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Restrictions on Visitation and Dialogue Support by Nurses between Terminally Ill Patients with Cancer and Their Families in the Post-COVID-19 Era in Japan

Shiho Asano[1]*, Midori Furuse[2]

[1]Department of Nursing, Japanese Red Cross Tohoku College of Nursing, Akita, Japan
[2]Faculty of Medicine, Yamagata University, Yamagata, Japan
Email: *asano@rctohoku.ac.jp

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Abstract

Purpose: This study aimed to clarify the actual state of dialogue support by nurses between terminally ill patients with cancer and their families in the face of visitation restrictions imposed in the post-COVID-19 era in Japan. **Methods:** The participants were 607 nurses with at least 2 years of experience working at 33 hospitals with more than 100 beds and currently involved in the care of terminally ill patients with cancer. Data were collected via an anonymous online questionnaire from February to March 2025. The questionnaire included items on basic attributes, visitation restrictions, online dialogue support, and a revised self-assessment scale for nurses about enhancing dialogue support between terminally ill cancer patients and their families. Statistical analyses, including unpaired t-tests, were conducted to calculate descriptive statistics. **Results:** The final analysis included 293 respondents (valid response rate: 48.3%), 90.4% of whom indicated that there were visiting restrictions in their hospital ward. No significant relationship was found between the presence or absence of visitation restrictions and the frequency of dialogue support practices. Those with experience providing dialogue support online using video calls or Zoom (36.5%) had significantly higher total scores on the dialogue support self-assessment scale ($p < 0.000$) than those without such experience (63.5%), and they tended to practice dialogue support between terminally ill cancer patients and their families more frequently on a daily basis. **Conclusion:** Since many facilities continue to restrict visits, it is important to provide dialogue support that takes into consideration the process before and after visits. Considering each patient's overall condition and the difficulty of having dialogue via a screen, online dialogue support that incorporates consideration for families serves as a catalyst for raising nurses' awareness of improving the quality of dialogue support and contributes to daily nursing practice.

Keywords

Visitation Restrictions, Dialogue Support, Terminal Illness Care, Cancer Patients, Family Nursing

1. Introduction

In Japan, the first person infected with Coronavirus Disease 2019 (COVID-19) was confirmed in January 2020. The COVID-19 outbreak then spread rapidly, and the government recommended restricting visitation to medical institutions and elderly care facilities as part of its infection control measures. In April 2020, a basic policy measure was announced, stating that, "visitations to medical institutions and elderly care facilities should be temporarily suspended—except in emergencies—to prevent infections transmitted by visitors" [1]. In fact, a complete visitation ban was maintained for more than a year. The policy measure was incrementally revised in response to changes in infection status. In November 2021, the Ministry of Health, Labour and Welfare issued a statement that included detailed standards (a compilation of case examples) related to the number of allowed visitors and duration of visits [2]. By November 2022, the policy wording had changed to "visitations are important for patients, users, and families." Due to the reclassification to Category 5 under the Infectious Disease Law in May 2023, the response policy shifted from administrative requests based on law to leaving decisions to the discretion of individual businesses and others. Nevertheless, regardless of the national policies or infection status, some medical institutions continue to restrict visitation to this day. This stems from the cautious stance of healthcare providers, rooted in differences in infection control measures among facilities and their past experiences with in-hospital infections and clusters. According to the views of the COVID-19 Advisory Board [3], even after the reclassification under the Infectious Disease Law, repeated outbreaks are expected to occur to some extent. Therefore, ongoing measures to prevent the spread of infection are considered necessary in settings such as medical institutions and elderly care facilities, where individuals at high risk of developing severe symptoms, such as hospitalized patients and elderly individuals, are present. It is also noted that, to meet the needs within the limited healthcare and long-term care resources, it is necessary to devise effective and sustainable infection control measures, with each facility contributing through innovative approaches. In particular, Japan is experiencing significant population aging, and considering the magnitude of the potential consequences of in-hospital infection outbreaks, the current state is that a cautious response to lifting visitation restrictions is being maintained.

Strict isolation and visitation restrictions protect vulnerable patients from infections and reduce the risk of infection for their families and healthcare providers who care for infected patients [4] [5]. However, these measures for protecting the safety of terminally ill patients are creating a difficult situation in which the patients are unable to spend their final days of life with their loved ones. In end-of-life care, limiting or prohibiting visits results in inadequate emotional and spiritual care/support for patients and anxiety and despair among family members [6] [7]. Furthermore, disruption of communication between terminally ill patients and their families is considered to contribute to the heightened risk of developing depressive feelings, anxiety, and complicated grief in their families [8]-[10]. Moreover, being denied an adequate opportunity for a final farewell with the patient due to visitation restrictions has been shown to trigger complicated and prolonged grief in bereaved families [11]. Therefore, in this day and age when we are expected to coexist with infections, it is urgent that we reconsider care approaches that connect terminally ill patients with their families, establish nursing practices that support the relationship between both parties, and achieve meaningful end-of-life care.

In Japan, the aging of the population has resulted in approximately 380,000 deaths per year due to cancer, making it the leading cause of death [12]. This trend is expected to continue in the future, and improving the quality of family care during the end-of-life stage is an urgent social issue. When dialogue is facilitated between terminally ill cancer patients and their families, their relationships are strengthened [13], and the satisfaction of bereaved families increases [14]. Nurses perceive patients and families as a single care unit, and they play an important role in maintaining and deepening the relationship between both parties through dialogue support. Nonetheless, it has been reported that nurses faced various conflicts, such as "how to communicate the thoughts of family members to patients when direct interaction is not possible" and "how to acknowledge the anxieties felt by the families" during end-of-life family care, under visitation restrictions imposed against the backdrop of COVID-19 infection prevention [15]. Even in dialogue support, it has been noted that understanding the feelings of terminally ill cancer patients within a limited time frame, while speaking on behalf of their families, is difficult [16]. Currently, in a healthcare environment in which coexistence with infections is the norm, nurses have developed practice methods based on the values of this new era, different from those before the infection outbreak, reconstructing end-of-life family care. Given these circumstances, focusing on the current state of dialogue support under visitation restrictions and the nurses' dialogue support practices offers hope that we can gain insights into the training of dialogue support skills that enhance end-of-life family care, as well as the reconstruction of dialogue support strategies on the frontlines of medical care.

Therefore, the objective of the present study was to clarify the current state under visitation restrictions and to examine dialogue support practices. Furthermore, looking ahead to improving the practical skills in dialogue support of nurses, as a secondary objective, the aim was to identify learning experiences, and difficulties faced during dialogue support, with the goal of gathering foundational resources for educational intervention. Here, dialogue support is defined as support that leads terminally ill patients with cancer and their families to exchange thoughts and feelings they have wanted to convey to each other to maintain and strengthen their relationship through mutual responses [17].

2. Methods

2.1. Participants and Data Collection

Fifty facilities in Japan were randomly selected from hospitals with more than 100 beds registered in the Welfare and Health Information Network Project of the Japan Health and Welfare Organization. Representatives of the nursing departments received a request letter, a consent form, and a return envelope, asking if they would participate in the study and, if so, how many participants would be included. In total, 33 facilities agreed to participate in the survey.

The nursing department representative was asked to select wards with opportunities to care for terminally ill cancer patients suitable for the study. A total of 607 nurses with at least two years of practical nursing experience from the selected wards were chosen as study participants. First-year nurses were excluded because their priority was to learn general nursing tasks and acclimate to the work environment. Managers at the head nurse level or above were also excluded from the study population.

Data were collected through an online survey. A research description with a QR code was distributed to the participants from February to March 2025 by a representative of the nursing department. Participation was voluntary, and responses were requested within two weeks of receiving the documents.

2.2. Survey Items

2.2.1. Characteristics of Participants

The basic attributes included age, sex, years of nursing experience, years of experience caring for terminally ill cancer patients, experience working in palliative care wards, and certification as a certified nurse or specialist nurse in the field of cancer.

2.2.2. Visitation Restrictions for Terminally Ill Patients

Questions were asked about the existence of visitation restrictions for terminally ill patients in the wards where they work, as well as the visitation hours and the number of visitors allowed under the restrictions.

2.2.3. Practical Situation of Dialogue Support between Nurses and Families of Terminally Ill Cancer Patients

The revised version of the self-assessment scale for nurses to enhance dialogue support between terminally ill cancer patients and their families [18] was used. This scale emphasizes family beliefs and perspectives and was developed using the Illness Belief Model [19] as its theoretical basis, which is a model that supports the healing of families through therapeutic conversations. The scale consists of the following four factors and 18 items and measures the practice status of dialogue support between terminally ill cancer patients and their families: Focusing on patients and families for a deeper understanding, assessing patients' and families' dialogue needs, engaging with patients and families with respect for each other's perspectives, and utilizing a team approach for seamless dialogue support. The responses were rated using the following 5-point scale: "1. Never," "2. Rarely," "3. Sometimes," "4. Often," and "5. Always." The scores ranged between 18 and 90, with higher scores indicating a greater frequency of engaging in dialogue support practices. The opportunities for engaging in dialogue support between terminally ill cancer patients and their families were rated using a 4-point scale as follows: "1. Not at all," "2. Rarely," "3. Sometimes," and "4. Frequently." Whether they had experience providing dialogue support connecting terminally ill cancer patients and their families using video calls or meeting apps like Zoom (hereafter referred to as "experience in providing dialogue support online") was also asked.

2.2.4. Learning Experiences Participating in Training on End-of-Life Family Nursing and Difficulties Encountered While Providing Dialogue Support

We asked whether they had participated in training on end-of-life family nursing. Referring to a qualitative study [16] that clarified the difficulties of dialogue support between nurses and terminally ill cancer patients and their families, the following eight items were addressed: "building a trusting relationship with the patient," "building a trusting relationship with the family," "addressing topics related to death," "understanding the values of both the patient and the family," "assessing the necessity of dialogue support," "determining the timing of dialogue support intervention," "evaluating the reactions of patients and families after dialogue support," and "evaluating one's own involvement after dialogue support." When providing dialogue support between terminally ill cancer patients and their families, participants were asked to select multiple items from these eight items that they considered challenging.

2.3. Analysis Method

Descriptive statistics were calculated using IBM SPSS Statistics (Ver. 28). A normal distribution was confirmed, and correlation coefficients and mean differences were calculated using Pearson's correlation coefficient and independent t-tests, respectively.

2.4. Ethical Considerations

This study was approved by the Ethics Committee of Japanese Red Cross Akita College of Nursing (No. 2024-114). We informed participants in writing that participation was voluntary, refusal would not result in any disadvantages, and results would be published in academic conferences and articles without identifying individuals, since the survey was anonymous. Participants were asked to check items to confirm their consent to participate in the online survey and their agreement with the research.

3. Results

3.1. Participants' Characteristics (Table 1)

Responses were obtained from 293 participants (response rate: 48.3%). Since there were no missing values, all responses were considered valid and used in the analysis. There were 277 female respondents (94.5%). The average age was 37.8 ± 9.6 years (range: 23 - 62 years), and the average number of years of nursing experience was 15.2 ± 9.3 years (range: 2 - 42 years).

Table 1. Participants' basic attributes (N = 293).

Item	Attribute	No. of people	(%)
Sex	Men	16	5.5
	Female	277	94.5
Age (y)	Mean ± SD	37.8 ± 9.6	
	20 - 29	82	28.0
	30 - 39	79	27.0
	40 - 49	96	32.8
	50 - 59	35	11.9
	≥60	1	0.3
Years of nursing experience	Mean ± SD	15.2 ± 9.3	
	2 - 4	40	13.7
	5 - 9	61	20.8
	10 - 19	89	30.3
	20 - 29	82	28.0
	≥30	21	7.2
Years of experience caring for terminally ill cancer patients	Mean ± SD	8.7 ± 7.5	
	<5	102	34.8
	5 - 9	83	28.3
	10 - 19	78	26.6
	20 - 29	21	7.2
	≥30	9	3.1

3.2. Visitation Restrictions at the End of Life (Table 2)

A total of 90.4% of the participants said that there were "visitation restrictions at their affiliated ward." Regarding restrictions on visiting hours, the most frequent response was "in the case of patients who are nearing death, permission to relax visiting hours can be obtained from the doctor" (47.8%), followed by "about 15 minutes" (27.0%). Regarding restrictions on the number of allowed visitors per visit, the most frequent response was "2 persons" (50.9%), followed by "in the case of patients who are nearing death, permission to relax the number of allowed visitors can be obtained from the doctor" (28.0%).

Table 2. Status of visitation restrictions (N = 293).

Item	Attribute	No. of people	(%)
Visitation restrictions at their affiliated ward	With visitation restrictions	265	90.4
(Restrictions on visiting hours and on the number of allowed visitors)	No visitation restrictions	28	9.6
Restrictions on visiting hours	About 5 minutes	1	0.3
	About 10 minutes	6	2.0
	About 15 minutes	79	27.0
	About 20 minutes	4	1.4
	About 30 minutes	35	11.9
	In the case of patients who are nearing death, permission to relax visiting hours can be obtained from the doctor.	140	47.8
	No restrictions on visiting hours	28	9.6
Number of allowed visitors under the restrictions	1 person	1	0.3
	2 persons	149	50.9
	3 persons	8	2.7
	4 persons	3	1.0
	In the case of patients who are nearing death, permission to relax the number of allowed visitors can be obtained from the doctor.	82	28.0
	No restrictions on the number of allowed visitors.	31	10.6
	No response	19	6.5

3.3. Comparison of Scores on the Revised Dialogue Support Self-Assessment Scale Based on the Presence or Absence of Visitation Restrictions (Table 3)

Those who responded that there were no visitation restrictions (n = 28, 9.6%) had a higher mean score on the subscale "Focusing on patients and families for a deeper understanding" of the revised dialogue support self-assessment scale than those who responded that there were visitation restrictions (n = 265, 90.4%), with a significant difference (4.2 ± 0.5, 3.9 ± 0.6, p = 0.044). In contrast, no significant difference was observed between the presence or absence of visitation restrictions and the total score on the revised Dialogue Support Self-Assessment Scale.

Table 3. Comparison of scores on the revised dialogue support self-assessment scale based on the presence or absence of visitation restrictions (N = 293).

	Visitation restrictions in place (n = 265)	No restrictions on visits (n = 28)		
Item	**Mean ± SD**	**Mean ± SD**	*t*	**p**
[Focusing on patients and families for a deeper understanding]	3.9 ± 0.6	4.2 ± 0.5	2.018	0.044
[Assessing patients' and families' dialogue needs]	3.8 ± 0.7	4.0 ± 0.7	1.761	0.079
[Engaging with patients and families with respect for each other's perspectives]	4.2 ± 0.5	4.3 ± 0.5	0.946	0.345
[Utilizing a team approach for seamless dialogue support]	3.7 ± 0.7	3.8 ± 0.8	0.924	0.357
Total: 18 items	70.4 ± 9.6	73.6 ± 9.5	1.718	0.087

3.4. Comparison of the Total Scores of the Revised Dialogue Support Self-Assessment Scale by Participant Characteristics (Table 4)

Those with experience in online dialogue support using videophones or meeting apps such as Zoom (36.5%) had a significantly higher average total score on the revised dialogue support self-assessment scale than those without such experience (63.5%) (73.3 ± 8.4, 69.2 ± 9.9, $p < 0.000$).

In terms of learning experience, those with learning experience in end-of-life family nursing (53.2%) had a significantly higher mean total score on the revised dialogue support self-assessment scale than those without learning experience (46.8%) (72.8 ± 9.1, 68.3 ± 9.6, $p < 0.000$).

In terms of difficulties in dialogue support practice, those who reported difficulty in "addressing topics related to death" (72.0%) had a significantly lower mean total score on the revised dialogue support self-assessment scale than those who reported no difficulty (28.0%) (69.7 ± 9.4, 73.3 ± 9.6, $p = 0.003$). In addition, those who reported difficulty in "assessing the need for dialogue support" (22.9%) had a significantly lower average total score on the revised dialogue support self-assessment scale than those who reported no difficulty (77.1%) (67.7 ± 9.6, 71.6 ± 9.4, $p = 0.003$).

Table 4. Comparison of the total scores of the revised dialogue support self-assessment scale by participant characteristics (N = 293).

Item	Breakdown	n	(%)	Mean ± SD	Total score Mean ± SD or correlation coefficient	*t*	p
Basic attribute							
Sex[a]	Male	16	5.5		67.06 ± 10.23	1.562	0.119
	Female	277	94.5		70.90 ± 9.52		
Age[b] (y)		293		37.8 ± 9.6	0.134		0.021
Years of practical nursing experience[b]		293		15.2 ± 9.3	0.148		0.011
Years of cancer nursing experience[b]		293		8.7 ± 7.5	0.09		0.125
Experience working in palliative care wards/units[a]	Yes	83	71.7		71.8 ± 10.1	−1.239	0.216
	No	210	28.3		70.3 ± 9.4		
Years of working experience in palliative care wards/units[b]		83		6.5 ± 6.0	0.091		0.412
Certification as a certified nurse or specialist nurse in the field of cancer[a]	Yes	12	4.1		79.2 ± 5.7	−3.175	0.002
	No	281	95.9		70.3 ± 9.6		
Visitation restrictions and opportunities for dialogue support							
Visitation restrictions in their affiliated ward[a]	Yes	265	90.4		70.4 ± 9.6	1.718	0.087
	No	28	9.6		73.6 ± 9.5		

Continued

Opportunities to be involved in dialogue support between terminally ill cancer patients and their families[a]	Sometimes, frequently	234	79.9	71.7 ± 9.6	−3.547	<0.000
	Rarely, not at all	59	20.1	66.8 ± 8.6		
Experience in providing dialogue support online[a]	Yes	107	36.5	73.3 ± 8.4	−3.669	<0.000
	No	186	63.5	69.2 ± 9.9		
Learning experience						
Experience learning end-of-life family nursing[a]	Yes	156	53.2	72.8 ± 9.1	−4.06	<0.000
	No	137	46.8	68.3 ± 9.6		
Difficulties encountered while providing dialogue support[a]						
1) Building a trusting relationship with the patient	Difficult	56	19.1	70.1 ± 11.0	0.523	0.601
	Not difficult	237	80.9	70.8 ± 9.2		
2) Building a trusting relationship with the family	Difficult	94	32.1	70.2 ± 9.9	0.549	0.583
	Not difficult	199	67.9	70.9 ± 9.5		
3) Addressing topics related to death	Difficult	211	72.0	69.7 ± 9.4	2.946	0.003
	Not difficult	82	28.0	73.3 ± 9.6		
4) Understanding the values of both the patient and the family	Difficult	127	43.3	70.0 ± 9.7	1.12	0.264
	Not difficult	166	56.7	71.2 ± 9.5		
5) Assessing the necessity of dialogue support	Difficult	67	22.9	67.7 ± 9.6	2.977	0.003
	Not difficult	226	77.1	71.6 ± 9.4		
6) Determining the timing of dialogue support intervention	Difficult	161	54.9	70.3 ± 9.7	0.704	0.482
	Not difficult	132	45.1	71.1 ± 9.4		
7) Evaluating the reactions of patients and families after dialogue support	Difficult	70	23.9	69.5 ± 9.1	1.209	0.228
	Not difficult	223	76.1	71.1 ± 9.7		
8) Evaluating one's own involvement after dialogue support	Difficult	102	34.8	69.9 ± 9.3	1.007	0.315
	Not difficult	191	65.2	71.1 ± 9.7		

[a] Unpaired *t*-test; [b] Pearson's product-moment correlation coefficient.

4. Discussion

4.1. Current Practices Implemented by Nurses to Support Dialogue between Terminally Ill Cancer Patients and Their Families under Visitation Restrictions

In the present survey conducted between February and March 2025, approximately 90% of respondents indicated that "visitation restrictions" were in place, suggesting that visitation management continues to this day. Regarding restrictions on visiting hours, the most frequent response was "in the case of patients who are nearing death, permission to relax visiting hours can be obtained from the doctor" (47.8%), followed by "about 15 minutes" (27.0%). Regarding the number of allowed visitors, the most frequent response was "2 persons" (50.9%). These restrictions are thought to still be in use, based on the initial guidelines outlined in the Ministry of Health, Labour and Welfare's compilation of visitation case examples [2], which included measures such as "limiting visiting hours to less than 15 minutes" and "limiting the number of visitors to two per group." The present study showed that, though each facility has its own framework, a certain degree of discretion appears to be given to the frontline, such as allowing physicians to decide whether to relax visitation restrictions as patients are nearing the end-of-life. This decision seems to be made comprehensively based on multiple factors such as the patient's medical condition, the family's wishes, and in-hospital infection control policies. The discretionary application of rules by physicians has the advantage of allowing for flexible responses tailored to each patient's circumstances. However, it is also true that consistency and transparency are required in visitation rules. To achieve this, it is important to establish general standards while ensuring that exceptions related to end-of-life visitation are shared among staff members. Maintaining consistency in standards while preserving flexibility is considered key to healthcare providers building trust with patients and their families. This is expected to help alleviate patients' and families' anxieties and concerns, and reduce the sense of unresolved issues among bereaved family members. Given these circumstances, there is a need to reestablish dialogue support strategies to maintain and strengthen the relationship between terminally ill cancer patients and their families. What is referred to here as dialogue support does not simply mean extending visiting hours. It includes nurse interventions before and after visitations that facilitate connections between patients and their families through dialogue. Indirect engagement around the time of visitations is important, for instance, initiating verbal contact before visits, monitoring the expressions of patients and their families, remaining nearby to watch over and help connect the feelings of both parties, assessing reactions after visits, and sharing the meaning of these reactions with the team. These involvements are believed to contribute to providing peace of mind to both patients and their families, as well as to maintain their relationship. A characteristic of dialogue among Japanese people is that patients and their families cope with the terminal stage by denying the imminence of death [20]. Moreover, there is an underlying culture of consideration, assuming that people understand each other without needing to be expressed in words [21]. Given these cultural background characteristics, which value a silent stance toward death and emphasize reading between the lines, what is needed is not the active promotion of dialogue in the short time available, but rather consideration, remaining nearby to watch over, allowing them to communicate with one another in their own words. The process-oriented involvement of nurses before and after the visits transcends the limited time frame of visitations and offers valuable insights that contribute to improving the quality of dialogue support.

The present study showed that nurses were supporting dialogue between terminally ill cancer patients and their families, regardless of whether there were visitation restrictions. Of all the respondents, 86.3% had been engaged in nursing duties since before the COVID-19 outbreak in 2020. The fact that many of the nurses had more than five years of practical nursing experience at the time of the survey (2025) suggests that they possibly had, on a daily basis, in-person experience providing dialogue support to terminally ill patients prior to the infection outbreak. During the COVID-19 pandemic, these nurses were unable to provide adequate end-of-life family care, perhaps resulting in feelings of regret and suffering. These experiences may have served as a turning point, stimulating their "own frames of reference" for supporting dialogue between terminally ill patients and their families. According to the transformative learning theory proposed by Mezirow, this type of stimulation promotes "critical reflection" on past experiences and values, leading to transformation in behaviors and attitudes, in other words, a "perspective transformation" [22]. The infection outbreak created a vacuum in direct family care. After this period, nurses may re-recognize the importance of end-of-life family care, shifting towards a sincere attitude in facing the values and suffering of patients and their families. It could be interpreted that these transformations, prompted precisely by the existence of visitation restrictions, were elevated into the value of wanting to support the relationship between patients and families through dialogue, and they were subsequently reconstructed as a practice integrated into the actions of nurses.

A noteworthy point is that respondents who answered that they had visitation restrictions tended to have a significantly lower frequency of practicing Focusing on patients and families for a deeper understanding of the revised dialogue support self-assessment scale. Focusing on patients and families for a deeper understanding is a factor that evaluates the extent to which nurses are interested in the families. It includes items such as, "I pay attention to the family as well as the patient from the time of admission" and "I try to face the patient and their family without any prejudice" [17]. The quantitative results of the present study provide support for a previous qualitative study [23], which found that, under visitation restrictions, nurses have fewer opportunities to interact with families, making it challenging to provide care that considers the relationship between families and the patients. These findings further emphasize that the decreased opportunities for direct interaction with families hinder practices that are conscious of the family's presence and make it more difficult for nurses to take on a bridging role that connects patients with their families. Nurses are there to help patients confront their remaining time, and they also serve to protect family dignity as the narrator. An attitude of seeking a deeper understanding of patients and their families, even in the face of these difficulties, forms the core of dialogue support provided by nurses. The findings of the present study confirm that "striving to maintain interest in and respect for the family as the expert of the illness," as described in the Illness Beliefs Model [19], has a greater impact on the quality of practice under visitation restrictions. The present study provides a theoretical and practical foundation for reexamining the role nurses should fulfill under visitation restrictions and the value of dialogue support in this context.

4.2. Differences in Dialogue Support Practices Depending on Nurse Characteristics

Recent advances in infectious disease control and telemedicine have brought attention to the use of video calls and meeting apps such as Zoom for visitations on the frontlines of medical care. The present study also showed that 36.5% of all nurses had experience in providing dialogue support online, indicating that a certain number of nurses are adopting these technologies. Nurses who are incorporating innovative approaches, such as using online meeting tools, tended to engage in dialogue support between terminally ill cancer patients and their families more frequently as part of their daily routine practice. It was suggested that the introduction of online technology may be affecting the frequency of everyday dialogue support practice. Since this survey only asked whether the subjects had experience providing dialogue support online, future surveys will need to clarify the specific extent of their involvement. According to a previous study on online visitation for terminally ill patients, it was reported that greater emotional consideration is required than for regular patients [24]. Furthermore, in the case of patients who withhold their true thoughts, it can be difficult to understand their intentions. A study reported that the patient's genuine feelings were not conveyed over the phone [25]. Patients in a weakened overall physical condition may not be able to operate their phones or social media on their own, further highlighting the need for visitations and individualized handling [26]. Thus, while in person, one can gauge the timing of communication with one another and say what they want to say, whereas once facing a screen, there may be things that cannot be expressed or may cause unexpected misunderstandings. Terminally ill cancer patients tend to be in poor overall physical condition; therefore, emotional consideration should be given to families who may feel anxious and saddened upon seeing such an appearance on screen. Dialogue support that considers such difficulties and incorporates thoughtfulness is expected to serve as a trigger for increasing awareness of nurses towards improving the quality of dialogue support, while also contributing to daily nursing practices. Providing dialogue support online is not only about acquiring technical skills; it can also be said to be a practice that promotes transformation in the attitudes of the nurses themselves. Even under physical restrictions, the desire and actions to connect patients with their families serve as a driving force, leading to an understanding of the essence of dialogue support and adding depth to the support. Moreover, sharing the findings of those with experience in providing support online can initiate a cycle of learning in nurses, leading to raising the organization's support capabilities.

Furthermore, those who found "addressing topics related to death" and "assessing the necessity of dialogue support" challenging tended to practice dialogue support less frequently than those who did not find them challenging. This difficulty may be rooted in inadequate training in end-of-life family care, likely due to the nurses' own emotional instability when facing death, as well as insufficient understanding of the relationship between patients and their families. However, some nurses have transcended these and are developing practical skills that can be used in providing support. An attitude of pausing before engaging in practice to contemplate questions such as how nurses themselves should perceive death and how to approach the distance between patients and their families is believed to influence the quality of dialogue support. The ability to empathize with their narratives and simply be present with them in their silence, remaining by their side, is a nursing practice nurtured through daily reflection. It was suggested that, in addition to specific methods and know-how for dialogue support, it is also desirable to incorporate training content that fosters the qualities needed to confront death.

In addition, those who had experience receiving training for end-of-life family nursing care tended to practice dialogue support more frequently. Knowledge and insights gained through past training experiences can deepen the understanding of the importance of dialogue support and may lead to implementation in practice. Educational Needs for Nurses to Support Dialogue between Terminally Ill Patients with Cancer and Their Families include enhancing the ability to be empathetically present and to see patients and their families through without turning away, while deepening the understanding of the patients and families and naturally introducing dialogue [27]. This study proposes training that includes educational content for modules on navigating conversations about death or best practices for facilitating emotionally sensitive online interactions, based on nurses' concerns and the practical implications for education. Future efforts are needed to develop educational programs that incorporate such context.

5. Limitations of the Study

There are limitations in generalizing the results of this study because the survey did not target all hospitals. However, this study holds certain significance in terms of clarifying the current state, since research on nursing practices under visitation restrictions while coexisting with infectious diseases is a new challenge in the current frontlines of medical care. In the future, the task in demand will be to evaluate the quality of dialogue support from both the care provider's perspective and the recipient's perspective, under more relaxed visitation restriction standards.

Furthermore, previous studies of mental and psychological palliative care interventions delivered via telemedicine have raised issues such as the indispensability of a high-quality internet connection for the success of telemedicine interventions, and the limited availability of human resources, namely nurses, who can mediate the support [24] [28]. In addition, in this study, it cannot be denied that some of the nurses who responded were working under an organizational background involving constraints in hospital infrastructure and human resources. In light of the fact that dialogue support combining in-person and online visitations is expected to continue in the future, there is a need to analyze the innovative approaches adopted by those with experience in providing online support, as well as their post-implementation evaluation. By addressing these issues, it is hoped that insights can be gained that will contribute to enhancing the quality of nursing care that supports the relationship between terminally ill patients and their families, even under visitation restrictions.

6. Conclusion

Among the 293 nurses in the present study, 90.4% indicated that there were visiting restrictions in their hospital ward. These nurses practiced dialogue support regardless of the status of visitation restrictions. Some nurses used online meeting tools, and those who did so practiced dialogue support more frequently on a daily basis. Terminally ill cancer patients tend to be in poor overall physical condition; therefore, emotional consideration should be given to families who may feel anxious and saddened upon seeing their appearance on screen. Dialogue support by online meeting tools that consider such difficulties and incorporate thoughtfulness is expected to serve as a trigger for increasing awareness among nurses towards improving the quality of dialogue support, while also contributing to daily nursing practices.

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Conflicts of Interest

The authors declare that there are no conflicts of interest related to the publication of this article.

References

[1] The Cabinet Agency for Infectious Disease Crisis Management (2020) Basic Measures to Prevent the Spread of COVID-19. https://www.kantei.go.jp/jp/singi/novel_coronavirus/th_siryou/kihon_h(4.7).pdf

[2] Ministry of Health, Labour and Welfare of Japan (2021) Examples of Hospital Visits with Considerations for Infection Control Measures. https://www.mhlw.go.jp/content/000858255.pdf

[3] Ministry of Health, Labour and Welfare of Japan (2023) Advisory Board for Countermeasures against COVID-19. https://www.mhlw.go.jp/content/10900000/001069237.pdf

[4] Magoon, V. (2020) Operationalizing Virtual Visits During a Public Health Emergency. *Family Practice Management*, **27**, 5-12.

[5] Lipsitz, L.A., Lujan, A.M., Dufour, A., Abrahams, G., Magliozzi, H., Herndon, L., *et al.* (2020) Stemming the Tide of COVID-19 Infections in Massachusetts Nursing Homes. *Journal of the American Geriatrics Society*, **68**, 2447-2453.

https://doi.org/10.1111/jgs.16832

[6] Onwuteaka-Philipsen, B.D., Pasman, H.R.W., Korfage, I.J., Witkamp, E., Zee, M., van Lent, L.G., *et al.* (2021) Dying in Times of the Coronavirus: An Online Survey among Healthcare Professionals about End-of-Life Care for Patients Dying with and without COVID-19 (The CO-LIVE Study). *Palliative Medicine*, **35**, 830-842. https://doi.org/10.1177/02692163211003778

[7] Feder, S., Smith, D., Griffin, H., Shreve, S.T., Kinder, D., Kutney-Lee, A., *et al.* (2021) "Why Couldn't I Go in to See Him?" Bereaved Families' Perceptions of End-of-Life Communication during COVID-19. *Journal of the American Geriatrics Society*, **69**, 587-592. https://doi.org/10.1111/jgs.16993

[8] Otani, H., Yoshida, S., Morita, T., Aoyama, M., Kizawa, Y., Shima, Y., *et al.* (2017) Meaningful Communication before Death, but Not Present at the Time of Death Itself, Is Associated with Better Outcomes on Measures of Depression and Complicated Grief among Bereaved Family Members of Cancer Patients. *Journal of Pain and Symptom Management*, **54**, 273-279. https://doi.org/10.1016/j.jpainsymman.2017.07.010

[9] Nielsen, M.K., Neergaard, M.A., Jensen, A.B., Vedsted, P., Bro, F. and Guldin, M. (2017) Predictors of Complicated Grief and Depression in Bereaved Caregivers: A Nationwide Prospective Cohort Study. *Journal of Pain and Symptom Management*, **53**, 540-550. https://doi.org/10.1016/j.jpainsymman.2016.09.013

[10] Gesi, C., Carmassi, C., Cerveri, G., Carpita, B., Cremone, I.M. and Dell'Osso, L. (2020) Complicated Grief: What to Expect after the Coronavirus Pandemic. *Frontiers in Psychiatry*, **11**, Article ID: 489. https://doi.org/10.3389/fpsyt.2020.00489

[11] Ann-Yi, S., Azhar, A. and Bruera, E. (2021) Dying Alone during a Pandemic. *Journal of Palliative Medicine*, **24**, 1905-1908. https://doi.org/10.1089/jpm.2020.0718

[12] Center for Cancer Control and Information Services (2025) Cancer Information Service. https://ganjoho.jp/reg_stat/statistics/stat/annual.html

[13] Kobayashi, A., Tsujikawa, M., Sugino, A. and Sakaguchi, M. (2016) Effects on Quality of Life (QOL) Following Admission into a Palliative Care Unit and Interactive Dialogue between Patients and Their Families. *The Japanese Journal of Clinical Research on Death and Dying*, **39**, 180-184.

[14] Keeley, M.P. (2007) 'Turning toward Death Together': The Functions of Messages during Final Conversations in Close Relationships. *Journal of Social and Personal Relationships*, **24**, 225-253. https://doi.org/10.1177/0265407507075412

[15] Iitsuka, M., Tsuchiya, Y. and Nomura, M. (2023) Survey of Family Visit Restrictions due to COVID-19 and the Thought of Family Members and Nurses: A Literature Review. *The Faculty Journal of Komazawa Women's University*, **2**, 25-34.

[16] Asano, S. and Furuse, M. (2024) Problems and Ingenuity of Nurses in Supporting Dialogue between Patients with Terminal Cancer and Their Families in the Post-COVID-19 Phase. *Open Journal of Nursing*, **14**, 657-672. https://doi.org/10.4236/ojn.2024.1412048

[17] Asano, S. and Furuse, M. (2023) Development of a Self-Assessment Scale for Nurses to Enhance Dialogue Support between Terminally Ill Cancer Patients and Their Families. *Journal of Japan Academy of Nursing Science*, **43**, 154-163. https://doi.org/10.5630/jans.43.154

[18] Asano, S. and Furuse, M. (2024) Practice and Factors Influencing Nurses' Support for Dialogue between Terminally Ill Cancer Patients and Their Families. *Journal of Japan Academy of Nursing Science*, **44**, 624-636. https://doi.org/10.5630/jans.44.624

[19] Wright, L.M. and Bell, J.M. (2009) The Illness Beliefs Model, Beliefs and Illness: A Model for Healing. 4th Floor Press.

[20] Watanabe, M. and Masujima, M. (2020) Development of a Nursing Program for Family Members of Patients with Advanced Cancer to Promote End-of-Life Discussions. *Journal of Chiba Academy of Nursing Science*, **26**, 39-48.

[21] Nakano, A. and Uryu, H. (2022) Family Nursing-Family Nursing to Enhance Empowerment. 1st Edition, Medicus Shuppan Publishers Co., Ltd.

[22] Mezirow, J. (1991) Transformative Dimensions of Adult Learning. Jossey-Bass.

[23] Matsumoto, A., Soejima, T. and Kamibeppu, K. (2022) Difficulties Associated with COVID-19 Pandemic and Visitation Restrictions for Nurses in Care for Families and How to Deal with Them. *Japanese Journal of Research in Family Nursing*, **28**, 15-29.

[24] Haniuda, Y., Tsubaki, M., Ikari, R., Mori, T. and Yokomizo, Y. (2021) Remote Visitation as an Example of End-of-Life Nursing for Patients with COVID-19: A Case Report. *Japanese Journal of Grief and Bereavement Research*, **2**, 87-93.

[25] Uesaka, M., Hashimoto, A. and Kurosawa, M. (2023) Families' Experiences of Non-Face-to-Face Visitations with Patients Receiving End-of-Life Care During the COVID-19 Pandemic. *Japanese Journal of Nursing and Health Sciences*, **21**, 82-90.

[26] Shiraishi, T., Ataka, K., Kimura, M., Nabeshima, N., Ito, T., Ide, A., *et al.* (2022) The Psychological Impact of Restricting Visits to Inpatients on the Inpatients Themselves, Their Families, and Health Care Providers under the COVID-19 Pandemic. *Palliative Care Research*, **17**, 65-70. https://doi.org/10.2512/jspm.17.65

[27] Asano, S. and Furuse, M. (2025) Educational Needs for Nurses to Support Dialogue between Terminally Ill Patients with Cancer and Their Families. *Open Journal of Nursing*, **15**, 439-449. https://doi.org/10.4236/ojn.2025.157032

[28] Palma, A., Rojas, V., Ihl, F., Ávila, C., Plaza-Parrochia, F., Estuardo, N., *et al.* (2021) Implementation of a Palliative Hospital-Centered Spiritual and Psychological Telehealth System during COVID-19 Pandemic. *Journal of Pain and Symptom Management*, **62**, 1015-1019. https://doi.org/10.1016/j.jpainsymman.2021.04.016