

STAS-J and the subscale of the EORTC QLQ C-30 was compared between the initial assessment and day 7; data were obtained for 45 patients for STAS-J and 22 patients for EORTC QLQ C-30. Data for days 14 and 28 were not used because too many patients had withdrawn by that time.

In the analysis of staff evaluation, we used descriptive statistics as well as determining the differences in patient background and PCCT activities between respondent cases and nonrespondent cases. Written comments were categorized based on the similarity of content.

Statistical tests were performed by Fisher's exact test, *T* test (nonpaired, paired), the Wilcoxon rank-sum test, and the McNemar test where appropriate. *P* values <.05 were considered to be significant with a two-tailed statistical test. All statistical analyses were performed using the statistical package SAS (version 9.1; SAS Institute Inc., Cary, NC, USA).

RESULTS

Of 180 patients referred to the PCCT during the study period, 53 patients were eligible. The main

reasons for ineligibility were previous referral (44%), too ill/confused (24%), and no family consent (12%) (Fig. 1).

As a result of the comparison between eligible and ineligible patients, there was no significant difference in patient background, the number of types of support provided by PCCT, and the number of PCCT visits to the patient/ward staff (data not shown).

Patient Characteristics

Table 1 shows the characteristics of the patients who participated in the study. Just over half of the patients were female (51%) and the mean age was 64 years old. Over half of the patients were referred by gastrointestinal surgery, 11% were referred by gastroenterological medicine, and 9% were referred by both gynecology and urology. Fifty-eight percent of patients scored under 2 in the ECOG PS, and about half of patients had anticancer treatment at the time of referral.

The main reasons for referral were pain management (85%), transition to home (15%), and transition to PCU (13%; Fig. 2).

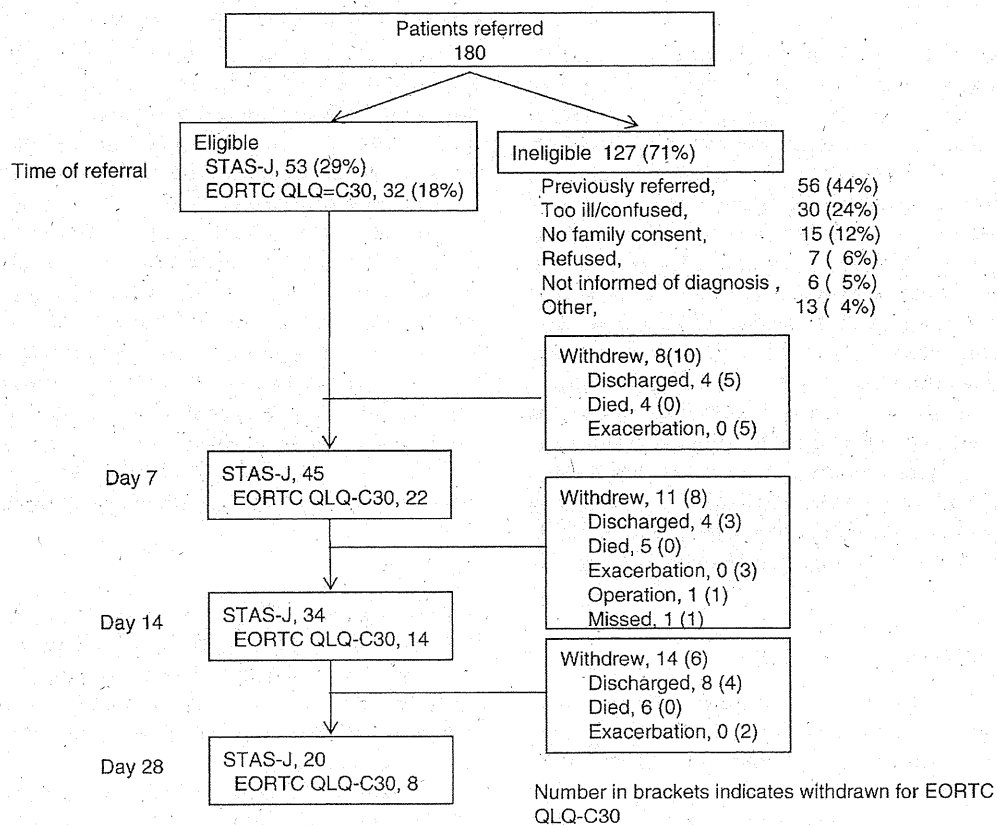


Fig. 1. Participants and flow during the study period.

Table 1. Characteristics of patients (N = 53)

	n	%
Sex		
Female	27	51
Age (mean \pm SD)	64.3 \pm 13.0	
Speciality of referring physicians		
Gastroenteral surgery	29	55
Gastroenteral medicine	6	11
Gynecology	5	9
Urology	5	9
Ear, nose, throat	3	6
Hematology	3	6
Others	2	4
Primary site		
Stomach, esophagus	12	23
Colon, rectum	8	15
Pancreas	5	9
Breast	5	9
Lung	3	6
Bile duct	3	6
Head & neck	3	6
Ovary, uterus	3	6
Kidney, urinary organs	3	6
Hematology	2	4
Liver	1	2
Others	5	9
Metastasis/recurrence	48	91
ECOG PS		
1	16	31
2	14	27
3	13	25
4	8	16
Receiving chemotherapy	24	45
Receiving radiation	8	15
Patient outcome when the observation period ended ^a		
During admission	22	42
Discharge	15	28
Death	14	26
Transferred elsewhere	2	4
Days from admission to PCCT referral (mean \pm SD/median)	19 \pm 26/8	
Days from PCCT referral to death ^b (mean \pm SD/median)	61 \pm 56/44	

PCCT: Palliative Care Consultation Team.

^aObservation period means from time of the referral to day 28, discharge, or death.

^bData from 35 patients who were confirmed dead during the research period (from February 2004 to March 2005).

PCCT Activities

Figure 2 shows the support that the PCCT provided after referral. The median number of referral reasons was 1 (range 1–3); in contrast, the median number of types of support was 3 (range 1–7). The main types of support offered were pain management, 94%; emotional support for patient, 49%; and emotional support for family, 36%. The mean number of visits to the patient or ward staff was 0.8 ($SD = 0.3$) per day or 0.7 ($SD = 0.2$) per day, respectively.

Change in Patient Outcome

Table 2 shows the change in STAS-J items at day 7. "Other physical symptoms" were significantly exacerbated ($p < .01$). No significant differences were observed in any of the other items.

Table 3 shows the change in EORTC QLQ C-30 subscales at day 7. Only insomnia improved significantly ($p < .01$). On the other hand, constipation was significantly exacerbated ($p < .05$). There were no significant differences in any functional scales.

Referring Staff Evaluation

Of 180 questionnaires distributed, 98 questionnaires were returned (54%). Responses were obtained from 68 nurses. The 68 nurses had a median clinical experience of 4 years, and most of them were female (97%).

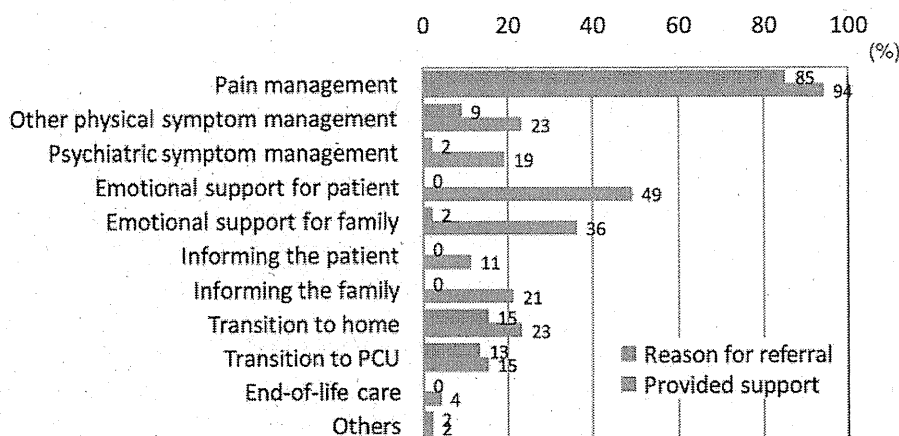
The results showed that the number of responses was significantly greater when the patients were referred from physicians in the surgical department ($p < .02$), when the observational period ended during admission ($p < .001$), when the PCCT provided support over 1 week ($p < .001$), when a greater amount of kinds of support was provided by the PCCT ($p < .03$), and when "informing the family" was provided more by the PCCT ($p < .02$).

Of 98 respondents, more than 90% considered the effect of the PCCT on the referred patients as "excellent" or "good," and were also satisfied with the support provided by the PCCT (Table 4). Twelve percent of respondents thought that the PCCT needed improvements. The respondent comments included "increasing the time for support," "enhancing cooperation with ward staff," "providing more information to patients and ward staff," "constant involvement in the case," "educating ward staff about the methods of psychosocial support," and "defining who explains the cost of the PCCT."

DISCUSSION

This study evaluated an established PCCT at a university hospital using a multifaceted approach.

It was found that the PCCT provided more support than requested from referring staff and that the provision of psychosocial support was exceptional. These results are consistent with previous studies (Kuin et al., 2004; Braiteh et al., 2007). This is probably due to the PCCT not only addressing the reason for referral but also undertaking comprehensive assessments of referred patients, and the assessment of psychosocial problems is difficult for general staff (McDonald et al., 1999). In other words, the PCCT is aware of the problems that ward staff overlook



PCCT, Palliative Care Consultation Team; PCU, Palliative Care Unit
 Provided support, PCCT members checked at the end of the observation period.
 Both reason for referral and provided support are multiple answered.

Fig. 2. (Color online) Reasons for referral and support provided by PCCT (N = 53).

and is thus able to provide extra support for patients and families.

Pain, which is the main reason for referral, was not improved during the first week. This result is not consistent with previous studies (Morita et al., 2005b; Yoshimoto et al., 2005). A possible cause of this inconsistency is differences in clinical activities among PCCTs. The PCCT of the present study took an educational approach (Sasahara et al., 2008) and, unlike PCCTs of previous studies, did not prescribe medications. Therefore, pain might not have been relieved sufficiently early. To confirm this hypothesis, a study with a longer observational period and a large number of patients is needed. In addition, the variation of clinical activities of PCCTs, their applicability (hospital type and degree of team maturation), and benefit should be discussed. It was shown that insomnia was significantly improved after 1 week, which means that the intervention for insomnia by the PCCT was adequate and the ward staff implemented the PCCT recommendation rapidly. Constipation was exacerbated during the first week. We assume this was caused by opioid medication being initiated or increased following a suggestion by the PCCT and that this was a temporary phenomenon. As with the results for pain, a study with a longer observation period is needed to confirm whether or not our assumption is correct.

The support by the PCCT was highly evaluated and satisfied the primary nurses. Some comments for improving the activities of the PCCT were noted. The PCCT should bear in mind those comments, but we do not think that the PCCT should necessarily accept and implement the changes requested by the ward nurses, because the PCCT itself has a

significant educational role for staff (Dunlop & Hockley, 1998). If the PCCT provides support merely as the ward staff requires, this would deskill their competence in palliative care (Jack et al., 2002).

This study also provided information about the backgrounds of patients referred to the PCCT. More than half of referred patients scored under 2 in

Table 2. Change of "over moderate" in STAS-J during first week (N = 45)

	Time of referral		Day 7		p value
	n	%	n	%	
Pain	35	78	29	64	.083
Other physical symptoms	17	38	32	71	<.01**
Patient anxiety	22	50	26	58	.491
Family anxiety	9	35	18	56	.059
Patient insight	24	65	22	56	1.000
Family insight	4	16	3	10	.564
Communication between patient and family	5	18	6	17	1.000
Communication among clinical staff	2	5	2	5	.564
Communication between patient/family and clinical staff	13	33	10	24	.564

STAS-J: Support Team Assessment Schedule—Japanese version. STAS-J was assessed by ward nurses who were charged with patient on the assessment day. Scores range from 0 to 4, with a higher score representing worse symptoms or more serious problems, and collapsed into "none/a little" (0, 1), and "over moderate" (2–4). The number in the table is the frequency of "over moderate." McNemar Test was used.

** $p < .01$.

Table 3. Change in EORTC QLQ-C30 during first week (N = 22)

	Time of referral		Day 7		p value ^a
	Median	Range	Median	Range	
Symptom scales					
Pain	58.3	0–100	58.3	0–100	.88
Fatigue	50.0	0–100	44.4	0–100	.33
Appetite loss	66.7	0–100	66.7	0–100	.25
Insomnia	33.3	0–100	16.7	0–100	.01*
Dyspnea	33.3	0–100	0.0	0–100	.40
Constipation	33.3	0–100	50.0	0–100	.05*
Nausea and vomiting	8.3	0–100	16.7	0–100	.72
Diarrhea	0.0	0–66.7	0.0	0–66.7	.50
Financial difficulties	33.3	0–100	33.3	0–100	.46
Functional scales					
Physical	40.0	0–93.3	40.0	0–86.7	.22
Role	33.3	0–100	33.3	0–100	1.00
Emotional	66.7	11.1–100	66.7	0–100	.79
Cognitive	75.0	0–100	66.7	0–100	.97
Social	66.7	0–100	66.7	0–100	.87
Global health and status	41.7	0–100	33.3	0–75.0	.07

Scores range from 0 to 100, with a higher score representing a higher level of functioning or more severe symptoms.

^aWilcoxon rank-sum test was used.

* $p < .05$.

performance status, and nearly half of referred patients were receiving anticancer treatment. These results show that patients are referred to PCCTs early in the disease process (Morita et al., 2005a). Moreover, when we compare patients from the present study with those admitted to PCU in Japan

(Tada et al., 2004), the current patients presented more severe levels of pain, fatigue, dyspnea, nausea and vomiting, and constipation. This indicates that one of the main roles of PCCTs is symptom management (Morita et al., 2005a).

Our study has several limitations. First, we were only able to evaluate some of the patients referred to the PCCT. Although we confirmed that there was no major background difference between participants and nonparticipants, this result might have other selection biases. Second, we evaluated the PCCT according to aspects of the PCCT's activities, patient's quality of life (QOL), and the referring staff's view. However, other important aspects of the PCCT, such as the transfer of care and education of ward staff, should also be evaluated. Third, the respondents to the staff evaluation might have had a more positive attitude toward the PCCT because the evaluations obtained concerned patients in which the PCCT had a deeper involvement.

In conclusion, we evaluated an established PCCT working in a university hospital using multiple aspects. The PCCT performed comprehensive assessments and provided extra support for referred patients. No patient's QOL was improved, with the exception of insomnia at 1 week after referral to the PCCT. Ward staff highly evaluated the activities of the PCCT. In the evaluation of PCCTs, further research about the variation of clinical activities of PCCTs, their applicability, and benefit is needed.

Table 4. Ward nurses evaluation of PCCT support (N = 98)

	n	%
How did the PCCT affected the referred patient? ^a		
Excellent	36	37
Good	59	60
No change	3	3
To what extent are you satisfied with the support provided by the PCCT for the referred patient? ^b		
Very satisfied	27	28
Satisfied	54	55
Somewhat satisfied	15	15
Somewhat dissatisfied	2	2
Do you think the PCCT needs to be improved?		
Yes	12	12
No	84	86
Not answered	2	2

PCCT: Palliative Care Consultation Team.

^aRated by four-response categories: excellent, good, no change, and worse.

^bRated by six categories from "very satisfied" to "very dissatisfied."

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Burden on Oncologists When Communicating the Discontinuation of Anticancer Treatment

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Objective: Communicating the discontinuation of anticancer treatment to patients is a difficult task. The primary aim of this study was to clarify the level of oncologist-reported burden when communicating about discontinuation of an anticancer treatment. The secondary aims were (i) to identify the sources of burden contributing to their levels and (ii) to explore the useful strategies to alleviate their burden.

Methods: A multicenter nationwide questionnaire survey was conducted on 620 oncologists across Japan (response rate, 67%).

Results: High levels of perceived burden were reported by 47% of respondents, and 17% reported that they sometimes, often or always wanted to stop oncology work because of this burden. There was a significant association between high levels of burden and: a feeling that breaking bad news would deprive the patient of hope; concern that the patient's family would blame the oncologist; concern that the patient may lose self-control; and a feeling that there was not enough time to break the bad news. Strategies perceived to be useful by oncologists included training in how to effectively communicate to patients discontinuation of anticancer treatment, a reduction in total workload to allow sufficient time to break bad news, and development of a multidisciplinary model to facilitate cooperation with other professionals and facilities.

Conclusions: Many oncologists reported high levels of burden relating to communication of discontinuation of anticancer treatment. A specific communication skills training program, sufficient time for communication and development of a multidisciplinary model could help alleviate the burden on oncologists.

Key words: burden – oncologists – communicating

INTRODUCTION

Breaking bad news is a stressful experience for the oncologist (1–6); moreover, it contributes to diminished confidence in communication skills and higher expectations of a negative outcome. The experience of dealing with distressed, angry and reproachful patients is also associated with

burnout (7). Previous studies have suggested that oncologist-perceived burden is caused by several factors associated with the patient, the patient's family, the oncologists themselves and the medical environment (8,9). An oncologist's communication style affects the extent of emotional distress felt by the patient and the patient's family (10). The most

difficult conversations involved discussing the discontinuation of curative treatment and admission to a hospice (4); therefore, it is important to clarify the extent of the burden experienced by the oncologist when communicating the discontinuation of anticancer treatment.

Many studies have been conducted to clarify patients' preferences and experiences in receiving bad news in oncology settings (11–14), and several clinical guidelines and expert recommendations have been published (1,15,16). Moreover, recent intervention trials have demonstrated that structured communication skills training can improve physicians' skills in breaking bad news (17–19).

Despite the existence of many experience-based recommendations and studies into the psychological effects on patients and their families, to our knowledge, only a few studies have explored the extent of the burden on oncologists when communicating the discontinuation of anticancer treatment. Therefore, the aims of the present study were to: (i) clarify the level of oncologist-perceived burden when communicating the discontinuation of anticancer treatment to patients; (ii) identify factors contributing to this burden; and (iii) explore potentially useful strategies to alleviate oncologist-perceived burden.

PATIENTS AND METHODS

SUBJECTS

The present study was a cross-sectional anonymous multicenter nationwide survey of oncologists in cancer centers across Japan. Questionnaires were mailed to 620 eligible oncologists in February 2007 and again 2 months later to those oncologists who had not yet responded. If the oncologists did not want to participate in the survey, we requested that they return the questionnaire without replying to any of the questions. The participating institutions were 12 cancer centers selected from the 15 cancer centers that make up the Japanese Association of Clinical Cancer Centers.

We recognized potential sampling bias with this method, but decided to use convenient institutions because we felt that the risk of sampling bias would be minimized by a large number of participants.

Eligibility criteria for the participants were as follows: (i) oncologists specializing in gastroenterology, respiratory medicine, breast oncology, hematology, medical oncology, urology, gynecology, otolaryngology, orthopedics, pediatrics, neurosurgery or dermatology; and (ii) the oncologist's name had to appear on his/her medical facility's website. The website of all Japanese cancer centers shows the complete list of all physicians in that center. We regarded the completion and return of the questionnaire as consent to participate in the study. The institutional review board of the principal investigator confirmed the study's ethical and scientific validity.

QUESTIONNAIRE

A questionnaire was developed based on a review of the literature (2,3,8,9) and discussions among the authors. Content validity was assessed by full agreement of the authors, and face validity was confirmed by a pilot test of 20 potential participants.

As background data, oncologists reported their age, gender, clinical experience in oncology, specialty, previous experience with formal communication skills training, attitudes toward disease and prognosis disclosure for terminally ill patients, and the number of patients to whom they would usually communicate the discontinuation of anticancer treatment annually.

The primary endpoint was oncologist-perceived burden imposed by communicating the discontinuation of anticancer treatment to patients. Given the lack of existing validated instruments, the following outcome parameters were developed by the authors. First, the level of oncologist-perceived burden was evaluated by the question, 'What level of burden do you feel when you communicate with patients about discontinuation of anticancer treatment?' Answers to this question were rated on a five-point scale ranging from 1 (I do not feel any burden at all) to 5 (I feel a heavy burden). In addition, we investigated the impact of the burden on motivation to continue working in oncology by asking oncologists, 'How often do you feel some level of desire to stop oncology work due to this burden'. Again, answers were rated on a five-point scale ranging from 1 (not at all) to 5 (always).

We extracted 20 potential sources of burden from the literature (8,9) and questioned oncologists on their level of perceived burden relating to each of these sources. Oncologists were requested to rate their degree of burden on a five-point Likert-type scale ranging from 1 (I do not feel any burden) to 5 (I feel a heavy burden).

In addition, we developed a list of 14 potentially useful strategies to alleviate oncologists' perceived burden derived from a previous report (20) and from a qualitative study using in-depth interviews with three oncologists. The oncologists were requested to rate their level of agreement with each of these strategies on a six-point Likert-type scale ranging from 1 (not necessary) to 6 (absolutely necessary).

STATISTICAL ANALYSES

For comparisons, respondents were classified into two groups: oncologists who rated themselves as 'heavily burdened' or 'burdened' (high-level burden) and then all other oncologists (low-level burden). This cut-off point was selected on the basis of the actual distribution of the data and enabled the entire sample to be divided into two equal-sized groups for comparison.

To explore the determinants of levels of oncologist-reported burden, we screened 7 background variables and 20 sources of burden. Univariate analyses were performed using Student's *t*-test or the χ^2 test, as appropriate. To assess the

results in 20 comparisons, the *P* value necessary for statistical significance was defined as 0.0025 (0.05/20) using the Bonferroni correction. Multiple logistic regression analyses were then performed using a forward elimination procedure. All potential predictors with statistical significance as ascertained by the univariate analyses were included as independent variables in multiple logistic regression analyses. All analyses were performed using SPSS version 11.0.

RESULTS

Of the 620 questionnaires mailed to oncologists, 10 were undeliverable because of incorrect addresses and 416 oncologists returned questionnaires, resulting in a response rate of 67%. Of the questionnaires returned, 3 were excluded due to missing data in primary endpoints and 19 were returned without any of the questions being answered. Thus, a total of 394 responses were analyzed, giving an effective response rate of 67% (394/591). The oncologists' characteristics are summarized in Table 1.

Overall levels of oncologist-reported burden relating to communication of the discontinuation of anticancer treatment were: heavily burdened, 13%; burdened, 34%; slightly burdened, 37%; not particularly burdened, 13%; or not burdened at all, 1.3% (Table 2). Clinical oncologists rated their level of desire to stop oncology work because of this burden as: not at all, 55% (*n* = 218); rarely, 26% (*n* = 106); sometimes, 11% (*n* = 45); often, 5.3% (*n* = 21); or always, 1.0% (*n* = 4).

The oncologists' ratings of the 20 potential sources of burden relating to the communication of discontinuation of anticancer treatment are given in Table 3. More than 20% of respondents reported feeling 'heavily burdened' or 'burdened' by the following factors: insufficient time to break bad news; feeling that breaking bad news will deprive the patient of hope; the possibility that the breaking of bad news is interrupted by other tasks; concern that the patient may lose self-control; opposition from the patient's family to breaking bad news to the patient; the fact that evidence from a certain group is not applicable to every patient; and, finally, an inability to answer philosophical questions regarding death and the value of life.

Univariate analysis (Table 4) showed that oncologists with high-level burden were significantly more likely to report the following concerns: feeling that breaking bad news will deprive the patient of hope; concern that the oncologist may be blamed by the patient's family; concern that the patient may lose self-control; insufficient time to break bad news; possibility that the time for breaking bad news is interrupted by other tasks; opposition from the patient's family to breaking bad news to the patient; evidence from a certain group is not applicable to every patient; an inability to answer philosophical questions regarding death and the value of life; feeling a sense of guilt because oncologists cannot provide adequate treatment; concern that the oncologist may be

Table 1. Background of respondent oncologists

Age (years)	
Median	43
Inter-quartile range	37–50
Male gender [no. (%)]	371 (91)
Oncology experience (years)	
Median	15
Inter-quartile range	8–20
Number of communications concerning discontinuation of anticancer treatment annually	
Median	8
Inter-quartile range	3–15
Attitudes toward disease and prognosis disclosure for terminally ill patients ^a [no. (%)]	
Routinely, without patient's request	55 (14)
If necessary, without patient's request	234 (59)
If necessary, and if the patient explicitly asks	78 (19)
Routinely, and if the patient explicitly asks	21 (5.3)
Specialty ^a [no. (%)]	
Gastroenterology	116 (30)
Respiratory medicine	50 (13)
Breast oncology	42 (10)
Hematology, medical oncology	42 (10)
Urology	32 (8.3)
Gynecology	30 (7.8)
Otolaryngology	24 (6.2)
Orthopedics	19 (4.9)
Neurosurgery	12 (3.1)
Pediatrics	13 (3.3)
Dermatology	5 (1.3)
Received formal training in breaking bad news [no. (%)]	59 (16.5)

^aPercentages do not add up to 100% because of missing data.

criticized by the patient; scientific evidence is not always predictable or reproducible; opposition from patients to breaking bad news to their families; fear of talking to patients whom the oncologist do not know very well; lack of confidence in oncological medical skills; uneasiness in changing roles from curing patients to caring for patients; and a concern that an objective stance cannot be maintained if the oncologist becomes too intimate with the patient.

Multiple logistic regression analysis (Table 4) revealed that independent determinants of high-level burden were: feeling that breaking bad news will deprive the patient of hope; concern that the oncologist may be blamed by the patient's family; concern that the patient may lose self-control; and insufficient time to break bad news. Seven backgrounds of the oncologist, including age, specialty, attitudes toward disease and prognosis disclosure for terminally ill patients, oncology experience, previous experience with

formal communication skills training, or number of communications concerning discontinuation of anticancer treatment annually, are not the determinants of levels of oncologist-reported burden.

Strategies to relieve oncologist-reported burden when communicating the discontinuation of anticancer treatment were also investigated. Table 5 lists the percentage of

Table 2. Levels of oncologist-reported burden when communicating discontinuation of anticancer treatment

	No. (%)
Heavily burdened	53 (13)
Burdened	136 (34)
Slightly burdened	147 (37)
Not particularly burdened	53 (13)
Not burdened at all	5 (1.3)

oncologists who agreed with each of the 14 strategies suggested to alleviate oncologists' perceived burden. More than 20% of respondents considered the following strategies to alleviate oncologist-reported burden as 'absolutely necessary': that an inpatient hospice is readily available and that patient information is exchanged smoothly among facilities; quiet and private rooms are available for breaking bad news; after breaking bad news, a nurse, psychologist or medical social worker is available to provide emotional support; and a reduction in oncologists' total workload to give them sufficient time to break bad news.

DISCUSSION

To the best of our knowledge, this is the first large multicenter nationwide survey to investigate oncologist-reported burden when communicating the discontinuation of anticancer treatment. The first important finding of the present study was the demonstration of the oncologist-reported burden when

Table 3. Sources of oncologist-reported burden when communicating discontinuation of anticancer treatment

	'Not burdened at all', no. (%)	'Not particularly burdened', no. (%)	'Slightly burdened', no. (%)	'Burdened', no. (%)	'Heavily burdened', no. (%)
Insufficient time to break bad news	12 (3.1)	61 (15)	90 (22)	151 (36)	82 (20)
Feeling that breaking bad news will deprive the patient of hope	12 (3.1)	34 (8.7)	152 (37)	135 (33)	63 (15)
Possibility that the time for breaking bad news is interrupted by other tasks	18 (4.6)	86 (21)	102 (25)	120 (29)	71 (17)
Concern that the patient may lose self-control	16 (4.1)	83 (21)	163 (39)	108 (26)	25 (6.0)
Opposition from family members to breaking bad news to the patient	39 (9.9)	96 (24)	134 (32)	91 (22)	36 (8.7)
Evidence from a certain group does not always apply to the patient	43 (10)	122 (31)	133 (32)	70 (17)	28 (6.7)
The oncologist is unable to answer philosophical questions regarding death and the value of life	37 (9.5)	122 (31)	140 (34)	74 (18)	21 (5.0)
Concern that the oncologist may be blamed by the patient's family	73 (18)	141 (35)	104 (25)	63 (15)	15 (3.6)
Feeling a sense of guilt because oncologists cannot provide effective anticancer treatment	83 (21)	140 (35)	102 (25)	56 (14)	14 (3.4)
Opposition from patients to breaking bad news to their families	70 (17)	171 (43)	87 (21)	47 (11)	19 (4.6)
Concern that the oncologist may be criticized by the patient	75 (19)	149 (37)	107 (26)	56 (14)	9 (2.2)
Fear of talking to patients whom oncologist does not know very well	84 (21)	138 (35)	108 (26)	54 (13)	10 (2.4)
Scientific evidence is not always predictable or reproducible	43 (10)	122 (31)	133 (32)	70 (17)	28 (6.7)
Lack of confidence in oncological medical skills	63 (16)	172 (43)	106 (26)	49 (12)	5 (1.2)
Concern that the oncologist does not have the latest knowledge	80 (20)	179 (45)	97 (23)	36 (8.7)	2 (0.5)
Uneasiness in changing roles from curing patients to caring for patients	111 (28)	176 (44)	68 (16)	34 (8.2)	4 (1.0)
Concern that oncologists cannot answer all knowledge-based questions posed by the patient	94 (24)	186 (47)	81 (20)	29 (7.0)	3 (0.7)
Oncologists fear their own illness and death	122 (31)	178 (45)	62 (15)	26 (6.3)	4 (1.0)
Concern that an objective stance cannot be maintained if the oncologist becomes too intimate with the patient	89 (22)	195 (49)	85 (20)	24 (5.8)	3 (0.7)
Fear that oncologists themselves may become very emotionally involved, such as expressing anger or sadness	107 (27)	209 (53)	59 (14)	18 (4.3)	0 (0)

Percentages do not add up to 100% due to missing data.

Table 4. Determinants of oncologist-reported burden when communicating discontinuation of anticancer treatment

	Univariate analyses			Multivariate analyses	
	Low level (n = 206)	High level (n = 190)	P value	Odds ratio (95% CI)	P value
Feeling that breaking bad news will deprive the patient of hope	3.1 ± 0.9	3.8 ± 0.8	<0.01	1.8 (1.4–2.5)	<0.01
Concern that the oncologist may be blamed by the patient's family	2.1 ± 0.8	2.8 ± 1.1	<0.01	1.5 (1.2–1.9)	<0.01
Concern that the patient may lose self-control	2.8 ± 0.8	3.4 ± 0.9	<0.01	1.4 (1.1–1.9)	<0.01
Insufficient time to break bad news	3.3 ± 1.0	3.8 ± 0.9	<0.01	1.2 (0.99–1.6)	0.049
Possibility that the time for breaking bad news is interrupted by other tasks	3.1 ± 1.0	3.5 ± 1.1	<0.01		
Opposition from family members to breaking bad news to the patient	2.7 ± 1.0	3.2 ± 1.1	<0.01		
Evidence from a certain group does not always apply to every patient	2.6 ± 0.9	3.0 ± 1.1	<0.01		
The oncologist is unable to answer philosophical questions regarding death and the value of life	2.5 ± 0.8	3.0 ± 1.0	<0.01		
Feeling a sense of guilt because oncologists cannot provide effective anticancer treatment	2.1 ± 0.9	2.7 ± 1.1	<0.01		
Concern that the oncologist may be criticized by the patient	2.1 ± 0.8	2.7 ± 1.0	<0.01		
Scientific evidence is not always predictable or reproducible	2.3 ± 0.8	2.7 ± 1.0	<0.01		
Opposition from patients to breaking bad news to their families	2.2 ± 0.8	2.6 ± 1.2	<0.01		
Fear of talking to patients whom the oncologist does not know very well	2.2 ± 0.9	2.5 ± 1.1	<0.01		
Lack of confidence in oncological skills	2.2 ± 0.8	2.5 ± 0.9	<0.01		
Uneasiness in changing roles from curing patients to caring for patients	1.9 ± 0.8	2.3 ± 0.9	<0.01		
Concern that an objective stance cannot be maintained if the oncologist becomes too intimate with the patient	1.9 ± 0.7	2.2 ± 0.8	<0.01		
Concern that the oncologist does not have the latest knowledge	2.1 ± 0.8	2.2 ± 0.9	0.24		
Fear that the oncologist may become very emotionally involved, such as expressing anger or sadness	1.9 ± 0.6	2.0 ± 0.8	0.24		
Concern that the oncologist cannot answer all knowledge-based questions posed by the patient	2.0 ± 0.8	2.2 ± 0.9	0.34		
Fear of the oncologists' own illness and death	1.9 ± 0.7	2.0 ± 1.0	0.78		

Oncologists who rated their burden level as heavily burdened or burdened (high-level group) are compared as a single group against all others (low-level group). Multiple logistic regression analyses used the high-level burden group as the dependent variable. Each condition was rated on a scale of 1 (do not feel any burdened) to 5 (feel heavily burdened).

communicating the discontinuation of anticancer treatment to patients. Of the oncologists surveyed, 47% reported high levels of burden when communicating the discontinuation of anticancer treatment. Moreover, 17% of the oncologists surveyed reported that they sometimes, often or always want to stop oncology work because of this burden. Multiple studies have revealed that a major contributor to physicians' burnout is communication with patients and families (21–26). The present study confirms that communication with patients and families is a major source of oncologists' work-related stress. In particular, the present study highlights that communicating the discontinuation of anticancer treatment can be a heavy burden for oncologists and that it is urgent that strategies are developed to alleviate this burden.

The present study also evaluated oncologists' opinions regarding the strategies likely to be effective in reducing this burden. The strategies perceived to be potentially effective

included: ready availability of an inpatient hospice and smooth exchange of patient information among facilities; availability of quiet and private rooms for the breaking of bad news; the provision of emotional support from a nurse, psychologist or medical social worker after the patient has received the bad news; and a reduction in oncologists' total workload to give them sufficient time to break the bad news.

Moreover, multiple logistic regression analyses revealed that independent determinants of high-level burden were: a feeling that breaking bad news will deprive the patient of hope; concern that the oncologist may be blamed by the patient's family; concern that the patient may lose self-control; and insufficient time to break bad news.

These results reveal that there are three main areas that, if addressed, could significantly alleviate oncologist-reported burden: (i) improving oncologists' communication skills; (ii) allowing sufficient time for communication with patients and

Table 5. Oncologists' opinion on strategies suggested to alleviate the burden associated with communicating discontinuation of anticancer treatment

	Necessary (%)	Absolutely necessary (%)
Inpatient hospice is readily available and patient information is exchanged smoothly among facilities	49	36
Quiet and private rooms are available for breaking bad news	56	25
After breaking bad news, a nurse, psychologist or medical social worker is available for emotional support	63	24
A reduction in the oncologist's total workload to give sufficient time for the breaking of bad news	54	23
While breaking bad news, a nurse, psychologist or medical social worker is available for emotional support	56	13
Having an opportunity to attend educational workshops about how to break bad news	51	6.8
A psychiatrist or psychologist is available for consultation if the oncologist feels overburdened	42	6.6
Before breaking bad news, having the opportunity to discuss the situation with colleagues and receive advice	54	6.1
After breaking bad news, specialists in physician-patient communication are available to give advice to the oncologist about how they should break bad news	60	5.5
Having opportunities to share experiences and feelings with the colleagues within the hospital	51	5.5
Before breaking bad news, information about what the patient and family want to know is available from nurses	65	5.0
Before breaking bad news, the oncologist receives a memo from the patient and family about what they want to know	61	3.8
After breaking bad news, the oncologist receives a questionnaire to identify what the patient and the family are feeling and thinking	65	3.3
Have an opportunity to share experiences and feelings with colleagues from other hospitals	47	3.0

their families; and (iii) developing a multidisciplinary care model with other professionals and facilities.

This study emphasizes the importance of communication skills. Previous studies suggested that communication skills training increases both patient satisfaction (27,28) and oncologists' confidence (29). However, to the best of our knowledge, existing communication skills training does not specifically address issues surrounding the discontinuation of anticancer treatments. The present study highlights the importance, under these difficult circumstances, of helping the patient maintain hope, dealing with the oncologists' fear of being blamed by the patients and their families, and strengthening patient self-control. The results indicate that a communication skills training program specifically targeting skills for communicating the discontinuation of anticancer treatment needs to be developed. This program should include strategies to deal with oncologists' concerns, such as that by breaking bad news to a patient, the oncologist will deprive the patient of hope, that the oncologist may be blamed by the patient's family and that the patient may lose self-control.

The oncologists surveyed stressed the importance of a reduction in their total workload to give them sufficient time to facilitate effective communication with patients. A previous study suggested that physicians face excessive workloads that are associated with a lower quality of patient care (30). Several studies have suggested that the perception of having insufficient time to communicate with patients is the factor most strongly associated with oncologist burnout (22,31). In Japan, according to a 2008 revision by the Ministry of Health, Labor and Welfare in Japan of the payment of fees for medical treatment, an additional fee for

outpatient care can be applied when a physician is directly involved in clinical practice for 5 min or longer. This indicates that the Ministry of Health, Labor and Welfare in Japan defines the time for consultation and implies that most physicians in Japan are too busy to spend 5 min or more on each outpatient. These results stress that a reduction in physicians' workload is vital.

Many oncologists surveyed in the present study agreed with the importance of multidisciplinary cooperation with other professionals and facilities. Two types of cooperation were considered to be particularly valuable: (i) that after breaking bad news, a nurse, psychologist or medical social worker was available to follow up with patients and their families; and (ii) the availability of other facilities, especially inpatient palliative care units. Previous studies have shown that cancer patients' participation in nurse-led interventions resulted in an improvement in depressive moods (32,33). Multiple intervention studies have indicated that practice-based interprofessional collaboration can improve patients' health-care processes and outcomes (34). Furthermore, existing literature indicates that regional palliative care programs succeed in increasing family satisfaction (35,36). These findings suggest that developing a multidisciplinary team to support oncologists, not only within a hospital, but also beyond the hospital (as a region), is of considerable importance in achieving patient and family satisfaction. As the number of palliative care units in Japan is not enough, increasing the reimbursement for inpatient hospice would be important as policy. Moreover, because oncologist burden was not measured in these previous studies, prospective observational or interventional studies are needed to determine whether a team

approach, such as in-hospital and regional palliative care programs, could alleviate oncologist burden.

The limitations of the present study include the moderate (67%) effective response rate, which may mean that the entire oncological population is not represented by the oncologists who participated in the present study. Furthermore, because this study was performed in Japan, the results are likely to be influenced by factors relating to Japanese culture and the Japanese health-care system and, as such, may not be applicable to other countries.

In conclusion, a considerable number of oncologists experienced high levels of burden in communicating the decision to discontinue anticancer treatment. To alleviate oncologist burden, potentially useful strategies include: (i) communication skills training specifically targeting discontinuation of anticancer treatment; (ii) a reduction in total workload to allow oncologists sufficient time to break bad news; and (iii) the development of a multidisciplinary model to facilitate cooperation with other professionals and facilities.

Authors' Contribution

H.O.: conception and design, provision of the study material, collection of data, data analysis and interpretation, manuscript writing and administrative support. T.M.: conception and design, provision of the study material, data analysis and interpretation, final approval of the manuscript, administrative support, and financial support. T.E., H.A., K.T., A.O. and K.S.: provision of the study material and final approval of the manuscript.

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Conflict of interest statement

None declared.

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短報

緩和ケア研修会を開催したことによる変化

—指導者研修会修了者の視点から—

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【目的】 がん対策基本法に基づき、がん医療に携わるすべての医師に対して基本的な緩和ケアに関する研修が行われている。本研究の目的は、緩和ケアの基本教育に関する指導者研修会修了者が感じている、研修会実施による変化を明らかにすることである。【対象と方法】 緩和ケアの基本教育に関する指導者研修会修了者12名により、「緩和ケア研修会を通じて得られたもの」についてブレインストーミングを行い、その内容を質的に分析した。【結果】 緩和ケア研修会の開催を通じて得られたものとして、連携の強化、知識・スキルの獲得、緩和ケアの認知度の向上、地域の緩和ケアリソースの把握、研修会受講生の行動変容、院内緩和ケア体制の整備の6つのカテゴリーが抽出された。【結論】 指導者研修会修了者は、緩和ケア研修会の開催により知識・スキルの獲得という直接的成果だけでなく、連携強化、緩和ケアリソースの把握などの間接的成果が得られていると感じていることが明らかとなった。

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Key words: 緩和ケア, 卒後研修, 悪性腫瘍, 質的研究

緒言

2006年のがん対策基本法が制定され、それに伴うがん対策推進基本計画において「がん医療に携わるすべての医師に対して基本的な緩和ケアに関する研修を行うこと」が目標として掲げられた¹⁾。これを受けて日本緩和医療学会では、教育研修委員会を中心にPEACE (Palliative care Emphasis program on symptom management and Assessment for Continuous medical Education) プロジェクトを開始した^{2,3)}。

PEACE プロジェクトは、①「がん診療に携わる医師に対する緩和ケア研修会 (以下、緩和ケア研修会) の開催指針 (以下、開催指針)」に基づいたプログラム開発と、②各病院や地域で緩和ケア研修会を開催する指導者を養成するための「緩和ケアの基本教育に関する指導者研修会 (以下、指導者研修会)」の開催の2つの柱からなるプロジェクトである。プログラム開発では、教育のためのマテリアルを作成・整備し、指導者研修会では、各地方やがん診療連携拠点病院で研修会を開催する指導者を育成し、育成した指導者が地域で緩和ケア研修会を開催することを支援する、いわゆる train the trainer 方式で研修会が広く全国で開催できるように計画されている。

指導者研修会は、参加型、体験型のプログラムで構成されている。まず、実際に地域で行われる研修会と同じプログラムを参加者として体験してもらう。ただし、この時に参加者の視点だけでなく、指導者の視点ももってもらうように強調し、ファシリテーターがどのような教育技法を用いて講義を行っているのかにも注目してもらう。次に、成人教育理論の基礎や小グループ学習、ロールプレイといった教育技法の特徴と活用方法、効果的なグループ分けを行う具体的な方法など、実際に教育を行ううえで役立つ知識や技術を学ぶ。そのうえで、小グループでお互いにプレゼンテーションを行い、フィードバック

をし合うことで、受講生のプレゼンテーション・スキルが向上することができるようなプログラム構成となっている。

指導者研修会受講生には、全セッションのプレゼンテーション用電子ファイルや、配布資料、DVD教材、研修会の開催マニュアル、指導者マニュアルなど、実際に自分の地域や施設に持ち帰ってすぐに実践できるように教育キット一式が手渡される。また、研修会修了者はメーリングリストに登録され、各地方での研修会の工夫や苦勞を共有し、さらに効果的な教育が実践できるように配慮されている。

2009年12月現在、計8回の指導者研修会で697名の指導者が養成され、がん診療連携拠点病院を中心に開催された緩和ケア研修会の受講修了者は10,000名を超えている。しかしながら、受講生が増加している一方で、受講生にどのような変化がみられ、地域や医療現場でどのような変化が起こっているのかについては明らかにはなっていない。

そこでPEACEプロジェクト開始後2年が経過した2010年1月に、緩和ケア研修会を地域で開催することが、研修会開催者である指導者自身、研修会参加者、所属している病院、地域にどのような変化をもたらしていると感じているかを明らかにするために本研究を行った。

対象と方法

① 対象

2010年1月、東京において「緩和ケアの基本教育に関する指導者研修会」「精神腫瘍学の基本教育に関する指導者研修会」の修了者に対して行われた「PEACE指導者フォーラム」の申込者に対し、メールで依頼を行い、承諾の得られた36名を所属地域、専門診療科、性別が偏らないように6つのグループに分け、そのうちの2グループ12名を本研究の対象とした。対

表1 対象者の背景 (n=12)

平均年齢		
年齢(範囲)	46 (38~55)	
性別		
男性	10	83%
女性	2	17%
専門分野		
緩和ケア	8	66%
精神科	2	17%
外科	2	17%
勤務先地域		
北海道	1	8.3%
関東甲信越	2	17%
中部	3	25%
近畿	2	17%
九州	4	33%

表2 緩和ケア研修会を通じて得られたと感じているもの (n=110)

1. 連携の強化	39
1) 地域医療・保健機関	14
2) 医療従事者間	13
3) ファシリテーター間	7
4) 行政	4
5) 患者団体	1
2. 知識・スキルの獲得	36
1) 緩和ケアの知識	17
2) 教育スキル	10
3) 態度の変化	9
3. 緩和ケアの認知度の向上	15
1) 院内	10
2) 院外	5
4. 緩和ケアリソースの把握	9
5. 研修会受講生の行動変容	6
6. 院内緩和ケア体制の整備	5

対象者の背景を表1に示す。

② 方法

「緩和ケア研修会を通じて得られたもの(個人・組織・地域)」をテーマに、1グループ6名の2グループで、ブレインストーミングを行った。ブレインストーミングは、参加者が「緩和ケア研修会を通じて得られた」と感じているものを、それぞれ一行程度の文章で1つのカードに記入し、できるだけ多くのカードを作成する方法で行った。この過程は新たなカードが記入されなくなるまで続けた。なお、討議の途中で新しいアイデアが出る可能性を考え、カードを追加記入することも許容した。

それぞれのグループには1名のファシリテーターがいたが、ファシリテーターは、ブレインストーミングの内容には介入を行わず、議論を促進した。

③ 解析

ブレインストーミングで収集されたカードを分析の対象とした。最初に、1名の研究者が、「緩和ケア研修会を地域で開催することが、自分自身、研修会参加者、所属している病院、地域にもたらしている変化」に関して記載されているものを選択し、1つのみの意味内容を含む文章を1単位とした。

次に、Krippendorffらの方法論⁴⁾を参考に内容分析を行った。すべての意味単位を内容の類似性に従い、帰納的に分類・抽象化し、サブカテゴリー、カテゴリー化した。内容分析は2名の研究者が独立して行い、分析過程に参加していない研究者のスーパービジョンのもとに3名で議論を行い、意見が一致するまで修正した。サブカテゴリーに該当する意味単位の数を数えた。

④ 倫理的配慮

調査趣旨、データの取り扱い、プライバシーの保護に関する項目を、研究参加前に文章と口頭で説明し、同意を得た。

結果

ブレインストーミングで収集されたすべてのカード150個から、分析対象となる意味単位は110個抽出され、これらは6つのカテゴリーに分類された(表2)。以下、カテゴリーを【】、サブカテゴリーを〈〉、データを「」内に示す。

最も多かったカテゴリーは【連携の強化】(n=39)であり、これはさらにその連携の対象によって「地域の先生と顔見知りになった」「相談しやすくなった」といった〈医療従事者間の連携の強化〉(n=13)、「ファシリテーター間の強い絆ができた」「緩和ケア担当者同士の連携が強まった」といった〈ファシリテーター間の連携の強化〉(n=7)、「都道府県担当者との連絡が密になった」といった〈行政との連携の強化〉(n=4)、「患者団体が立ち上がり、交流が増えた」といった〈患者団体との連携の強化〉(n=1)、「相手の病院の実情が分かっただけで紹介できるようになった」「職種の垣根がなくなってきた」といった〈地域医療・保健医療機関との連携の強化〉(n=14)という5つのサブカテゴリーに分類された。

2つ目のカテゴリーは【知識・スキルの獲得】(n=36)であり、「知識や経験の整理、新しい気づきがあった」「治療の幅が広がった」といった〈緩和ケアの知識の獲得〉(n=17)、「インタラクティブ・ティーチングに慣れた」「教えることの必要性が分かった」といった〈教育スキルの獲得〉(n=10)、「モチベーションが上がった」「参加者から多く気づかされた」といった〈態度の変化〉(n=9)の3つのサブカテゴリーに分類された。

3つ目のカテゴリーは【緩和ケアの認知度の向上】(n=15)である。これはさらに〈院内への緩和ケア認知度の向上〉(n=10)と〈院外への緩和ケア認知度の向上〉(n=5)の2つのサブカテゴリーに分類された。〈院内への緩和ケア認知度の向上〉には「緩和ケアチームへの紹介件数が増えた」などが、〈院外への緩和ケア認知度の向上〉には「地域のメディア、医師会が興味をもった」や「新聞の連載やテレビ取材が増えた」などが含まれていた。

4つ目のカテゴリーは【緩和ケアリソースの把握】(n=9)である。ここには「がん患者への在宅訪問診療を行っている医療機関が把握できた」「緩和ケアに関心をもっている医療従事者の把握」などが含まれていた。

5つ目のカテゴリーは【研修会受講生の行動変容】(n=6)である。ここには「開業医にも緩和の知識が広まり、在宅緩和がしやすくなった」「行動が少し変わった医師がいた」「職種間の溝が少し埋まった」などが含まれていた。

最後のカテゴリーは【院内緩和ケア体制の整備】(n=5)である。具体的には「緩和ケア外来が開設された」「緩和ケアチームが活動を開始した」など緩和ケアの供給体制整備が進んだことが挙げられていた。

考 察

今回われわれは、指導者研修会修了者が感じている、PEACEプロジェクトに基づく緩和ケア研修会を開催することによる変化を、質的に分析することにより探索した。

最も特徴的であったことは、研修会を通じて得られたものとして、知識やスキルの獲得以上に、連携の強化が挙げられていたことである。PEACEプロジェクトがモデルとした Education for Physicians on End-of-Life Care project (EPEC project)において、指導者に対して行った調査⁹⁾でも、講習を受けることで得られたものとして、緩和ケアの知識だけでなく、エンド・オブ・ライフに関わる医療従事者のネットワークが挙げられており、今回の調査と同様の結果であった。

緩和ケア研修会は、症状マネジメントを中心に学ぶ場ではあるが、それ以上に「地域の先生と顔見知りになった」「相手の病院の実情が分かったうえで紹介できるようになった」といった意見にみられるように、ネットワークの場として役立っていると感じていた。「地域連携」の重要性が述べられ、がん患者の在宅療養のニーズは高いものの、実際には地域での連携が進んでいるとはいえない状況である⁹⁾。連携を強化していく手段として、わが国における OPTIM (Outreach Palliative care Trial of Integrated regional Model) プロジェクト^{7,8)}や、英国の Gold Standard Framework (GSF)⁹⁾をはじめとする各国の地域緩和ケアプログラム¹⁰⁻¹²⁾の有効性が示されている。PEACEプロジェクトも、これらと同様に有効な手段である可能性が示唆される。

さらにこれは、がん対策基本法¹³⁾が求める「がん患者がその居住する地域にかかわらず等しく科学的知見に基づく適切ながんに係る医療を受けることができるようにすること」につながることであり、がん診療連携拠点病院が緩和ケア研修会を開催することの意義につながるものと考えられる。

また、指導者研修会を受講することで、教育スキルが獲得できたという意見も多くみられ、これも EPEC の評価⁹⁾と同様の結果であった。医師は教育について学ぶ経験がないまま、教師としての役割を要求されることが多く、教育に対してストレスを感じる人が多い¹⁴⁾。指導者研修会では、成人教育理論に基づいた教育技法を学んだり、インタラクティブ・ティーチング(双方向性講義)のスキルを獲得するためのトレーニングを行ったりしている。これら教育スキルを獲得することは、単に緩和ケア研修会だけに役立つことではなく、さまざまな医学教育の現場で活かすことのできるスキルであると考えられ、さら

に教えるという行為へのストレスを減らす可能性があると考えられる。

さらに、研修会受講生の行動が変容したと感じているという意見もみられていた。緩和ケア教育は、国内外でさまざまな試み^{5,15-17)}が行われているが、その教育効果の測定方法としては、教育を受ける前後での知識の変化や、医療者の緩和ケアに対する自信などを測定する方法がとられていることが多い¹⁸⁾。こういった方法は、疼痛を始めとした苦痛症状が実際に減少しているか、患者や介護者の満足度が上がっているかといった緩和ケアの質の向上を直接評価しているわけではない。本研究は、間接的にはあるが、地域での臨床医の変化を指導者が実感しているという結果であり、地域緩和ケアの質が向上していることを示している可能性がある。

今回の研究の限界について述べる。まず、本研究はファシリテーターとして緩和ケア研修会を開催している指導者の意見を集約した研究であり、実際に地域で起こっている変化を直接評価しているわけではない。今回得られた知見をもとに、緩和ケア研修会参加者の知識・技能・態度が変化したかどうかを測定する、患者・家族の満足度を調査するなどの方法で、地域での変化を定性的・定量的に直接測定する必要があると考えられる。さらに、本研究は、限られた参加者の意見を集約したものであることから、緩和ケア研修会指導者全体の意見を反映していない可能性がある。

しかし、今回得られた知見から、緩和ケア研修会を開催することは、単に研修会受講生の知識・スキルの獲得のみならず、地域連携や緩和ケアの認知度の向上にも役立っている可能性があると考えられる。今後、緩和ケア研修会に参加した医師の行動変容や、緩和ケアを受けた患者・家族からのアウトカム評価を行うことで、緩和ケア研修会の直接的な効果について検討していくことが必要と考える。

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著者の申告すべき利益相反なし

Rapid Communications

Changes attained through the Palliative Care Education Program based on Cancer Control Act of Japan from the trainers' perspective

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Purpose: The Palliative Care Education Program based on the Cancer Control Act has been held throughout Japan since 2008. The aim of this study is to identify changes attained through the program from the trainers' perspective. **Method:** The contents of the brain-storming sessions with the twelve trainers were qualitatively analyzed. **Results:** Six main categories of improvement were identified. These include: Reinforced cooperation; improved palliative care skills and knowledge; improved awareness of palliative care; improved understanding of the local palliative care resources; behavior modification of the participants; and development of in-hospital palliative care systems. **Conclusion:** Trainers recognized that holding the Palliative Care Education Program provides not only direct results such as greater knowledge and improved delivery of palliative care by physicians, but also indirect results such as enhanced cooperation and improved awareness of local palliative care resources.

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Key words: palliative care, post-graduate education, neoplasm, qualitative research

Table 1. Characteristics of participants of this study (n=12)

Age		
year (range)	46 (36-55)	
Sex		
Male	10	83%
Female	2	17%
Specialty		
Palliative Medicine	8	66%
Psychiatry	2	17%
Surgery	2	17%
Area		
Hokkaido	1	8.3%
Kanto-Koshinetsu	2	17%
Chubu	3	25%
Kinki	2	17%
Kyushu	4	33%

Table 2. Changes attained through the Palliative Care Education Program from the trainers' perspective (n=110)

1. Reinforcement of Cooperation with	39
1) the community	14
2) other physicians	13
3) facilitators	7
4) public administration	4
5) patient groups	1
2. Improved Skills and Knowledge in	36
1) Knowledge of palliative care	17
2) Education skills	10
3) Improved attitude toward palliative care	9
3. Improved Awareness of Palliative Care in	15
1) hospitals	10
2) communities	5
4. Improved Understanding of the Local Palliative Care Resource (s)	9
5. Behavior Modification of the Participants	6
6. Development of In-hospital Palliative Care System	5

原著

がん対策基本法に基づく緩和ケア研修会の企画・運営 および学習資料の問題点

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2008年から緩和ケアの基本的知識・技術を習得することを目的に緩和ケア研修会が全国で行われている。研修会ががん診療連携拠点病院を中心に行われているが、研修会運営や教材にどのような問題点があるのかは明らかになっていない。本研究では緩和ケア研修会の問題点を抽出し、その改善方法を探索することを目的として、研修会改善のためのワークショップを行った。ブレインストーミングで得られた内容を質的に分析し、企画運営、および内容・教育マテリアルについてそれぞれの問題点を明らかにした。問題点は多様で、計16個のカテゴリーに分類された。研修会開催者の物理的・心理的負担が大きいため明らかとなった。これら問題点の改善のためにはe-Learningを組み合わせた、プログラムの自由度を拡大するなどして開催の負担を軽減すること、モジュールの拡充を伴う教育マテリアルのさらなる改良、開催指針の改訂が必要と考えられる。

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Key words: 緩和ケア, 卒後教育, がん, 質的研究

緒言

がんをはじめとした、生命を脅かされる疾患に直面する患者とその家族に対して緩和ケアの必要性が叫ばれて久しい。しかし、わが国においてその普及は十分ではなく、その一因として医師など医療者に対する緩和ケアの基本教育の不足が指摘されている。

たとえば、わが国で「緩和ケアに関して十分な教育を受けた」と回答した医師は約20%、「症状緩和に関する知識・技術が十分だ」と回答した医師は約30%であり、欧米の報告と比べて少ないことが明らかとなっている¹⁻⁴⁾。

このような背景から、厚生労働省はがん対策基本法に伴うがん対策推進基本計画において「すべてのがん診療に携わる医師が研修等により、緩和ケアについての基本的な知識を習得する」ことを目標として掲げた。これを受けて、がん診療に携わるすべての医師が緩和ケアについての基本的な知識を習得し、がん治療の初期段階から緩和ケアが提供されることを目的に、これら医師に対する研修会を行うように各都道府県に厚生労働省健康局長通知「がん診療に携わる医師に対する緩和ケア研修会の開催指針」が出された⁵⁾。

日本緩和医療学会では、2008年度から厚生労働省の委託を受けて、「緩和ケアおよび精神腫瘍学の基本教育に関する指導者研修会」(以下、指導者研修会)を開催して指導者の育成を行うとともに、「がん診療に携わる医師に対する緩和ケア研修会」(以下、緩和ケア研修会)を開催するための標準プログラムや教育マテリアル(学習資料)開発および開催支援をPEACEプロジェクトと名づけ実践してきた⁶⁻⁸⁾。その結果、これまでに全国のがん診療連携拠点病院を中心として多くの緩和ケア研修会が開催されており⁹⁾、その修了者は2010年12月時点で20,000人を超えている。しかし、各都道府県、地域における研修会の実

施状況をみると、その実績にはばらつきがみられ、地域によっては研修会が円滑に行えていない可能性が示唆されている。また、緩和ケア研修会を開催している指導者からは、緩和ケア研修会の企画・運営上の問題点や、教育マテリアルの改善の必要性を指摘する声が始まっている。

日本緩和医療学会では研修会事業開始から2年が経過した2010年1月、緩和ケア研修会を通じて得られたことを明らかにするとともに、緩和ケア研修会の問題点を抽出しその改善方法を探索することを目的として、緩和ケア研修会改善のためのワークショップ(以下、ワークショップ)を行った。

本研究の目的は、ワークショップの際に行われたブレインストーミングの結果を再構成することによって、日本緩和医療学会が行うPEACEプロジェクトに基づいて行われている緩和ケア研修会の企画・運営および内容・教育マテリアルの問題点を明らかにすることである。

方法

① 対象

同日に同施設で、緩和ケア研修会および指導者研修会修了者のフォローアップの目的で、日本緩和医療学会によって行われた「PEACE指導者フォーラム」の参加申込者130名に対して、メールで『緩和ケア研修会の問題点とその改善方法』を明らかにするためのワークショップに対する参加の依頼を行い、承諾の得られた36名を対象者とした。

② 方法

1. ワークショップの概要

2010年1月16日、東京において行われた。

目的は、以下の3点である。①研修会を行って自分、所属して