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Sakashita, Akihiro ; Kizawa, Yoshiyuki ; Kato, Masashi ; Akizuki, Nobuya ; Nakazawa, Yoko ; Kaizu, Mikiko ; Yano, Kazumi ; Sato, Tetsumi…

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Akihiro Sakashita, M.D., Ph.D.
Department of Palliative Medicine, Kobe University School of Medicine
7-5-1 Kusunoki-cho, Chuo-ku, Kobe, Hyogo, 650-0017, Japan

Yoshiyuki Kizawa, M.D., Ph.D.
Department of Palliative Medicine, Kobe University School of Medicine
7-5-1 Kusunoki-cho, Chuo-ku, Kobe, Hyogo, 650-0017, Japan

Masashi Kato M.D.
Division of Medical Support and Partnership, Center for Cancer Control and Information Services, National Cancer Center, Tokyo, Japan

Nobuya Akizuki, M.D., Ph.D.
Psycho-Oncology Division, Chiba Cancer Center, Chiba, Japan.

Yoko Nakazawa, RN, MSH
Division of Medical Support and Partnership, Center for Cancer Control and Information Services, National Cancer Center, Tokyo, Japan

Mikiko Kaizu, RN, MSN
Graduate school of Health management, Doctoral Program, Keio University, Tokyo, Japan

Kazumi Yano, R.N,MSN.
Tokyo Teishin Hospital, Tokyo, Japan

Tetsumi Sato, M.D., Ph.D.
Division of Palliative Medicine, Shizuoka Cancer Center Hospital, Shizuoka, Japan

Akihiro Tokoro, M.D.
Department of Psychosomatic Internal Medicine and Supportive and Palliative Care Team, National Hospital Organization Kinki-Chuo Chest Medical Center, Osaka, Japan.

Corresponding author:
Akihiro Sakashita, M.D., Ph.D.
Department of Palliative Medicine, Kobe University School of Medicine
7-5-1 Kusunoki-cho, Chuo-ku, Kobe, Hyogo, 650-0017, Japan

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Abstract

Context: Hospital-based palliative care consultation teams (PCCTs) are rapidly being disseminated throughout Japan. The roles of PCCTs have changed over the past decade, particularly with the introduction of a modified national cancer care act to promote early palliative care and integrated oncology and palliative care.

Objectives: This study aimed to develop a consultation team standard for hospital-based palliative care in Japan.

Methods/Design: We developed a provisional standard based on literature review, and used a modified questionnaire-based Delphi method. Our Delphi panel comprised 20 experts selected from all relevant disciplines.

Results: All experts selected responded to the surveys over all rounds, and 14 of the 20 participated in the panel meeting. In the first-round, 79 of 109 statements were judged to be appropriate, and 30 of 109 led to disagreements. 16 of those 30 statements underwent minor revision, 1 was divided into two statements, and 13 remained unchanged. We then added 6 statements based on a discussion among participants and authors. Additionally, based on comments from an external reviewer, we revised the standard, resulting in 4 statements being combined into 2 for a new total of 114 statements. In the second-round, 108 of 114 statements were judged to be appropriate, and in the third-round, none of the 6 controversial statements were judged to be appropriate. The final version comprised 108 statements.

Conclusion: We developed a standard for PCCTs in Japanese cancer hospitals. This standard provides a useful guide for clinical activities and a tool to evaluate quality of palliative care.

Key Words

Palliative care, palliative care consultation team, standard, modified Delphi method, cancer

Running Title:

A Palliative Care Consultation Team Standard in Japan

Introduction

In the 1990s, palliative care consultation teams (PCCTs) comprising a multidisciplinary group of health care providers were established in many Western countries, with the aim of maximizing quality of life for patients and their families facing life-threatening illness. Since that time, the number of hospital-based PCCTs has increased markedly in various countries, including the United Kingdom, the United States, Canada, and Australia, and in all cases these teams play important roles in the overall health care system (1-4). Various systematic reviews (5, 6), randomized controlled trials (7,8) and cohort studies (9,10) have also reported on the efficacy and activity of PCCTs. Similar studies have also been undertaken in Japan (11-13), where PCCTs are expected to play an even more important role in the future.

In 2007, the Cancer Control Act and the Basic Plan to Promote Cancer Control Programs were enacted in Japan, addressing palliative care as a major issue in improving cancer care. These programs required all designated cancer hospitals to establish PCCTs within their institutes (437 hospitals, as of April 2018) (14). In 2008, structural requirements for the recommended PCCTs were established as follows: 1) members of the PCCTs must include full-time palliative care physicians, psychiatrists, nurses, and pharmacists; 2) a palliative care outpatient clinic must be offered; 3) PCCT conferences must be held more than once a week; 4) information about the activity and availability of PCCTs must be provided to patients and their families; 5) discharge support must be provided to the hospitalized patients; and, 6) palliative care consultations must be provided to community health care providers. Sasahara (15) developed a standard for PCCTs consisting of 37 statements in four areas to improve and standardize the quality and efficacy of care delivered by the teams. In 2014, the

Basic Plan to Promote Cancer Control Programs was revised to promote early palliative care and integration of oncology and palliative care, including a requirement that PCCTs play additional roles in conducting distress screening and enforcement of the community-based consultation. Thus, the required activities and the role of PCCTs in designated cancer hospitals in Japan have formally changed. Furthermore, skills and knowledge in the area of basic palliative care have improved in the past 10 years largely due to over 100,000 physicians having finished a 2-day basic palliative care education program (16, 17). This study therefore aimed to revise and develop a new standard for PCCTs that all designated cancer hospitals should achieve by 2020.

Methods

A consensus method using the subjective opinions of several experts is an established approach for developing a clinical care standard with clear methodology. Accordingly, we adopted a modified Delphi method (18) to develop a standard for PCCTs in Japan. Previous efforts to develop a standard in palliative medicine similarly used a modified Delphi method that provides panelists with the opportunity to discuss their decisions and opinions face to face between the rating rounds (15). This method also facilitates the participants' understanding of each statement developed, and the opportunity to make each objective more understandable and achievable.

Development of a Provisional Standard

To develop a provisional standard for PCCTs, we adopted the following procedures. First, the authors discussed the basic assumption of this standard and decided that it should be established at the fundamental level, designed to show a new PCCT what they need to provide at the very least. The subject focus was cancer patients because current palliative care in Japan mostly targets such patients, and we have insufficient clinical experience of palliative care for non-cancer patients. We applied the Donabedian model to develop the provisional standard. This conceptual model provides a framework for examining health services and evaluating quality of health care (19). According to the model, information about quality of care can be drawn from three categories: "structure," "process," and "outcomes". The standard can then also be used for evaluation, and the framework of the standard references existing standards and manuals on palliative care (15, 20-22). Second, one author (Y.K.) generated statements in line with the framework based on a literature review (15, 20-24). Third, the authors discussed the appropriateness and coverage of the statements to reach a consensus regarding validity, before formulating a provisional standard. We classified all statements under the Donabedian triad of structure, processes, and outcomes, and categorized five domains (philosophies and policies, care delivery system, content of activities, evaluation and improvement of care quality, activity evaluation) consisting of 109 statements.

Expert Panel Selection

For this Delphi study, we aimed to create a multiprofessional panel of 20 experts based on the following criteria: 1) clinicians with adequate experience as part of a PCCT, and 2) representatives of palliative care-related organizations. We contacted four such organizations (Japanese Society for Palliative Medicine, Japan Psycho-Oncology Society, Japanese Society of Cancer Nursing, Japanese Society for Pharmaceutical Palliative Care and Sciences) by mail and asked them to participate in this study and to recommend five panelists. As a condition to be a panelist, we proposed clinical experience with PCCTs of > 2 years. All respondents confirmed that they met the eligibility criteria and expressed a willingness to participate in this Delphi study. The present study was conducted in accordance with the Declaration of Helsinki and ethical guidelines with regard to clinical research. This study was reviewed by the institutional review board at Hyogo Prefectural Kakogawa Medical Center.

Survey process

The study was conducted from May 2015 to December 2015. Our Delphi study consisted of three rounds, each lasting 4 weeks and separated by 4 weeks.

Non-respondents were sent weekly e-mail reminders. No financial incentives were provided.

First, each panelist was asked to review existing standards and manuals on palliative care twice by e-mail, so as to standardize their knowledge regarding the roles and activities of PCCTs.

Second, two months later, we implemented a first-round survey, mailing a questionnaire with the outline of a provisional standard to each panelist. Each member was asked to rate the appropriateness of each statement using a nine-point Likert-type scale (inappropriate 1-3, intermediate 4-6, and appropriate 7-9). In cases where panelists were unfamiliar with items due to their specialty, ‘‘incapable of rating’’ was also offered. As the statements to be adopted by all PCCTs in designated cancer hospitals by 2020, we defined that it was appropriate even if it became mandatory for all designated cancer hospitals. Panelists who rated a statement as less than 6 were asked to give the reason. A consensus in this study was defined a priori when agreement (appropriate 7-9) was provided by a minimum of 75% of the experts. We also collected basic demographic information from the experts such as age, sex, type of clinical practice, and years of experience. A summary of the first-round survey was sent to each panelist and author, and disagreements were discussed by e-mail for two weeks. We then asked the panelists, especially those who would not be able to attend a panel meeting, to give their opinions.

Third, after discussion by e-mail, an expert panel meeting was convened on September 6, 2015 in Tokyo to discuss face-to-face those statements causing disagreement. At the meeting, a summary of the first-round survey and e-mail discussions was distributed. After the panel meeting, a summary of the meeting and a revised version of the standard were sent to all panelists to confirm corrections and determine whether there were additional opinions.

Fourth, in October 2015, we mailed all 200 representatives of the Japanese Society for Palliative Medicine the provisional standard, summary of first-round survey, and description of each panelist to request their opinion about the revised version of the standard as an external reviewer. We collected opinions from an external reviewer by e-mail, and then shared the opinions among all panelists by e-mail. We then revised the standard based on e-mail discussions among the panelists based on the external review.

Fifth, we implemented a second-round survey using the same method as in the first-round survey, and a revised version of the standard based on the expert panel meeting. For statements considered inappropriate, the relevant panelists were contacted by e-mail individually and we tried to reach a compromise.

Sixth, we conducted a third-round survey using the same method as in the first-round survey, but only for the statements that were not subject to compromise in the second-round survey. We deleted any statements for which consensus agreement could not be attained.

Statistical analysis

All statistical analyses were carried out using the statistical package SAS version 9.1 (SAS Institute, Inc., Cary, NC).

Results

Participant characteristics

Table 1 summarizes the participant characteristics. All participants had experience working in a PCCT and 14 (70%) participants had more than 8 years clinical experience in palliative care. Among 20 experts surveyed, 20 (100%) responded over all rounds, and 14 (70%) participated in a panel meeting.

First Delphi round

In the first-round survey, 79 of 109 (72.5%) statements were judged to be appropriate by more than 75% of respondents, and 30 of 109 (27.5%) statements led to disagreements.

In the panel meeting, all statements were examined carefully. We analyzed the reasons for the 30 disagreements and found that the minimum goal envisaged for PCCTs different among the members. We also ascertained that the range of PCCT activities set out in the statements was not sufficiently clear with respect to whether they applied to hospital inpatients or patients in the community. During the discussions by e-mail and in the panel meeting, the following resolutions were agreed: 1) the standard should be established by 2020, taking into account the wide-ranging skills of teams rather than the minimal or lowest acceptable practices; 2) the standard should be applied to cancer patients first and then expanded to other diseases in the future; and, 3) the standard should focus on consultation activities within a hospital. According to the results of the first-round survey and discussion at the panel meeting, the 30 statements that produced disagreement were dealt with as follows: 13 statements were unmodified, 16 statements underwent minor revision, and 1 statement was divided into 2 statements for clarity. Moreover, we added six statements based on a separate discussion among participants and authors. After the panel meeting, a summary of the outcomes and a revised version of the standard were sent to all panelists to confirm corrections or determine whether there were additional opinions. We then made final revisions of the standard based on a discussion among authors. Consequently, the statements numbered 116 across 5 domains.

In October 2015, we sent the revised version of a provisional standard, summary of the first-round survey, and a description of each panelist to 200 representatives of the Japanese Society for Palliative Medicine for their opinions as external reviewers. We received back 19 opinions from 4 external reviewers. Of note, the external reviewer feedback highlighted the lack of a clear pathway for integrating the PCCT activities and role with the existing palliative and oncology care. We revised the standard accordingly, resulting in 4 statements being combined into 2 to give a new total of 114 statements across 5 domains, and then conducted the second Delphi round.

Second Delphi round

In the second-round survey, all panelists responded and 108 of 114 (94.7%) statements were judged to be appropriate by more than 75% of respondents, 6 of 114 (5.3%) statements led to disagreements, leading to the third Delphi round to consider only those 6 statements.

Third Delphi round

In the third-round survey, all panelists responded with 0 of 6 (94.7%) statements judged to be appropriate by more than 75% of respondents, resulting in them being deleted from the standard. The final version of the standard (Appendix) consists of 108 statements across 5 domains.

Discussion

We developed a PCCT standard using a clear methodology in the modified Delphi method and a multidisciplinary panel of experts. The findings of this study could provide guidelines for new and existing PCCTs, and help them evaluate ongoing activities based on this standard, all of which contributes to improving the quality of palliative care for patients and their families. As the next step, we have started peer review and benchmarking of PCCTs for quality improvement using check lists from this standard.

Of prime importance, we established innovative processes to develop the standard. First, based on the modified Delphi method, we used e-mail discussion and panel meetings between the first and the second rounds of our study, wherein the participants discussed their ratings of each statement and shared their reasoning process and opinions with each other, with the aim of making the statements more adequate and achievable. Second, we selected expert panelists to create a multi-professional group, allowing us to create standards that reflect more specialized perspectives, but across several relevant professions and activities. Third, incorporating external reviewers enabled us to access perspectives from other disciplines directly, leading to a wider range of specialist opinions regarding the standard.

Another important finding from this study was the addition of new and broader perspectives into the standard including the integration of oncology and palliative care, early palliative care, community-based palliative care, and evaluation and improvement of care quality (15). Consequently, the new standard comprises 108 statements compared to 37 in the existing version. In particular, we limited the description of how PCCTs would contribute to the integration of oncology and palliative care, based on literature review (25-28). Although many organizations support such integration, it remains an abstract and complex concept that is poorly defined. The European Society for Medical Oncology (ESMO) has put forth 13 criteria for the incentive program of "ESMO designated centers of integrated oncology and palliative care" (29); however, a global consensus on indicators for integration is currently lacking. To better understand what integration entails, Hui et al (30) conducted a systematic review to identify the clinical, educational, research, and administrative indicators of integration in the published literature. These indicators would help us to better understand the concept of integration and could allow clinicians, patients, researchers, hospital administrators, and policy makers to better assess the level of integration of oncology and palliative care.

This new Japanese standard for PCCT has two major differences compared with the standard described previously in the United States of America and Australia (20-22). First, descriptions about spiritual care are scarce throughout the standard. Even in Japan, patients and their families suffer from spiritual pain, but they have not received adequate spiritual care (31), possibly because health care providers do not see spiritual care as part of their job, and patients and their families may feel that it is difficult to receive spiritual care. This cultural difference is clearly present between Japan and Western countries (32). In addition, health care providers specializing in spiritual care are not recognized with national qualifications, and therefore are not available in designated cancer hospitals in Japan. In addition, most of the designated cancer hospitals in Japan do not provide religious care, and only a few chaplains are included in PCCTs (33). For these reasons, spiritual care was not adopted as part of the standard that all designated cancer hospitals should achieve in 2020. Second, the finished standard did not sufficiently consider bereavement as a component of care. In Japan, although bereavement care is relatively well provided in palliative care wards (34), sufficient resources and systems for bereavement care are not being developed in designated cancer hospitals (35, 36). This situation is consistent with a previous report (37) that bereaved families did not receive specialized bereavement care and did not expect such support from physicians and nurses in Japan. In the future, we need to develop a system that can provide sufficient bereavement care within designated cancer hospitals.

Our study had several limitations. First, this standard focused on consultation activities within a hospital and thus we did not include sufficient consideration of community-based palliative care. Second, although our panel of experts comprised diverse professionals, the number of palliative care specialists was large compared to other professions. Therefore, this standard might not sufficiently reflect the experience and opinion of oncologists and PCCT users, i.e., patients. Third, this standard was revised mainly for PCCTs working in government-designated regional cancer hospitals, and thus might not be transferable to PCCTs for non-cancer patients, non-regional cancer centers, and other settings. Fourth, we clarified and changed our aims of the standard slightly in the panel meeting that influenced the reliability of the first Delphi round. We should have discussion about the aims of the standard in detail before the first Delphi round.

Conclusion

We developed a standard for PCCTs in designated cancer hospitals using a clear and established methodology. This standard comprising 108 statements across 5 domains might provide both the teams and institutions with a useful guide for clinical activities and a tool to evaluate quality of palliative care.

Competing interests

The authors declare that they have no competing interests.

Authors' contributions

All authors contributed to the design of the protocol. YK and AS organized the study structure. MK, NA, and AT managed the project, including collecting data for this study. YN, MK, KY, and TS performed the statistical analysis and drafted the manuscript. All authors read and approved the full manuscript.

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Table 1: Panelist demographics (n = 20)

	Number	Percentage of total (%)
Sex		
Male	9	45
Female	11	55
Age (years)		
30–39	3	15
40–49	14	70
50–59	3	15
Specialty		
Physician	5	20
Psychiatrist	5	20
Nurse	5	20
Pharmacologist	5	20
Clinical experience (years)		
5–9	1	5
10–19	11	55
20–29	8	40
≧ 30	0	0
Clinical experience in palliative care (years)		
< 2	0	0
2–4	1	5
4–6	1	5
6–8	4	20
8–10	6	30
≧ 10	8	40

Appendix

Hospital-Based Palliative Care Consultation Team Standard 2015

◆ All palliative care consultation teams in designated cancer hospitals should adopt this standard by 2020. These statements are the ones that are “appropriate even if they are specified in the designated requirements of designated cancer hospitals and their achievements are obligatory at all designated cancer hospitals.”

◆ Palliative care is intended for all patients facing life-threatening illnesses, and their families; however, in light of the current situation in Japan, this standard was predominantly created in regard to patients with cancer. This should not necessarily exclude care teams who provide palliative care from applying this standard to non-cancer patients and their families. Furthermore, even though this standard was created for the treatment of adult patients, this is also applicable for the treatment of pediatric patients.

◆ Even though the integration of palliative care with oncology is recommended by the American Society of Clinical Oncology, the European Society for Medical Oncology, and other medical societies, such integration is not clearly defined. Using the literature as a guide, we strove to describe in concrete terms the ideal approaches of palliative care consultation teams that are likely to contribute to integration the two areas of care.

Structure

I. Philosophies and Basic Policies

1. Philosophies

(1) Palliative care consultation teams carry out consultation activities with hospitals and regional health care providers using specialist clinical knowledge and skills in palliative care to improve the quality of life (QOL) of patients and their families.

(2) Palliative care consultation teams carry out educational and awareness-raising activities on the topic of palliative care targeted at medical and health care providers, patients and their families, and residents to improve the QOL of patients and their families.

2. Basic Policies

(1) Carry out consultation activities (advice and support) targeted at hospitals and regional health care providers

(2) Coordinate hospital resources, identify the multifaceted pains and needs of patients and their families, and provide necessary treatment and care

(3) Conduct comprehensive assessments of patients and their families on an interdisciplinary basis and share these with requesting health care providers

(4) Discuss, decide, and share objectives and policies related to care for patients and their families within palliative care teams as well as with requesting health care providers

(5) Provide direct care to patients and their families whenever needed with the consent of the requesting health care providers

(6) Provide palliative care to patients along with treatment to improve the course of disease (disease-modifying treatment) as needed from early diagnosis

(7) Carry out activities in accordance with the palliative care needs of patients and their families, as well as in accordance with hospital and regional characteristics and health care providers' needs regarding palliative care

(8) Ensure that seamless palliative care can be provided in hospitals, outpatient settings, and communities based on the needs of patients and their families

(9) Carry out educational and awareness-raising activities targeted at health care providers in hospitals on the topic of palliative care

(10) Carry out educational and awareness-raising activities targeted at health care providers in the region on the topic of palliative care independently or in collaboration with other resources

(11) Carry out educational and awareness-raising activities targeted at local residents on the topic of palliative care independently or in collaboration with other resources

II. Care Delivery System

1. Professionals comprising and cooperating with teams

   (1) A system is adopted in which teams either include or can cooperate as needed with the following professionals (cooperating professionals are preferably retained by hospitals, but can also be external resources who can be consulted at any time; e.g., a hospital does not have a dentist, but has one available for consultation)

   a) Physicians skilled in the alleviation of physical symptoms
   b) Physicians skilled in the alleviation of psychiatric symptoms
   c) Nurses with expertise/certification in the field of palliative care
   d) Pharmacists skilled in palliative care
   e) Medical social workers
   f) Individuals involved in medical psychology (such as psychologists)
   g) Health care providers involved in rehabilitation (e.g., physical therapists, occupational therapists, speech-language-hearing therapists)
   h) Registered dietitians
   i) Dentists and dental hygienists
   j) Liaison staff involved in palliative care (health care providers responsible for or supervising palliative care in a hospital department such as an outpatient clinic, hospital ward, or clinical department)
   k) Physicians, nurses, and pharmacists skilled in cancer treatment and associated adverse events
   l) Supervisors of discharge support and coordination departments
   m) Medical administrators

2. Activity system developments

   (1) Clearly position hospital palliative care consultation teams within the organization
   (2) Disclose the philosophies and basic policies of palliative care consultation teams in hospitals
   (3) Raise awareness of the scope of roles and responsibilities of palliative care consultation teams in hospitals and the community

(4) Set annual targets for palliative care consultation teams
(5) Raise awareness of palliative care consultation team systems (positioning in hospitals, constituent members, duration and content of activities, etc.) among patients, their families, and health care providers in hospitals
(6) Raise awareness within hospitals on the methods for requesting palliative care consultation teams (health care providers who can be requested, procedures, etc.)
(7) Consult health care providers from different fields in addition to physicians
(8) Develop a system wherein palliative care consultation teams can be used in parallel with treatment regardless of the disease stage, and raise awareness of this system among patients, their families, and their health care providers.
(9) Develop an outpatient palliative care service and raise awareness of this service among patients, their families, and their health care providers.
(10) Screen for pain in cooperation with related departments and identify the distress of patients and their families
(11) Clearly demonstrate the standards (criteria) according to individual pain screening results to consult with palliative care consultation teams
(12) Develop a system in which requests elicit a rapid response
(13) Develop procedures for publicizing the availability of palliative care to residents (e.g., websites and public relation brochures)
(14) Develop a system* by which the appropriate health care providers in the region can be consulted, and raise awareness of this system among patients, their families, and health professionals
(*Various methods exist depending on the circumstances of the region and hospital (telephone consultations, consultations using email, accompanying patients to appointments, etc.)
(15) Cooperate with related departments to provide information as needed to patients and their families on patient associations, patient salons, patient support groups, and bereavement associations

Process

III. Content of Activities

1. Clinical Activities
   (1) Care for patients and families includes the following support:
   a) Alleviation of pain
   b) Alleviation of physical symptoms other than pain

c) Alleviation of psychiatric symptoms (anxiety, depression, delirium, insomnia, etc.)
d) Treatment and care for adverse events of treatment for disease
e) Psychiatric support
f) Support for financial problems associated with treatment and care
g) Support for decision-making related to treatment and care
h) Support for adapting to treatment and care environments
i) Support for families and bereavement
j) Support for the distress of health professionals involved in care

(2) Care for various end-of-life problems: The following support is provided:

a) End-of-life care
b) Determining and implementing appropriate sedation
c) Withholding and discontinuing treatment
d) Care for grief

(3) Consultation activity procedures

a) Comprehensively assess patients and families based on data, including information from health care providers, patient appointments, interviews with family members, medical records, and various test results, and provide recommendations or direct care accordingly
b) Conduct assessments using standardized tools
c) Provide recommendations or direct care based on treatment guidelines and other criteria depending on each patient and their family
d) Discuss assessments/recommendations with requesting medical and health care providers
e) List the content of assessments/recommendations/direct care in medical records and other documentation
f) Follow-up and review the results of recommendations/direct care
g) Obtain approval from the attending physician before providing medical consultation or direct care to patients
h) Explain and obtain patient and family consent for the content of any direct care
i) Provide explanations and information on medical conditions, symptoms, subsequent course, how to spend time, and other matters as needed to patients and their families

j) Hold conferences with requesting health care providers as needed
k) Hold routine conferences within palliative care consultation teams to standardize treatment and care policies
l) Participate in conferences attended by other specialists such as cancer boards, and use expert knowledge on palliative care to participate in decision surrounding patient treatment policy

(4) Coordination and adaptation of care
a) Cooperate with liaison staff in hospitals to improve the quality of basic palliative care in wards and departments
b) Refer patients and their families to hospital or regional specialists as needed

(5) Regional cooperation
a) Plan for palliative care to continue as needed when a patient's place of treatment and care changes
b) Perceive the resources that provide palliative care in any given region (institutions and individuals) and provide information to patients, their families, and health care providers as needed

2. Coordination, Cooperation, and Application of Resources

(1) Coordination and cooperation with hospital resources

Applies to care provided in coordination and cooperation with the following hospital professionals and resources:

a) Physicians and nurses with other expertise
b) Interdisciplinary teams with other expertise
c) Consultation and support department supervisors
d) Cancer nurse consultation and outpatient services

(2) Coordination and cooperation with regional resources

Applies to care provided in coordination and cooperation with the following regional facilities:

a) Hospitals
b) Clinics
c) Home-visit nursing stations
d) Health insurance pharmacies
e) Palliative care wards

- f) Palliative care consultation teams of other hospitals
- g) Comprehensive community support centers
- h) Care and welfare offices

(3) Application of resources

- a) Support liaison staff activities
- b) Carry out consultation activities upon new requests from inpatients every week day
- c) Carry out consultation activities upon new requests from outpatients every week day
- d) Visit wards and outpatient clinics regularly to verify hidden needs of symptom relief and such, and offer advice as needed
- e) Assess information from inpatients under the care of team members every week day
- f) Provide support for the unbearable distress of inpatients as needed even at night and during holidays
- g) Resolve consultations by patient families and bereaved families regarding palliative care
- h) Develop and apply standardized evaluation methods and a palliative care manual that can be readily available within the hospital
- i) Cooperate with health care providers and institutions* that provide other specialized palliative care to build a network of specialists to oversee the entirety of palliative care in the region

  *These specifically include hospitals, clinics, home-visit nursing stations, health insurance pharmacies, palliative care wards, palliative care consultation teams of other hospitals, comprehensive community support centers, care and welfare offices, patient associations, and patient support groups.

3. Educational and Awareness-raising Activities

(1) Provide education on basic and specialized palliative care to liaison staff regarding matters often encountered in routine treatment and care

(2) Provide education and raise awareness of palliative care among hospital and regional health care providers through daily clinical activities

(3) Hold routine seminars, lectures, and other events on palliative care for hospital

and regional health care providers

(4) Provide education and raise awareness of the end-of-life process to hospital and regional health care providers, including end-of-life care, appropriate sedation, withholding and discontinuing treatment, family and bereavement care, and support for staff.

(5) Provide education and raise awareness of palliative care to inpatients, outpatients, and their families

(6) Provide education and raise awareness of palliative care to residents independently or in collaboration with other resources

(7) Disseminate information on palliative care to residents independently or in collaboration with other resources

IV. Evaluation and Improvement of Care Quality

1. Evaluation and Improvement of Care Quality

(1) Conduct routine case studies and conferences within palliative care consultation teams to evaluate and improve activities targeted at requested patients

(2) Exchange information about palliative care consultation team activities with other regional palliative care consultation teams to improve knowledge and skills

(3) Learn proactively about the newest forms of palliative care

(4) Present the content of palliative care consultation team activities in clinical, educational, and research fields through conference presentations, workshops, and manuscript submissions

Outcomes

V. Activity Evaluation

1. Self-Evaluation and Publication of Activities

(1) Collect and analyze information on entrusted patients and palliative care consultation team activities (disease names, reason for requests, number of requests, etc.) for evaluation purposes

(2) Publicize and announce palliative care team activities in hospitals and regions

(3) Assess and publicize annual care outcomes of palliative care consultation teams

(4) Assess and analyze hospital use of drugs, medical equipment, medical tools, and other resources related to palliative care

2. Mutual and Other-party Evaluation of Activities

(1) Benchmark domestic palliative care consultation team members and other active individuals, and create opportunities to review team activities