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ORIGINAL ARTICLE

Developing an interdisciplinary program of educational support for early-stage dementia patients and their family members: An investigation based on learning needs and attitude changes

Aya Seike,[1,2] Chieko Sumigaki,[1] Akinori Takeda,[1] Hidetoshi Endo,[1] Takashi Sakurai[1] and Kenji Toba[1]

[1]Center for Comprehensive Care and Research on Demented Disorders, National Center for Geriatrics and Gerontology, Obu, and [2]Kokoro Research Center, Kyoto University, Kyoto, Japan

Aim: The National Center for Geriatrics and Gerontology has begun to provide educational support for family caregivers through interdisciplinary programs focusing on patients in the early stage of dementia. These interdisciplinary programs have established two domains for the purpose of "educational support": cure domains (medical care, medication) and care domains (nursing care, welfare). In the present study, we examined the learning needs and post-learning attitude changes of patients and their families who participated in these programs in order to assess the effectiveness of an interdisciplinary program of educational support in each of these domains.

Methods: A total of 170 participants (51 dementia patients, 119 family members) were included in the study. Data were obtained from electronic health records, and through a written survey administered before and immediately after each program.

Results: A high percentage of patients and family members desired knowledge about the progression and symptoms of dementia, as well as measures to prevent progression, both of which fall under the medical care content. For patients, education in the medical care content increased their motivation to live. For families, education in the medical and nursing care contents promoted their understanding of dementia, while education in medication and welfare contents improved their skills for handling dementia patients and their symptoms.

Conclusion: Both patients and family members expressed a need to learn medical care content, including the progression and disease symptoms of dementia, and methods to prevent the progression of dementia symptoms. Their responses showed that learning medical care was effective for understanding dementia. We suggested that medical care content was the core of interdisciplinary educational support for early-stage dementia patients and their family members. **Geriatr Gerontol Int 2014; 14 (Suppl. 2): 28–34.**

Keywords: attitude changes, early-stage-dementia, educational support, interdisciplinary, learning needs, medical care content.

Introduction

The number of dementia patients in Japan is steadily increasing. In response to this situation, the "Future Direction of Dementia Policy -June 2012-" highlighted "early diagnosis and early care" as the foundation of care.[1] The Japanese Ministry of Health, Labor and Welfare advocates the strengthening of day-to-day family support in the community, irrespective of the stage of dementia.[2] Previous studies have shown that providing family caregivers of dementia patients with a psycho-educational program for a fixed period improves the trust between caregivers and patients, and provides caregivers with an understanding of the disease and coping ability for caregiving.[3,4] Chien *et al.* stated that when care managers provided sessions on self-care and restoring or building family relationships, the patients' symptoms stabilized, caregivers felt their care to be less burdensome, and the admission rates and periods of admission to medical institutions decreased.[5] In

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Correspondence: Dr Aya Seike MSW MPH PhD, Center for Comprehensive Care and Research on Demented Disorders, National Center for Geriatrics and Gerontology, 35 Gengo, Morioka-cho, Obu, Aichi 474-8511, Japan. Email: ayahime@ncgg.go.jp

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addition, counseling for dementia patients' family members enabled prolonged home care.[6,7] However, all of these studies have methodological shortcomings. For example, when selecting study subjects from the population of dementia patients requiring care, these studies categorized symptoms too broadly, ranging from slight to severe. In addition, study program providers (interveners) were only chosen from the paramedic profession rather than from an interdisciplinary group.

In order to address some of these issues, the Center for Comprehensive Care and Research on Memory Disorders (Monowasure-Center) of the National Center for Geriatrics and Gerontology (NCGG) embarked on an interdisciplinary program of educational support for dementia patients and their families immediately after the definitive diagnosis of dementia. We examined the learning needs and post-learning attitude changes of patients and their families in order to assess the effectiveness of this interdisciplinary program of educational support.

Methods

Operational definition

First, the interdisciplinary research team set up two operational definitions. We defined the first few months after a definitive dementia diagnosis as the "early stage." Next, we set up a program offered through an interdisciplinary collaboration as "early-stage educational support."

Psycho-educational program

We divided the program structure broadly into two domains: the "cure domain" concerned with diagnosis, treatment and medication for dementia, and the "care domain" concerned with care methods and social support for dementia patients. Furthermore, the cure domain consisted of medical care content and medication content, the care domain consisted of nursing care content and welfare content. We then set up four content categories for each domain (Table 1), and assigned physicians, pharmacists, nurses and psychiatric social workers as interveners.

Participants

The study protocol was approved by the institutional review board of the NCGG of Japan. Candidate patients and their family caregivers submitted informed consent before participating in the study. The total number of participants was 170. This research included several cases in which there were two or more family participants to one patient. In these cases, all participating family members in the household were counted in the number of participants. Following are the details of the 170 study participants (Fig. S1).

The study participants were 51 dementia patients (henceforth referred to as "patients") who had been given a definitive dementia diagnosis only a few months before participation in the program (August 2012 to August 2013). The 51 patients targeted in the study comprised 41 patients who participated in both the cure and the care domains, and 10 patients who participated in only the care domain. Furthermore, the study also targeted 119 family members of patients, raising the total number of participants to 170. These 119 family members comprised 53 who participated in both the cure and the care domains, and 66 who participated in only one domain. Of these 66 single-domain participants, 27 participated in the cure domain, and 39

Table 1 Structure of educational program

Domain	Program content	Intervener	Time provided (min)	No. times	Theme
Cure	Medical care	Physician	15	One time/one month	Basic knowledge about dementia
	Medication	Pharmacist	15	One time/one month	Pharmacological treatment and management through medication
Care	Nursing care	Nurse	15	One time/one month	Understanding dementia patients as "people with dementia" and coping methods
	Welfare	Psychiatric social worker	15	One time/one month	Provision of information concerning social resources that help patients and their caregivers in the community

participated in the care domain. Participation in each domain was based on request rather than random allocation.

Assessment and questionnaires

The items of type of dementia, Barthel Index (BI),[8] Mini-Mental State Examination (MMSE),[9] Dementia Behavior Disturbance Scale (DBD)[10] and Zarit Burden Interview (ZBI)[11] were collected through patients' electronic health records, and descriptive questionnaires issued before and after each program. The questionnaire items administered before attending the program inquired about personal attributes and what the participant desired to learn. After completion of the program, we examined participants' learning needs and attitude changes for each domain, using four items: (i) degree of usefulness for future life and caregiving; (ii) degree to which anxieties about life and care are resolved; (iii) degree of improvement in future life and increase in incentive for care; and (iv) degree to which understanding of dementia is promoted. For the responses, we used a five-point Likert scale with possible answers to each question being: (i) completely disagree; (ii) disagree somewhat; (iii) cannot say either way; (iv) agree considerably; and (v) agree very much.

Statistical analysis

We carried out a statistical analysis of the quantitative data and categorized the qualitative data. For the data analysis of χ^2-test, we used the SPSS windows version 21.0 program (SPSS, Chicago, IL, USA).

Results

Characteristics of patients and family members

Characteristics of both patients and family member participants were analyzed (Table 2). Patients' clinical characteristics were analyzed according to sex, age, type of dementia, the BI, the MMSE score and the DBD. Among the clinical characteristics, Alzheimer's disease was the most common type of dementia (88.2%). In addition, some participating patients showed early-stage dementia with MMSE (mean ± SD) scores of 19.9 ± 4.5.

The family member characteristics analyzed were sex, age group, family relationship to patient, living with patients and the ZBI. Approximately 70.0% of family member participants were females, and approximately 50.0% of family member participants were in the old age group. In the family member's relationship to patient group, "spouse" accounted for the highest proportion of responses (47.9%).

Learning needs according to program contents and change in participant attitude

Cure domain (program content: Medical care/ Medication).

Table 2 Baseline characteristics of patients and family members

The items	*n* (%)	Mean ± SD
Patients characteristics ($n = 51$)		
Sex (female)	30 (58.8)	
Age (years)		78.8 ± 6.6
Types of dementia		
Alzheimer's disease	45 (88.2)	
Vascular dementia	5 (9.8)	
Dementia with Lewy bodies	1 (2.0)	
Barthel Index		94.5 ± 15.9
MMSE (total score)		19.9 ± 4.5
DBD scale (total score)		13.1 ± 8.1
Living with family members (at home)	47 (92.1)	
Family members' characteristics ($n = 119$)		
Sex (female)	83 (69.7)	
Older age group (from 60s to 80s)	59 (49.5)	
Patient's spouse	57 (47.9)	
Patient's daughter or son	41 (34.5)	
Patient's daughter or son-in-law	14 (11.8)	
Living with patients (at home)	114 (95.8)	
ZBI (total score)		19.6 ± 4.5

DBD, Dementia Behavior Disturbance Scale; MMSE, Mini-Mental State Examination; ZBI, Zarit Burden Interview.

Learning needs

A total of 27 patients and 80 family members gave complete answers regarding learning needs (Table 3). The majority of the patients' answers were categorized as "Understand how the advance of dementia can be prevented" and "Gained a general understanding of dementia." Many patients expressed a desire to know how to slow down the progress of dementia, as well as general things to keep in mind when going about their daily lives. Patients also stated their desire to confirm whether their current disease and symptoms were real.

With regard to family members, the majority of answers were in the categories "Gain understanding about dementia" and "How to cope with dementia and the patient."

Attitude change

With regard to program 1, "Leads to understanding of dementia" and "Useful for future care and living methods" had high values of more than 80.0% for patients, and more than 70.0% for family members (Table 4). We did not find a statistical difference, but more than 70.0% of the patients answered "Leads to increased motivation to live," and similarly, more than 70.0% of family members answered that it "Leads to a resolution of anxiety about life and care."

For program 2, results for "Led to a resolution of anxiety about life and care" were approximately 70.0% for both patients and family members. In this program, family members' attitudes appeared to change, with 72.5% of family members, a markedly high result, answering that the program is "Useful for future care and living methods" and "Leads to increased motivation to live."

Care domain (Program content: Nursing care/Welfare).

Learning needs

On the topic of learning needs, 30 patients and 92 family members gave complete answers (Table 3). An extremely high proportion of patients (90.0%) answered that the program helped them to "Gain a general understanding of dementia." This result showed patients'

Table 3 Learning needs according to program contents

Domain	Content	Category	Patients $n = 27$	Family members $n = 80$
Cure	Medical care/Medication	†Gain a general understanding of dementia	8 (29.6%)	35 (43.8%)
		†Learn how to prevent dementia from progressing	10 (37.0%)	5 (6.3%)
		Gain knowledge on the treatment methods for dementia	5 (18.5%)	16 (20.0%)
		Learn how to approach dementia	0 (0.0%)	18 (22.5%)
		†Resolution of psychological anxiety and conflict	4 (14.8%)	3 (3.8%)
		Find fellow dementia patients and caregivers	0 (0.0%)	2 (2.5%)
		Examine ways in which to announce dementia	0 (0.0%)	1 (1.3%)
			Patients $n = 30$	Family members $n = 92$
Care	Nursing care/Welfare	Learn care methods	0 (0.0%)	56 (60.8%)
		†Gain a general understanding of dementia	27 (90.0%)	17 (18.5%)
		†Learn how to prevent dementia from progressing	12 (40.0%)	0 (0.0%)
		Learn living methods	0 (0.0%)	5 (5.4%)
		Learn theories of coping with dementia patients	1 (3.3%)	6 (6.5%)
		Acquire information on the various types of social support	0 (0.0%)	4 (4.3%)
		Connection with community and whether or not to announce dementia	0 (0.0%)	2 (2.2%)
		†Resolution of psychological anxiety and conflict	1 (3.3%)	2 (2.2%)
		Learn ways to make use of social resources	0 (0.0%)	1 (1.1%)
		Other	4 (13.3%)	0 (0.0%)

†Categories raised (as needs) in both categories.

Table 4 Cure domain: Change in participants' attitude according to program contents

Program content	Questions inquiring about	Responses[†]	Patients (n = 27)	Family members (n = 80)	P-value (χ^2-test)
1. Medical care	Q1: Program content is useful for future care and living methods	Agree	21 (77.7%)	60 (75.0%)	$P = 0.97$
		Disagree	6 (22.3%)	20 (25.0%)	
	Q2: Program content linked to a resolution of anxiety concerning life and care	Agree	19 (70.3%)	58 (72.5%)	$P = 0.85$
		Disagree	8 (29.7%)	22 (27.5%)	
	Q3: Program content linked to improvement in future life and increase in motivation to live	Agree	19 (70.4%)	54 (67.5%)	$P = 0.95$
		Disagree	8 (29.6%)	26 (32.5%)	
	Q4: Program content linked to understanding of dementia	Agree	22 (81.5%)	66 (82.5%)	$P = 0.78$
		Disagree	5 (18.5%)	14 (17.5%)	
2. Medication	Q1: Program content is useful for future care and living methods	Agree	17 (62.9%)	58 (72.5%)	$P = 0.09$
		Disagree	10 (37.1%)	22 (27.5%)	
	Q2: Program content linked to a resolution of anxiety concerning life and care	Agree	18 (66.6%)	59 (73.7%)	$P = 0.42$
		Disagree	9 (33.4%)	21 (26.3%)	
	Q3: Program content linked to improvement in future life and increase in motivation to live	Agree	16 (59.2%)	58 (72.5%)	$P = 0.06$
		Disagree	11 (40.8%)	22 (27.5%)	
	Q4: Program content linked to understanding of dementia	Agree	16 (59.2%)	55 (68.7%)	$P = 0.30$
		Disagree	11 (40.8%)	25 (31.3%)	

[†] For each question, we calculated the answers by using a five-point Likert scale whereby we combined the number of participants who selected "Agree very much" and "Agree considerably" as those who selected "Agree"; we counted those who selected "Completely disagree," "Disagree somewhat" and "Cannot say either way" as "Disagree." We additionally used a χ^2-test.

desires to learn the means to prevent their dementia from worsening. In other words, patients wanted to learn about treatments and living methods that could stop the progression of their dementia.

As for family members, 60.8% showed a desire to "Learn care methods." Family members desired to know more about the ways to approach problem behaviors in dementia patients.

Attitude change

In program 3, the degree of attitude change among patients was polarized at approximately 60.0% (Table 5). Those whose degree of attitude change was 60.0% or above answered that it was "Useful for future living methods" and "Leads to increased motivation to live." As for the degree of attitude change among family members, the results were high (70.0%) on all four items. The highest items were "Leads to a resolution of anxiety about life and care," and "Leads to understanding of dementia," at 76.1% and 78.3% respectively. A significant difference was observed in the latter (χ^2-test, $P < 0.05$).

With regard to program 4, the degree of attitude change among patients remained at approximately 60.0% for all four items, with the highest of these, at 66.6%, being "Leads to increased motivation to live." As for family members, no significant difference was observed, but "Useful for future life and care" and "Leads to a resolution of anxiety about life and care" were high at 72.8% and 71.7%, respectively.

Discussion

Although educational support programs typically target family caregivers,[12] the present study was unique in that it targeted patients as well. As very little time had passed since the definitive dementia diagnosis, both patients and family members might have been confused or anxious,[13,14] but they showed high expectations for learning. In considering these concerns and expectations, it is important to examine the learning needs and attitude changes throughout the program.

As shown in Table 2, both patients and family members were aging. We reasoned that there was elderly care by the elderly because of the high rate of "spouse" in the family relationship to patient. Dementia conditions will worsen little by little from diagnosis, even if patients have early-stage dementia. Therefore, the necessity for learning about the cure and care of dementia was suggested as preparation for preventing care burden and care breakdown.

Many patients and their family members showed learning needs for medical care content in the cure

Table 5 Care domain: Change in participants' attitude according to program contents

Program content	Questions inquiring about	Responses[†]	Patients (n = 30)	Family members (n = 92)	P-value (χ^2-test)
3. Nursing care	Q1: Program content is useful for future care and living methods	Agree Disagree	19 (63.3%) 11 (36.7%)	65 (70.7%) 27 (29.3%)	$P = 0.82$
	Q2: Program content linked to a resolution of anxiety concerning life and care	Agree Disagree	18 (60.0%) 12 (40.0%)	70 (76.1%) 22 (23.9%)	$P = 0.17$
	Q3: Program content linked to improvement in future life and increase in motivation to live	Agree Disagree	19 (63.3%) 11 (36.7%)	67 (72.8%) 25 (27.2%)	$P = 0.59$
	Q4: Program content linked to understanding of dementia	Agree Disagree	17 (56.6%) 13 (43.4%)	72 (78.3%) 20 (21.7%)	$P = 0.40$
4. Welfare	Q1: Program content is useful for future care and living methods	Agree Disagree	19 (63.3%) 11 (36.7%)	67 (72.8%) 25 (27.2%)	$P = 0.21$
	Q2: Program content linked to a resolution of anxiety concerning life and care	Agree Disagree	19 (63.3%) 11 (36.7%)	66 (71.7%) 26 (28.3%)	$P = 0.73$
	Q3: Program content linked to improvement in future life and increase in motivation to live	Agree Disagree	20 (66.6%) 10 (33.4%)	62 (67.4%) 30 (32.6%)	$P = 0.72$
	Q4: Program content linked to understanding of dementia	Agree Disagree	19 (63.3%) 11 (36.7%)	63 (68.4%) 29 (31.6%)	$P = 0.96$

[†] For each question, we calculated the answers by using a five-point Likert scale whereby we combined the number of participants who selected "Agree very much" and "Agree considerably" as those who selected "Agree"; we counted those who selected "Completely disagree," "Disagree somewhat" and "Cannot say either way" as "Disagree." We additionally used a χ^2-test.

domain, including dementia progression, symptoms and ways to prevent progression. Family members tended to desire information about the progression of dementia and treatment methods appropriate for stopping it, as well as the symptoms that appear. Such results support the demand for a program with continuity between cure and care.

When we attempted to verify the efficacy of each program according to attitudinal change, we found that the results were different depending on participants' attributes. The most notable results among patients were in the medical care content (program 1) "Degree of usefulness for future life," "Degree of increased motivation to live" and "Degree to which the program helped participants understand dementia." Many patients felt this program helped to them seek a way of life that prevents dementia from worsening.

With regard to family members, "Degree of resolution of anxiety about life and care" was markedly high across all the programs. Examining the programs individually, "Degree to which understanding of dementia was promoted" was markedly high for medical care content (program 1) and nursing care content (program 3), and "Degree of usefulness for future life and care" was markedly high for medication content (program 2) and welfare content (program 4). We could infer that, in each case, cure and care were shown to be effective as one unit, with "gaining understanding of dementia patients and their symptoms" in the former, and "learning methods for sustainable care" in the latter. Interdisciplinary educational support, consisting of both cure and care content, can provide appropriate psychological care. Another benefit of interdisciplinary educational support is that, through learning the knowledge and skills necessary for living with dementia, patients and their family members spontaneously involved themselves in medical consultations and treatment. This benefits healthcare providers by facilitating medical consultations, and empowers patients and family members about cure and care.

The present study provides evidence for three assertions:

1 Both patients and family members feel a need to learn medical care content including dementia progression, symptoms and methods to prevent progression.
2 Learning medical care content would lead to their use of knowledge and an increased motivation to live.
3 Learning medical care content is effective in helping family members understand dementia, and leads to the acquisition of skills for coping with dementia patients and their symptoms.

Following these three points, we suggest that medical care content was the core of interdisciplinary educational support for early-stage dementia patients and their family members. Finally, there is a need to continue research to verify this program's effectiveness.

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Disclosure statement

The authors declare no conflict of interest.

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Supporting information

Additional Supporting Information may be found in the online version of this article at the publisher's web-site:

Figure S1 Flow chart of the study protocol.

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REVIEW ARTICLE

Educational program in Japan for Dementia Support Doctors who support medical and care systems as liaisons for demented older adults in the community

Yukihiko Washimi,[1] Kentaro Horibe,[1] Akinori Takeda,[1] Takashi Abe[2] and Kenji Toba[3]

[1]Department of Cognitive Disorders, National Center for Geriatrics and Gerontology, Obu, [2]CEO HAM Human-Social Institute LCC, Tokyo, and [3]President of National Center for Geriatrics and Gerontology, Obu, Japan

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Now that the number of elderly people has increased and the number of dementia patients is rapidly increasing, dementia might be regarded as a common disease. Under these circumstances, the establishment of systems to support the elderly with dementia from the early stages, and to provide primary care doctors and care workers with necessary education is an urgent issue. Up to the end of 2012, a total of 2680 doctors had been certified as Dementia Support Doctors (DSD). The DSD's function and roles are: (i) to support primary care doctors and care specialists involved in the medical care, and general care of dementia patients; (ii) to facilitate multidisciplinary cooperation led by a Community General Support Center; and (iii) to give lectures about dementia to primary care doctors and educate people in the community. DSD are more skilled than primary care doctors in the following functions: differential diagnosis; outpatient services to deal with behavioral and psychological symptoms of dementia; community liaison; and home care. **Geriatr Gerontol Int 2014; 14 (Suppl. 2): 11–16.**

Keywords: community liaison, Dementia Support Doctor, educational program for Dementia Support Doctors.

Introduction

Now that the number of patients with dementia is rapidly increasing with the increase of the number of elderly people, dementia might be regarded as a common disease. In fact, primary care doctors are now more frequently engaged in the care of patients with dementia, regardless of their specialty, and, consequently, it has become necessary for all of them to have a certain level of ability to treat the disease. Furthermore, in dementia care, appropriate role-sharing among medical professionals is important, while it is necessary to cooperate with care workers and administrative institutions.[1] Under these circumstances, the establishment of systems to support the elderly with dementia from the early stages, and provide primary care doctors and care workers with the necessary education is an urgent issue. To address this, the Ministry of Health, Labor, and Welfare launched a plan in 2005 to train Dementia Support Doctors (DSD), playing a central role in community-based activities to support dementia patients. Subsequently, in 2006, another plan called the Skill-up Program of Dementia Medicine for Primary Care Doctors was initiated mainly by DSD, and, up to the end of 2012, a total of 2680 doctors had been certified as DSD. The total number of doctors who had completed the Skill-up Program of Dementia Medicine for Primary Care Doctors by the end of 2011 was 28 024. The government aims to increase the number of DSD to 4000, and that of doctors who have completed the Skill-up Program of Dementia Medicine for Primary Care Doctors to 50 000 by 2017.[2] The present article reports appropriate DSD training systems, while discussing the roles and activities of DSD. It also provides an outline of training programs focusing on long-term care services.

Educational program for DSD

With a Grant for Plans to Promote Health and Medical Services for the Elderly, the Ministry of Health, Labor, and Welfare launched the Research Project on Community Systems to Provide Early Identification and Appropriate Care for the Elderly with Dementia in 2004. In line with this, a working group was organized to examine methods to provide the Skill-up Program of Dementia Medicine for Primary Care Doctors,[3] with a

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Correspondence: Dr Yukihiko Washimi MD PhD, Department of Cognitive Disorders, National Center for Geriatrics and Gerontology, Obu, Aichi 474-8511, Japan. Email: washimi@ncgg.go.jp

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view to discussing the content of such training, as well as methods and systems to cooperate with doctors specializing in dementia care, who support Primary Care Doctors' medical practice and roles in the community. The DSD Training Program was initiated in 2005, and the Skill-up Program of Dementia Medicine for Primary Care Doctors in 2006. The former, aiming to train DSD who provide primary care doctors with advice regarding the early diagnosis of dementia, and play a central role in dementia care, was initially led by the National Center for Geriatrics and Gerontology as a commissioned business. In 2005, training materials, such as texts and DVDs, were developed, and, in 2006, training seminar sessions took place in Sapporo, Tokyo, Fukuoka and Obu (twice), producing a total of 318 DSD (covering 44 prefectures and 13 ordinance-designated cities). Following this, five seminar sessions a year have been held mainly in Tokyo, Nagoya, Osaka or Kyoto, and Fukuoka. Those who want to participate in these sessions should be recommended by the medical associations located in relevant ordinance-designated cities or their prefectures. Although those with medical associations' recommendation initially accounted for the majority, an increasing number of participants in recent years have made requests for participation to the medical associations located in ordinance-designated cities or their prefectures. To follow changes in clinical trial methods and systems, and reflect participants' opinions, training texts have been revised every year; up to 2012, four versions had been published. A major revision took place in 2012, and, in 2013, new texts have been adopted. The purposes of such revisions include: to focus on DSD-specific issues more closely, rather than conventional primary care doctor training; to provide the latest information regarding diagnosis and treatment; to increase sections related to medical liaison systems in order to enhance participants' understanding of the importance of cooperation between medical and care professionals when supporting the elderly with dementia requiring long-term care; and to promote case studies and discussions. Each training session takes place from a Saturday afternoon to the following Sunday morning. In addition to learning methods to teach primary care doctors the content of each domain, participants are provided with lectures regarding the importance of DSD and primary care doctor training programs by an officer invited from the Office for Dementia and Elder Abuse Prevention, the Ministry of Health, Labor, and Welfare, and officers invited from the Japan Medical Association. Participants also freely discuss challenges for DSD in the establishment of systems to facilitate the early diagnosis and treatment of dementia in the community. By promoting discussions among doctors based in different areas, it is possible to clarify the status of each area's approach and points for improvement.

Current status and challenges of DSD

The roles of DSD include: (i) supporting primary care doctors and care professionals engaged in dementia care; (ii) establishing multiprofessional liaison systems led by the Community General Support Center; and (iii) giving lectures about dementia-specific training for primary care doctors and education for residents. In short, it is expected that DSD will promote cooperation between different medical professions, and between medical and care professions. (Fig. 1) As previously mentioned, the current total number of DSD is 2680; those specialized in fields generally related to dementia, such as psychiatry, neurology, geriatric medicine and neurosurgery, account for 42%, and those specialized in

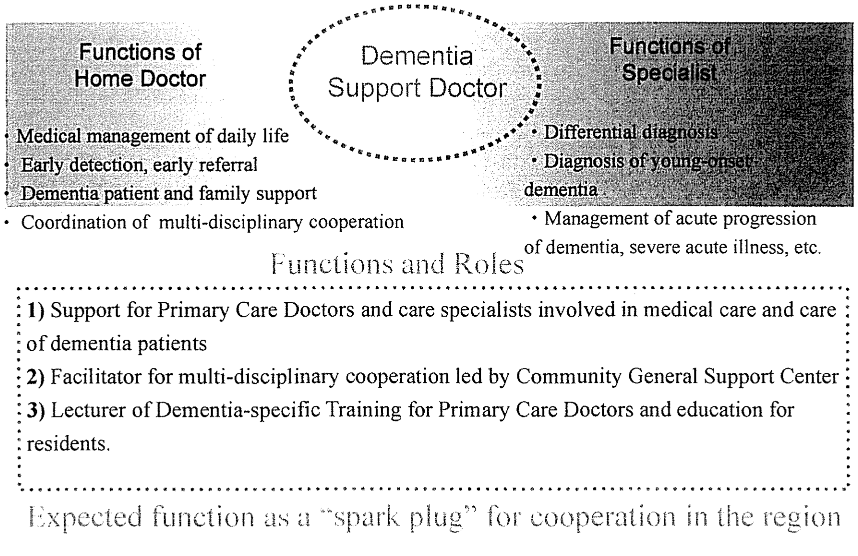


Figure 1 Functions and roles of Dementia Support Doctor.

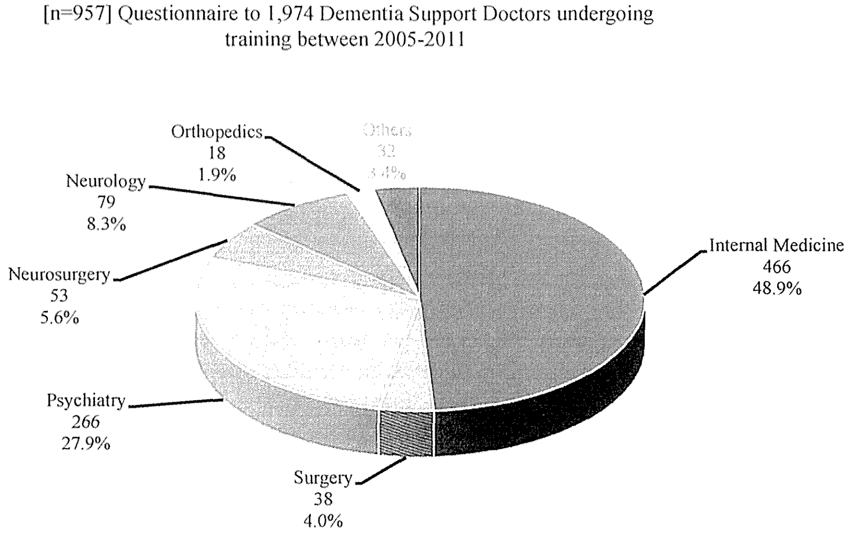
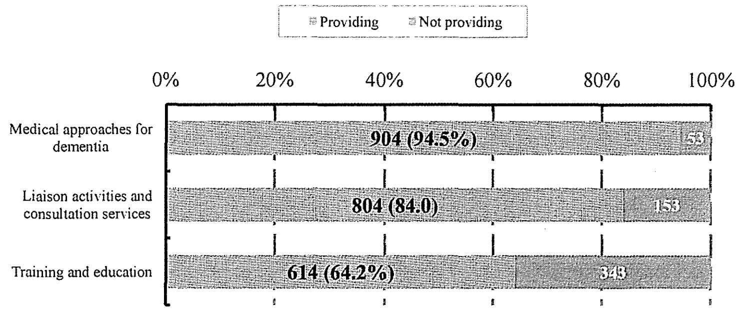


Figure 2 Breakdown of clinical departments of Dementia Support Doctors.

other fields of internal medicine, orthopedics, and urology account for 58%. Although DSD of the former group are frequently required for specialized medical services, such as the differential diagnosis of dementia, diagnosis of early-onset dementia, and treatment of advanced symptoms and severe somatic complications, those of the latter group are frequently required for primary care doctor functions, such as daily medical management, early identification and treatment of diseases, patient and family support, and multiprofessional cooperation. Considering that the necessary DSD functions also vary among different areas, it has been pointed out that the roles of DSD are unclear. According to a survey carried out from January to February 2011 involving DSD-related departments of a total of 66 municipalities, including 47 prefectures and ordinance-designated cities, those with 10–19 DSD accounted for the majority (24), followed by those with 30 or more (13) and those with fewer than 10 (16).[4] The number of DSD was highest in Tokyo (284), followed by Chiba (88) and Hiroshima (72). Support for The Skill-up Program of Dementia Medicine for Primary Care Doctors was available in 95.5%, and education for residents was provided in 48.5%, whereas community liaison systems were not established, or their establishment was uncertain in 60%. As a reason for the latter, a large number of municipalities answered that community liaison was regarded as part of community-based activities, and they were not actively engaged in them; this shows that administrative bodies might not have been involved in the establishment of community liaison systems. Furthermore, information regarding accessibility to DSD in each area is important; however, DSD lists were available to the Community General Support Center in 70%, to residents in 50% and not available in 30% of all areas. Regarding networks among DSD, broad area networks (the metropolitan area and districts) had been established in 14 (21.5%), and local networks (local demographic division of medical services where the DSD gives medical care) had been established in 12 (18.5%) areas. In 2012, a direct questionnaire survey was carried out to clarify the status of DSD,[5] involving 1974 doctors who had completed the training program within the period between 2005 and 2011. The questionnaire sheet was distributed by mail, and 957 responded (response rate: 48.5%). Respondents were specialized in: internal medicine (48.9%), psychiatry (27.2%) and neurology (8.3%). Specialists certified by dementia-related academic associations accounted for 41.4% (Fig. 2). Their daily DSD activities included: (i) medical care for dementia patients (904: 94.5%); (ii) medical and multiprofessional liaison activities (804: 84.0%); and (iii) training and education (614: 64.2%; Fig. 3). The contents of (i) included treatment (96.9%), early identification (88.9%) and diagnosis (87.3%), nearly 90% of all DSD were carrying out these activities daily. A liaison system had been established with residents in 87.4%, long-term care support specialists in 78.0%, and the Community General Support Center in 73.9%; nearly 80% answered that a liaison system had been established. In contrast, a liaison system with primary care doctors had been established at a relatively low rate of 65.9%. The respondents participated in the planning and development of training and educational programs, such as dementia-specific training for primary care doctors (83.1%), multiprofessional training (79.3%) and educational seminars for residents (83.4%). These activities were carried out daily by approximately 80% of all DSD. These results suggest that individual DSD might be carrying out activities, such as medical services, liaison activities and education, daily in general; however, a liaison system with primary care doctors, [n=957] Responses from 1,974 who completed DSD training program between 2005 and 2011



Medical approaches for dementia: Providing approaches for diagnosis, early identification, and treatment

Liaison activities and consultation services: Cooperating with family doctors and Community General Support Centers, while providing consultation services

Training and education: Supporting training for family doctors and multiple professions and educational seminars for residents

Figure 3 Activities of Dementia Support Doctors.

compared with residents and the Community General Support Center, had been established less frequently, showing the necessity of promoting and improving approaches in this respect. Regarding the large number of DSD (and medical institutions) as available resources, it might be necessary to sufficiently utilize them as a medical base supporting residents, care providers and primary care doctors engaged in dementia care. It might also be necessary to discuss and determine their roles, functions, and directionality in consideration of the statuses of related medical fields and association-certified specialists. In order to appropriately utilize DSD in the community, the municipalities' and Community General Support Centers' understanding is indispensable; in line with this, it might be desirable to develop community systems, while discussing appropriate methods to promote DSD activities, including grants for comprehensive dementia support plans among municipalities, Community General Support Centers and medical associations.

Awata carried out a study using the Medical Service Questionnaire Sheet for Dementia to evaluate the ability of general clinics located in the Tokyo metropolitan area to deal with dementia, and reported that medical institutions with doctors who had completed The Skill-up Program of Dementia Medicine for Primary Care Doctors showed a significantly greater ability than those without this training in the following respects: primary care doctor functions; differential diagnosis; outpatient services to deal with behavioral and psychological symptoms of dementia; community liaison; and home care.[6] He also pointed out that medical institutions with DSD showed even higher levels of these functions (Fig. 4).

To promote liaison among DSD, and provide a basis for their information exchange, a portal site named the DSD Network (http://www.dsd-network.jp) was launched in May 2011, with a Grant for Geriatric Medicine Research and Development. The contents shown in Table 1 are viewable on this site, with a view to facilitating DSD activities. As another approach to support DSD, follow-up training programs have been used in some areas since 2009 to provide the DSD with opportunities to acquire new knowledge and learn other areas' approaches. In addition, as described in the following section, multiprofessional simulation conferences are being planned to enhance the knowledge of long-term care and liaison systems.

Long-term care training programs for doctors

In dementia care, it is essential to have a viewpoint based on a daily living activity model, in addition to a medical model. In other words, dementia care aims to improve patients' quality of life, rather than providing treatment and life-saving approaches, and focuses on disabilities (maintenance of activities of daily living), rather than diseases (maintenance of a normal physiological state). In line with this, it might be necessary to establish appropriate systems to provide team-based approaches with cooperation from multiple professions, as well as medical professionals. Honma pointed out that it is not reasonable to draw a line between medical and long-term care services when supporting dementia patients, and it is necessary to share knowledge and ideas among all those involved in dementia care, based

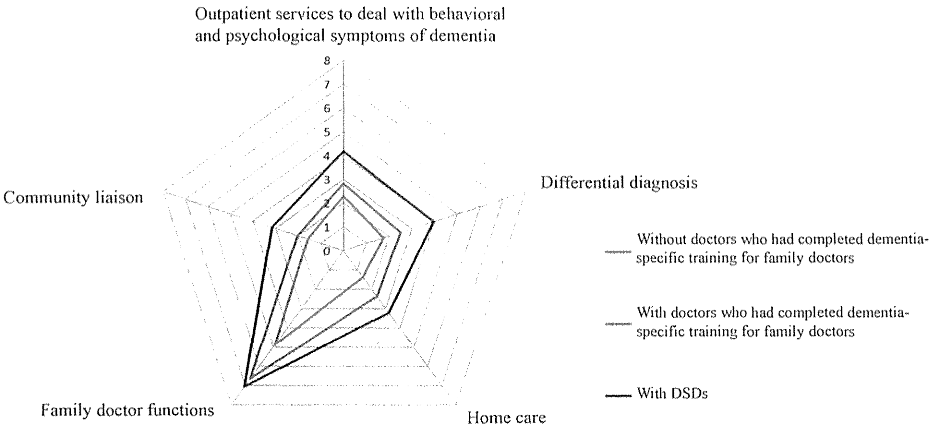


Figure 4 Outcomes of Dementia Support Doctors (DSD) and dementia-specific training programs for primary family doctors.

Table 1 Contents of the Dementia Support Doctors portal site

Category 1	Examples of community-based activities
Contents	
Nagata-ku, Kobe City, Tokyo Metropolitan Area, Nagoya City, Shiga Prefecture, Nagano Prefecture	
Category 2	Dementia-related issues
Contents	
Roles of DSD: Development of new dementia guidelines, vascular dementia, development of neuroimaging for diagnosis of dementia, dysphagia due to dementia, non-pharmacological therapies, treatment of delirium, early-onset dementia (presenile dementia)	
Status of long-term care insurance systems (under commission), status of medical centers specialized in dementia care	
Category 3	Materials, texts and DVDs previously used for DSD training
Category 4	List of DSD (by prefecture)
Category 5	Case studies
Category 6	Activities of academic study groups

DSD, Dementia Support Doctors.

on common training programs; however, such programs have not yet been developed.[7] Furthermore, although study visits to long-term care facilities and nursing training programs have already been adopted in some medical schools as part of education regarding long-term care, these approaches are completely insufficient. Considering that Japan is becoming a super-aged society, this might be a serious problem, requiring prompt solutions.

Conclusion

Increasing the numbers of medical and care professionals specializing in dementia, and establishing systems to provide them with necessary education is urgently required.

Acknowledgement

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Disclosure statement

The authors declare no conflict of interest.

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Geriatrics Gerontology INTERNATIONAL Medline Indexed

Geriatr Gerontol Int 2014; **14:** *735–739*

Position statement from the Japan Geriatrics Society 2012: End-of-life care for the elderly

The Japanese Geriatric Society Ethics Committee: Setsu Iijima,[1] Nobuko Aida,[2] Hideki Ito,[3] Hidetoshi Endo,[4] Takashi Ohrui,[5] Takako Sodei,[6] Kenji Toba,[4] Kenji Hara,[7] Yumiko Momose,[8] Kazumasa Uemura,[9] Hiroshi Nakano,[10] Hisayuki Miura[4] and Masafumi Kuzuya[11]

[1]Rehabilitation Services Bureau, National Rehabilitation Center for Persons with Disabilities, Tokorozawa, [2]Department of Nursing, Nagoya University Graduate School of Medicine (Health Sciences), Nagoya, [3]Tokyo Metropolitan Geriatric Hospital and Institute of Gerontology, Tokyo, [4]National Center for Geriatrics and Gerontology, Obu, [5]Division of Geriatric Pharmacotherapy Institute of Development, Aging and Cancer, Tohoku University, Sendai, [6]Ochanomizu University, Tokyo, [7]Department of Neurology, Takai Hospital, Tenri, [8]School of Nursing and Health, Aichi Prefectural University, [9]Center for Medical Education, Nagoya University School of Medicine, Nagoya, [10]Division of Geriatric Medicine, Nippon Medical School, Tokyo, and [11]Department of Community Healthcare and Geriatrics, Nagoya University Graduate School of Medicine, Nagoya, Japan

The Japan Geriatrics Society published a revised version of its position statement regarding the end-of-life care for elderly patients, based on the overall consensus by the members of the ethics committee in 2012. This revision is intended to catch up with current changes of views on the end-of-life care for older people over the past decade. There are many suggestive items regarding the matter in this statement, and the authors believe it will be of specific guidance for those who are caring for older people in their final stage of life in the super-aged society. Also, the statement can be useful in many other countries, where aging of the population is not yet an urgent concern, but will be so in the future. We believe that this "position statement" can offer guidance in an ethical respect for those who are or will be engaged in end-of-life care for older people. We also hope that the release of the current statement provides an avenue for broader discussion in a society with an increasing aged population. **Geriatr Gerontol Int 2014; 14: 735–739.**

Keywords: end-of-life care, position statement, quality of life, sociomedical science.

Introduction

Ten years have passed since the Japan Geriatrics Society published its "position statement" regarding "End-of-Life Care for the Elderly". Since then, the Japanese public has acquired a greater awareness of their rights in medical care, and the medical care has been changing from doctor-centered to patient-centered. When the previous version of the position statement was published, there was a strong trend to regard discussions about death and the last stage of life as taboo. However, the number of discussions at academic conferences and seminars, and books on these issues has been increasing, and the mass media also takes up the theme more frequently. It is known that people strongly prefer to maintain their dignity until the last phase of their lives rather than merely prolonging their lives, although the definition of dignity remains unclear. Since the long-term care insurance was established in 2000, the number of home services and long-term care facilities has been increasing. The place of death is also expanding from medical care facilities to home or long-term care facilities.

In contrast, the pressures for the quick discharge of patients from hospitals have been increasing in order to reduce the escalating medical costs. This leads to decisions regarding policies for care without adequate discussions with patients and their families.

Since 2005, the annual number of deaths has exceeded the number of births in Japan. In 2025, when all the baby boomers will be aged 75 years or older, it is estimated that the number of deaths will be twice the number of births. The percentage of elderly will also increase; therefore, the importance of end-of-life care for the elderly will be greater.

Based on these changes in the situations and views of end-of-life care for the elderly over the past 10 years, the

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Correspondence: Professor Masafumi Kuzuya MD PhD, Department of Community Healthcare and Geriatrics, Nagoya University Graduate School of Medicine, 65 Tsuruma-cho, Showa-ku, Nagoya 466-8550, Japan. Email: kuzuya@med.nagoya-u.ac.jp

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Japan Geriatrics Society Ethics Committee has decided to revise the position statement in order to conform to the actual circumstances. We hope that this position statement will not only guide medical experts who are facing various difficulties in practice, but also ensure that the best care is provided to the elderly in the last stage of life, and to help the patients' families find peace of mind.

Basic standing

"Aging" and "death", two aspects of life phenomena including reproduction, development, birth and growth, are important aspects with specific significance. Having dealt with life phenomena that contain "aging" and "death", the life sciences have advanced along not only with the natural sciences, but humanities and social sciences as well. Geriatric medicine that deals with "aging" and "death" should be holistic and emphasize "bioethics," based on the vast knowledge from broad areas of the humanities, social and natural sciences. Five principles proposed by the United Nations in the *Principles for Older Persons* (UN General Assembly, 1991), including "Independence", "Participation", "Care", "Self-fulfilment" and "Dignity," are also fundamental principles of the Japan Geriatrics Society.

Objectives of this position statement

All individuals have the right to receive "optimal care" with full respect for each individual's values, philosophy, faith and religion in their last stage of life. The Japanese Geriatrics Society believes that every person possesses these rights, and announces this position statement regarding "End-of-Life Care for the Elderly" with an aim to protect and promote these principles.

Definitions of terms

"End-of-life stage" is defined as "a condition in which the illness is irreversible and progressive, no available treatment can improve the condition or halt its deterioration, and death is considered to be unavoidable in the near future".

Rationale

As the elderly tend to have more than one disease and/or disability, and they are psychologically and socially vulnerable, the trajectory of their "end-of-life" varies between individuals. This makes it difficult to predict how many days or months they have until they are near death. Therefore, we did not provide a definite timeframe for "end-of-life stage".

"Optimal care" is defined as "appropriate care based on all the intellectual and cultural achievements, including not only medical knowledge nor technology used for the diagnosis and treatment of disease, but also other natural sciences, humanities and social sciences".

Rationale

"Optimal care" does not necessarily mean that all patients will receive all of the modern, advanced medical care, or long-term care. Individuals vary greatly, and some might have organ dysfunction(s) or genetic differences that could lead to reacting to drugs differently from the general adult population. Appropriate medical care without under- or overtreatment that takes into consideration the individual characteristics, and that values the quality of life (QOL) of their remaining days is regarded to be "optimal care". It is one of the most important duties of the Japan Geriatrics Society to clarify "optimal care" for the elderly based on the existing scientific evidence.

"Care" is defined as "long-term care, nursing care, medical care and other support provided for the patients and their families, whether formal or informal".

Rationale

The elderly in the final stage of life require comprehensive care that involves the cooperation of various professions. "Care" in English includes "medical care"; however, "care" in Japanese tends to be used exclusively for the meaning of "long-term care". Therefore, the expression "medical care and long-term care" is used in the Japanese version, with knowledge of its redundancy.

A high "QOL" in this position statement is defined as the state wherein the elderly have a high level of subjective happiness, satisfaction and physical comfort (with minimized suffering). As the mental and physical changes associated with aging varies between individuals, it seemed inappropriate to define "the elderly" just by biological age. We therefore decided not to define patients as "elderly" based on specific ages.

Position 1: Opposition to age discrimination (ageism)

Every elderly person who needs care, or who has dementia, has the right to receive "optimal care".

Rationale

It is one of the basic human rights that everyone should receive "optimal care". "Optimal care" should be guaranteed for everyone regardless of age, whether they have severe impairment or not, in any care setting. Whether tube feeding (such as gastrostomy), tracheotomy or respirators are the best care for the person should be carefully examined. Namely, if any treatments might imperil a patients' dignity or increase distress, withholding or withdrawing the treatment should be considered.

Position 2: Care respecting individual preferences and culture

The end-of-life care for the elderly should be provided with full consideration of the family and ethical values peculiar to the Japanese, and fully respecting each patient's views of life and death, their values, philosophy, faith and religion.

Rationale

The disclosure of the diagnoses and medical conditions should not be incomplete simply owing to a patients' age, an individual's view of life and death, their values, philosophy, faith or religion. Sharing information about the prognoses and disease progression that could complicate the need for "end-of-life care" is necessary. The patients' desires should be respected throughout the discussion. However, it should be noted that the wills of the elderly patients could be unstable and fluid, or might not be able to express themselves sufficiently. In cases where the patient's will is difficult to confirm as a result of the presence of cognitive dysfunction or impaired consciousness, it is important to show full respect based on what the patient previously said or how he or she behaved. This information should be collected from the patients' families, and best efforts should be made to identify the patients' wishes. Attending doctors need to clearly distinguish the families' desires from the actual patients' will. In order to make the patients' wishes clear, the introduction of an advance directive should also be considered.

In contrast, the Japanese generally have a tendency of entrusting everything to decisions made by specialists and accept the consequences as a fate. Such cultural background has made the Japanese "views of life and death" different from those of the Western world, which puts an emphasis on "autonomy" above all. Disclosing information to the elderly patients is sometimes refused by their families, which has been accepted socially. Telling the patient about the prognosis without respect to the aforementioned background factors does not provide sufficient support, and might be nothing more than relaying a sentence of death. Medical experts therefore need to have the ability to gain insight into the patients' wishes, and encourage patients who are not good at self-expression to express their real desires.

Position 3: Giving priority to the patients' satisfaction

Utmost consideration should be directed towards the palliation of pain and maintenance of the best possible QOL in end-of-life care for the elderly.

Rationale

Care that palliates pain, reduces the fear of death, and maintains and improves the QOL for the remaining days should be the main focus of end-of-life care. End-of-life care is regarded as "care that not only reduces the pain or other physical symptoms, but also helps the patients' psychological and mental health needs, to achieve a better QOL".

Position 4: Care for the involved families

End-of-life care for the elderly includes care for their "families and so on" as well as the patients.

Rationale

The patients' families play an important role in end-of-life care. When a patient's family members and the patient agree, medical experts need to explain the medical condition to everyone. Medical experts need to actively support families by alleviating their sorrow. Support for families and persons attached to patients leads to better support for patients. Support for families to accept that patients are in the process of dying should be provided, as well as grief care for families after the patients' death. The phrase "families and so on" here means family members, friends, caregivers and so on who are involved in the end-of-life care of the patients.

Position 5: Necessity of team-oriented approach

End-of-life care for the elderly requires an interdisciplinary approach involving a wide range of specialties including medicine, nursing, social care and rehabilitation.

Rationale

It is desirable that care for dying patients is offered as a team. The team members should include not only attending doctors, but also nurses, social workers, caregivers, rehabilitation staff, pharmacists, psychologists, volunteers and family members. The team members should provide all possible knowledge and technology depending on the patients' demands. Attending doctors are required to be equipped with a wide range of knowledge, skills and consideration regarding the comprehensive care given by a variety of specialists in order to play a central role in the medical team. It is desirable that the end-of-life care team discuss the patients on a regular basis through conferences and workshops. Furthermore, discussions with families, patients and a variety of specialists concerned with the treatment makes for better end-of-life support, resulting in a better quality of treatment, so better results can be obtained.

Position 6: Making death education obligatory

In order to provide the optimal care for patients in the final stage of life, those who are engaged in end-of-life care, such as those involved in medical and social care and welfare work, should receive practical education regarding death and end-of-life care. In addition, enlightenment regarding optimal care in the final stage of life in terms of holistic medical care is required to improve the public understanding of optimal end-of-life care.

Rationale

Many of those who are engaged in end-of-life care in Japan, such as medical and social care professionals, have not received any education specific to end-of-life care. So-called "death education" regarding the Japanese views of life and death, and the process of accepting death should be required for professionals either as part of the school curriculum or as continuing education. In addition, practical education for symptom control, nursing and long-term care, as well as communication skills, need to be provided.

With regard to the education of physicians, geriatric departments at medical schools and the Japan Geriatrics Society should make an effort to standardize Japanese end-of-life care education by generating a model curriculum.

In addition, the dissemination of "end-of-life care" and "death education" that aims to improve the public understanding of "end-of-life care" will secure the dignity of the dying patients, and maintain and improve their QOL. It is the responsibility of the Japan Geriatrics Society to ensure that the aforementioned points are addressed.

Position 7: Continuing discussions are required at medical institutions

Medical institutions should establish an ethics committee or equivalent to discuss the medical treatment and care for dying patients, and to support the patients and their families in their decision-making process to help realize "optimal care".

Rationale

The ethics committee should compile and publish ethical guidelines. The ethics committee should be composed of various professions, and should also have external members. The system should appreciate external evaluations to consolidate their fairness in operation. An announcement of the ethical guidelines will help ensure the accountability with regard to end-of-life care for the elderly, and continued critical discussion among the public is required to result in a national consensus. For the purpose of active and fair discussions, it is necessary to foster the people's view of life and death, and to provide education to cultivate the interest in and understanding of end-of-life care. This will enhance the people's ability to select which care is optimal for them and to make the best decision regarding their end-of-life care.

Position 8: Making uninterrupted progress and reflecting it in the practice

There should be continuous efforts made and research should be carried out to establish and "standardize" the "scientific basis" regarding the decision-making process, methods and skills related to all aspects of end-of-life care. It is also necessary to prove that these are beneficial for maintaining and improving the patients' QOL. Sufficient funding will be necessary for such efforts.

Rationale

Some guidelines provide useful information about some medical procedures and treatments at the final stage of life, such as the use of analgesics. It is desirable that all medical procedures and care are proven to be beneficial for the patients' QOL. Furthermore, research is particularly required in the areas of: (i) what it means to realize end-of-life care with an emphasis on "autonomy" of the elderly; (ii) QOL measurement at the final stage of life; and (iii) end-of-life care provided in non-medical facilities or at home. In addition, interdisciplinary research based on the Japanese view of life and death involving those of humanities and social sciences, is necessary. However, although the number of researchers who have an interest in these areas is increasing, the research environment still needs to be improved, and the research funding is far from sufficient.

The "scientific basis" and "standardization" based on the aforementioned research are expected to exclude attending doctors' "arbitrariness" to secure the patients' "autonomy".

Position 9: Enhancing public awareness of palliative care

Palliative care should be applied for everyone in their final stage of life.

Rationale

The elderly often suffer from various diseases other than cancer, such as dementia, heart failure and respiratory failure. Although the specific disease that causes death might be different, many elderly patients have a similar process in the last stage of life, and those without cancer often have similar pain to cancer patients. Because of the recent advances in medical research about the mechanisms of pain, palliative care technology has been greatly improved. It is desirable that the latest research findings and technology can be applied to any patient in the final stage of life.

Position 10: Expansion of the medical care and welfare system

In order to realize ideal "end-of-life care", systemic and financial support are indispensable.

Rationale

During the past 30 years, the systems concerning the medical and long-term care of the elderly, including their reimbursements, have drastically changed. Medical and long-term care facilities have needed to keep up with these changes. In order to offer appropriate end-of-life care for the elderly, the development of a stable and sustainable system is indispensable. It will be helpful to prepare good environments and to ensure that there is sufficient manpower for the elderly to live a peaceful final stage of life, to ensure the quality of care and to allow for a wider application of palliative care (hospice program) to non-cancer patients.

Position 11: The role of the Japan Geriatrics Society

It is necessary to promote scientific verification and continuous public discussions regarding the end-of-life care for the elderly.

Rationale

Nearly 10 years have passed since we published the last position statement. Although the long-term care insurance system has been firmly established, the environment of the end-of-life care for the elderly has greatly changed. The recognition of end-of-life care for the elderly in society, including the general public and the mass media, has been enhanced. However, the scientific data regarding this issue and the discussions among various professionals and the public are still insufficient. It is necessary to not merely imitate the foreign welfare policies for the elderly, but to continue discussions with full consideration of the Japanese views of life and death, and the family environment. It is the responsibility for us, the Japan Geriatrics Society, to realize better end-of-life care for the elderly by actively delivering our opinion to influence the national policy.

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第55回日本老年医学会学術集会記録
〈教育講演〉

在宅医療

三浦　久幸

Key words：在宅医療，高齢者，地域包括ケア，在宅医療連携拠点事業，人材育成事業

（日老医誌　2014；51：117-119）

在宅医療の現状及び課題

在宅医療が注目されている背景として，日本の高齢化に伴い医療提供体制の見直しが迫られているということがあげられる．日本の高齢化は進み，2010年の高齢化率は23.0％と世界第1位であり，2025年には団塊の世代の人全員が75歳以上となり，後期高齢者が2千万人を越える見込みである．このような状況の中，国内の死亡場所の推移をみると1950年頃には自宅死亡率が80％以上で，病院死亡率は10％強であったが，この傾向は1976年以降逆転し，2011年では病院・診療所を併せた死亡率が76.8％，自宅死亡率が11.7％となっている．人工呼吸器の普及など，病院でなければ当時は行えなかった医療技術等の普及による影響が大きいと考えられるが，この結果として一般の人が身近な生活の中で自然な死を体験する機会がきわめて少なくなっている．最期に療養を希望する場所についての国民へのアンケート調査ではおよそ6割の方ができるだけ長い自宅での療養を希望している反面，介護する家族に負担がかかることや，症状が急変したときの対応などに不安を感じている人が多いことが明らかとなっている．

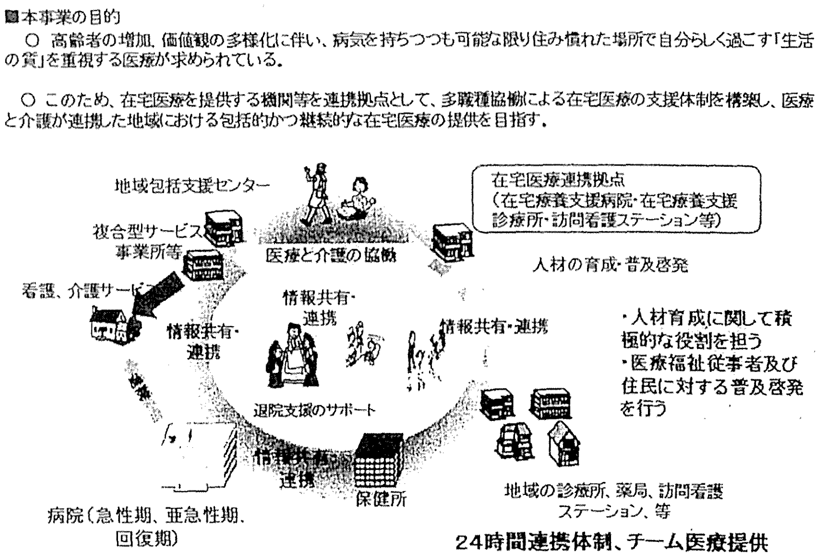
在宅医療推進に向けての国の動き

より質の高い医療を提供しながら，住み慣れた地域で暮らしてゆくために，在宅医療の整備が喫緊の課題となっている．これまでの在宅医の献身的な活動に依存してきた状況に対し，2012年度から厚生労働省の事業[1]として，全国105カ所での「在宅医療連携拠点事業」(図1)が開始された．在宅医療連携拠点事業は，地域の在宅医療の24時間体制の構築や医療と介護の連携を促進するなどタスク達成型の事業として行われた．2013年度からは地域医療再生基金による県の事業「在宅医療推進事業」に移行したが，これまでの集計では全国約300カ所以上に在宅医療に関する拠点ができる見込みである．全国の市町村数約1,700の約5分の1以上に拠点が形成されることになる．2012年度は同じく厚生労働省の事業として「多職種協働による在宅チーム医療を担う人材育成事業」[1]が行われ，全国の県医師会，県行政担当者，在宅医療連携拠点事業担当者を中心に在宅医療に関する都道府県リーダー養成のための事業が開始され，全国で約250人が研修を受講した．都道府県リーダーは2012年度中に各県での「地域リーダー研修」を行い，地域リーダーはさらに2013年度以降の地域での多職種協働の研修会を行う予定となっている．これらの活動を通じ，医師会，行政，在宅医療スタッフが協働し，在宅医療を地域全体に面展開する動きが全国で広がっている．当面の目標は，地域包括ケアにおける在宅医療の供給体制（量）の確保であるが，近い将来には，在宅医療の量のみでなく質をどう確保していくかが重要な課題となる．

在宅医療推進への病院の関わり

国立長寿医療研究センターにおける在宅医療支援病棟は地域の在宅医療活性化の（モデル的）病棟として位置づけられ，2009年4月に当センター内に新しい機能病棟として開設された．病棟ベッド数は個室8室（有料），2人床6室の計20床からなる．看護体制は16名，7：1看護である．試みとして新しい病診連携のシステムを作っており，病棟を利用する在宅医を登録医，その在宅医により訪問診療を受けている在宅患者を登録患者としている．登録医の判断により入院が決定され，登録患者の入院必要時，登録医が専用回線（ホットライン）で入院を依頼する．診療体制は登録医と入院中の病院主治医

Home medical care
Hisayuki　Miura：独立行政法人国立長寿医療研究センター在宅連携医療部



■本事業の目的

○ 高齢者の増加、価値観の多様化に伴い、病気を持ちつつも可能な限り住み慣れた場所で自分らしく過ごす「生活の質」を重視する医療が求められている。

○ このため、在宅医療を提供する機関等を連携拠点として、多職種協働による在宅医療の支援体制を構築し、医療と介護が連携した地域における包括的かつ継続的な在宅医療の提供を目指す。

図1　2012年度在宅医療連携拠点事業
（文献1）より引用一部改変）

の二人主治医体制であるが，総合病院の中の病棟という利点から，臓器別の専門的治療は必要に応じ受けられる．また，救急から看取り，レスパイト等，入院対応が必要とされる全ての事態に対応するため，対象疾患・入院目的に制限は設けていない．入院後は退院前カンファレンスや必要時の退院前の自宅訪問等，多職種協働による在宅への復帰支援を行っている．この病棟はさらに，他病棟に入院された患者のうち，退院後は訪問診療に移行する予定の患者に対し，当病棟への転棟により，ご家族への密な退院支援を介して，退院後の不安を解消するような活動も並行し行っている．

2009～2011年度のこの病棟への入院患者は延べ769件（393名，22～104歳；平均77.9歳±11.6歳，男：女＝446：323）であり，平均入院日数は19.6日であった．入院患者の基礎疾患としては神経・筋疾患（25.7%）が最も多く，悪性腫瘍（25.0%），脳血管疾患（14.8%），認知症（10.9%），呼吸器疾患（9.4%）が続いた．入院目的は，急性疾患・慢性疾患の急性増悪が多い（56.8%）が，胃瘻交換，レスパイト，看取り目的等多岐に渡っている．3年間の病棟利用患者の在宅死亡率は33%であった．病棟開設後の3年間に，地域の在宅医（診療所）と病院の連携が開設時の登録医12名から78名に広がった．また，死亡退院患者を除く在宅復帰率が93%で，自宅への復帰がスムースに行われていた．入院患者の在宅死率は2009年度の愛知県平均（11.9%）の約3倍高い割合であり，この病棟は在宅死率の上昇をその目的としているわけではないが，シームレスな病診連携が結果として在宅死率を上昇させる可能性があることが示された．死亡退院を除くとレスパイト入院患者の約94%が自宅に退院しており，在宅療養継続のためのレスパイト入院の必要性を裏付けていた．病棟では在宅医療チームと病院チームとの医療スタッフの協働の一環として，退院時カンファレンスや退院前の自宅訪問を積極的に行っている．さらに，多職種連携の促進のため，当センターでは地域のヘルパーに対して，在宅医療スタッフとの連携研修を行うとともに，センターと在宅医，在宅患者，訪問看護ステーション間のICTを用いた医療・介護スタッフの情報の共有化にむけての事業・研究を並行し行っている．このように在宅医，訪問看護師，包括支援センター，介護，行政のスタッフが集まり，地域活性化に向けての活動行うに当たり，病棟の活動のみでなく，地域の在宅医療・介護を総合的に推進する病院の役割は重要であると考えられる．

高齢者のための新しいコミュニティ作り

医療，介護，福祉を統合し，提供するシステムとして，地域包括ケアシステムの構築が求められている．地域包括ケアシステムの定義は地域包括ケア研究会（平成20年老人保健健康増進等事業）[2]によれば，「ニーズに応じた住宅が提供されることを基本とした上で，生活上の安全・安心・健康を確保するために，医療や介護のみならず，福祉サービスを含めた様々な生活支援サービスが日