

米国地方都市における在宅ホスピスボランティアの選考と研修について

概要

小規模ホスピスにとってボランティアの役割は極めて重要である。

ボランティアとして活動するには、選考されて研修を受けることになる。

この研修プログラムでは、ボランティア内容の習得、体験的学習、相互の選考、チーム作りならびに広報活動を学ぶ。

ボランティアの選考に当たっては、独自の信念・価値観に固執する者、悲嘆にくれる者、一方的にしゃべるなど好ましくない性格の人々はボランティアには不向きである。研修講座ではホスピス概念、チーム編成、コミュニケーションスキル、死の認識、共感、基礎看護技術、死が家族にもたらす影響、癌の医学知識、ペインコントロールならびに医師の役割を学ぶ。本稿はこれらの学習目的を遂行するため事例にて解説し、ミシガン州

北部地域の在宅ホスピスボランティアを養成するプログラムとしてよく機能しており、効果的なアプローチを提示するものである。

導入

地方の在宅ホスピスは、医師、看護師、ソーシャルワーカー、心理療法士、聖職者ならびに一般人のボランティアに頼っている。ボランティアとして活動するためには研修が必要であるが、選考から研修にいたる実践的な書物が少ないため、本稿では交流のないボランティア同士の関係を深め、チームとして活動できるように一つの方法を紹介している。

地域紹介

ミシガン州北部に位置するエスカナバは人口15,000人を擁し、127の急性期病床を有するカソリック系病院がある。この医療機関には、4つの介護施設とメンタルヘルスセンターが併設されており、周辺地域住人4万人が利用している。同地域には35人の医師がおり、プライマリケアと専門医がほぼ半数である。また、北70マイルに所在するミシガン州立大学では家族問題講座が開設されている。

住人の多くは北欧系で60%がローマカソリック教徒であり、林業、製造業、観光業ならびにサービス業に従事している。この地域の毎年の死亡数は370人でそのうちの60人が癌などの終末期の患者である。

ベイディノックホスピスは非営利団体で入院施設はなく、看護師を患者の自宅に派遣して無料でサービスを提供している。ボランティアには実費のみが支払われる。

ほぼすべての患者は自宅で死を迎え、家庭医と牧師はケアチームの一員となり終末ケアに携わっている。

ホスピスボランティアに向かない性格

- 1) 独自の信念、価値観に固執する者。
- 2) 深い悲しみにいる者。
- 3) 常に人のあらいを探る者。
- 4) 相手に話をさせず一方的にしゃべり、患者に不愉快感を与える者。

教授法

研修の目的を遂行するには下記の教授法があるが、それぞれに長所と欠点がある。

講義

内容を理解させるにはよいが、講義に積極的ではない研修生にとっては受身になり易い。20分を超える講義は避けること。配布資料を準備すること。

パネルディスカッション

ホスピスの経験者をスピーカーに招き、司会者の上手な進行で研修生全員が参加できるが、内容を習得させるには不向き。

グループセッション

小さなグループに分けて課題を与えるため、すべての研修生が参加でき、メンバー同士で実務的な経験が得られるが、情報を伝えるには欠点。

映画、スライド、テープ

映像、オーディオを媒体としてホスピスの実態を学ぶことができる。

体験的な訓練

自らの死亡記事を書き、小説の内容から死を考えるなどさまざまな方法による体験を通して学ぶことができる。

トレーナー（講師）

トレーナーの人は重要であり、グループをまとめる能力を有し、死を認識しているソーシャルワーカー、学校、地域メンタルヘルスの心理療法士、地域を熟知する医師など柔軟性、率直さ、柔和さ、さらには参加者の経験を活用できる資質を有する人物が望ましい。

研修日程

週一回、夜間3時間の研修を6回実施する。クラス規模は15-20名、ラウンジにて

ゆったりとした雰囲気の中で行われる。参加者には毎回の出席が義務付けられる。

セッション 1

ホスピスについて

ホスピスの歴史ならびに地域のホスピスプログラム内容を学ぶ。

研修者の紹介

研修者同士とコーディネーターをよく知ること。

コミュニケーション入門

言語と非言語のコミュニケーションの重要性を学ぶ。

最初に経験した死の回想

死に対する個人的な感情を整理する。

セッション 2

死—霊的、社会的側面

死に対する霊的、神秘性について考える。

一般的なホスピスケアで生じる死に対する問題点を考える。

死についての個人の認識

死を自分のものとしていかに捉えるか。

共感について

ホスピスケアで重要である共感を明らかにし、その共感を相手に伝える表現方法。

セッション 3

看護師以外の研修者への看護技術

ホスピスケアで必要な看護技術の習得。

傾聴

言葉以外でも傾聴することで共感を表現する。

セッション 4

死とその家族

死にいく患者の家族が抱える問題を知る。

感情の受容

患者を助ける前に、自分自身の感情を受容する重要性を理解する。

セッション5

傾聴

傾聴の大切さと、とりわけ静寂の意義を考える。

静寂をイメージする

心を落ち着かせ、「今」の瞬間を大切にすゝる気持ちを心で感じる。

信頼感

普段見過ごしがちな他人を信頼する気持ちを実践で体験する。

セッション6

死の定義

死を法律ならびに実務の観点から解説する。

癌を社会と医療の観点からみる

癌の病態と癌に対する社会の誤解を知る。

終末期患者の身体的痛み

痛みの病理学と痛みをコントロールする薬剤とその投与法の説明。

医師の2面的な役割と患者の期待

死に行く患者とその家族が抱く医師への失望感の原因を理解する。

ボランティアの最終選考

6回の研修終了時にボランティアは願書と質問・要望書を提出できる。トレーナーは提出書類と研修中の成績を鑑みて合格の判断を行ゐる。合格すると修了書が発行され、合格者に適したホスピコーディネーターに紹介され、当面はホスピスワーカーのアシスタントとして一緒に仕事をしながら経験を積んで独立していくことになる。

結論

専門家も含めすべての参加者はホスピス研修を受けた後に患者に接することができる。本研修には60名が参加し、目標に向かって研鑽を積んでいる。この研修は参加者にとっては成長するための教育と実践の観点を持つものでもある。コーディネーターと患者からの意見はボランティアの資質を向上する上で役立つ。研修終了後も活動中のボランティアは毎月一回会合を持ち、そこで出る示唆に富む情報はボランティアを育成する上でコーディネーターにとっても貴重な情報となる。ボランティアのなかには患者に接する機会がないことに不満をもつ者もいるが、家族の看護を補佐するのもボランティアの大きな仕事である。

研修を終了した参加者のほぼ全員がボランティアとして働くことができる。オリエンテーションセッションはボランティアが働くことができるようグループ作りを行う一方で、新たなボランティアの支援システムとしての役割も担っている。また、研修中にボランティアの参加動機を明らかにし、個人の限界を知らせることで、適切なホスピスボランティア活動を可能にする。また、ボランティアが目的意識を持つことで、トレーナーにとってもボランティアの再編成が不要になる。

(詳細については、Paul L. Werner, Phillip S. Chard, Carl Hawkins, Thomas Marshall (1982), The selection and training of volunteers for a rural, home-based hospice program, *Patient counselling and health education*, Vo.3, No.4,124-131.を参照)

II - 4 Overview of Hospice/Palliative Care System in Japan

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Summary: For the purpose of suggesting Community-based participatory Care System for Home-based Hospice in Japan. To analyze the characteristics of hospice law, cost system, and management system through the comparison among foreign countries' hospice law, cost system, and management system, we surveyed 3 hospitals, 3 hospice agencies, 3 hospice day care centers, 3 home hospices to collect the data of organizational structure, facilities, equipment, manpower, payment for hospice care, contents of service etc.

Mainly accepted patients should be adults with terminal stage malignant tumors. But criteria for accepting patients for care are more flexibly applied in Home-based hospice care than in the case of Hospital-based hospice care. A typical hospital-based hospice care team includes physicians, nurses, social workers, a pharmacist, a chaplain, and volunteers, but home-based care it difficult to involve a psychiatrist, dietician or physical therapist because of the smaller size of care operation.

The medical cost of patients receiving hospice/palliative care is paid by the health insurance program to which they subscribe, according to the medical service fee prescribed for the treatment, tests, and care provided. Palliative care ward hospital charges are calculated at the fixed rate of 37,800 yen per day. The home-based palliative care fees per day are reported to be about 9,000 yen including examination and test fees. For a result of expanding the home care clinic system in Japan, day care at a clinic or home-visit nursing care station has become possible. Regarding the control of quality of hospice/palliative care, few facilities have, and implement, a clearly specified quality evaluation system.

It is important for care team members sharing and working towards the goal of care by playing their role as specialist professionals while exchanging views, and collaborating, thereby promoting better patient QOL. As an important element of cancer care, the law encompasses the stipulations for reinforced promotion of continuing education and training for doctors and nurses who have excellent knowledge of and skills in palliative care.

A. Purpose

To suggest Community-based participatory Care System for Home-based Hospice in Japan, analyze of characteristics of hospice law, cost system, and management system through the comparison among foreign countries' hospice law, cost system, and management system.

B. Methods

1. Contents of Analysis: Survey 12 hospice institutions for hospice management system (3 hospitals, 3 hospice agencies, 3 hospice day care centers, 3 home hospices): organizational structure, facilities, equipment, manpower, etc.

- Hospice law : General provisions, recipient eligibility, duration of coverage, election and revocation of hospice care, conditions of participation, covered services, payment for hospice care, utilization control, right of appeal, etc.

- Hospice cost system: Hospice budget on governmental level, detailed hospice payment system, amount of clients' payment, etc.

- Hospice management system: Type of hospice services, contents of service, manpower, equipment, etc.

2. Workshop with international co-researchers (Yonsei University, National Yang-Ming University, St. Luke's College of Nursing)

C. Results and Discussions

<Management system>

Hospice care in Japan was modeled after St. Christopher hospice in England which was funded

by Sisily Sonders and has become increasingly popular. In 1982, cancer was recognized as the number one cause of death among Japanese. Since 1983, an annual terminal Care Conference has been held in Japan. Since 1990, Palliative Care has been covered by national health care insurance. The concept of hospice/palliative care has been gradually expanded and awareness among the public has grown. Due to the aging and the increased longevity of the Japanese population the number of cancer patients has increased dramatically. Therefore, hospice/palliative care units are having difficulty of caring for the increased number of cancer patients. To cope with this, government certified palliative care units were started at many large hospitals. Into 2006, the Cancer Control Act was enacted, and cancer treatment and palliative care took a dramatic turn. Under this law, palliative care in the community is a priority. In the future, hospice/palliative care could be extended to suffering patients from other disease.

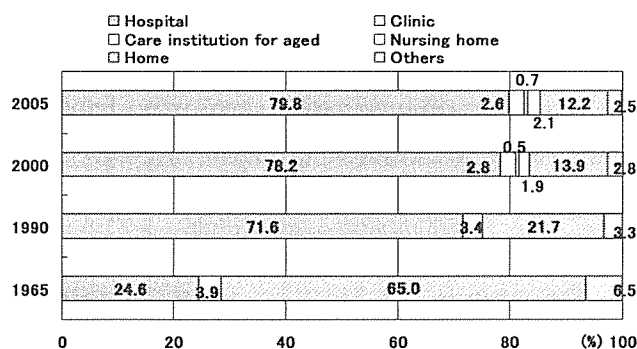
Although hospice care in Japan modeled after St. Christopher hospice, it now includes palliative care. In Japan, the term "Palliative Care" has become more popular than hospice care. A reason of this situation is using a word of palliative care on the occasion of institutionalizing a hospice care. The definition of palliative care in Japanese nursing is based on that presented by WHO in 1987. Unlike in the past, nowadays, palliative care is used to treat all stages of cancer not only the end stage.

In Japan, the estimated number of cancer deaths in 2005 was 325,000 persons, which accounted for one-third of the total number of deaths. Given

the rapid aging of the population in Japan, the prevalence of cancer as well as cancer mortality will continue to rise in coming years. As the mortality from cancer increasing through to 2020, cancer will come to represent half of all mortality in Japan.

In surveys of Japanese people, 50% of respondents indicated that they would prefer to die at home. Until 40 years ago, in Japan, over 60% of the people died in their own homes, but currently, 10% die at home (Fig.1).

Fig.1 Place of death in Japan (Ministry of Health, Labour and Welfare, Statistics and Information Dept.)



I'd like to review the health situation in Japan to better understand hospice/palliative care (Table.1).

Table.1 The feature of Japan's Palliative Care Unit

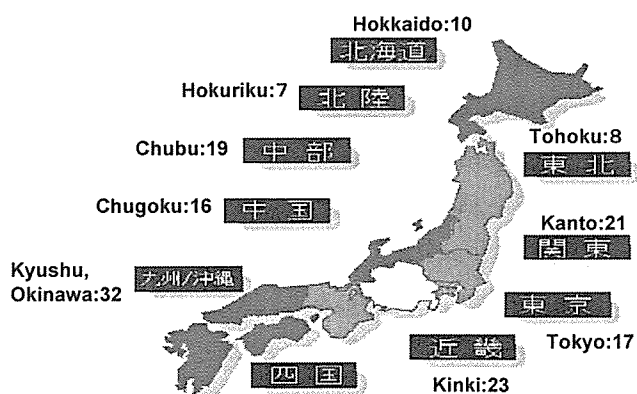
- In Japan, people have universal health care system
- Cancer has been the leading cause of the death since 1982
- Japan has the world's highest longevity rate
- Palliative care has been revolved focusing on cancer treatment
- Promoting Palliative is a government priority; these are new programs
- Respect the family's opinion for the choice of the treatment
- Improvement in palliative care unit in many facilities and introduction of a new finance system .

In Japan there is a universal health care system. Cancer has been the leading cause of death since 1982. Japan has the world's highest longevity rate. Palliative Care focused on cancer patients. Palliative Care has spread due to the government's effort to prioritize it. Families have been increasingly involved in the choice of cancer treatment.

Japan's hospices/palliative care can generally be divided into two types; Hospital- and Home-based hospice care. From 1990, "Palliative Care Unit" has been recognized as a health care treatment under national health insurance. The concept of hospice/palliative care has been gradually expanded and public awareness has increased.

As of February 2007 there are 163 Palliative Care Units with a total of 3,118 beds nationwide (Fig.2).

Fig.2 Palliative Care Unit Approved (PCU) - Hospital-Based (Feb. 2007)
<http://www.bayline.or.jp/jard/>



Most units are in urban areas. There is one prefecture which does not have any units. In addition, there are five thousand seven hundred Home-based hospices. Both Hospital- and

Home-based hospices, as shown in Table.2, have criteria for accepting patients for care.

Table.2 Necessary Condition for Receiving Hospice/ Palliative Care (“Standard of the Hospice/Palliative Care” from Hospice Palliative Care Japan)

1. Patients affected malignant tumor, AIDS, diagnosed as incurable disease and who do not desire to have aggressive treatment.
2. Desire to receive by adult patients, their family.
3. Good understanding of disease condition and prognosis.
4. Services are not discriminate for social, economic or religious reasons.

In either case, accepted patients should be adults with terminal stage malignant tumors. It is also suggested that patients should desirably understand their disease and conditions. These criteria are more flexibly applied in Home-based hospice care than in the case of Hospital-based hospice care. As such, Home-based hospice care provides hospice care for patients other than described above, such as patients with terminal chronic cardiac failure and children with a terminal-stage illness. For both Hospital- and Home-based hospice care, patient registration for hospice/palliative care is processed according to the following steps (Table.3):

Table.3 Registration of Hospice Services

- Explanation of the advancing condition to the patient from attending physician.
- ⇕
- Decision making where a patient might receive hospice care.
 - Referral of the patient’s attending physician.
 - Application of the client and/or the client’s family.
 - ⇓
 - Approval of attending physician.
 - Patient’s and/or their family agreement for hospice care.

Patients are given an explanation about their situation by their attending physician, in which cancer treatment effectively arresting the progression of cancer is reaching its limit. Treatment must now be shifted to hospice care that focuses mainly on relieving symptoms. Patients and families make decisions as to facilities and system for the hospice care. Based on their decisions, the attending physician writes a referral to the facility where the patient wishes to receive the hospice care, the patient or the family then applies to the facility of intended care. The physician in charge of hospice care reviews the application. In providing hospice care, some facilities require patients or families to give consent.

Unlike in some countries, there is no limit to time spent in hospices in Japan. The average length of a patients stay at a hospice/palliative care unit is approximately 25 days.

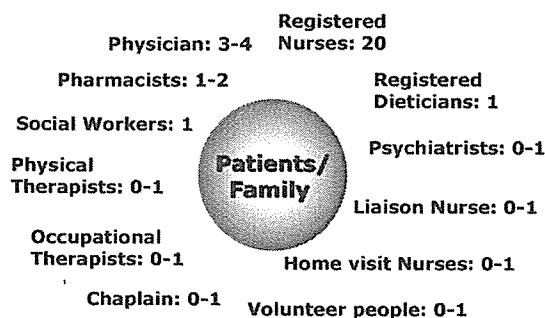
The picture (Fig.3) shows a typical Hospital-based hospice care team; the team includes physicians, nurses, social workers, a pharmacist, a chaplain, and volunteers.

Fig. 3 The picture of a typical Hospital-based hospice care team



The diagram (Fig.4) presents a typical picture of care team members. The figure shown with each job title refers to the average number of professionals involved in a care team.

Fig. 4 Team member of Palliative Care Unit



A care team for Home-based hospice care may be the same as that for Hospital-based care, However the smaller size of care operation often makes it difficult to involve a psychiatrist, dietician, or physical therapist (Fig.5).

Fig. 5 Team members of Home-Based Hospice

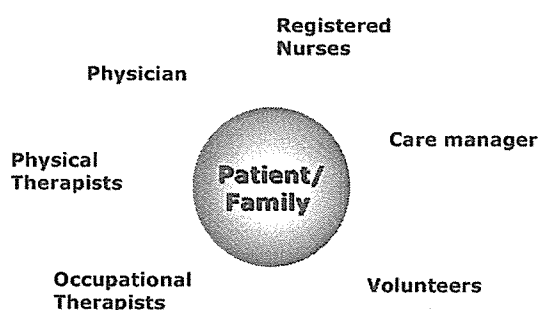


Table.4 shows the minimum educational requirement for hospice care team members.

Table.4 Minimum Educational Requirement for Hospice Personnel

Types of hospice care	Hospital-Based Hospice	Facility-based hospice	Home-Based Hospice
Doctor	6 years basic education and 2 years training. Successful candidates at the national examination for medical practitioners		
Registered Nurse	3 to 4 years basic nursing education Successful candidates at the national examination for registered nurses		
Social Worker	4 years basic education and successful candidates at the national examination for social welfare counselor		
Churchman /minister	If the facility is affiliated with a religious organization; few are .	Flexible	
Volunteer	In many palliative care units, but the members differ.		Flexible

Obviously, medical professionals including physicians, nurses, and social workers must be fully qualified based on the respective national examinations. In order for an institution to be eligible for National Health Insurance, physicians are required to meet the following criteria for clinical experience; they must be a full-time palliative care unit physician with experience in the palliative treatment of patients with malignant tumors. For nurses, although it is stated, there must be more than one nurse. Some facilities have annual training programs in line with the requirements for individual professionals, to help nurses and physicians develop their professional skills.

The assignment of care team members depends on the facilities. According to the results of our study, the duties of each professional can be described as follows (Table.5):

It is critical for them to work as a team in order to provide comprehensive care for the better quality of life of their patients and families. In Japan, Hospice Palliative Care Japan sets the standards for care teams, as shown in this slide. The Fig.6 highlights the importance of care team members sharing and working towards the goal of

care by playing their role as specialist professionals while exchanging views, and collaborating, thereby promoting better patient QOL.

Table.5 Duties of each professional

- **Doctor**
 - Management of pain and other afflictive symptoms mainly by pharmacotherapy and conservative treatment
 - Management of cachexia, decreased respiratory and circulatory functions, and systemic symptoms
- **Nurse**
 - Caring for pain and other afflictive symptoms
 - Caring to have patients to maintain psychological and physiological ease and peace
 - Daily support based on the patient's preferences and needs
 - Emotional / spiritual care
 - Continuous monitoring of patient condition
- **Social Worker**
 - Psychological and social support for dying patients and their family

peer-review on treatment policies, nursing plan assessment, and working meetings to review the status of bed occupancy and individual activities, may be considered to be part of the quality evaluation.

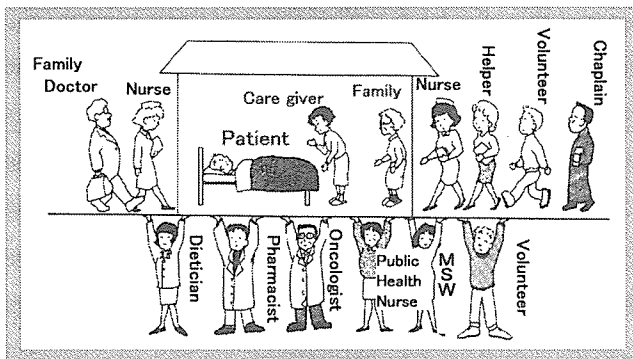
Table.6 Quality Control

- Evaluation by Japan Council for Quality Health Care
- Peer review
- Audit of nursing plan
- Care – Provider System Committee

<Payment>

Payment for hospice/palliative care is mainly covered by the health insurance system in Japan. Health insurance can mainly be categorized into two types: national health insurance and workplace health insurance. Most of the Japanese citizens subscribe to these insurances. The health insurance system is operated through the premiums (taxes) paid by the members (“the insured”), subsidies from the national government, and other sources. Under the workplace health insurance system, premiums are paid by employees according to individual income. They are collected by companies of employees, and finally contributed to the appropriate health insurance unions.

Fig. 6



Regarding the control of quality of hospice/palliative care, few facilities have, and implement, a clearly specified quality evaluation system.

The Table.6 is a quality control of palliative care. Hospitals with Palliative Care Unit are evaluated by Japan Council for Quality Health Care, and the palliative care unit is required to report on the matters specified by the hospital function review board. Case conferences,

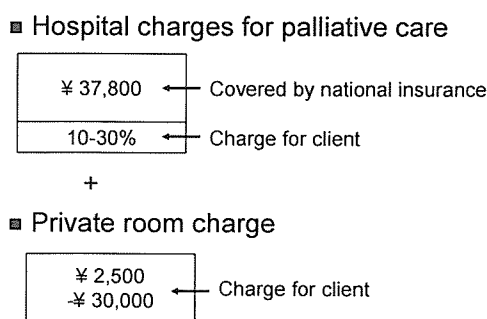
The medical cost of patients receiving hospice/palliative care is paid by the health insurance program to which they subscribe, according to the medical service fee prescribed for the treatment, tests, and care provided. On the sliding scale, depending on the income and age, the insured must bear part of the medical fees at a rate of 10%, 20%, or 30% (Fig.7).

Fig.7 Percentage of Medical Expense Paid by the Patient: National Health Insurance

Those under 3 years of age	Those between 3 and 69 years of age	Those between 70 and 74 years of age
20%	30%	10% * 20% for those with a designated income or higher

Based on these characteristics of health insurance in Japan, I would like to discuss specifically how the medical fees of hospital-based or home-based hospice care are paid. Palliative care ward hospital charges are calculated at the fixed rate of per day as the medical service fee based on the Medical Care Law. All expenses for treatment, tests, and care for the patient are included in this amount. It means that whichever treatment, test, and care the patient receives, the patient would not be charged higher, and the patient bears 10 to 30% of this amount. For patients bearing 30%, the amount per day paid by a patient is about 12,000 yen. Some hospitals may also charge room fees. This is not covered by medical care insurance and is paid by the patient (Fig.8).

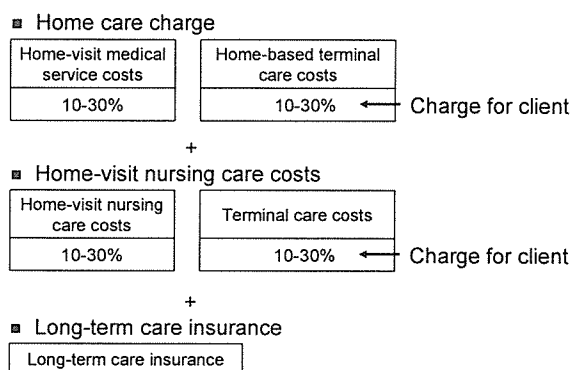
Fig.8 Government Payment: Hospital - Based Hospice



According to a Ministry of Health, Labour and Welfare survey, the cost for in-patient (inpatient) treatment per month is about 410,000 yen. It has also been reported that such cost increases up to 1 million yen, one month before death. Since payment for hospital-based hospice care is based on a fixed rate per day, medical fees for any treatment and care provided exceeding government limit must be paid by the hospital. To stop such increases in medical fees, the Ministry has set down policies to promote use of home-based hospice care service.

As shown in the Fig.9, home-based hospice care is palliative care for patients spending the last stage of their illness at home, with the cooperation of doctors of the home care clinic, and nurses of the home visiting nursing station. For example, home-based hospice care support group Pallium is a company which runs both a home care clinic and home visiting nursing station. It provides home-based hospice care service for one part of the Sumida ward, Tokyo. Pallium has one doctor, five home-visiting nurses, one care manager, one administrative staff, one physical therapist, one volunteer coordinator, and 20 registered volunteers.

Fig.9 Government Payment: Home-Based Hospice



Patients are charged the following three medical fees mainly for home-based hospice care service: home visiting examination fees, total home-based terminal care fees, and home visiting nursing care fees. This slide shows the medical fee for home-based hospice care. All are per day prices. 10% to 30% of the amount is paid by the subscriber and the remaining amount by the appropriate health insurance program. The examination and test fees are included in the total home-based terminal care fees. The medical fees per day are reported to be about 9,000 yen.

Home-based hospice care allows terminal cancer patients above the age of 40 and elderly persons requiring care to use the long-term care insurance system according to care certification. For example, if a patient qualifies for home-based hospice care after certification of degree of care required (care need), the patient can receive help in bathing and care goods. In Japan the long-term care insurance program is independent from the health insurance program. It is enforced based on the Long-term Care Insurance Law, established in 1997 with the aim to support the independence of elderly persons. Insured persons above 40 requiring care are able to use nursing services in accordance with the support required. The long-term care requirement certification and support requirement certification based on the screening judgment are resulted by the long-term approval board in a community. As home-based hospice care service allows medical care insurance to be combined, nursing care service can be provided taking into account the daily lifestyle of each individual. Currently, there are

6,000 facilities around the country which are registered as home care clinics providing home-based hospice care service (Table.7).

Table.7 Long term care insurance

- Objective: To help old people live an independent life
- Application: Insured person (over 40 years) who received an approval for nursing care from the Care Need Certification Committee

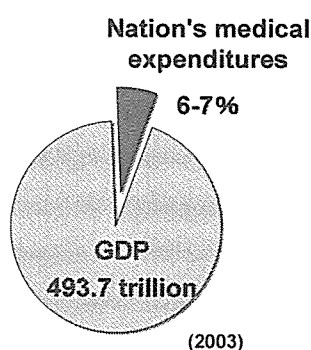
However, several home-based hospice care problems are being pointed out. One is that the linkage between clinic, home-visiting nursing station, and welfare services provided by the local community is complicated and difficult to understand for use. Difference in quality of care by facility is large. The greatest challenge, however, is said to be the system for transferring patients from hospitals providing cancer treatment to home for hospice care is not running as effectively as required. Cancer patients in Japan have strong trust in their doctors. So when they are told by their doctors to switch to home-based hospice care during the terminal stage, they feel they are being abandoned by their doctors, and many choose to die in hospitals (Table.8).

Table.8 Problems of Home-based Hospice

- Complexity and difficulty of cooperation between clinics, home visiting nursing stations, and welfare services provided by community
- Difference in quality of care between facilities
- Insufficient system to transfer from the cancer treating hospital to home-based hospice physicians
- Patients strongly trust physicians of the cancer treating hospital. If they are recommended to shift to home-based hospice service, they feel abandoned. Many people choose death at the cancer treating hospital

Japan's national medical expenditures in 2003 totaled 32 trillion yen, which is equivalent to about per person. Medical costs account for essentially 7% of GDP. With the growing graying population in this country, the reduction of medical costs is a national issue. With the major focus on the reduction of inpatient treatment cost, the Ministry of Health, Labour and Welfare aims to reduce medical costs by about 500 billion yen in fiscal 2012, specifically by increasing the use of home-based hospice care service, which means decreased percentage of patients spending their final day at hospital. The ministry is therefore putting efforts into promoting home-based hospice care use (Fig.10).

Fig.10 Nation's medical expenditures (2003)



<Laws>

The practice of hospice/palliative care is governed mainly by the Medical Care Law and the Health Insurance Law. The purpose of the Medical Care Law is to secure a system to provide medical services to contribute to the preservation of public health; it can be said that this is a law pertinent to the hardware side of hospice/palliative care. The Health Insurance Law

is the oldest legislation among ones concerning social insurance in Japan, which is designed to implement insurance payment for people's illness, injury or death, or childbearing. This law aims at contribution to the stabilization of people's life as well as the improvement of public welfare. It is figuratively a law regarding the software side of hospice/palliative care. The Medical Care Law establishes the way of setting up, managing and improving a hospital, clinic, or midwifery center, and other relevant matters. This is a law concerning medical institutions; and the responsibility and obligation of individual doctors and nurses are written in the Medical Practitioners Law and the Public Health Nurses/Midwives/Registered Nurses Law. In 1997, the third amendment to the Medical Care Law was implemented. On the occasion of the revision, the system for regional medical-support hospitals became effective, giving a boost to diffusion of home-based hospice care (Table.9).

Table.9 Standards for hospital charges of the palliative care unit (Social Insurance Law)

1. Generally patients with malignant tumor or AIDS are admitted to receive palliative care, which is provided on a care unit basis
2. The number of nurses providing care service is one for every seven or less patients throughout a day. If a higher assignment ratio of nurses is achieved in the care unit, the number of nurses engaged in the midnight shift shall be two or more, irrespective of the provision aforementioned
3. A sufficient system or organization is established to provide palliative care service
4. Sufficient equipment and facilities are installed to provide palliative care service
5. A system to decide patients' admission to and discharge from the care unit is developed
6. An appropriate percentage of sickrooms providing a particular care environment as an option, which is specified by Article 63.2 of the Health Insurance Law and Article 17.2 of the Health and Medical Service Law for the Elderly, are provided
7. Already examined by the Japan Council for Quality Health Care

We will describe the systems for the software side: first, hospital-based hospice care. It was in 1990 that hospice/palliative care became institutionalized as a formal medical care item, “charges of hospitalization in a palliative care unit” under the Health Insurance Law. In order for a hospital to apply health insurance to be able to charge a patient for hospitalization in a palliative care unit as a medical service fee, it has to meet “the establishment standards” for the approved facilities of palliative care unit required by the Ministry of Health, Labor, and Welfare. The establishment standards are shown in the Table.9. The criteria of this establishment standards involved facility details and the number of staff, as well as quality of care, for example, “the hospital has received an evaluation of medical practices”. This criterion is called “evaluation of palliative care practice” and implemented by a third party, the Japan Council for Quality Health Care (Table.10).

Table.10 Necessary condition for receiving Hospice/ Palliative care (“Standard of the Hospice/Palliative care” from Hospice Palliative cares Japan)

1. Patients who are affected malignant tumor, AIDS, diagnosed as incurable disease and those who do not desire to have aggressive treatment.
2. Grown-up patients and their family or any of them desire for receiving hospice/palliative care.
3. It's desirable that patients and family well understand the disease and the conditions. If they did not understand, it is necessary to give explanation according to their demanding.
4. We do not any discrimination against patients by social, economical and religious reasons.

The Japanese Hospice Palliative Care Council established the Evaluation Criteria Review

Committee in 2003, and revised “the hospice/palliative care program criteria” and also prepared “the evaluation guideline” for self-assessment of care practiced at each facility. The details are shown in the slide. (Fig.) For example, hospital-based hospice will alleviate a distressing symptom, such as pain, with appropriate care and treatment; it will address physical, mental, social, and spiritual needs of the patient and his/her family to provide care; it will provide interdisciplinary care based on a team approach.

As for home-based hospice care, the home care clinic system was newly established in 2006 under the revision to the Medical Care Law. This system has allowed clinics that make house calls or provide visiting care on a round-the-clock basis to be covered by medical insurance (Table.11).

Table.11 Home-based Hospice, system for home care support clinics

- Clinic: Assignment of doctors or nurses who could receive calls round the clock
- Development of a system that can provide visiting nursing care round the clock
- Cooperation with care support specialists (care managers)

The requirements of the system include the following: a clinic is required to allocate doctors or nurses who are reachable 24 hours a day, to secure a system that enables provision of 24-hour visiting care, and to collaborate with nursing care managers who are in charge of liaison and coordination between medical services and nursing care services. Given the present circumstances, the setting up of home-visit

nursing care stations that cooperate with doctors at home care clinics to send nurses has stagnated; the number of such clinics stays at 5,700 across the country. A shortage of nurses has become a serious problem.

For a result of expanding the home care clinic system in Japan, day care at a clinic or home-visit nursing care station has become possible. Terminal cancer patients use day care at a home-visit nursing care station as a Long-term care service. The contents of the service provided include rehabilitation for cancer, interaction with other users, and dining together, constituting a service for patients to spend meaningful, quality time. The fee is calculated to be a little over 1,600 yen per hour, which is covered by Long-term care insurance. In home-based hospice, with a combination of health insurance and Long-term care insurance, it has become possible for patients to receive substantial care including day care. For smooth operation of day care, strong collaboration between medical practitioners and nursing-care professionals is necessary (Table.12).

Table.12 In case of using Day care service

- Costs for using day care services: per person, day
 - 3 hrs-6 hrs→about ¥ 10,000
 - 6 hrs-8 hrs→about ¥ 15,000
- Obligation fee (10% of the total cost because of long-term care insurance)
 - 3 hrs-6 hrs→about ¥ 10,00
 - 6 hrs-8 hrs→about ¥ 15,000
 - + food costs(actual expenses are only about ¥300)

In the meantime, there need to be volunteers or any other collaborators who take patients to and

from home care clinics; and actually, only a small number of facilities are able to put it into practice.

Up to this point, we have provided an explanation about the laws concerning hospice/palliative care in our country. Although enacting the relevant laws has been implemented for a little more than two years, a shortage of home care doctors and visiting nurses who put the laws into action has become a major concern. For this reason, in Japan, Cancer Control Act was instituted in 2006 for the purpose of further promotion of hospice/palliative care. The outline of the legislation is shown in the Table.13.

Table.13 Basic Law on Cancer Treatment (Effect on April/2007)

- | | |
|---|--|
| <ul style="list-style-type: none"> ■ Objective: Promote the measures of cancer treatment in a comprehensive and a systematic manner. <ul style="list-style-type: none"> □ Basic plan on the promotion of the cancer treatment □ Promotion of the prevention of cancer and early detection □ Equalization of the cancer treatment □ Development of the system of the cancer treatment <ul style="list-style-type: none"> ■ Establishment of information system about cancer treatment □ Establishment of Council for Cancer Treatment | <ul style="list-style-type: none"> ■ Additional resolution <ul style="list-style-type: none"> □ Cancer registration □ Second opinion □ Oncologist □ Healthcare team □ Regional alliances □ Palliative care |
|---|--|

This law aims at a promotion of the cancer care system. As an important element of cancer care, the law encompasses the stipulations for reinforced promotion of continuing education and training for doctors and nurses who have excellent knowledge of and skills in palliative care.

Ⅲ. 研究成果の刊行に関する一覧

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