes. Methods: The Rodgers’ evolutionary model of concept analysis was used. A literature search for papers published from 2000 to 2017 was conducted using the keywords: “cancer,” “place,” “death,” and “decision-making” for the search of the electronic databases. Results: Thirty articles were selected for this analysis. As a result, five attributes, six antecedents, and five consequences were extracted. [options to choose as a place of death], [wishes of the patients themselves], [consideration of the burden on the family], [open discussions with other persons concerned], and [best choice according to circumstances] are considered to be the characteristics in the decision-making about the place of death for cancer patients. Conclusions: This concept is defined as “The best choice according to circumstances of the cancer patients among different options for a place of death, resulting from a careful evaluation of the wishes of these patients and the burden on the family, as well as through open discussions with other persons concerned.” Nurses need to assist patients discuss deaths with important others, such as family members, in making decisions about the place of death. Further studies are necessary to elucidate the details of the categories and relationships shown in the attributes in this study, investigating the actual conditions of the patients and their families.

Key words: Cancer, concept analysis, decision-making, the place of death

Abstract

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Introduction

The concept of decision-making is important to understand human behaviors and social phenomena, and it is used in various fields in the social sciences. In the medical field, with the development of treatment methods, patients have more options for tests and examinations, treatments, and places to die, and this has drawn attention to the decision-making of patients. Until the early 20th century, it was common to die at home, but since then places of deaths in hospitals have increased,
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performed a concept analysis
and that there are cases where the preferred we performed
Consequently,
and it may be assumed that it is not easy for cancer
As described above, decision-making about the place of death for cancer patients is a concept
of changes in physical conditions.
According to the steps of Rogers, we performed analyses as follows: (1) Identify the concept and associated expressions (including surrogate terms); (2) Identify and select an appropriate realm (setting and sample) for data collection; (3) Collect data relevant to identify: (a) the attributes of the concept and (b) the contextual basis of the concept, including interdisciplinary, sociocultural, and temporal (antecedent and consequential occurrences) variations; (4) Analyze data regarding the above characteristics of the concept; (5) Identify an exemplar of the concept, if appropriate; and (6) Identify implications, hypotheses, and implications for further development of the concept.

The concept of decision-making about a place of death for cancer patients has been used since early 2000. For this reason, we decided to search articles published between 2000 and 2017. We searched the Scopus, CINAHL Plus, MEDLINE, and Ichushi Web databases for original articles in medical, nursing, and psychological, and social science fields using the combinations of keywords “neoplasms OR oncology OR cancer,” “death OR end-of-life,” “place OR location OR site,” and “decision making,” and retrieved 400 articles for all the fields. Of these, we selected 20 articles from among the identified articles by excluding 334 articles that had no descriptions about the decision-making about a place of death.
six articles that focused on childhood cancer patients and their parents, three articles focusing on noncancer patients, and one article focusing on cancer patients with developmental disorders, 27 case study reports, and nine articles addressed at only medical professionals. Adding ten articles from a manual search using commonly known literature and cited articles to the twenty, we reviewed thirty articles in total.

**Data collection and analysis**

We extracted attributes that show the nature of the concept, antecedents that show the events occurring prior to the concepts, and outcomes that show the events resulting from the occurrence of the concepts in a coding sheet. From the articles that focused on the families of cancer patients, descriptions concerning the situations of cancer patients were extracted. Dividing the descriptive data of antecedents, attributes, and outcomes into codes (one code per meaningful context), and evaluating similarities and dissimilarities of the codes, and classified the codes into subcategories and categories. Based on the results, we defined the concept of decision-making about a place of death for cancer patients and created a conceptual diagram structuring the relation of antecedents, attributes, and outcomes. To ensure the validity of the analysis, the entire process of the analysis was supervised by researchers specializing in oncology nursing.

**Results**

Employing Rodgers’ concept analysis approach, the attributes, antecedents, and outcomes shown in Figure 1 were extracted as the concept of decision-making about a place of death for cancer patients. Categories are indicated with square brackets ([ ]) and subcategories with angular brackets (< >).

**Attributes**

Five categories and 15 subcategories were extracted as attributes to the decision-making about a place of death for cancer patients [Table 1].

**Options to choose as a place of death**

As <Options to choose as a place to die>, “Hospital,” “Home,” and “Hospice” have been reported.

**Wishes of patients themselves**

This category includes the following subcategories: <Relief of pain symptoms>, including pain and anxiety, availability of <Support for daily living> such as voiding assistance, <Maintaining life as the patient wishes> such as wishing to stay at the present home, and <Reliable family and medical professionals> such as wishing to stay with the family at home.

**Consideration of the burden on the family**

Cancer patients conducted <Assessment of care skills of the family> and were concerned about the burden on the family. Patients also gave consideration to the balance between their own wishes and the burden on the family, hoping that their wishes would be realized without imposing any serious burden on the family and trying to strengthen the relationship with the family while thinking that this may become a burden on the family.

**Open discussions with other persons concerned**

In making decisions of a place of death, the cancer patients had an open discussion with important others, such as family members and medical professionals. In the discussion with family members, patients tried to <Confirm the wishes of the family members> and <Understand the feelings of both the patients and the family members> through discussion based on information provided by medical professionals and engaged in <Sharing opinions with medical professionals> by confirming the differences in perceptions of life expectancy and place.

**Best choice according to circumstances**

Patients made <Choices according to circumstances> such as selecting the best place considering the changes in disease conditions. However, many cases were faced with difficult choices. Further, there are <Decisions that value the wishes of both patients and family members>, as a result of patients thinking about the matters together with their family.

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**Figure 1** Decision-making about the place of death for cancer patients: Attributes, antecedents, and outcomes
and selecting the best choice for both parties.\cite{18} There are also \textless Decisions that value the wishes of patients\textgreater, where patients and family members decide to support the patient wishes\cite{21} and that patients explain their ideas convincingly to the family members.\cite{19}

**Antecedents and outcomes**

Six categories were extracted as antecedents for a place of death for cancer patients [Table 2].

Cancer patients were in the situation where they need to make decisions of a place of death due to [Worsening of the physical conditions of patients], such as \textless Situations where there is no response to invasive treatment\textgreater,\cite{15,29} \textless Declining physical functioning\textgreater,\cite{24,30} and \textless Appearance of pain symptoms\textgreater.\cite{8,10,29,30} A place of death was agreed on when the disease conditions coincided with an [Awareness of the patient on the disease conditions], such as \textless Understanding of that the disease condition is worsening\textgreater.\cite{9,19,23,24}

**Table 1: Attributes to decision-making about the place of death for cancer patients**

| Category | Subcategory | Code | Reference |
|----------|-------------|------|-----------|
| Options to choose as a place of death | Options to choose as a place of death | Options of a place of death include “hospitals,” “home,” “hospice,” and “nursing home” | 15, 16 |
| Wishes of patients themselves | Relief of pain symptoms | Patients can receive palliative care from medical professionals at home | 8 |
| | | Hospitals and hospices can alleviate pain symptoms. Hospitals and hospices can alleviate pain symptoms | 8, 11, 17-19 |
| | Support for daily living | Families can entrust medical professionals with support of activities in daily life | 10, 17 |
| | | Patients can rely on help about voiding from medical professionals | 9 |
| | Maintaining life as the patient wishes | Patients wish to stay at their own home | 8, 18, 20, 21, 24 |
| | | Patients can maintain their usual lifestyle at home | 8, 18, 20-24 |
| | | Wish to be in a hospice where there is as much privacy as they like | 21 |
| | | Wish to die in a beautiful and relaxing hospice | 18 |
| | | Families can maintain their usual roles | 9, 24 |
| | Reliable family and medical professionals | Wish to stay at home with family members | 8, 20, 22, 24 |
| | | Wish to die surrounded by family members | 21 |
| | | There are medical staff and volunteers like the family in hospices | 18, 21 |
| | | Have people who can always share emotions nearby | 21 |
| Consideration of the burden on the family | Concerned about the burden on the family | Wish not to impose a burden on family members | 8-11, 19, 21, 23, 24 |
| | | Patients wish not to leave families with memories related to death | 18 |
| | | Location of the hospital is convenient for families | 19 |
| | | Economic burden is smaller | 19 |
| | | Patients hope that their wishes would be realized without imposing any burden on the family | 10, 11, 18 |
| | | Try to strengthen the relationship with the family while thinking that it could become a burden on the family | 11 |
| | Assessment of care skills of the family | Family members of patients can help them at home anytime | 21 |
| | | Assess whether patients can have adequate nursing care by family members at home | 9, 10, 22 |
| | | Assess the limitations and possibilities of family care | 21 |
| Open discussions with other persons concerned | Confirm the wishes of the family members | Confirm the intention of families through discussion with them | 9, 21, 25 |
| | | Discuss with families and find good ways for everyone | 18 |
| | | Discuss with family members and understand feelings of all parties | 9, 24 |
| | Understand the feelings of both the patients and the family members | Accept proposals of physicians on a place of death | 15 |
| | | Discuss with the medical professionals based on information provided | 26 |
| | | Eliminate gaps in understanding about life expectancy and place to die between patients and medical professionals | 15, 24 |
| | | Discuss with patient and family including medical professionals | 24 |
| | Explanations and proposals of medical professionals | Choose the best place considering the changes in disease conditions | 9, 10, 18, 27 |
| | | Make a difficult choice when there is no other way | 28 |
| | | Choose the best place for patients and people around them | 11 |
| | | Decide considering the best way for both patients and their families | 18 |
| | | Patients and their families decide a place together | 19 |
| | | Patients and their families decide a place together to realize the wishes of the patients | 21 |
| | | Patients explain their thoughts and the family members will accept them | 19 |
Table 2: Antecedents for decision-making about the place of death for cancer patients

| Category                        | Subcategory                                                                 | Code                                                                 | Reference |
|---------------------------------|-----------------------------------------------------------------------------|----------------------------------------------------------------------|-----------|
| Worsening of the physical conditions of patients | Situations where there is no response to invasive treatment | No options for invasive treatment left | 15, 29    |
|                                 | Declining physical functioning                                              | Able to provide the end-of-life care at home with the physical functions declined | 24, 30    |
|                                 | Appearance of pain symptoms                                                 | Unable to care of patient when pain symptoms increased                | 8, 10, 29, 30 |
| Awareness of the disease conditions | Understanding of that the disease condition is worsening                   | Think about where to spend terminal period understanding that the disease condition is deteriorating | 9, 23    |
|                                 | Difficulty in predicting the physical changes                               | Unable to think about where to spend the terminal period and not accepting the disease condition | 19, 24    |
|                                 | Acceptance of death                                                         | Patients cannot easily make a choice because it is difficult to predict the physical changes until death | 9, 10    |
| Intention of patients and family | Understanding of the family about the disease condition                    | Convinced that death is approaching                                    | 8, 21, 23 |
|                                 | Acceptance of the family of death                                           | Complex feelings but not convinced that death is close                 | 16, 24    |
|                                 | Understanding of the family on a place of death                             | Families are confused because the understanding of the medical condition of the family and medical professionals differ | 24    |
|                                 | Attitudes toward the decision of patient and family                         | Families face the fact that the death of the patient is close          | 28, 30    |
|                                 | Experience of care which patients received in the past                      | Previous places where patients were cared for affect the decision of the place of care and death | 10, 18, 22, 24 |
| Barriers to discussing death with others concerned | Cultural and religious values of patients                                   | Cultural significance in dying at home                                 | 7        |
|                                 | Thoughts of the family hoping to support the wishes of the patients         | Cultural values concerning nursing care affect the decision           | 10       |
|                                 | Differences in the intentions of patients and family                        | Religious beliefs affect the decision                                 | 10       |
|                                 | Difficulty for the patient and family to talk about a place of care and death| Patients wish to realize the desires of patients wishing to die at home | 21, 24, 29 |
|                                 | It is difficult for patients to talk about medical topics with medical professionals | Families undertake nursing care to realize the wishes of patients        | 10, 29, 30 |
|                                 | It is difficult for patients to talk about expert medical issues with medical professionals | Families wish to let patients live in a free and comfortable environment | 24, 30    |
|                                 | Medical professionals make the idea of patients on death ambiguous          | Patients and families will have different opinions concerning the place of death, and how to spend the terminal period | 7, 17, 28, 29 |
|                                 | Medical professionals are concerned about the emotional response of patients to the approaching death | It is difficult to speak frankly with the family because the burden on the family increases | 9        |
|                                 | It is difficult for medical professionals to discuss with patients because of the difficulty in predicting the prognosis and course to death | Because patients are not informed of their life expectancy, it is difficult to talk frankly with their families | 28, 29, 37 |
|                                 | It takes time to arrange services to stay at home                           | Previous places where patients were cared for affect the decision of the place of care and death | 29, 30    |
| Social resources available      | Nursing care services at home                                               | Patients will require support from medical professionals at home as the disease conditions worsen | 21       |
|                                 | Characteristics of community                                                 | Availability of support from medical professionals at home is limited | 9        |
|                                 | It is common to die at home in wealthy communities                          | Availability of 24 h services by visiting nurses and nursing care staff, frequency of visits by a doctor, and availability of parenteral drugs affect the death at home | 33       |
|                                 | Fewer people desire death at home in densely populated communities           | Availability of 24 h services by visiting nurses and the length of the nursing care services at home affect the death at home | 34       |
|                                 | Medical professionals patients can consult with                             | Patients can consult with medical professionals about palliative care  | 36       |
|                                 | There is a key medical professional                                         | There is a key medical professional                                    | 35       |
|                                 | Patients can consult with medical professionals about decision-making       | Patients can consult with medical professionals about decision-making  | 11       |
|                                 | Patients need support from the family to stay at home                       | Patients need support from the family to stay at home                  | 10, 17    |
| Support from the family         | Families are aware of roles concerning nursing and end-of-life care        | Families are aware of roles concerning nursing and end-of-life care    | 28, 37    |
|                                 | Males prefer to die at home                                                 | Families are aware of roles concerning nursing and end-of-life care    | 28, 37    |
|                                 | Families can take care of patients because they have experience of giving end-of-life care for other family members | Families feel uneasy about taking care of patients at home and providing end-of-life care | 9, 24    |
|                                 | Families feel uneasy about taking care of patients at home and providing end-of-life care | Families cannot take care of patients at home because of their work and health conditions | 28, 37    |
|                                 | Information on the facilities providing end-of-life care is needed          | Information on the facilities providing end-of-life care is needed     | 21        |
and <Acceptance of death>. In cases where family members are involved in the decision-making about a place of death, patients made the decision when the disease conditions coincided with the [Awareness of the family about the disease condition and the place of death], such as <Understanding of the family about the disease condition>, and <Understanding of the family on a place of death>. It is reported that there is a tendency in cultures that patients have positive attitudes and determination and that the family plays an important role in decision-making. From this background, the [Intention of patients and family] for a place of death involves the following subcategories: <Attitudes toward the decision of patient and family>, <Experience of care which patients received in the past>, <Cultural and religious values of patients>, <Thoughts of the family hoping to support the wishes of the patients>, and <Differences in the intentions of patients and family> related to the place of death and how the patient spends time till the end of life. As [Barriers to discussing death with others are concerned], there were situations where patients and family cannot talk openly due to the <Difficulty for the patient and family to talk about a place of death>, and situations where the decision-making did not proceed due to <Difficulty for the patient to talk about the disease conditions and death with medical professionals> as illustrated by the reports that it is difficult for patients to ask medical professionals about medical matters, and that medical professionals make the ideas of patients on death ambiguous. Further, as [Social resources available], <Characteristics of community>, <Nursing care services at home>, <Medical professionals patients can consult with>, and <Support from the family> were extracted.

Five categories were extracted as outcomes of the decision-making about a place of death for cancer patients [Table 3]. <Realization of death in the preferred way> is illustrated by <Death at the place the patient preferred> and <Mental stability of patient>. With the time spent together by patient and their family members at home, patient [Maintained relationship with their family]. <Satisfaction of the family> is illustrated by the report that family members felt it accomplished by providing nursing care for the patient and [Regrets and self-accusation of the family] is illustrated by the report that the family felt regret and self-accusation because they did not look after the patient at home. <Maintaining the mental health of family members> was extracted from the report that the family became less depressed when the patient died at a place preferred.

Related concept

From the articles analyzed, “Advanced Care Planning” was extracted as a concept related to decision-making about a place of death. It was reported that through the advanced care planning, the preference of the place of death was discussed, and the discussion for decision-making about the place of death continue till finalization of advanced care planning. These suggest that advanced care planning is reflected in the decisions made for the place of death.

Example presented by a case

After undergoing treatment for 10 years, and with no treatment options left, Jane, a breast cancer patient aged 53, faced the necessity to make decisions on palliative and life-sustaining treatments. When Jane had to decide where she would spend the days left to her, she had <Options to choose as a place to die>: stay at home with undergoing hospice care and at special nursing care home or hospice. At the same time, she had to make a decision of life-sustaining treatments, including cardiopulmonary resuscitation and admission to the hospital or intensive care unit. Jane wanted to spend the final days as she wished, but she had [Wishes of patients themselves], such as hoping to live much longer and spend time with husband and daughters at home while giving [Consideration of to the burden on the family] because she will impose a burden on her husband and daughters who look after her. However, Jane thought that if she chooses hospice, she would not be able to live as she wishes and thinks about death more fully. The family of Jane hoped that she would receive the best care so that Jane’s wishes would be granted. For this reason, Jane repeatedly had [Open discussions with other persons concerned], such as with husband, daughters, physicians, and nurses, and Jane made a decision to make the [Best choice according to circumstances], living in a hospice as the best place for Jane, while sharing the emotions and thoughts with her family.

Discussion

Definition of concept

Based on the attributes, antecedents, and outcomes extracted in this study, we defined the decision-making about a place of death for cancer patients as “The best choice according to circumstances of the cancer patients among different options for a place of death, resulting from a careful evaluation of the wishes of these patients and the burden on the family, as well as through open discussions with other persons concerned.”

Characteristics of the concept

Here, we discuss the characteristics of the concept of decision-making about a place of death for cancer
patients, focusing on the [Wishes of the patients themselves], [Consideration of the burden on the family], and [Open discussions with other persons concerned]. These are considered to be attributes characteristic to the decision-making about a place of death for cancer patients because they were characteristics not clearly reported in the previous studies that performed a concept analysis of decision-making.\(^6,41\)

Simon\(^{42}\) mentions that options are evaluated and compared in decision-making. It may be inferred that the cancer patients evaluate and compare options of a place of death, and make a decision of a place based on their wishes, such as to have support for alleviation of pain symptoms and activities in daily living, to be able to live in ways they prefer, have family members and reliable medical professionals, and be less of a burden on the family. Miyashita et al.\(^{43}\) report that the concept of a good death for cancer patients in the terminal stage includes “physical and mental afflictions being alleviated,” “staying in a quiet environment,” “keeping a good relationship with family and friends,” “having reliable physicians and nurses,” and “not imposing a burden on family and other people.” These were in common with the attitude of cancer patients in the terminal stage contemplating their own wishes and the burden on their families. This suggests that contemplating options of a place of death based on their own wishes and the burden on the family and making the decision may lead to a [Realization of death in the preferred way] and [Satisfaction of the family].

Further, when cancer patients in the terminal stage make decisions of a place of death, they conducted [Open discussions with other persons concerned], such as family members and medical professionals. This type of decision-making has to be performed in a situation with uncertainties of the outlook of the medical condition of the patient, difficulty in sharing the inevitability of death among the patient, family, and medical professionals in a short period of time. For this reason, it is indispensable for the three parties to discuss openly to enable the [Best choice according to circumstances]. As an antecedent [Barriers to discussing death with others concerned] was also found, it may be inferred that talking about death openly may be difficult. However, it is indispensable for the three parties to face and talk about the death of the patient and the sorrow arising at the death to ensure a [Best choice according to circumstances] and [Realization of death in the preferred way].

**Review of applicability to practice**

As the applicability of the findings to practice, we first discuss the details of antecedents and outcomes. Nurses can utilize the concepts extracted as antecedents for a viewpoint of assessments to assist cancer patients in the terminal stage in making the decision of a place of death. It was suggested that the decision-making about a place of death may need to be conducted repeatedly depending on the changes in physical conditions because it is related to the [Worsening of the physical conditions of patients]. Further, nurses need to assess how patient and family understand the disease conditions and how they think about death because decision-making about a place of death for cancer patients is related to the [Awareness of patients袒]

| Table 3: Consequences of decision-making about the place of death for cancer patients |
|---------------------------------|---------------------------------|-----------------|-----------------|
| Category                        | Subcategory                     | Code            | Reference       |
| Realization of death in the preferred way | Death at the place the patient preferred | Patients die at their preferred place | 26 |
|                                |                                 | Patients who die in a desired place had a high score in the good death inventory | 38 |
|                                |                                 | Patients can stay in comfort | 21 |
|                                |                                 | Patients can stay well adjusted at home | 24 |
|                                | Mental stability of patient     | Patients and family can stay together at home | 21, 30 |
| Maintained relationship with their family | Ensure time for patients and family members to spend together | Families feel accomplishment from administering patients with the nursing care | 30 |
| Satisfaction of the family     | Accomplishments of family toward nursing care | Families feel convinced that the decision was the best choice | 10 |
|                                | Consent of family to the decision on a place | Families feel regrets and self-accusation when they cannot take care of patients at home | 38 |
| Regrets and self-accusation of the family | Regrets and self-accusations of the family arising from the end-of-life care | Families feel less depressed when patients die at their preferred place | 38 |
|                               | Decrease in grief and feelings of depression of family members | Families feel less grief when patients die at their preferred place | 39 |
|                               |                                 | Families feel less of grief and depression when they have been less burdened in decision-making for a place | 29 |
about the disease conditions] as well as the [Awareness of
the family about the disease conditions]. If cancer patients
and their families are not aware of the disease conditions,
they may not be able to understand the necessity for making
decision of a place of death, and there may be cases where
patients and family are afraid of facing death.[44,45] This
makes it necessary for nurses to pay careful attention in
encouraging patients to understand the disease conditions.
For a [Realization of death in the preferred way] and a
[Maintained relationship between patients and their
family], extracted as outcomes can be used as an index when
nurses evaluate the decision made by patients together with
the patients. However, it is necessary to keep in mind that
there will be cases where evaluation of patients is difficult
due to the poor conditions of the patient and that the
result of decisions by patients may affect the [Satisfaction
of the family], [Regrets and self-accusation of the family],
and [Maintaining the mental health of family members],
as well as that of the patients, depending on the time of
the evaluation. Nurses must pay careful attention to the
bereaved family of patients specifically when the patients
are unable to die at a preferred place, because the family
members may feel regret and suffer from self-accusations,
feeling grief, and depression as a result.

Next, as an important point which nurses have to keep
in mind when assisting cancer patients in making the
decision of a place of death, we discuss the assistance to
patients and their families who are unable to communicate
sufficiently with medical professionals. In decision-making
about a place of death for cancer patients, [Open discussions
with other persons concerned] is an important element.
However, there are [Barriers to discussing death with others
concerned]. It is difficult for patients who are not informed
of the life expectancy to talk about a place of death with
the family, and it is also difficult for patients and medical
professionals to talk about the disease conditions and death.
These difficult situations make it difficult to make a decision
of a place of death. Traditionally, it was uncommon for
medical professionals in Japan to inform families, instead of
patients themselves, of patient life expectancy, and leave the
decision to inform the patients of the life expectancy to the
family.[46] However, in recent years, this tradition to inform
the families of the life expectancy of their beloved family
member has changed, and according to Ichikura et al.[47]
“the likelihood of doctors delivering bad news to patients
and family members (as opposed to family members only)
about the end of life increased from 2006 to 2012.” For
this reason, nurses need to attend to cancer patients in a
faithful manner, and understand what and how much the
patients want to know in making decisions of a place of
death. Further, when families play an important role in

making decisions for cancer patients, nurses need to identify
the relationship between patients and their families and
family functions,[48] and also need to assess the wishes of
the families as well as of the patients. If the patients and
their families have different wishes, it is necessary to provide
assistance to accommodate the feelings and thoughts of
patients and their families.

Conclusion
This study conducted a concept analysis of the
decision-making about a place of death for cancer patients
using thirty articles published in Japan and other countries.
As a result, five attributes, six antecedents, and five outcomes
were extracted, and this concept is defined as “The best
choice according to circumstances of the cancer patients
among different options for a place of death, resulting from
a careful evaluation of the wishes of these patients and the
burden on the family, as well as through open discussions
with other persons concerned.” Nurses need to assess the
intentions of and relationships with patients and family and
provide assistance for cancer patients so that they will be
able to discuss a place of death with their family and other
persons concerned, as well as express their own feelings and
ideas, and reach a mutual understanding. Further studies
are necessary to elucidate the details of the categories and
relationships shown in the attributes in this study from the
experience of patients and their families, and to develop a
support model that will help cancer patients in the terminal
stage of their illness and their families to make decisions
of a place of death.

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