however, is often under-recognized by medical staff members in clinical oncology settings, including oncologists and oncology nurses,[16,17] and this is not exceptional even in the palliative care setting.[18]

Screening is the optimal strategy for detection of such diseases as MD and ADs, which are prevalent, not evident, treatable, and benefit from early treatment.[19] In addition, because treatability of depression among advanced/terminally ill cancer patients can heavily depend on the patient's remaining survival time,[20] there is a strong need to develop brief screening instruments that can be used in routine palliative care practice. Lloyd-Williams et al.[21] recently reviewed the screening tools for detecting depression in the palliative care setting, and demonstrated the usefulness of several screening instruments, such as a single-item interview ("Are you depressed?") and a brief self-rating questionnaire (e.g., Hospital Anxiety and Depression Scale [HADS]), among others. Of these instruments, a single-item interview, "Are you depressed?," may be especially recommended as a screening because of its brevity and excellent screening performance in a North American study (sensitivity 1.00, specificity 1.00, positive predictive value [PPV] 1.00, and negative predictive value [NPV] 1.00).[22] Contradicting this view, limited findings of this approach were observed in the UK palliative care population (sensitivity 0.55, specificity 0.74, PPV 0.44, and NPV 0.82).[23] This discrepancy may have been produced by cultural differences, but there have been no further studies regarding the screening performance of the single-item interview. In addition, no study in palliative medicine has yet evaluated the likelihood ratio (LR) and stratum-specific likelihood ratios (SSLRs) of screening instruments that are now being increasingly recognized as a more convenient and generalizable method of interpreting diagnostic information regarding performance than an optimal cutoff and sensitivity and specificity approach.[24,25] Finally, to the best of our knowledge, there have been no studies investigating the performance of a screening instrument in the Asian palliative care population.

In the present study, we assessed the performance of screening instruments, including the single-item interviews and the brief self-rating questionnaire, for depression in Japanese terminally ill cancer patients.

Methods

Patients

The current study was conducted as part of previously published studies investigating suicidality and psychological distress in terminally ill Japanese cancer patients and detailed methods have been described elsewhere.[3,26] Consecutive patients were recruited upon registration with the Palliative Care Unit (PCU) of the National Cancer Center Hospital East, Japan. The eligibility criteria for patient recruitment in the study were (a) age 18 years or older, (b) being newly registered with the PCU, (c) not currently undergoing curative cancer therapy, such as surgery, chemotherapy, or radiotherapy, (d) knowledge of the cancer diagnosis, (e) being not too ill to complete the questionnaires and participate in an interview taking at least 30 minutes, (f) not suffering from cognitive impairment as judged by a score of 24 or more on the Mini-Mental State Examination (MMSE),[27,28] and (g) having no difficulty in verbal communication.

This study was approved by the Institutional Review Board and the Ethics Committee of the National Cancer Center of Japan and was conducted in accordance with the Helsinki Declaration. Written informed consent was obtained from each subject before enrollment into this study.

Screening for Psychological Distress

We tested five different methods as screening for depression. Three methods were two different single-item interviews ("Are you depressed?" and "Have you lost interest or pleasure?") and the combination of these two interviews that are part of the MD module of the Structured Clinical Interview for DSM-IIIR (Diagnostic and Statistical Manual of Mental Disorders, 3rd edition revised).[29] The remaining two methods were the total and depression scores of the Japanese version of the HADS.[30,31] The total score of the latter measure was shown to have a sensitivity and specificity of 0.77 and 0.85, respectively, by Le Fevre et al.[9] when used to screen for depression in a palliative care population. HADS was developed for use in medically ill patients, and questions about physical symptom are excluded. It is a self-report questionnaire consisting of 14 items, and subjects rate how they felt during the previous week on a 4-point Likert scale. The HADS consists of an anxiety and depression subscale (0–21 points each), and total scores can range from 0 to 42. Higher scores indicate more severe depression and anxiety. The Japanese version of HADS was validated in a cancer population.[31] HADS is the most frequently used screening tool used in the palliative care setting.[32]

In this study, the screening performances for two different types of depression, namely, both ADs and/or MD and MD only, were examined separately.

Assessment of ADs and MD

The subjects were assessed for the presence of ADs and MD by a trained psychiatrist using the Structured Clinical Interview for DSM-III-R. A diagnosis of MD was made when a patient had five (or more) of the following symptoms during the same two-week period and the symptoms represented a change from previous functioning; at least one of the symptoms was either depressed mood or loss of interest or pleasure in nearly all activities: (1) depressed mood, (2) loss of interest or pleasure, (3) significant weight loss or decrease or increase in appetite, (4) insomnia or hypersomnia, (5) psychomotor agitation or retardation, (6) fatigue or loss of energy, (7) feelings of worthlessness or excessive or inappropriate guilt, (8) diminished ability to think or concentrate, or indecisiveness, and (9) recurrent thoughts of death, recurrent suicidal ideation, or attempted suicide. The essential feature of ADs is the development of clinically significant emotional or behavioral symptoms in response to an identifiable psychosocial stressor or stressors; there are several subtypes, depending on the predominant symptom (e.g., depressed mood, anxiety, disturbance of conduct). In principle, the diagnosis of AD should not be made if the disturbance meets the criteria for another specific disorder (e.g., MD); however, the diagnosis may be made in the presence of another psychiatric disorder if the latter does not account for the symptoms.

The reliability (kappa coefficient) of the interview ratings was investigated by having another trained psychiatrist attend the first 29 consecutive interviews as a second rater. These scores were 0.65 for ADs and 0.87 for MD.

Study Procedures

After obtaining the patients' consent, a trained psychiatrist administered the MMSE. Eligible patients participated in the screening interview and then in a structured clinical interview to assess their depression. After that, they were asked to complete the HADS. The present study was conducted at the first outpatient visit after PCU registration.

Statistical Analysis

Screening performance was investigated by calculating sensitivity, specificity, the PPV, NPV, and LR. SSLRs for HADS were also calculated. LR and SSLR are expressions of the odds (odds = probability/1-probability) that a positive test result will be obtained in an actual case.[33] When the pretest odds (or prevalence) of the target condition is known, the LR and SSLR can be used to calculate the posttest odds of the condition actually being present given a positive test.[25] The LR and SSLR are independent of prevalence and less subjective to, although not totally free from, spectrum bias (change in test characteristics due to a different mix of disease severity and comorbidity) than the optimal threshold and are hence expected to be more generalizable across situations.[24] All statistical procedures were conducted with the SPSS 10.0J for Windows (SPSS Inc., 1999).

Results

A total of 764 cancer patients registered with the PCU during the study entry period, but 507 of them were ineligible (too ill, $n = 443$; cognitive impairment, $n = 50$; etc.). Of the 257 eligible patients, 28 refused to participate and 20 could not be contacted (e.g., because of emergency admission to another hospital), and 209 patients (27.4%) participated in the current study. The mean (SD) age of these patients was 61 (10) years; 137 (66%) subjects were male and 51 (24%) were in full-time employment. One hundred and eighty-one (87%) were married, and 148 (71%) had received more than 9 years education. Twelve (6%) lived alone. The most frequent primary cancer site was the lung ($n = 80$, 38%), followed by colon ($n = 24$, 12%), head and neck ($n = 15$, 7%), and liver ($n = 15$, 7%). As previously reported, the patients' demographic data, such as age, gender, and cancer site, were similar to those of patients receiving palliative care in Japan, and their social status, based on marital status, education, and household size, was also similar to that of most Japanese cancer patients.[3]

ADs were diagnosed in 33 patients (15.8%; depressed mood in 11.5%, mixed emotional features in 4.3%), and MD was diagnosed in 14 (6.7%) patients.

Screening for ADs and/or MD

The results of the screening performance of the single-item interviews are shown in Table 1. Their specificity was over 0.95, but the sensitivity of both single-item interviews as a screening method was less than 0.50. Their sensitivity remained low even when used in combination (the screening result was considered positive when a result of either of the two single-item interviews was positive), while other indicators, including PPV and NPV, showed acceptable performance.

Concerning the HADS, the suggested optimal cutoff points of the total score and the depression score of the HADS were 12/13 and 6/7, respectively, after striking a balance between sensitivity and specificity (data not shown). Applying these cutoff values provides somewhat higher sensitivity and AUC (area under the receiver) than those of the single-item interviews (Table 1). The results of SSLRs approaches, however, demonstrate more clearly the advantages of the continuous measure, HADS (Table 2). The findings of the SSLRs of total score and depression subscale score of the HADS suggest that both scores are useful for screening for ADs and/or MD, and that the SSLRs approach provides much more useful information than the single-item interviews and the dichotomized approach of the HADS.

Screening for MD

The findings of the present study on the performance of screening for MD indicated that the single-item interview "Have you lost interest or pleasure?" performed better than "Are you depressed?" on several indicators of screening performance, including sensitivity, AUC, and the LR of the single-item interview. Combining the two single interviews (screening result was considered positive when a result of either of the two single-item interviews was positive) did not provide any clear advantage over using the single-item interview, "Have you lost interest or pleasure?," when indicators of screening performance were taken into consideration in totality.

Regarding the screening performance of the HADS, the suggested optimal cutoff points of the total score and the depression score of the HADS were 16/17 and 8/9, respectively, after striking a balance between sensitivity and specificity (data not shown). The screening performances of this cutoff approach of the HADS seem to be somewhat inferior to that of the single-item interviews, as most indicators of the screening performance of the HADS were slightly worse than those of the single-item interviews (Table 1). The results of the SSLRs approach of the total score and depression subscale score of the HADS are shown in Table 3. The findings of the SSLRs approach suggest that using this screening strategy can provide more additional useful information than the cutoff approach, as different LRs can be obtained for different scores. Thus, although the cutoff approach of the HADS provides limited screening performance, the SSLRs approach of the HADS seems to contribute to a different type of advantage that the single-item interview cannot yield.

Discussion

This is the first study clarifying the performance of depression screening instruments widely used in Western palliative population among Japanese terminally ill cancer patients. When the screening target includes both an AD and MD, our findings suggest that the HADS is a more useful screening method than the single-item interviews. This finding is similar to the recent study reported from the United Kingdom, which demonstrated that a brief self-rating scale, the Edinburgh Depression Scale, is a more reliable instrument than the 0–10 verbal rating scale and the single interview, "Are you depressed?," for detecting depression in palliative care patients (sensitivity 0.70, specificity 0.80).[34,35] In addition, using the SSLR of the HADS is more strongly recommended, as this approach can provide more useful information than the dichotomized method, cutoff value approach.

The SSLR approach has several advantages.[24] First, this approach, in conjunction

Table 1

Performance of Different Screening Instruments for Depression in Terminally Ill Japanese Cancer Patients

Instrument	Sensitivity	Specificity	PPV	NPV	AUC	LR+	LR−
Screening for adjustment disorders and/or major depression							
Are you depressed?	0.47 (0.32–0.60)	0.97 (0.93–0.98)	0.81 (0.67–0.96)	0.86 (0.81–0.91)	0.72 (0.62–0.82)	15.17 (6.33–36.36)	0.55 (0.42–0.72)
Have you lost interest?	0.47 (0.32–0.60)	0.96 (0.91–0.98)	0.76 (0.60–0.91)	0.86 (0.81–0.91)	0.71 (0.62–0.81)	10.83 (5.06–23.18)	0.56 (0.43–0.73)
Are you depressed or have you lost interest?	0.68 (0.53–0.79)	0.94 (0.89–0.96)	0.76 (0.63–0.89)	0.91 (0.87–0.95)	0.81 (0.73–0.89)	11.03 (5.96–20.42)	0.34 (0.23–0.51)
HADS (total score ≥ 13)	0.80 (0.66–0.89)	0.67 (0.59–0.74)	0.41 (0.31–0.51)	0.92 (0.87–0.97)	0.80 (0.72–0.86)	2.44 (1.88–3.17)	0.29 (0.16–0.52)
HADS (depression score ≥ 7)	0.78 (0.63–0.87)	0.58 (0.50–0.65)	0.35 (0.25–0.44)	0.90 (0.85–0.96)	0.79 (0.71–0.85)	1.85 (1.47–2.34)	0.38 (0.22–0.65)
Screening for major depression							
Are you depressed?	0.79 (0.49–0.90)	0.92 (0.87–0.95)	0.41 (0.22–0.59)	0.98 (0.97–1.00)	0.85 (0.72–0.98)	9.58 (5.63–16.29)	0.23 (0.09–0.58)
Have you lost interest?	0.93 (0.64–0.97)	0.92 (0.87–0.95)	0.45 (0.27–0.63)	0.99 (0.98–1.00)	0.92 (0.84–1.00)	11.32 (6.99–18.33)	0.08 (0.02–0.35)
Are you depressed or have you lost interest?	1.00 (0.73–1.00)	0.86 (0.80–0.90)	0.33 (0.19–0.48)	1.00 (0.98–1.00)	0.93 (0.89–0.97)	6.96 (4.96–9.78)	0.04 (0.01–0.26)
HADS (total score ≥ 17)	0.71 (0.42–0.86)	0.77 (0.71–0.82)	0.19 (0.08–0.29)	0.97 (0.95–1.00)	0.79 (0.67–0.92)	3.13 (2.08–4.72)	0.37 (0.17–0.80)
HADS (depression score ≥ 9)	0.86 (0.56–0.94)	0.69 (0.62–0.75)	0.17 (0.08–0.26)	0.99 (0.97–1.00)	0.82 (0.70–0.94)	2.80 (2.09–3.77)	0.21 (0.07–0.64)

AUC = area under the receiver operating characteristics curve. Values in parentheses show the 95% confidence interval.

with the Bayes theorem, is intuitive. It nicely incorporates the differences in pretest probabilities (or prevalences) between populations and illustrates in clearer terms what we should do in diagnostic processes of an individual or a group of individuals. A useful nomogram proposed by Fagan facilitates the translation of SSLRs into predicted probabilities.[25,33,36] Second, in the case of a continuous scale (which most tests in medicine are) such as HADS, SSLR retains more information than that given by a single cutoff and sensitivity and specificity approach as shown in Tables 2 and 3. For example, given a patient whose pretest probability of depression is 25% and he/she scores a total HADS score of 16, this provides an approximately 50% posttest probability. On the other hand, given another patient whose pretest probability of depression is 25% and he/she scores a total HADS score of 8, this provides an approximately 10% posttest probability. Thus, routine use of the HADS may help the medical staff detect patients' clinical depression in an early and appropriate manner, including the presence of ADs and MD.

Another interesting finding is the screening performance of the single-item interview from a Japanese perspective. Our finding that the single-item interview, "Are you depressed?," failed to show excellent screening performance is more similar to the UK findings than to the North American findings. The discrepancies observed between the findings in the United States, United Kingdom, and Japan may be attributable to underlying cultural and/or language differences and they warrant further empirical exploration.

Regarding screening for MD in terminally ill cancer patients, the findings obtained in this study demonstrate that both single-item interviews and the HADS possess useful screening performance. The single-item interview screening requires some training for use by non-mental-health professionals, because it is part of a structured diagnostic interview. Nevertheless, its brevity suggests clinical usefulness in palliative care as well as in the busy clinical oncology practice. The findings obtained in this study demonstrated that both single-item interviews have good screening performance; however, the brief question "Have you lost interest?" is superior to the question "Are you depressed?"

Table 2
SSLRs of the HADS for ADs and/or MD in Terminally Ill Cancer Patients

Total Score of HADS	AD/MD Present (*n*)	AD/MD Absent (*n*)	SSLR (95% CI)
0–4	0	31	0.05 (0.01–0.38)
5–9	7	51	0.49 (0.25–0.96)
10–14	7	38	0.65 (0.33–1.30)
15–19	20	30	2.25 (1.43–3.54)
20–24	7	8	2.95 (1.20–7.25)
>25	5	3	5.26 (1.55–17.90)

Depression Score of HADS	AD/MD Present (*n*)	AD/MD Absent (*n*)	SSLR (95% CI)
0–2	0	35	0.05 (0.01–0.34)
3–5	7	42	0.59 (0.30–1.17)
6–8	9	43	0.73 (0.40–1.34)
9–11	13	30	1.48 (0.86–2.56)
12–14	11	8	4.53 (2.0–10.12)
>15	6	3	6.22 (1.90–20.36)

CI = confidence interval.

Several studies suggest that there are several cross-cultural differences between depressive symptoms experienced by the Western compared with the Asian population. For example, it is said that depressive Asian people are more likely to complain of somatic symptoms.[37,38] In addition, there exist eminent differences between Western and Asian cultures in communication styles such that Western cultures tend to encourage open and direct expression of a full range of emotions while Asian cultures tend not to promote open expression because harmony in interpersonal relationship is highly valued.[39] The underlying cultural differences may be one possible explanation of our findings, because these Asian cultural tendencies may be responsible for the greater usefulness of the one-question interview about anhedonia than the one about depressive mood as a screening tool for mood disorder. In any event, the present study indicated that the single-item interview "Have you lost interest?" is a better and more effective screening than "Are you depressed?" for MD in terminally ill Japanese cancer patients. Nonetheless, applying the self-rating scale, HADS, has several potential advantages, such as no need for training of the medical staff. In addition, using the SSLRs approach of the HADS can provide different kinds of useful information for staff, as mentioned above. Routine use of the HADS can also help the medical staff detect patients' MD in the palliative care setting. Thus, because the potential advantages of each instrument should be different, usage of each instrument should depend on the aim of the screening and the clinical situation (e.g., regular routine use, interviewer's skill).

Table 3
SSLRs of the HADS for MD in Terminally Ill Cancer Patients

Total Score of HADS	MD Present (*n*)	MD Absent (*n*)	SSLR (95% CI)
0–4	0	31	0.18 (0.03–1.26)
5–9	2	56	0.51 (0.18–1.46)
10–14	1	44	0.39 (0.10–1.47)
15–19	5	45	1.39 (0.69–2.80)
20–24	3	12	3.23 (1.18–8.85)
>25	3	5	7.34 (2.28–23.57)

Depression Score of HADS	MD Present (*n*)	MD Absent (*n*)	SSLR (95% CI)
0–2	0	35	0.16 (0.02–1.11)
3–5	2	47	0.61 (0.21–1.75)
6–8	0	52	0.11 (0.02–0.75)
9–11	4	39	1.31 (0.60–2.90)
12–14	4	15	3.35 (1.39–8.05)
>15	4	5	9.43 (3.20–27.82)

CI = confidence interval.

It may be important to note that a previous study demonstrated that when screening for psychological distress was coupled with feedback, the results of the screening alone did not seem to be useful for improving the patient's outcome in a clinical oncology setting.[40] On the other hand, several reports have suggested the usefulness of integrated screening programs. Those programs provide pharmacotherapy by oncologists based on antidepressant algorithms[41,42] or psychological intervention delivered by the cancer nurse under the supervision of a consultant psychiatrist, for those patients who screened positive.[43] Thus, these studies suggest that an integrated program that combines screening for psychological distress with subsequent provision of appropriate treatment and/or intervention is needed. In addition because special conditions should be addressed in palliative care setting, such as the necessity for the management of depression in patients with very limited prognoses, further studies to develop such an integrated program focusing on the palliative population are needed.

The present study has several advantages. One is its large sample size. The number of participants was generally small (typically under 100 patients) in many other studies conducted in the palliative care setting. The second advantage is good reliability of the diagnosis of depressive disorders by trained psychiatrists used as the gold standard in the present study.

The present study has also several limitations. Like previous studies, potential assessment bias was the most important limitation, because the single-item interviews and diagnostic interviews were not conducted in a blinded manner. Because only 27.4% (209/764) of the subjects at baseline could be included in the analysis, generalizing the results may be problematic, and because the study was conducted in one institution, institutional bias may be another problem. Finally, because this study focused on terminally ill Japanese cancer patients receiving palliative care, the results may not be applicable to patients with terminal cancer in other settings and in other Asian countries.

In conclusion, different screening instruments may be recommended depending on which depressive disorders we want to target, and which specific population we want to target. Our findings suggest that both the single-item interview, "Have you lost interest?," and HADS are useful for MD, while the HADS is recommended for screening for ADs and/or MD in terminally ill Japanese cancer patients.

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Original Article

Good Death in Japanese Cancer Care: A Qualitative Study

Kei Hirai, PhD, Mitsunori Miyashita, RN, MHlthSc, Tatsuya Morita, MD,
Makiko Sanjo, RN, MHlthSc, and Yosuke Uchitomi, MD, PhD
Graduate School of Human Sciences (K.H.), Osaka University, Osaka; Department of Adult Nursing/Terminal and Long-Term Care Nursing (M.M., M.S.), Graduate School of Medicine, Tokyo University, Tokyo; Palliative Care Team and Seirei Hospice (T.M.), Seirei Mikatabara Hospital Shizuoka; and Psycho-Oncology Division (Y.U.), National Cancer Center Research Institute East, Chiba, Japan

Abstract

One of the most important goals of palliative care is achieving a "good death" or a "good dying process." The primary aim of this study was to identify the components of a Japanese "good death" through qualitative interviews with cancer patients, their families, physicians, and nurses. Semistructured interviews were conducted. Thirteen advanced cancer patients, 10 family members of such patients, 20 physicians, and 20 nurses were recruited from five regional cancer institutions in Japan. Content analysis was applied to answers, and 58 attributes were extracted and classified into 17 categories as follows: Freedom from pain or physical/psychological symptoms, Having a good family relationship, Dying in one's favorite place/environment, Having a good relationship with medical staff, Not being a burden to others, Maintaining dignity, Completion of life, Maintaining a sense of control, Fighting against cancer, Maintaining hope, Not prolonging life, Contributing to others, Control of future, Not being aware of death, Appreciating others, Maintaining pride, and Having faith. The most frequently cited category was "Freedom from pain or physical/psychological symptoms" and the least common was "Having faith." This study identified important components of a good death in Japan. A future quantitative survey is planned to clarify the generalizability of these findings as the primary endpoint of palliative care in Japan. J Pain Symptom Manage 2006;31:140–147. *© 2006 U.S. Cancer Pain Relief Committee. Published by Elsevier Inc. All rights reserved.*

Key Words
Good death, palliative care, end-of-life care, quality of death and dying

Introduction

One of the most important goals of palliative care is achieving a "good death" or a "good dying process." However, because the concepts of good death are still unclear, it is difficult to determine the primary endpoint of palliative care. Therefore, conceptualization of the components of good death is needed. Recent Western studies have succeeded in identifying the components of a "good death" and the "quality of death and dying." Payne et al.[1] found that patients characterized good death as dying in one's sleep, dying quietly, dying with dignity,

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Address reprint requests to: Kei Hirai, PhD, Graduate School of Human Sciences, Osaka University, 1-2 Yamadaoka, Suita, Osaka 565-0871, Japan. E-mail: Kei@hus.osaka-u.ac.jp

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being pain-free and dying suddenly, whereas medical staff characterized a good death in terms of adequate symptom control, family involvement, peacefulness and being free from distress, and bad death was described as involving uncontrolled symptoms, the lack of acceptance and being young. Steinhauser et al.[2] identified pain and symptom management, clear decision making, preparation for death, completion of life, contribution to others, and the affirmation of the whole person by qualitative research. Patrick et al.[3] found six domains: symptoms and personal care, preparation for death, the moment of death, family, treatment preferences, and whole person concerns. Because of difference in cultural backgrounds, especially family involvement in the decision-making process,[4] the Japanese concepts of good death will be different from those in the Western countries. Nonetheless, in Japan there has been no research exploring the concepts of "good death." Therefore, the current qualitative study was conducted to explore the components of a Japanese "good death."

Methods

This study was designed as a preliminary study of quantitative research for assessing the structure of good death by community sampling in Japan. The study examined a mixed sample composed of mainly two types of participants: the nonmedical population consisting of advanced cancer patients and their family members and the medical staff population consisting of physicians and nurses in palliative care and acute cancer settings. The analyses were carried out for the data combining all samples.

Participants

Participants were advanced cancer patients, their family members, physicians, and nurses in palliative care and acute cancer settings of five regional cancer institutes in Japan (Ibaraki pref., Gunma pref., Shizuoka pref., Hiroshima pref., and Yamaguchi pref.). Sixteen participants (four for each group) were allocated for each institution, and the patients who met the following conditions were recruited: having incurable advanced cancer, knowing their diagnosis, having no cognitive impairment, and being aged from 20 to 80. The physicians and the nurses in acute settings were required to have more than two years of clinical experience in cancer treatment. The physicians and the nurses in palliative care settings were also required to have more than 2 years of clinical experience in specialized palliative care service. We obtained written informed consent from all the participants.

Interview Procedure

Semistructured interviews were conducted by five interviewers, including the authors of this article (K.H. and M.M.), two graduate school students of psychology, and one research nurse. The interviews followed an interview guideline developed by the authors through careful consideration of the purpose of this study. There were two sets of questions. One set contained predetermined open-ended questions for patients and family members such as the following: "If your disease were incurable, what would be most desirable or good thing for you to do?" and "If you were dying, what would be most desirable or good thing for you to do?" The other set included predetermined open-ended questions for nurses and physicians as follows: "If your patients were incurable, what do you think would be most desirable or good thing for them to do?" and "If your patients were dying, what do you think would be most desirable or good thing for them to do?" For both procedures, the participants were asked to respond freely to the questions.

Analyses

All the interviews were audiotaped and transcribed. Content analysis was performed on the transcribed data. First, a psychologist (K.H.) and a research nurse (M.M.) extracted all statements related to study topics, such as good death, bad death, quality of death and dying, and quality of life in advanced cancer, from the interview transcripts. Then, they carefully conceptualized and categorized the attributes of the transcripts based on similarities and differences in the content under the supervision of an experienced palliative care physician (T.M.) and made the definitions for all categorized attributes. Finally, two coders among the research nurses independently determined whether each participant had made remarks that belonged to any of the attributes according to the definitions of the attributes. When their coding was inconsistent, they made the final judgment together after discussion. The concordance rate and Kappa coefficient of the determinations of the categories by the two independent coders were 93.7% and 0.80, respectively. Furthermore, generated attributes were categorized into more abstracted supracategories according to the similarities and theoretical explanations based on the full agreement of the authors.

In addition, we conducted descriptive analyses on the frequencies of the attributes. The frequencies of supracategories were counted by combining the frequencies of their attributes. We summarized four groups into nonmedical populations (patient and family) and medical staff (physician and nurse), and Pearson's chi-square test, or Fisher's exact methods, where appropriate, was used to test group differences in the responses for each category. If the cells had an expected count of less than five, we used Fisher's exact test results. All the statistical analyses were performed by using the SPSS software package (version. 10.0).

Results

Characteristics of the Participants

There were a total of 63 participants, including 13 patients, 10 family members, 20 (10 PCU, palliative care units) physicians, and 20 (10 PCU) nurses (Table 1). In several institutions, the enrollment of nonmedical populations was insufficient because of the absence of suitable participants. Although several institutions did not fully recruit the required number of participants due to absence of suitable participants during the study periods, we did not recruit additional participants because the number of extracted attributes was satisfactorily saturated by the end of the planned study periods. There was no refusal of enrollment to this study. Fifty-seven percent of the participants were female, and the mean age was 45 ± 14 years. The patients' primary sites of cancer were lung ($n = 5$), pancreas ($n = 5$), liver ($n = 2$), and others ($n = 2$). Patient expected survival time from interviews was 1–3 months ($n = 6$), 3–6 months ($n = 2$), 6 months–1 year ($n = 3$), and unknown ($n = 2$). Patient performance status (ECOG PS) was 0 ($n = 2$), 1 ($n = 3$), 2 ($n = 4$), 3 ($n = 3$), and 4 ($n = 2$).

The Attributes of Good Death

A total of 58 attributes were extracted and categorized as follows (Table 2): *Freedom from pain or physical/psychological symptoms, Having a good family relationship, Dying at one's favorite place/environment, Having a good relationship with medical staff, Not being a burden to others, Maintaining dignity, Completion of life; Maintaining a sense of control, Fighting against cancer, Maintaining hope, Not prolonging life, Contributing to others, Control of future, Not being aware of death, Appreciating others, Maintaining pride, and Having faith.*

The attributes indicated by over 50% of the participants were "Being free from pain and physical distress," "Being able to stay at one's favorite place," "Spending enough time with one's family," "Being calm," "Having a reliable physician," "Having family support," and "Discussing one's treatment with one's physician." The attributes indicated by only one participant were "Seeing people whom one wants to see," "Being reconciled with people with whom one is on bad terms," "Having a medical staff with whom one can discuss personal fears of death," "Not receiving sympathy from others," and "Dying without consciousness."

Table 3 shows the frequencies and percentages of each of the 17 categories among the four groups. In all groups, the most commonly indicated category was "Being free from pain or

Table 1
Participant Demographics

	Patient	Family	Physician	Nurse
Numbers, *n*	13	10	20	20
Age mean (SD), years	62.2 (11.7)	54.4 (11.5)	38.6 (6.5)	34.9 (7.6)
Gender, *n* (%) of male	7 (53)	1 (10)	19 (95)	0 (0)
Professional career mean (SD), years			13.3 (6.1)	12.8 (6.6)

Table 2
The Attributes and Categories of Japanese Good Death

Items	*n*	%
Freedom from pain, physical, and psychological symptoms	60	95
(1) Being free from pain and physical distress	59	94
(2) Being calm	36	57
Having a good family relationship	55	87
(3) Spending enough time with one's family	40	63
(4) Having family support	32	51
(5) Having family by one's side when one is going to die	15	24
(6) Being able to express personal feelings to one's family members	12	19
(7) Family is prepared to one's death	7	11
(8) Believing that one's family will go well after one's death	5	8
Dying at one's favorite place/environment	54	86
(9) Being able to stay at one's favorite place	44	70
(10) Living like being at home	26	41
(11) Living in calm circumstances	6	10
Having a good relationship with medical staff	54	86
(12) Having a reliable physician	32	51
(13) Discussing one's treatment with one's physician	32	51
(14) Having a nurse with whom one feels comfortable	28	44
(15) Having people who can listen to me	26	41
(16) Receiving consistent care from the same physician and nurse	8	13
(17) Leaving all decision making to one's physician	6	10
(18) Having a physician or nurse with whom one can discuss fears of death	1	2
Not being a burden to others	36	57
(19) Having no financial worries	30	48
(20) Not being a burden to family members	10	16
(21) Not making trouble for others	9	14
Maintaining dignity	32	51
(22) Being respected for one's values	30	48
(23) Not being treated as an object or a child	2	3
(24) Being free from trivial routines	2	3
Completion of life	31	49
(25) Being prepared for dying	14	22
(26) Family has no regrets for one's death	13	21
(27) Having no regrets for dying	13	21
(28) Feeling one's life being completed	8	13
Maintaining sense of control	28	44
(29) Being independent in daily activities	16	25
(30) Being mentally clear	13	21
(31) Being able to eat	7	11
Fighting against cancer	20	32
(32) Believing that one used all available treatments	15	24
(33) Fighting against disease until one's last moment	5	8
(34) Living as long as possible	3	5
Maintaining hope	28	44
(35) Having something to enjoy	17	27
(36) Living positively	13	21
(37) Living in hope	7	11
Not prolonging life	16	25
(38) Dying a natural death	15	24
(39) Not being connected with medical instruments or tube	9	14
Contributing to others	18	29
(40) Maintaining one's role in family or occupational circumstances	16	25

(*Continued*)

Table 2
Continued

Items	n	%
(41) Feeling that one can contribute to others	3	5
(42) Feeling that one's life is worth living	2	3
Control of one's future	14	22
(43) Having the planned arrangements of one's grave, funeral, and last will	6	10
(44) Knowing how long left to live	4	6
(45) Controlling time of death, like euthanasia	3	5
(46) Knowing what to expect about one's condition in future	3	5
Not being aware of death	12	19
(47) Dying as one sleeps	6	10
(48) Living as usual without thinking about death	6	10
(49) Dying without awareness that one is dying	1	2
Appreciating others	7	11
(50) Saying good-bye to dear people	3	5
(51) Feeling thankful to people	3	5
(52) Seeing people whom one wants to see	1	2
(53) Being reconciled with people	1	2
Maintaining pride	6	10
(54) Not having a change in one's appearance	4	6
(55) Not exposing one's physical weakness to family	3	5
(56) Not receiving sympathy from others	1	2
Having faith	4	6
(57) Feeling that one in protected by higher power beyond oneself	4	6
(58) Having faith	2	3

physical/psychological symptoms," the second "Having a good family relationship," and the third "Dying in one's favorite place/environment." On the other hand, the least indicated item was "Having faith." There were statistically significant differences among groups in the category responses on the attributes of "Not being a burden to others," "Completion of life," "Maintaining hope," and "Not prolonging life." The attribute "Completion of life" showed a higher frequency in the physicians' and nurses' responses than patients' and families' responses, whereas in the other attributes, the opposite results were obtained (Table 3).

Table 3
Differences in Category Response Among Groups ($n = 63$)

	Patient		Family		Physician		Nurse		
Category	n	%	n	%	n	%	n	%	*P* Value
Freedom from pain and physical and psychological symptoms	11	85	10	100	20	100	19	95	0.55
Having a good family relationship	11	85	10	100	17	85	17	85	0.70
Dying at one's favorite place/environment	11	85	8	80	17	85	18	90	0.71
Having a good relationship with medical staff	11	85	8	80	17	85	18	90	0.71
Not being a burden to others	10	77	8	80	10	50	8	40	0.01
Maintaining dignity	3	23	7	70	10	50	12	60	0.38
Completion of life	4	31	3	30	12	60	12	60	0.02
Maintaining a sense of control	4	31	7	70	7	35	10	50	0.68
Maintaining hope	9	69	7	70	5	25	7	35	0.00
Fighting against cancer	7	54	3	30	4	20	6	30	0.13
Contributing to others	5	38	3	30	5	25	5	25	0.41
Not prolonging life	4	31	6	60	5	25	1	5	0.01
Preparation for death	6	46	0	0	4	20	4	20	0.58
Not being aware of death	3	23	2	20	3	15	4	20	0.75
Appreciating others	2	15	1	10	1	5	3	15	0.70
Maintaining pride	2	15	0	0	2	10	2	10	1.00
Having faith	2	15	0	0	1	5	1	5	0.62

Discussion

This study identified the 58 attributes and the 17 categories as common components of "good death" or "quality of death and dying" in Japan. The common components most often identified in Western literatures were pain and symptom control,[1–3,5–11] family relationship,[1,3,5–9,11,12] burden to others,[5,6,9] the sense of control,[6,12] dignity,[1–3,10,12] environmental well-being,[5,7] preparation,[2,7,11] hope,[8] faith and spirituality,[5,8] contribution to others,[2,11] completion,[2,5,11] good relationship with medical staff,[5,11,13] and inappropriate prolongation of life.[5,6] These results indicate that good death in Japan shared many common components of good death in the Western countries. As the four components (pain and symptom control, family relationship, environmental well-being, and relationship with medical staff) were indicated by over the 80% of the participants of all the groups, they seem to be especially important domains of good death in Japan. In these categories, we confirmed significant group differences of opinion on completion, hope, and inappropriate prolongation of life. Previous western studies also confirmed group differences and identified components of a "good death" or "quality of death and dying."[1,2]

On the other hand, the current study produced several unique findings that had not been revealed in previous Western studies. First, although the Western studies demonstrated the importance of clear decision making or autonomy in decision making,[2,3,9] decision making was not highlighted in this study. In the category of "Having a good relationship with medical staff," there were some attributes alluding to decision making, such as "Discussing one's treatment with one's physician" or "Leaving all decision-making to one's physician." However, these attributes seemed to reflect the preference for maintaining a good relationship with medical staff rather than the patients' autonomous decision making. A previous survey on the self-determination of Japanese patients found that 47% patients tend to accept recommendations of physicians, even if such recommendations were against their wishes.[14] Therefore, the Japanese patients would not necessarily consider that the autonomy was essential for good death. These results suggest that whereas some Japanese patients prefer to have autonomy in the process of decision making, many others prefer to entrust decisions to their physicians. It was also reported that there was a high prevalence of entrusting all decisions to the family or their physician in Japan.[15] This entrusting pattern is called an Omakase Model, in which the Japanese word 'omakase' means entrusting, and is pointed out to remain functional alongside the model in which the patients fully participate in their treatment.[16] Our results confirmed this model and emphasized the importance of entrusting in the decision-making process in Japanese end-of-life care.

Second, a component alluding to fighting spirit and fighting against cancer, which was seldom found in other studies, was frequently found in this study. Fighting spirit was regarded as an effective coping strategy in advanced breast cancer,[17] and high fighting spirit was significantly correlated with adherence to chemotherapy.[18] The findings of this study might indicate that the patients enrolled in this study were likely to have a positive attitude toward the cancer treatments. However, as there was no significant difference in response between patient/family and physician/nurse, and 30% of physicians and 20% of nurses indicated the attributes of fighting against cancer, this result would emphasize that taking all the available treatments is an important factor for achieving Japanese good death.

Third, the three common components focusing on family and human relationships, "Having a good family relationship," "Not being a burden to others," and "Appreciating others," were identified. These components would indicate key Japanese cultural aspects. A previous study revealed that the Japanese family has higher cohesiveness and control than the western family function.[19] Also, the opinions of family members tend to exert a greater influence on clinical decision making in Japan than in the United States.[15,20] In addition, we confirmed that patients and family members more often regarded "Not being a burden to others" as important for their good death compared to medical staff. A smaller Japanese survey on good death revealed that participants over 60 years old preferred to die in the morning or daytime compared with nighttime, to die in the hospitals compared with their homes, and in spring or fall, because their death would cause no burden to others: participants often said, "I want to die in spring or fall, as funeral attendees may feel discomfort when it is too hot or cold."[21] Therefore, in the Japanese cultural context, close relationships with family members and family preferences are highly respected, and the results would show that emphasizing family relationship and avoiding burdening one's family were critical concepts of good death, especially in the Japanese nonmedical population.

Fourth, a unique category "Maintaining pride," which includes attributes such as "Not having a change in one's appearance," "Not exposing one's physical feebleness to surrounding people," and "Not receiving sympathy from others," was identified. Although this category seems to be similar to 'dignity,' the emotional distance of the relationship with others or the social world is highlighted in this category. The emotional distance seems to be influenced by the Japanese cultural tendency, which emphasizes the importance of the relationship with significant others and the social world[22] and seems to be related to the dynamics of family relationships as noted above.

A limitation of this study was that the sample was small and recruited from selected institutions. However, because the sample consisted of people from four major viewpoints of cancer medical settings: patients, their family members, physicians and nurses, and the analysis adopted minor opinions, the attributes seemed not to have leaks, so that the study could be valid. It is believed that a quantitative study using the attributes found in this study will empirically prove the details and the structure of the important elements of achieving good death in Japan.

Conclusion

This study identified the important components of good death in Japan. The main categories of good death were *Freedom from pain or physical/psychological symptoms, Having a good family relationship, Dying in one's favorite place/environment, Having a good relationship with medical staff, Not being a burden to others, Maintaining dignity, Completion of life, Maintaining a sense of control, Fighting against cancer, Maintaining hope, Not prolonging life, Contributing to others, Control of future, Not being aware of death, Appreciating others, Maintaining pride, and Having faith.* Many of them were commonly found in the previous Western studies, though this study also identified four original and unique attributes. A future quantitative survey is planned to clarify the generalizability of these findings and construct the concept of a good death in Japan as the primary endpoint of palliative care.

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特集　がん緩和医療教育の現状と課題

がん緩和医療の教育プログラム
多職種教育のあり方

松島たつ子*

緩和ケアは多職種からなるチームによって提供されるものであり，ケアの質の向上をめざすとき，多職種を視野に入れた教育プログラムを検討していく必要がある．緩和ケアの基本となることについては，ケアに参与するチームメンバーの共通の理解が重要となる．各職種が別々に学ぶのではなく，学習の場を共有することは，互いの専門性を理解し，また，一緒に何かをおこなうという意識を育てることができ，チームケアを進めていくうえで非常に有効な方法と考える．チームケアを実践する一施設で試みられている全メンバーが一緒に学ぶ教育プログラムを紹介しながら，臨床現場での多職種教育の現状，今後の課題について述べる．

はじめに

近年，わが国でも緩和ケアへの認識が深まり，その必要性の高まりを受けて，緩和ケア病棟届出受理施設数の増加，一般病院における緩和ケアチームの活動の活発化，さらに在宅で療養を希望する患者への緩和ケアの提供など，緩和ケアが広く提供されるようになってきた．その結果，医師，看護師をはじめ，ソーシャルワーカー，薬剤師，栄養士，理学療法士，作業療法士，音楽療法士，アロマセラピスト，宗教家，ボランティアなど，さまざまな職種，立場の人びとが緩和ケアに参与し，その数も増加している．

KEY WORDS
緩和ケア
チームケア
多職種教育
ステップアップ方式
地域ネットワーク

一方，この分野の人材育成は，緩和医療の広がりのスピードに追いついていないというのが現状である．また，各職種の教育については，他稿にて詳しく述べられていると思うが，それぞれの専門分野で別々に，独自に検討されている．しかし，緩和ケアは多職種からなるチームによって提供されるものであり，ケアの質の向上をめざすとき，一部の職種の教育だけでなく，また，各専門領域でそれぞれに教育を充実させるだけでなく，多職種を視野に入れた教育プログラムを検討していく必要があると考える．

そこで，本稿においては各職種に対する教育の

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* MATSUSHIMA Tatsuko/ピースハウス病院ホスピス教育研究所

あり方をそれぞれ別々に述べるのではなく，チームケアを実践する一施設で試みられている全メンバーが一緒に学ぶ教育プログラムを紹介しながら，臨床現場での多職種教育の現状，今後の課題について述べる．

なお，緩和医療と緩和ケアという2つの表現があり，本稿のテーマでは緩和医療という言葉が使用されており，その違いが問題になると思うが，ここでは，ほぼ同様の意味と捉え，全人的なケアという視点から，おもに，緩和ケアという言葉を用いることとする．

1．緩和ケアの基本と教育

教育を考えるにあたり，緩和ケアの基本となるものを再確認してみるとつぎのような点があげられる．①痛みをはじめとするさまざまな身体症状の緩和，心理社会的問題への対応，さらに生きる意味を探求するスピリチュアルな問題への対応まで，全人的ケアを提供する．②患者のみならず，その家族（友人など，患者にかかわる人びとを含む）へのケアもおこなう．③ケアの対象となる人びとのQOL（quality of life）の向上と維持をめざす．④患者・家族の自律と選択を尊重し，意思決定の過程を支援する．⑤こうしたケアを実践するために多方面の専門家が参加・協力する．そのチームは単に多職種が集まって役割を分担するだけでなく，互いにネットワークをつくり，協働していく．⑥上記①～⑤を実現するために対患者・家族，また，多職種間において，互いに率直でオープンなコミュニケーションをおこない，それぞれの価値観や生き方の違いを認め，尊重する．

こうした視点から，緩和ケアの教育プログラムを考えると，教育テーマとしては，**表❶**にあげられるような多方面からの学びが必要になる．それぞれの項目について，各職種のもっている知識や関心度が異なり，また，どこまで知識，技術を深める必要があるかはその専門領域によって違ってくる．しかし，ケアに参与するチームメンバーは，こうしたテーマに関心をもち，基本的なことは共通に学ぶ必要がある．その際，各職種が別々に学ぶのではなく，学習の場を共有することによって，互いの専門性を理解し，また，一緒に何かをおこなうという意識を育てることができ，チームケアを進めていくうえで非常に有効な方法と考える．

表❶　緩和ケア教育のテーマ（例）

1. 緩和ケア
    a. 歴史と理念
    b. サービスの諸形態
    c. 世界，わが国の現状
2. がんの理解と症状マネジメント
    a. がんの疫学，診断，治療，臨床経過
    b. 終末期のおもな症状とアセスメント
    c. 症状緩和の方法
        ・薬理学的
        ・非薬理学的
    d. 死の予知と死亡時の対応
3. 心理・社会・霊的ケア
    a. トータルペインと包括的ケア
    b. 終末期患者の心理
    c. 社会的ニーズとケア
    d. 霊的ニーズとケア
    e. 喪失と悲嘆
    f. 家族への援助
4. コミュニケーション・カウンセリング（対人関係）
    a. 自己理解・他者理解
    b. コミュニケーションスキル
    c. カウンセリングの理論と実際
    d. チームケアとメンバーシップ
    e. ストレスとその対処
5. 倫理・哲学・法学
    a. 生と死—死の定義，死生観，安楽死・尊厳死，脳死・臓器移植など
    b. インフォームド・コンセント
    c. ホスピス・緩和ケアとQOL
    d. 倫理的諸問題
6. その他（調査研究，教育，管理など）

2．臨床における多職種教育の試み

緩和ケア教育プログラムが確立され，基礎教育から専門家育成までの継続教育，また，専門職としての公的な認定制度の普及が望まれる．しかし，すでに緩和ケアはさまざまな場に広がり，質の高いケアが期待されている．教育制度の確立を待つ

だけでなく，それぞれの臨床現場における教育への取組みが必要となっている．

筆者の所属するピースハウス病院，1993年に開設された独立型ホスピスでは，スタッフが仕事をつづけながら学習できるプログラムを開発した．以下，この教育プログラムを紹介し，実践のなかで学ぶ意義と可能性について紹介する．

ピースハウス病院では，医師，看護師，薬剤師，ソーシャルワーカー，チャプレン，栄養士，音楽療法士，訪問看護師，ボランティアなど，多職種からなるチームによってケアを提供している．そして，これらのチームメンバーが一緒に学ぶ教育プログラムを教育委員会が中心になって開発している．

1）教育プログラムの基本方針

本プログラムの基本的方針はつぎの5つである．

a．知識と技術の統合

基本的な知識は，講義や文献を通して学ぶことになるが，それらはあくまでも基本であり，患者一人ひとりのケアの実践に応用できるとき，その学びは真に学習者のものとなっていく．本プログラムは，臨床の場が学習の場という考え方をもとに，日常の実践を通して学びを深め，知識と実践を統合していくことをめざす．

b．自己学習支援

成人教育の基本でもあるが，一人ひとりのスタッフが学習の必要性を自覚し，自発的に学んでいく過程を支援する．したがって，教育プログラムとしては，緩和ケアの基本を学ぶ自己学習ノートの準備，各種検討会・勉強会の企画，施設外との教育ネットワークづくりなど，さまざまな形で学習する機会を提供し，それらをどのように活用していくかは各スタッフの選択，責任とする．

c．ステップアップ方式

学習者にとって，学びの成果を自覚できることは重要である．臨床経験，学習経験に応じてステップアップしていく教育プログラムとする．

d．チームによる，チームのための教育

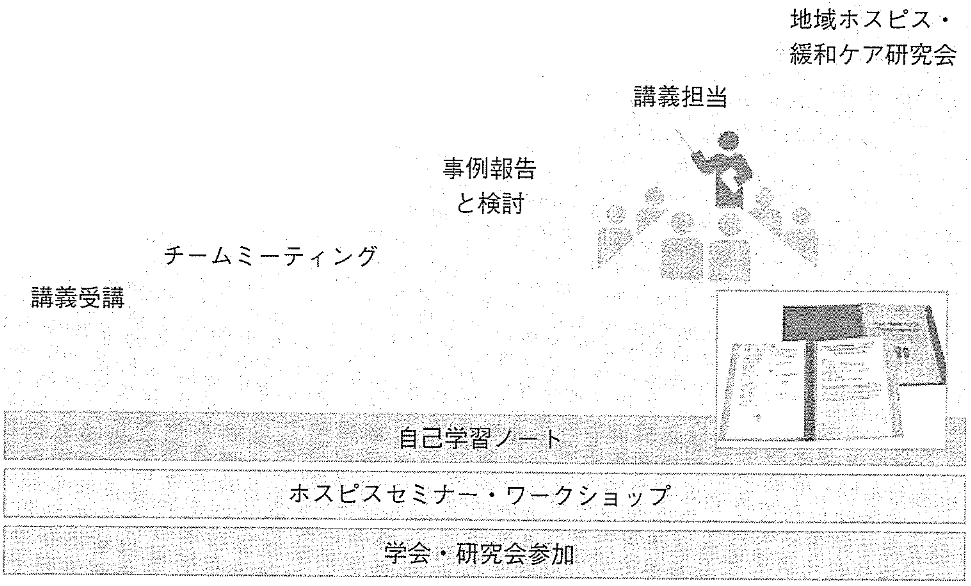
チームとして何かをなそうとするとき，各メンバーが企画段階から参加し，最初から一緒に考え，行動をともにすることは仲間意識を育て，協力し合う関係を育てていくうえで大変重要である．教育においても，一部の職種や特定の人がプログラムを企画し，指導する立場に立つのではなく，各チームメンバーが主体的に関与し，チーム全体を視野に入れた学習プログラムをもつとき，チームとして成長していくことができる．

e．地域ネットワーク

患者を地域社会のなかで生活をする人としてとらえるとき，ケアは一施設で完結するものではない．一般病院，がん専門病院，開業医，訪問看護ステーション，福祉サービス部門・施設など，さまざまな医療・福祉関係者との継続的な協働作業が必要である．そこで，学習の場を地域の医療福祉関係者とともにもつことで，教育を通して地域連携にもつなげていくことをめざす．

2）教育の目標設定とステップアップ学習方式

緩和ケアに参加するスタッフは，卒業直後の新人ではなく，それぞれの専門分野において臨床経験をもっているが緩和ケアに従事するのははじめてという者が多い．また，近年では，他の施設での経験をもった者がチームに加わることもある．そこで，当教育プログラムでは，到達目標を3段階で示すこととした．第1段階は，入職時オリエンテーションのレベルで，まずは緩和ケアの概念や病院の理念を理解し，チームの一員としての自覚をもち，基本的な知識を習得する．第2段階では，各職域において，一人のスタッフとして行動できるようになる．第3段階は，チームのなかでリーダーシップを発揮し，指導的な役割をもつことができるようになる．基本的には第3段階の達成時期を3年と設定しているが，入職時にすでに第3段階の能力をもつ者から，長く第2段階にとどまる者など，個人差があり，到達期間はそれぞ



図❶ 教育プログラム―ステップアップ方式―

れの成長レベルにあわせて適応していく．

この3段階の目標に到達するために，臨床現場での経験と関係をもたせながら学習の場，学習方法をステップアップしていく様子を示したものが図❶である．

a．第1ステップ

オリエンテーションとして，すべての新人スタッフが同じ席上で，ホスピス・緩和ケアの基本的考え方，各職種の役割や機能について，院内のそれぞれの専門家から講義を受ける．また，ボランティアとハウスキーパー(環境整備)のはたらきについては実習もおこなう．オリエンテーションをおえると，現在のところ看護師が対象であるが，自己学習ノート(チェックリスト)が渡される．この学習ノートには，ケアに必要な基本的な項目が質問形式で掲載され，また，参考文献なども紹介されており，スタッフは実践での経験を積むとともに，このノートを利用して自己学習を進めていく．

b．第2ステップ

チームを構成するスタッフとして機能しはじめると，全職種が参加する日々のチームミーティングに参加し，他のメンバーと意見交換をしながらさらに学びを深めていく．内容としては，症状マネジメント，心理社会的問題への支援，家族の問題，倫理的課題への対応など多岐にわたり討議する．チームミーティングでは，患者や家族へのケアについて討議するだけでなく，「チームの日」という場を設定し，自分たちの課題，自分自身への気づきを深めることも大切にしている．また，喪失と悲嘆，ストレス，死生観など，さまざまなテーマについて自由に語り合う「ホスピスケア研究会」などもあり，互いの知識や経験を分かち合いながら学ぶ場となっている．

c．第3ステップ

月1回，一事例について検討する事例検討会がある．論点を絞って多職種でじっくり議論することにより，多面的なものの見方，考え方を学び，取りあげられたテーマについて理解を深めることができる．また，この会に参加するだけでなく，自ら事例を提示する役割を与えられる．発表担当者は，スーパービジョンを受けながら事例提示の準備をおこなうが，文献検討やスーパーバイザーとの討議など，この準備のプロセスが重要な学びの機会となる．なお，発表担当は，看護師同士など同一職種が組む場合もあるが，栄養士と看護師，音楽療法士とチャプレンなど，異なる職種が一緒