Challenges of completing of an advance directive (1)

41

- Often based on "what if" scenarios rather than reality
  - We cannot know exactly what will happen in the future, nor can we address all possibilities
- Patients' desire for treatment may change over time
- Surrogate decision-making role can be hard
  - Does the surrogate have freedom in making decisions or must they strictly follow the advance directives?

Vig, Sudore, Berg, et al, 2011

Challenges of completing of an advance directive (2)

42

- Creating a national standardized approach
- Often focus on procedures and treatment more than patients' values and preferences
- Often rely on checklists rather than open and ongoing communication between patients, physicians, and families
- Teaching physicians communication skills

43 Facilitating Advance Care Planning: Two Examples

Case 1: Outpatient Clinic

44

- Mrs. A is an healthy 60 year old woman with a history of mild osteoarthritis; she comes to your clinic for a routine examination
- You have decided to introduce advance care planning
  - How would you begin?

ACP in an Outpatient Setting

45

- *"Mrs. A, I'd like to talk with you about something I try to discuss with all of my patients. It's called advance care planning. In fact, I feel that this is such an important topic that I have done this myself, with my own physician. Are you familiar with advance care planning?"*
- *"Have you thought about the type of medical care you would like to have if you ever became too sick to speak for yourself? That is the purpose of advance care planning, to ensure that you are cared for the way you would want to be, even in time when communication may be impossible..."*

Knight SJ, *An Internet-based End of Life Care Education Program*

ACP in an Outpatient Setting (2)

46

- *"Advance care planning will help both of us to understand your values and goals for health care if you were to become [very sick]. Eventually we may put your choices into a written document that I would make part of your [medical] record. We call this document an advance directive, and it would only be used if you were to lose the [ability] to make decisions, either temporarily or permanently..."*
- You give the patient a copy of the form that you use to have this type of conversation. You have her make a follow-up appointment with you.

Knight SJ, *An Internet-based End of Life Care Education Program*

ACP in an Outpatient Setting (3)

47

- Next visit
  - You decide to ask questions about specific scenarios that could happen to Mrs. A to learn what is important to her

Knight SJ, *An Internet-based End of Life Care Education Program*

ACP in an Outpatient Setting (4)

48

- You may say ...
  - *"Mrs. A, I suggest that we start by considering a few examples as a way of getting to know your thinking. I will use examples that I use for everyone. First, imagine you were in a coma with no awareness. Assume there was a slight chance that you might wake up and be yourself again, but it was not likely. Some people would want us to withdraw treatment and let them die, others would want us to attempt everything possible, and yet others would want us to try to restore health, but stop treatment and allow death if it were not working. What do you think you would want under these circumstances?"*
  - Another scenario could include
    - Onset of dementia when there is already an advanced life-threatening illness

Knight SJ, *An Internet-based End of Life Care Education Program*

Case 2: Inpatient palliative care service

49

- Mr. C is a 69-year-old man who was admitted to the palliative care service with metastatic pancreatic cancer, diagnosed shortly after his retirement as a career firefighter. He had received one course of palliative chemotherapy before admission.
- His major symptoms consisted of pain, nausea and vomiting. He had to strictly adhere to a liquid diet due to a duodenal stricture. His pain was managed with fentanyl patch (every 3 days) and oxycodone (every 4 hours) as needed.

Case 2: Inpatient palliative care service

50

- My first step
  - Prepare myself by speaking with his oncology to learn his prognosis; gather as much information as possible about his disease
    - Be as certain as possible that a cure is not likely
- Next steps
  - Arrange for a time to meet with Mr. C and his family
    - I would start by asking ...
      - Tell me what you know about your condition? What your other doctors have told you?
  - After I learn what his (and his family's) understanding is of his disease and prognosis, I would ask him what are his goals for care

Case 2: Mr. C's goals of care

51

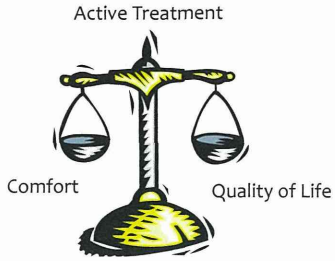
- Mr. C wanted **to live as long as possible** and to **receive any treatment that might extend his life.**
- He did not want intensive care unit level of care or cardiopulmonary resuscitation, but he wanted **to receive treatments such as IV fluids, antibiotics, transfusions, X-rays, ERCP**, etc.
- Based on his goals of care, the palliative care team worked hard to provide the care he desired. An order for DNAR was placed in his medical record.

Case 2: Mr. C's goals of care

52

- As Mr. C's condition gradually worsened, we continued to have discussions with him and treat his symptoms
- After he became comatose, his wife followed his advance directive to guide his treatment until he died

End-of-life care …



Treatment Continuum

54

Life-prolonging → life-supporting → life-releasing

["Cure"] [palliative care] [actively dying]

Conclusion

55

- Advance care planning is a process of communication and should be reviewed and updated regularly
- Advance care planning can help honor the patient's wishes and guide treatment when she/he can no longer speak for her- or himself
- Physicians (and other healthcare professionals) are in a unique position to facilitate ACP and AD discussions, but physician education focused on communication skills is needed

Thank you!

56

Photo by Brenda Nussey 2012

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57

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Palliative care in Chile

A brief overview

Chile

General information

Population:	17,248,450 people
Demographic density:	22.8/km
MDs per 10,000 people:	10.3
Population 65+	10%

Health expenditure (PPA int $)

Percentage of GDP (2010):	8%
Expenditure per capita (2010):	1199
Expenditure per capita by the state:	578

70% of mortality is from NCDs

Source: Atlas of Palliative Care in Latina America, 2012

Palliative care

Training: 12 schools of medicine out of 21 include palliative care in the curricula.
(30 professors were given lectures on this schools)

Only 2 universities offer graduate training on palliative care ("Specialist in Palliative medicine" and "Palliative medicine and continuous care" in a medicine school).

Source: Atlas of Palliative Care in Latina America, 2012

Accesibility to Palliative Care

In the public system is free. In the private system the co-payment is 20%.
All cancer patients are referred to palliative care.
Palliative care has a strong focus on oncology

Opioids

There is a vast arrange of opioids and there are no access problems, especially for the 70% in the public system.

Source: Atlas of Palliative Care in Latina America, 2012

Cultural views on end-of-life

Catholic doctrine

Distinguishes between ordinary and extraordinary care*:

- Nutrition and hydration to patients in persistent vegetative states is considered ordinary.
- Treatment that do not offer reasonable hope or benefit can be rejected and are seen as extraordinary
- Euthanasia is forbidden

Place of treatment

Home if possible, but hospital and hospice are acceptable**.

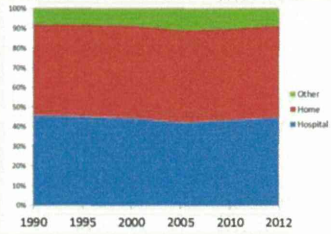
Sectary views

Pain is considered as a redeemer of bad actions (purification)

Source: *Cultural and religious aspects of palliative care, Steinmber 2011
**Multicultural palliative care guidelines, Taylor 1999

Placement of death

For population 5+



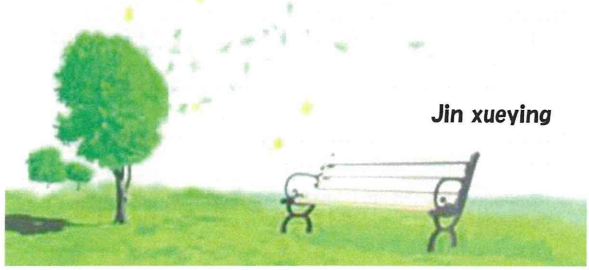
For population 65+

Year	*Hospital*	*Home*	*Total*
1990	39.3	56.1	4.2
1991	39.0	56.6	4.1
1992	39.0	56.6	4.2
1993	39.3	56.2	4.3
1994	39.3	56.1	4.4
1995	40.3	54.8	4.5
1996	40.8	54.4	4.4
1997	41.4	54.1	4.3
1998	41.6	53.8	4.4
1999	42.0	53.5	4.4
2000	42.1	53.0	4.7
2001	41.9	53.0	5.1
2002	36.2	53.3	10.1
2003	38.5	55.6	5.9
Total	40.2	54.8	5.0

Palliative care in Chile

A brief overview

End of life and attitude towards palliative care in China



Jin xueying

China

General information
Population: 1.4 billion
Demographic density:139.6/km2

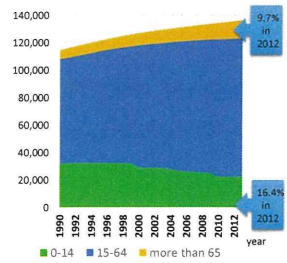
Health expenditure:(2010)
% of GDP:5.6%
Expenditure per capita:649.4$

Religion:

- Government implement Atheism education.
- Freedom of religion is guaranteed by China's constitution(From 1993)

Source: National Bureau of Statistics of the People's Republic of China, 2010

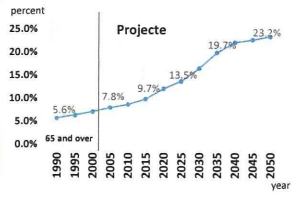
Population of China, 1990-2012



Source: National Bureau of Statistics of the People's Republic of China, 2013

Number of Older Chinese

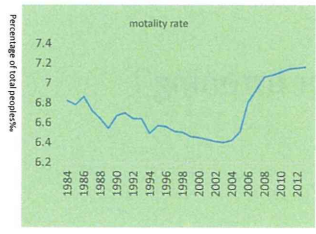
Population age 65 and over, selected years 1990-2005, and projected 2010-2050



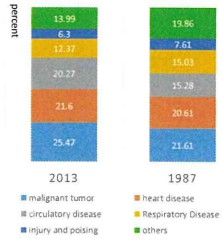
Source: The aging of the population of China Population on research Vol.29, No.6, November 2005

Mortality

Mortality Rate, 1984-2012



The proportion of the 6 most significant contributors to death , 1987 and 2013



Source: National Bureau of Statistics of the People's Republic of China, 2013

The status quo of Palliative care

- palliative care is available
- but it is still very limited
- it is not mandatory to teach courses on palliative care in Chinese medical universities.
- The potential Need for Palliative Care is Huge

Attitude towards Palliative care:

- The whole Chinese society does not regard palliative care as an important development.

Why?

- Chinese cultural values regarding to the end of life
- Financial constraints

Government:

- no designated funds from the government for palliative care,
- few policies to support palliative care development.

Cultural views:

- Citizens in society do not like to talk about hospice
  - consider it unlucky or a bad omen when discussing palliative care.
  - consider as an abandonment of hope and, even worse, of the patient.
- Patients are considered to be "waiting for death" if provided hospice and palliative care services
- Health professionals are reluctant to engage in hospice work because they feel depressed constantly over facing death.

Thank you for listening !

Mortality and location of death and Palliative care in Korea

Jang Saem

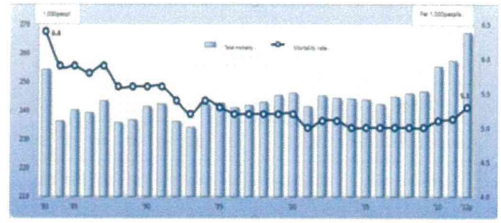
Korea

General information
Population : 49,039,986 people
Demographic density : 503/km^2

Health expenditure in PPA int$
Percentage of GDP(2010) : 7.1%
Expenditure per capita(2010) : 2035

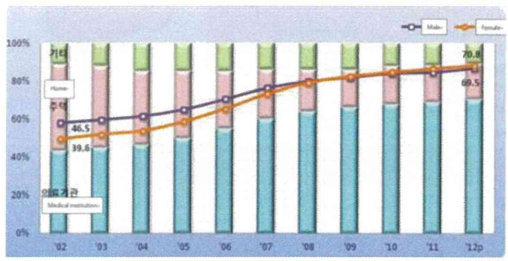
Source : analysis on the level of national health expenditure and associated Factors in the OECD coutries, National assembly budget office 2012

Total mortality and Mortality rate



Source: Statistics birth and death in 2012, Statistics Korea, 2012
http://kostat.go.kr/portal/korea/kor_nw/2/1/index.board?bmode=read&bSeq=&aSeq=271934&pageNo=1&rowNum=10&navCount=10&currPg=&sTarget=title&sTxt=%EC%B6%9C%EC%83%9D%EC%82%AC%EB%A7%9D

Proportion place of death



Source: Statistics birth and death in 2012, Statistics Korea, 2012
http://kostat.go.kr/portal/korea/kor_nw/2/1/index.board?bmode=read&bSeq=&aSeq=271934&pageNo=1&rowNum=10&navCount=10&currPg=&sTarget=title&sTxt=%EC%B6%9C%EC%83%9D%EC%82%AC%EB%A7%9D

Proportion place of death(2010~2013)

year	Total (people)	Home	Medical institution	Residential institution
2010	255,405	20%	68%	3%
2011	257,396	20%	69%	3%
2012	267,221	19%	70%	4%
2013	266,257	18%	71%	4%

Source: Annual report on the cause of death statistic(2010-2013), Statistics Korea
http://kosis.kr/wnsearch/totalSearch.jsp

Palliative care

Status of budget for specialized agency of Palliative care

(unit : billion won)

Year	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
budget	2.4	8	10.5	13	13	17.3	21.6	23.1	27.2	27.2
Number of institution	15	21	23	30	34	40	43	44	52	54
Number of bed	261	362	415	524	565	654	701	733	841	883
Utilization rate(%)	-	-	7.3	9.1	10.6	9.1	10.6	11.9	12.7	-

source: Status of budget for specialized agency of Palliative care, Ministry of health and welfare, 2013

Culture views

Citizens considers "death" as a bad thing ,and refuse to discuss about palliative care and even learn about it. However, the government and the hospitals believe that palliative care is needed in Korea.

THE 10TH GLOBAL AGEING SEMINAR

END OF LIFE IN GLOBAL AGING

Palliative Care in Uganda

Speaker: Laker Josephine
Graduate School of Comprehensive Human science, Tsukuba University

2015/1/27

GENERAL INFORMATION

Population total	38 million
GDP(current US dollar)	$21.49 billion
Public spending on health as a % of GDP	2.5%
Life expectancy	59 years

Source(UNICEF Demographic indicators)

Leading Causes of Death in Percentage Source(CDC Global health Countries Profile)

1. HIV 17%	6. Cardiovascular Diseases 4%
2. Malaria 12%	7. Cancer 4%
3. Lower Respiratory Infections 7%	8. Diarrheal Diseases 3%
4. Tuberculosis 5%	9. Road Injuries 3%
5. Meningitis 4%	10. Ischemic Heart Disease 2%

End of life

- Lacking but needed for the development of effective, appropriate service provision. little is known about the care majority receive or how they die except for the few that were at the hospice facilities.
- Hospice Uganda is a principal partner to Hospice Africa, an NGO that works to provide an appropriate palliative care service to patients with cancer and/or HIV/AIDS and their families
- Accessibility of palliative care is based on :

  Affordability- only 10% of over 200,000 Ugandans in need of palliative care and treatment have access to the facilities
- Religion Versus Culture views of pain

Cultural views on end of life

- Two sided view (Religious believe and tradition)

Process Verses fulfillment of life or life cut short (dying young and old)

The Acholi (Luo) tradition

- Dying young is met with grievances, loss, pity and often met with lost of questioning. Older persons - with grey hair often calls for a celebration of life. They are often viewed as a blessing

  (celebration- Feasting(eating and drinking), dancing and some traditional rituals are often performed)

The 1st International Conference on Global Aging Tsukuba

Opening Remarks 9:45-10:00 Venue: International Conference Room, University Hall				
9:45-10:00		Opening Remarks	Yoshiki Tsuboi 坪井美樹 Hitomi Matsuda 松田ひとみ	Provost of Faculty of Humanities and Social Sciences Chair of Doctoral Program in Human Care Science

Oral Session Ⅰ (English and Japanese) 10:00-11:10 Venue: International Conference Room, University Hall Chair: Ai Oishi				
10:00-10:20	O-Ⅰ-01	Library services for the elderly in an aged society in Japan	Saori Donkai	Faculty of Library, Information and Media Science
10:20-10:30	O-Ⅰ-02	Proenvironmental behavior, happiness, and perceived future happiness among the elderly: an exploratory analysis on Swedish and Japanese survey data	Naoko Kaida	Faculty of Engineering, Information and Systems
10:30-10:40	O-Ⅰ-03	The relation between perceived social support on depression of carers of community-dwelling elderly people from a nationwide survey in the Republic of Chile	Felipe Sandoval	Graduate School of Comprehensive Human Sciences
10:40-10:50	O-Ⅰ-04	高齢者救急のポリファーマシー	Toshikazu Abe 阿部智一	筑波大学附属病院水戸地域医療教育センター・総合病院水戸協同病院
10:50-11:00	O-Ⅰ-05	LOH症候群におけるテストステロン補充療法のインスリン抵抗性に対する効果	Takahiro Suetomi 末富崇弘	臨床医学系泌尿器科
11:00-11:10	O-Ⅰ-06	頸部装着型デバイスを用いた嚥下スクリーニング方法の開発	Yohei Teramoto 寺元洋平	フロンティア医科学専攻

Photo Session 11:10-11:20
Venue: Lawn outside University Hall

Poster Session 11:20-12:10
Venue: University Hall Annex
Chair: Toshie Manabe

11:20-11:25	P-01	高齢者ケアを担う看護者の手指衛生の実践に影響する要因	Noriko Okamoto 岡本紀子	人間総合科学研究科 ヒューマン・ケア科学専攻　高齢者ケアリング学分野
11:25-11:30	P-02	高齢者によるまちづくり活動と公共図書館の関わり－鹿児島県鹿屋市柳谷集落を中心に－	Sayaka Izumi 泉沙也香	情報学群知識情報・図書館学類
11:30-11:35	P-03	Effects of Cognitive Stimulation Therapy Japanese version (CST-J) for people with dementia: a single blind, controlled clinical trial	Katsuo Yamanaka	Faculty of Human Science
11:35-11:40	P-04	Activity of Daily Living (ADL) factors among Japanese Older Adults: Analyses of Age and Gender differences	Takafumi Monma	Faculty of Health and Sport Sciences
11:40-11:45	P-05	Factors related to the subjective well-being by gender in middle age people - Tsukuba aging survey	Yoko Moriyama	Department of Health Services Research, Faculty of Medicine
11:45-11:50	P-06	Releasing oppressed feelings in the caregivers of Japanese parents with dementia: a pilot intervention study	Yumi Hashizume	Faculty of Medicine, School of Medicine and Medical Sciences
11:50-11:55	P-07	Population aging and care burden of the family in Asia	Yumiko Miyashita	Department of Health Services Research, Faculty of Medicine
11:55-12:00	P-08	The utilization of healthcare services among rural elderly in North Thailand	Watcharakorn Riabroi	Department of Clinical Trial and Clinical Epidemiology, Graduate School of Comprehensive Human Sciences
12:00-12:05	P-09	Personality factors and self-perceived health in Chilean elderly population	Pedro Olivares-Tirado (Felipe Sandval)	Department of Health Services Research, Faculty of Medicine
12:05-12:10	P-10	A pilot study to explore actual monthly consumption of the people under the Public Livelihood Assistance Program (PLAP) in Japan －A Receipt Study based on ethics－	Hideto Takahashi	Biostatistics office, Faculty of Medicine

Luncheon 12:10-13:00 Venue: University Hall Annex				
12:30-12:45		Video Message　ビデオメッセージ	Marilyn Luptak etc.	Center for Aging The University of Utah
			Pedro Olivares-Tirado	Superintendence of Health, Chile　チリ保健省　筑波大学非常勤研究員 ヒューマンケア科学専攻ヘルスサービスリサーチ分野博士課程卒業生
			Neantro Saavedra-Rivano	The Program in Economic and Public Policy Management (PEPPM)

Key-note presentation (English) 13:00-13:30 Venue: International Conference Room, University Hall				
13:00-13:30		Long-term care for older people: The Japanese example	Mayumi Hayashi	Institute of Gerontology, King's College London, UK

Oral Session Ⅱ (English) 13:30-15:30 Venue: International Conference Room, University Hall Chair: Yumi Hashizume, Toshikazu Abe				
13:30-13:50	O-Ⅱ-01	Towards a Cultural Gerontology	Herrad Heselhaus	Department of Literature and Linguistics
13:50-14:10	O-Ⅱ-02	Population Ageing in Africa: Trend and Impact Analysis	Josephine Laker	Global 30 program
14:10-14:30	O-Ⅱ-03	The well-being of elderly self-neglectors	Yoshiaki Takahashi	Faculty of Engineering, Information and Systems
14:30-14:40	O-Ⅱ-04	Aspiration pneumonia and DAB	Shinji Teramoto	Hitachinaka Medical Research Center

14:40-14:50	O-Ⅱ-05	Age- and Socioeconomic-related Risk Factors for Hospitalized Pneumonia due to Influenza A(H1N1)pdm09 in Mexico	Toshie Manabe	Department of Health Services Research, Faculty of Medicine
14:50-15:10	O-Ⅱ-06	Singular Experiences: Media representation and lived experiences of single women across the life course	Kristie Collins	Faculty of Humanities and Social Sciences
15:10-15:30	O-Ⅱ-07	The Power and Challenges of Numbers: Population Ageing in Africa	Moges, Abu Girma	Faculty of Humanities and Social Sciences
15:30-15:40		Break		

Oral Session Ⅲ (Japanese) 15:40-17:00
Venue: International Conference Room, University Hall
Chair: Ichiro Okubo

15:40-15:50	O-Ⅲ-01	ひきこもりの子どもを抱える家族の高齢化と支援ニーズに関する研究	Tamaki Saito 斎藤環	医学医療系
15:50-16:10	O-Ⅲ-02	子供の健康の評価と母親の教育水準の関係	Koichi Ushijima 牛島光一	システム情報系社会工学域
16:10-16:20	O-Ⅲ-03	震災が介護サービス利用・要介護度の推移等に与えた影響	Nobuyuki Izumida 泉田信行	人間総合科学研究科
16:20-16:30	O-Ⅲ-04	認知症医療と介護の連携の現状－全国調査より	Atsuko Yoshimura 吉村敦子	人間総合科学研究科 疾患制御医学専攻
16:30-16:40	O-Ⅲ-05	高齢女性のドメスティック・バイオレンスの認識と予防啓発に関する意見	Tomoko Suga 須賀朋子	社会精神保健学分野
16:40-17:00	O-Ⅲ-06	ドイツにおける「年齢に公正な労働世界」報告書をめぐって	Yoko Tanaka 田中洋子	人文社会系　国際地域研究・国際日本研究専攻

Closing Session 17:00-17:15
Venue: International Conference Room, University Hall

17:00-17:15		Commendation: Best young scientist oral presentation Best young scientist poster presentation Closing Remarks	Miyoko Motozawa 本澤巳代子 Nanako Tamiya 田宮菜奈子	Faculty of Humanities and Social Sciences Faculty of Medicine

The 2nd International Conference on Global Aging Tsukuba

Opening Remarks 9:00-9:10 **Venue: Special Conference Room, University Hall**				
9:00-9:10		Opening Remarks	Nanako Tamiya	Faculty of Medicine

Key-note presentation (English) 9:10-9:30 **Venue: Special Conference Room, University Hall** **Chair: Nanako Tamiya**				
9:10-9:30		**Key-note presentation** Long term care for older people in Latin America: a growing challenge	Peter Lloyd-Sherlock	Social Policy and International Development University of East Anglia (UK)

Oral Session (English/Japanese) 9:30-12:25 **Venue: Special Conference Room, University Hall** **Chair: Ken Masuda, Haruhiko Inada, Toshie Manabe**				
9:30-9:50	**O-01**	高齢化・工業化・人口移動の日独比較	Yoko Tanaka	Faculty of Humanities and Social Sciences
9:50-10:10	**O-02**	Population Aging in Ethiopia: Adaptation Mechanisms and Public Policy	Abu Girma Moges	Faculty of Humanities and Social Sciences
10:10-10:25	**O-03**	韓国農村における高齢化・家族・グローバル	Hyemi Lee	Graduate School of Humanities and Social Sciences
10:25-10:40	**O-04**	Aging as an Attribute of Humanism and Exertion of Noosphere	Georg von Fingerhut	School of Social and International Studies, G30
10:40-10:55	**O-05**	Age and Happiness: Comparative analysis between five countries	Yoshiaki Takahashi	Faculty of Systems and Information Engineering
10:55-11:15	**O-06**	Friederike Mayröcker – An Aesthetic of Aging	Herrad Heselhaus	Department of Literature and Linguistics, Faculty of Humanities and Social Sciences
11:15-11:35	**O-07**	Population Aging in Africa Exploring Multi-Social System Environment in Political, Economic and Cultural Landscape	Ken Masuda	Graduate School of International Health Development, Nagasaki University
11:35-11:50	**O-08**	Effect of Local Government's Vaccination Policies on the Uptake Rates of Pneumococcal Polysaccharide Vaccine (PPSV) for Old Persons	Hiroko Sugiyama	Graduate School of Political Science - Public Management Major, Waseda university

11:50-12:05	**O-09**	Consolidation time dependent memory generalization as a mechanism of memory inaccuracy in aging	Ayano Fujinaka	School of Medicine
12:05-12:20	**O-10**	The relation between burden of care and health-related quality of life of caregivers of community dwelling elderly people in Chile	Felipe Sandoval	Department of Health Services Research
12:20-12:25		Comments from Special Guest	Gerhard Igl	Institute of Social Law and Health Law, University of Kiel (Germany)

Luncheon 12:25-13:30

12:25-13:30	Posters and Exhibits are available in University of Tsukuba 30th Anniversary Hall (Exchange Hall)

Special Presentation (English) & Exhibits 13:30-13:45
Venue: University of Tsukuba 30th Anniversary Hall (Exchange Hall)

13:30-13:45		**Special presentation** Development of Assistive Robotics for Aging Society 生活支援ロボット・介護支援ロボットの現状と課題	National Institute of Advanced Industrial Science and Technology 産業技術総合研究所
		Exhibitors	National Institute of Advanced Industrial Science and Technology NTT DATA Corporation

Poster Session (English/Japanese) 13:45-15:25
Venue: University of Tsukuba 30th Anniversary Hall (Exchange Hall)
Chair: Tomoko Wakui, Hideto Takahashi, Toshie Manabe

13:45-13:55	**P-01**	Activity limitation and the relation with health status in Japanese older adults	Takafumi Monma	Graduate School of Comprehensive Human Sciences
13:55-14:05	**P-02**	Severity of dementia and circumstances of falls in Japanese institutional settings: A prospective multicenter study using multiple correspondence analysis	Yoshiyuki Kawano	Division of Disability Sciences, Faculty of Human Sciences
14:05-14:15	**P-03**	Patternization of the transition of Care-level -trial in one prefecture data in Japan ある自治体における要介護度変化のパターン化の試み	Masamitsu Mikoshiba	Department of Health Services Research
14:15-14:25	**P-04**	The health observation support for local elderly persons by the youth in Kamisu	Satomi Omotani	Department of Clinical Trial and Clinical Epidemiology
14:25-14:35	**P-05**	The trends of Japanese family caregiving: country report	Tomoko Wakui	Tokyo Metropolitan Institute of Gerontology
14:35-14:45	**P-06**	Towards a co-production approach in developing Adult Social Care data collection in England	Jonathan Kilworth	London Borough of Harrow, London UK and Health & Social Care Information Centre, Leeds, UK

14:45-14:55	**P-07**	Factors Associated with Self-Rated Health for Old People in the Philippines	Shiho Kashiwagi	Faculty of Humanities and Social Sciences
14:55-15:05	**P-08**	Health related quality of life among native ethnic older persons in Chile	Pedro Olivares-Tirado	Studies and Development Department, Superintendence of Health, Santiago, Chile
15:05-15:15	**P-09**	A Descriptive Analysis of the Conditions of Older Persons in Uganda	Josephine Laker	Department of Health Services Research
15:15-15:25	**P-10**	Is there common description of ethics in original articles published in welfare?	Hideto Takahashi	Faculty of Medicine, Fukushima Medical University

Special Guest Comments and Commendation 15:25-15:35 **Venue: University of Tsukuba 30th Anniversary Hall (Exchange Hall)**				
15:25-15:35		Comments from Special Guest	Gerhard Igl	Institute of Social Law and Health Law, University of Kiel (Germany)

Closing Session 15:35-15:45 **Venue: University of Tsukuba 30th Anniversary Hall (Exchange Hall)**				
15:35-15:45		Closing Remarks	Miyoko Motozawa	Faculty of Humanities and Social Sciences

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POSTER PRESENTATION Open Access

Polypharmacy as a risk factor for hospital admission among elderly using emergency transport

Toshikazu Abe[1,2*], Nanako Tamiya[2], Takako Kitahara[1], Yoshinori Hasegawa[1], Yasuharu Tokuda[3]

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Background

Aging is an urgent global-scale issue and Japan is the frontrunner of aging. Emergency department (ED) admission of the oldest-old challenges emergency physicians and polypharmacy has been considered as one of its possible risk factors. The aim of this study was to analyze hospital admission among patients aged 85 years and older using ambulance transport regarding its relationship with polypharmacy.

Materials and methods

A retrospective observational cohort study was conducted on consecutive patients (age >85 years old) with ED transports by ambulance between April to December in 2013, in a community teaching hospital in Japan. Patients with out-of-hospital cardiopulmonary arrest were excluded. Data were collected from computerized records about demographics, chief complaints, vital signs and level of consciousness at arrival, final diagnoses at discharge, and polypharmacy (defined > 5 baseline medications) at outpatient clinics. Primary outcome was requirement for admission to the hospital. We also analyzed symptomatic drug adverse events.

Results

Of the 3084 adults (≥18 years old) who were transported to our hospital by ambulances, 381 (13%) were aged ≥85 years old; 233 (61%) were women. 261/381 (69%) patients were admitted to the hospital. The mean number of their baseline medication was 6.8±3.9. 250/347 (72%) patients had polypharmacy. 27 (7%) patients had apparent symptomatic drug adverse events. Although apparent drug adverse events were not related to polypharmacy (p=0.392), patients with polypharmacy were more likely to be admitted to the hospital after adjusted for age, gender and vital signs at arrival using multiple logistic regression (odds ratio 2.1 [95% CI, 1.0-4.3], p=0.049). Heart and respiratory rates in vital signs at arrival were also associated with admission (P<0.001 and P<0.001, respectively).

Conclusions

About 70% of the oldest-old patients using ambulance transport were admitted to the hospital. They had been prescribed a number of baseline medications. These medications caused apparent symptomatic drug adverse events, which was one of the most preventable reasons for admission. Polypharmacy could be one of the major risks for admission at ED in addition to unstable vital signs.

Authors' details
[1]Department of Emergency Medicine, Mito Kyodo General Hospital, University of Tsukuba, Mito, Ibaraki, Japan. [2]Department of Health Services Research, Faculty of Medicine, University of Tsukuba, Tsukuba, Ibaraki, Japan. [3]Japan Community Healthcare Organization, Tokyo, Japan.

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[1]Department of Emergency Medicine, Mito Kyodo General Hospital, University of Tsukuba, Mito, Ibaraki, Japan
Full list of author information is available at the end of the article