

3. 呼吸困難に対して呼吸訓練、活動の調整やリラクゼーションなどの理学的介入のほか、心理的介入をすべきかもしれない。
4. 咳嗽に対してオピオイドを投与すべきである。
5. 呼吸困難をもたらす胸水貯留はドレナージすべきかもしれない。
6. 予後が良くない患者の呼吸困難をもたらす胸水貯溜に対しては胸腔穿刺を繰り返すべきかもしれない。
7. 非小細胞肺癌患者の繰り返す悪性胸水貯留に対しては、胸腔穿刺を行ない胸郭形成術をすべきである。
8. 小細胞肺癌の悪性胸水には全身化学療法をすべきである。
9. 中心性の起動閉塞には気管支鏡で処置をすべきである。

咯血

Recommendations

1. 大量の咯血時まず気道確保を行い、必要ならば気管内挿管をすべきかもしれない。
2. 大量咯血時では気管支鏡を行い、出血部位を同定し止血をすべきかもしれない。
3. 大量の咯血時に気管支動脈塞栓術を検討されることもある。
4. 大量の咯血後や持続する咯血に対して、根治不可能な場合には放射線療法をすべきである。

気管支食道瘻

Recommendations

1. スtentを留置すべきかもしれない。
2. 外科的処置はすべきではない。

上大静脈症候群

Recommendations

1. 放射線療法かstent留置術もしくは両者の併用療法をすべきである。

3. 終末期医療

ACCP(the American College of Chest Physicians)が End-of-life care in patients with lung cancer^{161,162} と題して、NGC(the National Guideline Clearinghouse)でガイドラインを示している。

このガイドラインは、肺癌患者のQOLの向上を目的とし、そのために必要なこととして主治医と患者・家族とのコミュニケーションのあり方、病院の倫理委員会の果たすべき役割、ホスピス・ケアの提供について示している。また、米国内に肺が

ん患者の終末期医療についてのガイドラインはこれ以前には無かったため、このガイドラインは英国のガイドライン¹⁶³⁻¹⁶⁵を参考のうえ、利用可能な英語文献に基づいて作成された。

主治医と患者・家族とのコミュニケーションのあり方

Recommendations

1. 患者に行われる実際の治療と患者の希望を一致させるために (a) 現実的、実用的、敏感かつ思いやりを持つこと (b) 傾聴すること (c) 患者の気持ちを表現させること (d) キーパーソンと接すること (e) 目標を常に再評価し続けることをすべきである。
 2. 治療計画を立てる際に終末期について考慮すべきである。
 3. 診断について伝え、毎日接していく中でケアを調整していくべきである。
 4. 治療者は末期におけるコミュニケーションについての教育を受けなければならない。
 5. ホスピス・ケアや緩和ケアはチームで治療早期に開始すべきである。
 6. advance directiveの有無について尋ねカルテに明示すべきである。advance directiveを持っていない場合には準備することを提案すべきである。
 7. advance directiveをもつ患者に対して、そのadvance directiveの信頼性が疑われるときには病院弁護士、もしくは倫理委員会に相談すべきである。
- 患者は、治療者から知らされている情報よりも、更に多くの情報を知りたがっているが、治療者と終末期の医療について話しあうためには治療者の心構えが必要である。治療者と患者のコミュニケーションが疾患に及ぼす影響については未だ明らかにはなっていないが¹⁶⁶、両者の間のコミュニケーションが不十分であることは示されており¹⁶⁷⁻¹⁷¹、とくに心理社会的問題についてはほとんど時間が割かれていない^{172, 173}。4301人の患者を対象とした研究で、患者の要望と実際に行われている治療の間に差が認められていることが示されており、治療者と患者の間に明らかなコミュニケーションの問題があった。また、治療の決定時に患者と家族を交えて行うことが死にゆく過程を受け入れていくことにつながるが、トレーニングされた看護師が、患者と家族から患者の要望について情報を収集し、それを治療者に客観的妥当性ととも伝えたが、15%のケースでしかこの情報について治療者は患者・家族と話し合わなかった¹⁷⁴。
 - 治療者の示す予後について、患者は間違った解釈をしたり拒絶することも知られている^{175, 176}。これらを踏まえて、治療者と患者・家族とのコミュニケーションが重要であることが強調される。
 - ケアの目標には患者の他者との関係の修繕や別れを援助することも含まれてお

り、死に際して生をまっとうした思いにつながる¹⁷⁷。

- 患者と死について話し合うことは困難であるが、コミュニケーションスキルの訓練を受けることで困難な情報を提供することが可能になることが示されている¹⁷⁸⁻¹⁸¹。
- 治療を初期からの患者を中心においた医療が、後に行われる緩和ケアへの移行を容易にする¹⁸²。
- advance directiveを示した患者のうち、その意思がカルテに明示されたものは11.3%のみであった¹⁸³。また、advance directiveを示した患者のケアが、advance directiveを持たない患者と大きな差がみられなかったという報告もある^{184, 185}。

病院の倫理委員会の果たすべき役割

Recommendations

1. 法律、患者の自己決定権と判断能力、インフォームドコンセント、延命治療の差し控え、代理人の希望、家族不在での患者の意思決定について、倫理基準から解釈し治療者と患者・家族との争議を仲裁すべきである。
 2. 倫理的観点から、予想される問題についてあらかじめ基準や対応を定めておくべきである。
- 米国では、無作為に選んだ346の病院のうち、93%が倫理委員会を設置していた¹⁸⁶。委員会で倫理的問題を解決するには3つの方法があり、(a) 法令や判例、ガイドラインなどの情報を提供する。(b) 不確かな問題点や、価値観や規範の対立について明らかにし分析する。(c) 倫理的問題を解決することで、治療者と患者・家族とのコミュニケーションを良くし話し合いやすくすることである^{187, 188}。
 - 275の倫理委員会に対して行った調査では、年間に平均で公式には8.1件、非公式には4.3件のケースの相談を受けていた。これらのケースのうち患者の自己決定権と判断能力に関することが38%、コミュニケーションの改善が35%、終末期医療に関することが7%、新技術や研究に関することが7%、コスト抑制に関することが3%であった¹⁸⁹。
 - 倫理委員会に相談したことで、「倫理的問題が明らかになった」「医療チームの教育になった」「臨床判断の確証を増した」「患者のマネージメントに役立った」などと有益であったと考えている治療者は90%以上にも及んだ¹⁹⁰。
 - 治療者と患者・家族間の争議について、倫理委員会が与える影響について詳細に検討したものは無いが、16件の事例について倫理委員会の出した結論に異議を唱えたものは、40人の病院関係者のうち2人、6人の患者家族のうち2人だけであ

った¹⁹¹。

ホスピスの利用

Recommendations

1. 緩和ケアは、患者と家族にとって最善のQOLを目指すべきである。
 2. ホスピス・ケアは、終末期医療を患者の長期的な経過の一部と考えなければならない。
 3. 緩和ケアに多様性を持たさなければならない。
- がん医療とは、診断に始まり、がんと症状に対する治療、再発の管理、そして末期の支持療法と長い経過を有するものではあるが、肺がん患者の5年生存率は15%であり¹⁹²、肺がんによる死亡がほとんどであることから、肺がん患者においては治療の中に終末期医療を含まざるを得ない。
 - 治療者は治癒を第一に目指した医療から、支持療法中心の医療への移行のタイミングを見逃してはいけない。ホスピス・ケア利点は在宅で行えることであり¹⁹³、疼痛除去¹⁹⁴や患者の満足¹⁹⁵、そしてコスト削減¹⁹⁶にもつながる。

まとめ

がん患者において、疾患の進行に伴い患者の病状は常に変化し続ける。治癒的治療が可能な疾患であれば、診断当初には治癒を目標としていた場合でも、疾患が進行するにつれ治療の目標も大きく変化していき、ケアの重要度が増してくることがある。それに伴って提供するケアの質も変化していき、病期によっては治療の多くを緩和ケアに集中すべきである。がん患者に対する医療においては、治癒 (cure) とケア (care) が完全に区別されることはなく、多くの場合この両者のバランスをとりながら治療を行っていくことが重要である。

緩和ケア領域の医療の進歩により、がんに伴う多くの身体症状のコントロールが可能になってきた。しかし、終末期に自殺幫助や安楽死を考える患者のその多くの理由は、疼痛などの身体症状ではなく、個人の価値観によるものであった¹⁹⁷⁻²⁰¹。それは、抑うつや精神的苦痛、霊的 (実存的) 苦痛によるものであり、とくに、うつ病は終末期において多く認められる²⁰²。その有病率は自殺幫助を願う患者の4.5%-53%であり、しばしば見過ごされている²⁰³。

このように、終末期において患者は全人的にケアされていくべきであるが、多くの非小細胞肺がん患者は診断されてから一年以内に死亡し、手術により根治可能な患者は約20%程度である。したがって、できるだけ早期から医師は患者・家族とコミュニケーションをとり、患者の希望に沿った終末期医療を目指すべきである。そ

して、拡大しつつあるホスピス・ケアはがんに伴う症状緩和に効果をもたらすほか、患者の在宅でのケアを促していくことができる。米国では患者の最善の QOL を目指した医療を提供すべく法律や制度、ガイドラインが整いつつあるが、いまだ日本においては、この領域については未発達であり、今後の早期の普及が望まれる。

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分担研究報告書

英国における終末期医療および尊厳死の実態

分担研究者 松島英介 東京医科歯科大学大学院心療・緩和医療学分野
研究協力者 野口 海 東京医科歯科大学大学院心療・緩和医療学分野

研究要旨：わが国において尊厳死を求める患者に対し、いかなる緩和ケアシステムを構築する事が可能か、真摯な議論を行う上で必要と思われる情報収集の一環として、英国における終末期医療の現状につき調査分析した。英国の人口動態、死因、医療保険システムの状況を把握し、悪性腫瘍の位置づけ、終末期患者の現状、緩和医療教育及び安楽死の法的側面について明らかにするとともに、今後の方向性について考察した。

A. 研究目的

わが国において尊厳死を求める患者に対し、いかなる緩和ケアシステムが必要かという問題について解決するためには、まず初めに諸外国における現状調査を行い、わが国の体制と比較検討して、問題点を浮かび上がらせる必要がある。

英国は世界的にみても、終末期医療の先進国といえる立場にあり、日本にとって参考になる部分が多いように考えられる。英国の現状を分析し、緩和医療システム上のメリット、デメリットを把握することは、日本国内における終末期医療のあり方を検討する上で参考になるものと考ええる。

同時に尊厳死・安楽死問題についての法的側面の動向を調査し、社会文化的背景の相違を考慮に入れながら、参考となる議論・思想をピックアップすることで、日本の今後の緩和医療の展望を模索する。

B. 研究方法

英国の終末期医療、緩和医療に関する情報をインターネット、書籍、パンフレットなどを通じて収集した。ホスピス学会や緩和医療学会など関連諸団体の学会誌をレビューした。さらに、各種団体や患者会が抱えている問題点を調べ、サポート活動の可能性とその限界や問題点について、情報を収集した。

（倫理面への配慮）

本研究においては、特に個人データを取り扱うものではなく、既に研究論文として発表されているか、一般的に明らかにされた調査内容を集めて分析するものであり、直接、間接的に倫理面に触れるものではない。また、聞き取り調査においても、個人が特定されないように充分配慮した。

C. 研究結果

英国人口約 5800 万人のうち、悪性腫瘍の死因は第 2 位で、年間死亡数は約 13 万 5 千人で