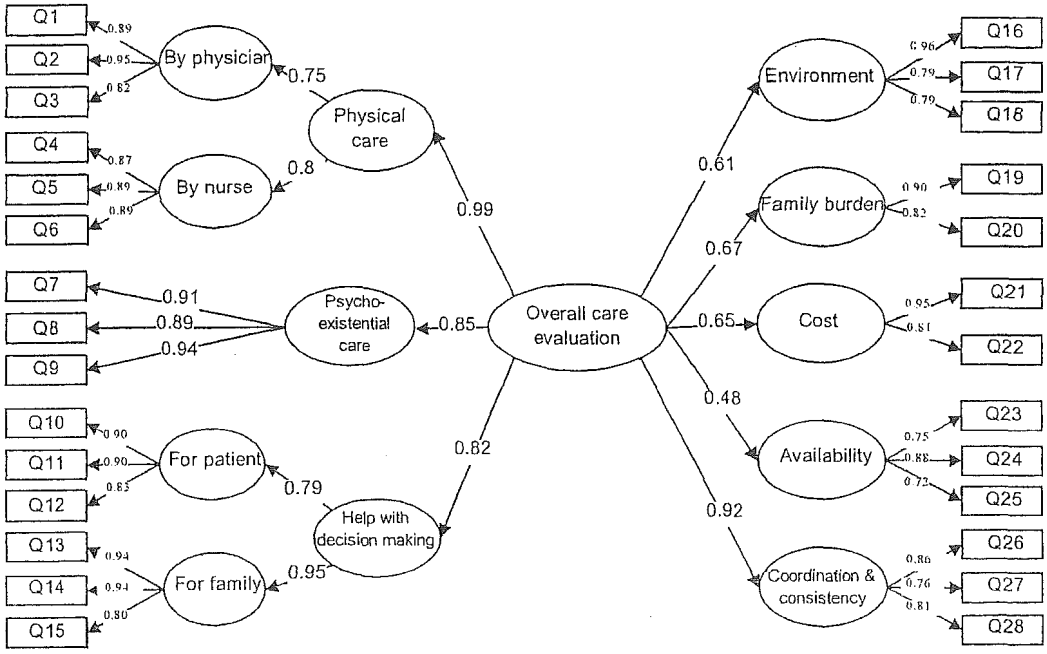

Fig. 1. The factor structure of the Care Evaluation Scale.

Table 3 shows the correlations of CES subscales with perceived experiences and satisfaction levels of the corresponding areas. The subscale scores of the CES were moderately correlated with the perceived-experiences and satisfaction levels.

Demographic Data

The mean ± SD scores of the CES subscales were: 80 ± 17 (physical care by physicians), 82 ± 17 (physical care by nurses), 82 ± 16 (psycho-existential care), 81 ± 16 (help with decision-making for patients), 83 ± 17 (help with decision-making for family), 80 ± 18 (environment), 77 ± 16 (family burden), 80 ± 17 (cost), 77 ± 19 (availability), and 81 ± 16 (coordination and consistency). The mean of total score of the CES was 80 ± 12.

Table 3
Convergent and Discriminant Validity of the Care Evaluation Scale

	Perceived Experience[a]	Satisfaction[a]
Physical care by physician	0.41	0.56
Physical care by nurse	0.44	0.60
Psycho-existential care	0.42	0.53
Help with decision-making	0.52	0.54
Environment	0.36	0.49
Family burden	0.42	0.39
Cost	0.43	0.51

[a] $P < 0.001$ in all items.

Effects of Expectations, Depression, and Social Desirability

Table 4 demonstrates that the degree of expectation was not significantly associated with the CES subscale scores. Expectations had relatively weak but significant associations with perceived experiences and satisfaction levels.

Table 4
Effects of Expectation on the Care Evaluation Scale, Perceived Experience, and Satisfaction

	Care Evaluation Scale	Perceived Experience	Satisfaction
Physical care by physician	−0.03	0.20[a]	0.12[b]
Physical care by nurse	0.07	0.09	0.14[b]
Psycho-existential care	−0.01	0.25[c]	0.16[a]
Help with decision-making	0.10	0.22[c]	0.25[c]
Environment	−0.02	0.20[a]	0.21[c]
Family burden	0.00	−0.07	0.12[b]
Cost	0.04	0.04	0.14[b]

[a] $P < 0.01$.
[b] $P < 0.05$.
[c] $P < 0.001$.

Figure 2 shows the path diagram of the longitudinal effect of depression on the CES and satisfaction. Controlling the effects of the baseline CES and depression levels, the change of depression had no significant effect on the CES score in the follow-up phase, whereas it had a significant effect on the satisfaction score. In addition, the scores on the Social Desirability Scale were not significantly correlated with the CES subscales ($r = 0.03$ to 0.13, $P > 0.07$).

Discussion

The most important finding of this study was the development of an instrument to measure the bereaved family's perceptions about the necessity for improvement in structure/process aspects of end-of-life care. The psychometric properties of the scale are acceptable. The reliability was shown by excellent internal consistency (overall Cronbach's alpha coefficient = 0.98) and fair test–retest reliability (intra-class correlation coefficient = 0.57). Construct validity was established by confirmatory factor analysis.

The scale has 10 subscales, namely physical care (by physicians and by nurses), psycho-existential care, help with decision-making (for patients and for family), environment, family burden, cost, availability, and coordination and consistency. The themes of the subscales are consistent with prior hypothesized concepts and previously identified essential dimensions of care: symptom palliation, nursing care, information sharing, facility, family care, cost, and availability;[6] competence, attention to psychological problems, information, facilities, cost, access, and continuity of care;[22] and professional performance, attitudes of caregivers, and amenity of organization.[25]

The finding that the CES was only moderately associated with perceived experience and satisfaction levels indicates its discriminate and convergent validity. Using a conceptual model, outcomes such as quality of death/dying and satisfaction can be influenced by various patient- and family-related factors.[10,11] The finding in our study supports this hypothesis and strengthens the advantage of this scale as an indicator for quality improvement.

Of special note is that the CES was not significantly influenced by the degree of expectations, depression, or social desirability, while perceived experience and satisfaction were significantly correlated with expectations and depression. Several empirical studies have revealed a disadvantage of satisfaction as an indicator of care quality, because it is significantly influenced by patient/family expectations, depression, and social desirability.[12–16] The findings of this study strengthen the value of the CES as an indicator to quantify directly evaluation of care.

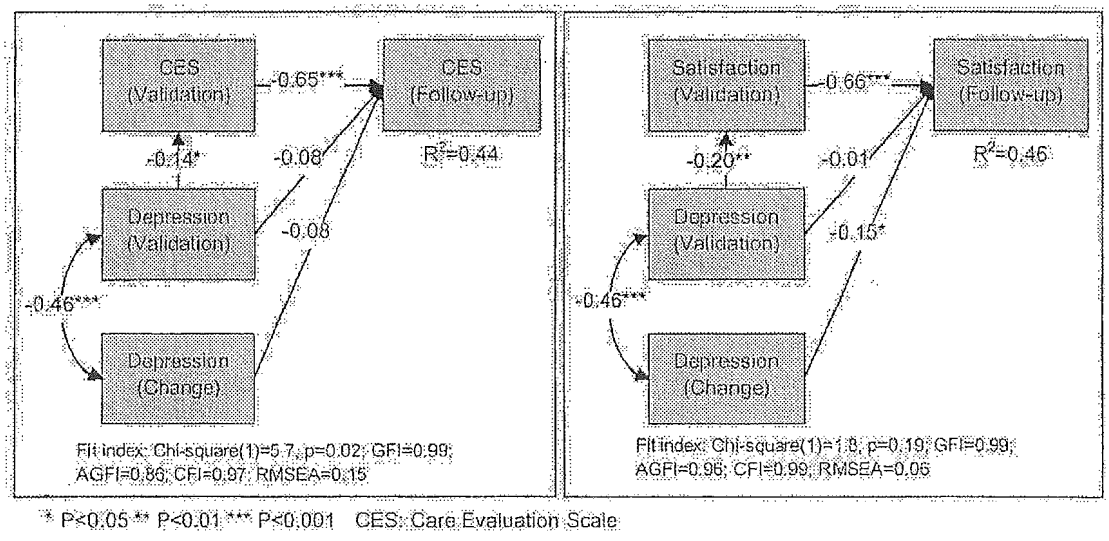

Fig. 2. The longitudinal effect of depression on the Care Evaluation Scale and satisfaction.

The strengths of this study were the success in obtaining a nationwide sample, clear conceptualization in scale development, and direct input of bereaved families' opinions from the prior large survey. However, this study had several limitations. First, participation in the study was obtained from only a limited number of potential participants (38%), possibly due to methodological complexity. The comparison of participant backgrounds was impossible due to lack of data from non-consenting families, and this study population thus might not have been representative of all the potential samples to be investigated. Second, as the degree of perceived experience and satisfaction was measured with ad-hoc scales due to lack of validated instruments, the reliability and validity of these measurements might not be sufficient. Third, although we used a double back-translation process, the differences between Japanese and English require caution in interpreting the findings. Fourth, as the evaluation scores were still generally high, potential ceiling effects might limit the usefulness of the CES. This can be examined in a comparison study using general hospital samples in the future. Fifth, the proxy and retrospective nature of the rating could cause a bias. Finally, the possibility that true change might occur within the retest period might affect the results of longitudinal analyses.

In conclusion, the Care Evaluation Scale is a useful tool to measure the bereaved family's perception about the necessity for improvement in structural/procedural aspects of palliative care. This scale has several unique and preferable characteristics. First, the CES quantifies the evaluations of care structure/process, not outcomes and satisfaction. Second, the evaluation directly represents the family-perceived necessity for improvement. Third, the CES was designed to be available for various settings and subjects: home care, acute care, and patients. Fourth, the CES is not affected by the degree of expectations, depression, and social desirability of the respondents, and has satisfactory psychometric properties.

Acknowledgments

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Appendix

The Items of the Final Care Evaluation Scale Version

Physical care
- By physician
  - Q1 Doctors tried to relieve physical discomfort of the patient.
  - Q2 Doctors dealt promptly with discomforting symptoms of the patient.
  - Q3 Doctors had adequate knowledge and skills.
- By nurse
  - Q4 Nurses responded promptly to the patient's needs (e.g., nurse calls).
  - Q5 Nurses had adequate knowledge and skills.
  - Q6 Nurses helped the patient to enjoy daily life (recreation, music, and hobbies).

Psycho-existential care
- Q7 Consideration was paid to relieving the patient's concerns and worries.
- Q8 The staff took appropriate measures when the patient became depressed.
- Q9 The staff tried so that the patient's hope could be accomplished.

Help with decision-making
- For patient
  - Q10 The doctors gave sufficient explanation to the patient about their present condition and the details of medical treatment.
  - Q11 The doctors gave sufficient explanation to the patient about the expected outcome.
  - Q12 Consideration was given so that the patient could participate in the selection of treatment.
- For family
  - Q13 The doctors gave sufficient explanation to the family about the patient's condition and the details of medical treatment.
  - Q14 The doctors gave sufficient explanation to the family about the expected outcome.
  - Q15 The family's wishes were respected in the selection of treatment.

Environment
- Q16 The patient's room was convenient and comfortable.
- Q17 Sound proofing measures were adequate.
- Q18 Toilet and washstand facilities were adequate.

Family burden
- Q19 Consideration was given to the health of the family.
- Q20 Consideration was given so that the family could have their own time and continue to work.

Cost
- Q21 The contents of the bills were easy to understand.
- Q22 The total cost was reasonable.

Availability
- Q23 Admission (use) was possible when necessary without waiting.
- Q24 The procedures of admission (use) were simple.
- Q25 Admission (use) was in accordance with the wishes of the patient and family.

Coordination and consistency
- Q26 There was good cooperation among staff members such as doctors and nurses.
- Q27 The same doctors and nurses provided care.
- Q28 Treatment was planned with appropriate consideration of the previous course of the disease.

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平成17年度　研究報告書

Observations and Recommendations Internal Medicine Residency Program National Tokyo Medical Center December 5-7, 2005

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Background

In May, 2005 I was invited to visit National Tokyo Medical Center (NTMC) to review the Internal Medicine residency program. The date set for this was early December, 2005. In July, I met Dr. Kiyoshi Kinjo, Co-Director of the Internal Medicine Residency Program at Teine Keijinkai Hospital (TKH) at the annual meeting of the Japan Society of Medical Education, in Tokyo. Dr. Kinjo requested that I visit TKH during a future visit to Japan. From 1-11 December I visited the residency programs at both NTMC and TKH.

At NTMC I was asked to perform a formal evaluation and make suggestions for the improvement of the residency program. I have provided my observations and associated recommendations in five categories:

1. Conferences
2. Residents and Organizational Structure of the Residency Program
3. Internal Medicine Curriculum
4. Faculty Development
5. Threats and Opportunities for the Residency program

In addition to time spent at NTMC with the staff and residents, I also was able to visit with Drs. Takuma Kimura and Shinji Matsumura at dinner one evening, and with several of the junior residents at dinner another night. I have known Dr. Matsumura since I was a visiting professor at the University of Tokyo, and with him I visited the NTMC General Medicine Clinic to observe residency teaching in 2001. Through Dr. Matsumura I had formed a very positive impression of the NTMC Internal Medicine Residency before my December, 2005 visit.

Conferences (New Admission Conference; Ambulatory Clinic and Conference; Evidence-Based Medicine and Emergency Medicine Conferences)

New Admission Conferences. The morning New Admissions Conferences were well attended and well led. I was impressed with the leadership and teaching of Dr. Chong. The residency program had done a good job in preparing the presenters and facilitating participation residents. Some of the classic concepts of adult learning were actively employed (1, 4, 6)

Adults learn better . . .
1. When they want or need to know something 2. When they have some control over the learning content and learning style 3. Through active physical and mental participation in learning activities 4. When there is a realistic, relevant problem 5. When they can immediately apply what they have learned 6. When they can observe more experienced role models

The review of recent, active cases presents the residents with realistic, relevant problems (4). Raising clinical questions about each patient creates "teachable moments" (1). The presence of many respected clinical faculty members provides exemplary role models, and a high level of expertise (6).

It was apparent to me that the residents and the staff had developed a positive learning climate for these conferences. In general throughout the residency, the learning climate was very good, a tribute to the quality of the staff and the senior residents as teachers.

However, I observed that many of those present during the conferences were passive and uninvolved: many of the residents appeared not to be expected to join in clinical reasoning or discussion of the diagnostic or management plans, meaning that the adult learning principles 3 and 5 were not applied to most of the more junior residents not presenting. It was unclear whether the focus of the conference was to bring the staff physicians up to date on newly admitted patients, or to provide education for all the residents present.

In addition, because many patients were presented, the discussions were quick and somewhat superficial. Deeper exploration of the clinical reasoning and decision-making could not be explored, and obvious errors in the answers of both the presenters and other residents were sometimes not corrected (e.g. "because the patient did not have a S3, he could not have been in heart failure").

Recommendations

- Select one or two patients for in-depth discussion each conference

- Encourage all residents to actively participate by asking them to interpret data, contribute to differential diagnosis, and make diagnostic and therapeutic suggestions in one or two cases chosen for more complete discussion
- Support graduated learning: ask junior residents more basic questions, senior residents more advanced questions
- Encourage residents to explicitly use information acquired earlier in the residency program (by citing articles they have read, or the ideas they have learned in lectures and previous case conferences)
- Encourage residents to make reasoning processes explicit
- During the above-mentioned in-depth discussions, identify clear clinical questions and ask a resident to use literature to answer the question in a short (2-3 minute) presentation the next day to reinforce learning

Ambulatory Clinics and Conferences. First year residents seeing patients in the Ambulatory Clinic are precepted by more senior residents. After they evaluate each patient, they discuss the patient with the resident in the conference room. They then ask the patient to return to the examination room and complete their discussion with the patients. During their first few months of clinics the resident may join them during history taking, physical examination, and closing discussion. After the interns have become more proficient, the preceptors may neither observe the first year resident nor do an independent assessment of the patient.

The teaching methods now in use raise several concerns:

1. Many beginning Japanese residents have little medical school experience with history-taking, physical examination and patient counseling compared with beginning Western residents. In spite of this, in Western Internal Medicine residency programs, staff physicians will review the care of *every* outpatient for at least two years of the residency. (Concern: failure to use evaluation of history taking and physical examination as the basis for feedback and teaching)
2. Residents seem reluctant to acknowledge to patients that they are still learning medicine for fear that it will create anxiety or in other ways interfere with their relationship with the patient. (Concern: medical paternalism
3. If a more senior resident or faculty member does not review the history and physical examination, it is impossible to recognize and correct errors. (Concern: patient safety and the implicit message that it is acceptable for an inexperienced physician to provide care based on un-checked data)
4. The failure to review the history and physical examination of each patient suggests that neither are important (Concern: negative hidden curriculum)
5. Diagnostic and therapeutic decisions agreed to between the precepting resident and the junior resident may be based on incorrect information and therefore may be unnecessary or even harmful

Recommendations

- Full disclosure to patients so that they will know that a more junior physician will be seeing them and that a more senior, experienced physician will be

supervising their care. In the Western system we teach our residents that patients have the right to know who is caring for them. We have very few patients who decline the care of students or residents, and most patients appreciate the extra attention and care they receive in teaching settings.

- After presenting a patient's history and physical examination to the preceptor, the preceptor should return with the junior resident for a brief, focused review of essential parts of the history and examination. In this way differences in findings can be resolved, incomplete knowledge and skills corrected, and accurate information assured
- Review of patients should continue until an expected level of proficiency is achieved, as objectively measured in an OSCE or with standardized patients
- Even after proficiency in history taking and physical examination are achieved, the preceptor should examine at least one or two of the more complex patients in each clinic session, probably for all PGY 1, PGY 2, and PGY 3 residents.

After observing in one clinic and discussing the teaching methods with both staff members and senior residents, I prepared a short formal discussion of teaching methods and curriculum for a General Internal Medicine clinic. I have attached that presentation (Appendix 1).

Evidence-Based Medicine and Emergency Medicine Conferences

Residents led both of these conferences. They were well attended and there was active participation, although once again many of the junior residents (PGY 1, PGY 2) were passive. The learning goals and learning climate of both conferences was excellent.

Recommendations

- In Western Internal Medicine residency programs, senior- or chief residents frequently lead conferences of this type. I was unable to tell if Dr. Kimura and Dr. Bito provide "coaching" for the residents preparing these conferences to help with identifying learning goals and to provide expertise in teaching methods, the techniques of evidence-based clinical reasoning, and clinical content. If they or other faculty do not, this would be a useful faculty contribution

Residents and Organizational Structure of the Residency

Put simply, the senior residents at NTMC are very good. The program has developed a deserved reputation for attention to education that is attracting students from diverse medical schools, who bring to the residency character traits that are more easily selected than taught: curiosity, a strong desire to develop into excellent doctors, compassion and empathy, collegial supportiveness, and emotional honesty.

Junior residents. The best way to attract strong students for training in Internal Medicine is to have good senior residents. I was impressed with your new R1-R2 residency program. I was only able to talk with about a dozen of the junior residents. Based on this very limited sample, many seem to have come to NTMC *without* the intention of pursuing careers in general internal medicine. This means that a very

large portion of your faculty and senior resident teaching time is being expended on learners whose goals are different than those of the senior residents.

Part of the attraction of you residency program for these junior residents is the reputation you have earned for training in general internal medicine. Many have come because you have created desirable rotations in other sites, particularly in Pediatrics.

The R1-R2 residents are a very large group for a relatively small faculty to teach.

Senior residents. The R3-R4-R5 resident group is quite small to provide for the number of outpatients and inpatients for whom you are providing clinical care. As a result, the amount of time the senior residents spend on more-or-less continuous inpatient rotations is extremely high compared to Western residencies.

While the focus of your residency is General Internal Medicine, in Western residency programs, there is a requirement that both generalists and specialists train medical residents. I was unable to meet with specialists during my visit (e.g. a Cardiologist or a Gastroenterologist), but the impression I received from your senior residents is that the relationship of specialists as teachers for your residents can be problematic. You have too few senior residents for each resident to be able to spend time on most medical specialties, as is required in the West, and apparently, specialists serving as consultants for your inpatients and outpatients sometimes fail to provide either explanations for their or teach fundamental principles.

Resident satisfaction. The loyalty of the residents towards the residency program and each other is the best possible barometer of your success in meeting both the residents' training and personal needs. In my discussions with both junior and senior residents, there was some ambivalence about the training experience. Of course, as an outsider and guest, I was not in a position to either explore this in depth or to correctly interpret even the limited comments the residents expressed.

The intensity of the time commitment for Japanese residents is very high, with little time or opportunity for continuous rest, personal development outside of medicine, or for relationships with family and friends. Learning and safety research suggests that both patients and learners benefit when residents have time for rest, for study, and for pursuing personal interests and relationships.

Resident progression. With the mandatory rotating two-year internship, your future residents training in General Internal Medicine will begin their R3 year with a great deal more clinical experience and far stronger skills than in the past. Since there currently is not a national standard for either the length or the content of training in General Internal Medicine, your residency program will need to reassess how many years beyond the R1-R2 training will be required to produce an excellent General Internist.

Recommendations

- Consider creating a task force (consisting of NTMC General Internal Medicine faculty, one or two directors of other General Internal Medicine residencies, and

one or two practicing General Internists) to address the goals, structure, and content of your General Internal Medicine residency. Among the questions to be addressed:

- How many R1 and R2 residents can you teach while maintaining focus and excellence in your core General Internal Medicine residency?
- Given the mandatory R1-R2 training, does the General Internal Medicine Residency need to be three additional years?
- How can you increase the level of teaching in medical subspecialties by using subspecialists as teachers in your residency program
- In order to provide time for specialty rotations (inpatient consultations, specialty clinics), can the residency program add senior residents?
- How satisfied are the residents with their experience? How well does your training prepare them for community practice as General Internists?
- What should be the curriculum for a General Internal Medicine residency, and what experiences should be added to the residency?

- It might be very helpful if you conducted a survey of your current residents and former residents to explore their perceptions of their training, what they identify as strengths and weaknesses of your residency program, and to hear their ideas about what would make their training even more excellent, and this period of their lives more rewarding
- We have found it very useful for selected faculty and all senior residents (your R3-R5 residents) to have an annual, one- or two-day retreat to review the residency program and to plan for future change. During these retreats, other faculty perform the work ordinarily done by the residents

Internal Medicine Curriculum

During my visit, I outlined a plan for analyzing and creating curriculum. I have provided a copy of that tool as Appendix 2.

Faculty Development

NTMC has a long history of inviting visiting teachers from other countries. A number of General Internal Medicine residency programs in Japan now have visiting teachers. Some have a different teacher every 1-2 months, and others have visiting teachers who stay for a year or longer. I think that visiting teachers would be helpful at NTMC, especially in areas that you might want to strengthen-for instance, Medical Ethics, Geriatrics, Palliative Care, Oncology, physical diagnosis, and clinical reasoning.

One developmental step you might consider is create two positions following the usual length for General Internal Medicine training for true chief residents-that is, residents whose role is primarily to lead conferences, serve as junior (or co-) attendings, and to provide support to individual residents in both their personal and their educational growth.

A second developmental step to consider is to formally train chief residents and faculty as educators. To think in the very long-term, one goal might be to have one of your residents who will train in the United States return as a clinician-educator

in your program. Another would be to send a current junior faculty member who has had several years of teaching experience to the Stanford Faculty Development Program (SFDP). I would be happy to discuss this with you and to make a contact with Drs. Skeff and Stratos, who lead that program.

A third developmental step is to have R4 chief residents or junior faculty spend several weeks or a month in Japanese or Western residency programs that emphasize educational methodology. These visits could be set up so that your teachers cab observe outstanding teachers, and also be observed and coached using new teaching skills.

I also recommend that Dr. Kimura, Dr. Chong, and perhaps other staff members at NTMC take advantage of the two meetings in the United States that focus on Internal Medicine education—the semi-annual meetings of the Association of Program Directors in Internal Medicine (ADPIM), and the annual meeting of the Society of General Internal Medicine (SGIM). APDIM meets in October and April; during the April meeting there is also a two-day workshop for new chief residents that might be very rewarding for your new chief residents.

Threats and Opportunities for the Residency Program

In my lecture I discussed several new developments in Japanese medical education that will have an impact on residency programs in my lecture. Among these are:

1. Duty hour limits. How would an 80-hour work week, no period of service longer than 30 hours, 10 hours for sleep between one day and the next, and one 24-hour day without clinical duties affect your residency? Will you have too few senior residents if duty hour limits are required?
2. Creating standards for "Internal Medicine" training, including content and skills goals for each year of training
3. The possibility that MS 5 and MS 6 students will have more effective clinical training during medical school, so that the R1 and R2 residents can be trained at a more advanced level
4. Evidence-based medicine. How many of your conferences employ EBM standards?
5. Competition from other residency programs. Do you have a clear concept of what skills and knowledge General Internists will need in practice? Have you defined the field of General Internal Medicine? Are your R3-R5 residents happy with the program, and will they encourage others to come?
6. The increasing number of women entering medical training, with the possibility of women starting families during training

In the United States, physicians have created organizations to improve the quality of medical practice and medical training. I have suggested to several General Internal Medicine residency program directors the possibility of creating a Japanese Association of Internal Medicine Program Directors to improve Internal Medicine education throughout Japan. The exchange of ideas and development of standards I think would be of great benefit both to residents and to patients.

Summary

My short visit to NTMC was very rewarding. The residents and the faculty were impressive. I identified a number of strengths in your residency program.

In inviting me, you suggested that your faculty wanted to address the training of your General Internal Medicine residents now that you have the new mandatory R1-R2 training. I was able to see many opportunities for you to take advantage of the strong students you are attracting as junior residents and the improved skills future residents will bring to their training in General Internal Medicine

I am very pleased that you invited me, and I will be most supportive of your residency and your faculty. I hope that I have another opportunity to discuss your residency and work with your residents.

Curriculum Analysis
GIM Clinic for PGY 1-2 Residents

	Goals	Teaching Methods	Evaluation	Feedback
Knowledge				
Clinical Skills (History, PE, W/U, DDX, Presentation)				
Technical Skills (Procedures)				
Attitudes Values Behavior				
Lifelong Learning Habits				

Curriculum Analysis
GIM Clinic for PGY 1-2 Residents

	Goals	Teaching Methods	Evaluation	Feedback
Knowledge	Core Knowledge Common diseases Diseases with broad scope across specialties Unusual cases that teach important concepts	Reading Preceptor discussions Consultant discussions	Preceptor Combined faculty review Written tests	Preceptor Program Director
Clinical Skills (History, PE, W/U, DDX, Presentation)	History-taking PE Understanding use and inter-pretation of labs tests & imaging DDX Presentation skills Written workup	Preceptor observation Calibration Correction Expansion Demonstration Staff and peer role-models	Clinic OSCE Preceptor	Preceptor Program Director
Technical Skills (Procedures)	Office procedures	Preceptor supervision and demonstration	Clinic OSCE Preceptor	Preceptor Program Director
Attitudes Values Behavior	Introduction of patient to teaching hospital practice Clarifying roles and expect-ations Patient education Remote communication	Formal courses Videotape review Direct observation Patient feedback	Preceptor Combined faculty review Written tests Patient feedback Nurse feedback	Preceptor Program Director
Lifelong Learning Habits	Answering clinical questions		Written tests	Preceptor Program Director

What are the main educational reasons for PGY 1 and PGY 2 residents to practice in the GIM clinic?

1. **What are the most important educational tools?**

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2. **What are the main educational reasons for PGY 1 and PGY 2 residents to practice in the GIM clinic?**
    a. **Physicianship**
    b. **To understand the practice of outpatient internal medicine**
3. **What are the most important educational tools?**
    a. **The patient evaluation**
    b. **Reviewing the patient with a more expert clinician**
    c. **Discussion of the patient with peers and more senior physicians**
    d. **Answering clinical questions raised as the result of the patient evaluation**
    e. **Followup over time**

Adults learn better . . .
成人がよりよく学習するのは…

- when they want or need to know something
- when they have some control over the learning content and learning style
- through active physical and mental participation in learning activities
- when there is a realistic, relevant problem
- when they can immediately apply what they have learned
  when they can observe more experienced role models

Ⅳ　研究成果の刊行に関する一覧

研究成果の刊行に関する一覧

書籍

著者氏名	論文タイトル	編集者	書籍名	出版社名	出版地	出版年	ページ
浅井 篤	実験的治療の福音と悲劇性についての簡単な考察：「レナードの朝」(1990年、米国) を観て		先端倫理研究			2006 印刷中	
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