プライマリケアについて

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Competency lists for urban general practitioners/family physicians using the modified Delphi method

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Table 3 Final list

Round3-No.	competency domain	definition of competency	explanation of competency
R3–1.	Cultural competence	can understand the diverse socio-economic status and cultural background of patients and provide care that takes into account diverse medical needs.	understand the diverse socio-economic status (social status, education level, lifestyle, occupation, income, insurance, etc.) and cultural background (race, religion, thought, beliefs, customs, etc.) of patients and provide care that takes into account the diverse medical needs that accompany the situation.
R3–2.	Care for people at a social disadvantage	can understand social determinants of health and health inequalities, and can work with multiple occupations to provide appropriate care to a wide variety of populations with inadequate medical care.	understand social determinants of health and health inequalities, and can work with multiple occupations to provide appropriate care to a wide variety of populations with inadequate medical care (social isolation, withdrawal, poor areas, low income, uninsured, homeless, race/ethnic minorities, immigrants, LGBT, HIV/AIDS patients, commercial sex workers, criminal history, etc.)
R3–3.	Family-oriented care	can consider diverse values and relationships with the family, communicate effectively with the necessary stakeholders, and provide appropriate care for the patient.	share information about the patient's medical condition and make important decisions by taking into consideration various values and relationships with family members (not limited to blood relatives, but including common-law relatives and close acquaintances, various household structures and residential situations, etc.) and by communicating effectively with necessary parties. By communicating effectively with the necessary parties, they are able to provide support for decision-making that is appropriate for the patient and appropriate care.
R3–4.	Adjustment of the scope of care	can flexibly adjust the scope of care they provide to meet the diverse needs and problems of patients, taking into account the characteristics of a wide variety of surrounding medical institutions.	GPs can flexibly adjust the scope of care they provide to meet the diverse needs and problems of patients in terms of expanding or contracting the scope of care based on the characteristics of the various surrounding medical institutions (segmented specialties, trends in treatment policies, access, etc.) while maintaining a complete picture of the patient.
R3–5.	Coordination of care with specialized medical institution	can grasp the characteristics of a wide variety of medical institutions with fragmented specialties, and make appropriate referrals to and coordinate care with specialized medical institutions according to the needs and circumstances of the patient.	GPs can grasp the characteristics of a wide variety of medical institutions with fragmented specialties, and make appropriate referrals and linkages to specialized medical institutions according to patients' diverse needs and circumstances (medical conditions, underlying diseases, socioeconomic status, transportation).
R3–6.	Integration of fragmented medical care	can take responsibility for the integration of medical care for patients who are experiencing the negative effects of fragmentation of care.	can take responsibility for organizing medical visits and providing comprehensive care to patients who have multiple diseases and are suffering from the negative effects of fragmented care due to visits to multiple specialties, by building trusting relationships and collaborating with doctors in specialties and other professionals inside and outside the facility.

Table 3 (continued)

Round3-No.	competency domain	definition of competency	explanation of competency
R3–7.	Coordination of care with multiple professions	can grasp the characteristics of a wide variety of care and welfare services and community social resources, and make appropriate referrals and collaborations in collaboration with multidisciplinary professionals according to the needs and circumstances of the patient.	can grasp the characteristics of a wide variety of care and welfare services (e.g., nursing homes, long-term care facilities, home nursing agencies) and community resources (e.g., civic activities, hobby groups), and can make appropriate referrals and collaborate with them according to the patient's situation in collaboration with multidisciplinary professionals (e.g., care managers, nurses, community comprehensive support center staff).
R3–8.	Community Oriented Care -Health Promotion	can identify health issues that are characteristic of the region/community and effectively collaborate with a wide variety of stakeholders to address them.	can identify health issues that are characteristic of the region and community in which they practice, and work effectively with a wide variety of stakeholders, including the people concerned, surrounding residents, and multidisciplinary professionals, to address health issues through ongoing planning, implementation, and evaluation. For example, it is possible to address the health problems of specific groups, such as poor areas, areas with frequent ambulance use, elderly single households, foreign residents, night shift workers, and single-parent families.
R3–9.	Community Oriented Care -emergency care	can collaborate and tackle the issues of emergency medicine that are characteristic of each region at the field level of primary care.	can share issues with related parties (hospitals, clinics, ambulance crews, etc.) regarding emergency medical care in each medical area, cooperate from the field level of primary care, and implement some measures. For example, there are discussions on cases of tampering with emergency patients, efforts to ensure the continuity of patient information during emergency consultations on holidays and nights, and measures for patients who frequently undergo emergency consultations.
R3–10.	Details -Occupational health	can provide appropriate care for occupational health-related health problems that are common or characteristic of each practice area.	can provide appropriate care as an industrial physician or in collaboration with an industrial physician for health problems related to industrial hygiene that are common or characteristic in each medical area. For example, not only chemical and physical health disorders such as organic solvents, dust, noise, and vibration, but also psychosocial health disorders such as mental health and overwork, ergonomic health disorders such as VDT work and working attitude, or overseas workers. It is possible to flexibly respond to different needs depending on the medical treatment area, such as biological health problems like measures against infectious diseases.

Table 3 (continued)

Round3-No.	competency domain	definition of competency	explanation of competency
R3–11.	Details-Infectious diseases	The GP can identify patients with suspected frequent infections in urban areas and take appropriate initial action.	GP can identify patients with symptoms and risk factors that should be suspected to be frequent infectious diseases in urban areas such as tuberculosis and sexually transmitted diseases such as HIV infection, and recall those diseases as a differential diagnosis, which is necessary. Appropriate initial measures such as conducting tests and coordinating/introducing with health centers and specialized medical institutions can be performed.
R3–12.	Details-Mental Health	can respond appropriately to mental health problems in patients of all ages and collaborate with psychiatrists and related agencies.	can respond appropriately to mental health problems in patients of all ages (especially children and young people with developmental disabilities, school refusal and elderly depression, delirium, or multi-generational drinking, smoking, drug addiction, etc.) It is possible to deal with various primary care levels and cooperate with psychiatry and related organizations.
R3–13.	Details-Dementia care	can carry out appropriate diagnosis and treatment for patients suspected of having dementia, and care management in collaboration with multiple occupations.	can appropriately cooperate with specialists in the diagnosis and drug treatment for patients suspected of having dementia, and can cooperate with multiple occupations (nurses, rehabilitation workers, care managers, caregivers, etc.) in care management to improve the quality of life, and also appropriately cooperate with administrative procedures as necessary (such as the written opinion of the attending physician for the use of long-term care insurance and the preparation of documents for the adult guardianship system).
R3–14.	Details-Behavioral transformation	can provide guidance using behavior modification theory to patients with lifestyle-related diseases.	can provide guidance to patients with lifestyle-related diseases using behavioral change theory based on various lifestyles.
R3–15.	Details-Palliative care	can provide appropriate decision support and palliative care to patients with cancer or non-cancerous diseases.	can continuously and appropriately support the decision-making of the patient, their family, or the surrogate decision-maker for patients in the treatment stage to the terminal stage of cancer or non-cancer disease. In addition, it is possible to provide appropriate palliative care at the place (home, admission facility, hospital, hospice, etc.) according to the patient's wishes and circumstances while coordinating and coordinating with each person concerned.
R3–16.	Organization management	can work on the organizational management of clinics and hospitals based on the role of primary care in each region.	can work on appropriate organizational management of clinics and hospitals (improvement of patient convenience, improvement of quality of medical care provided, division of roles with surrounding medical institutions and network formation, etc.) based on the role of primary care in each region.
R3–17.	Lifelong learning	GPs can learn about common illnesses to maintain their ability to practice regardless of the frequency of treatment opportunities.	can intentionally learn to maintain competence in common diseases, including emergencies and chronic diseases, regardless of the frequency of opportunities to practice in a setting with good access to surrounding specialty care facilities.

Table 3 (continued)

Round3-No.	competency domain	definition of competency	explanation of competency
R3–18.	Education	can provide opportunities to learn the characteristics and significance of urban primary care in student and internship education.	can provide opportunities to learn the characteristics and significance of urban primary care at various student and internship education opportunities in community medical training. For example, through clinical training in urban areas, it is possible to provide an opportunity to learn that primary care is necessary not only in non-urban areas and depopulated areas but also in urban areas.

悠翔会暮らしケアクリニック

- 書類：特別看護指示書、ワクチン指示書等
- 特別看護指示書とは..
  - 急性感染症等の急性増悪時、末期の悪性腫瘍等以外の終末期、退院直後で週4回以上の頻回な訪問看護の必要を認めた場合に主治医の診療により1人につき1月に1回限り交付するもの（特別訪問看護指示書の指示期間中は、医療保険の訪問看護になる）特別訪問看護指示書が交付された日から十四日以内は毎日訪問看護を行うことができる
  - 但し、気管カニューレを使用している状態にある患者、真皮を越える褥瘡の状態にある患者の場合は1月に2回まで交付することができる。

抗精神病薬

アルツハイマー病を始め認知症疾患に対する抗精神病薬の使用は適応外使用であり、患者のリスクベネフィットを考慮し、充分なインフォームドコンセントを行って使用する。有効性の評価を行い、常に減薬、中止が可能か検討する。

【[illegible]】

幻覚･妄想に対して、リスペリドン、オランザピン、アリピプラゾールなどの使用を推奨する。クエチアピンの使用を検討してもよい。
レビー小体型認知症の BPSD に対して、クエチアピンとオランザピンの使用を考慮しても良い。
不安に対して、リスペリドン、オランザピンの使用が推奨され、クエチアピンの使用を考慮してもよい。
焦燥性興奮 (agitation) には、リスペリドン、アリピプラゾールは有効性が実証されており使用を推奨する。オランザピンについては使用を検討してもよい。チアプリドも興奮や攻撃性に対する有効性が報告され、脳梗塞後遺症に伴う精神興奮・徘徊・せん妄に保険適応もあるため考慮してもよい。
暴力や不穏に対して抗精神病薬の使用を考慮してもよい。
睡眠障害に、リスペリドンの使用を考慮してもよい。
徘徊に対するリスペリドンの使用を考慮してもよいが、科学的根拠が不十分である。
性的脱抑制に、抗精神病薬の使用を考慮するが、科学的根拠は不十分である。

なお、保険適応外使用にはなるが、クエチアピン、ハロペリドール、ペロスピロン、リスペリドンに関しては、原則として、器質的疾患に伴うせん妄・精神運動興奮状態・易怒性に対して処方した場合、当該使用事例を審査上認めるとの通達がある（2011 年 9 月 28 日、厚生労働省保険局医療課長、保医発 0928 第 1 号。社会保険診療報酬支払基金、第 9 次審査情報提供）。

【副作用】

高齢認知症患者への抗精神病薬投与により死亡率が 1.6 ～ 1.7 倍高くなる（米国食品医薬品局 (FDA)、2005 年及び 2008 年）。また、転倒や骨折のリスクも高まるので注意を要する。
よくみられる副作用として、眠気、ふらつき、過鎮静、歩行障害、嚥下障害、構音障害、寡動、振戦、起立性低血圧、食欲低下などがあるので注意する。

【留意点】

（必ずチェックしてから薬物投与を開始して下さい。）

- □ 低用量で開始し、症状をみながら漸増すること。
- □ 副作用の発現が少ないセロトニン・ドパミン受容体拮抗薬もしくはドパミン受容体部分刺激薬を使用する。
- □ 抗精神病薬の併用（2 剤以上）は避ける。
- □ 2 週間位の時間をかけて薬効を評価する。症状を完全に消退させるまで増量するのではなく、QOL 確保の観点から非薬物療法との併用のもと維持用量を検討する。
- □ 副作用を認めたら速やかに減量もしくは中止を検討する。悪性症候群など重篤な副作用が出現した時は直ちに中止する。
- □ 抗精神病薬の副作用は、使用開始後の早期に出現する場合は見つけやすいが、一ヶ月以上もしくはさらに長期に使用している段階で出現することもあるので注意すること。

作用機序	薬剤名	対象となる BPSD の症状	注意点	半減期（時間）	用量（mg）*
セロトニン受容体・ドパミン受容体遮断	リスペリドン	・幻覚 ・妄想 ・焦燥 ・興奮 ・攻撃	高血糖あるいは糖尿病を合併している場合にも使用可能。 パーキンソン症状に注意。	20-24	0.5-2.0
	クエチアピン		高血糖あるいは糖尿病では禁忌。 DLB に対して使用を考慮しても良い。 鎮静・催眠作用あり。	6-7	25-100
	オランザピン		高血糖あるいは糖尿病では禁忌。 DLB に対して使用を考慮しても良い。 鎮静・催眠作用あり。	22-35	2.5-10
ドパミン受容体部分刺激	アリピプラゾール		高血糖あるいは糖尿病では慎重投与。 鎮静・催眠作用が弱い。	47-68	3-9

＊用量は添付文書、国外の文献およびエキスパートオピニオンを参考　　DLB：レビー小体型認知症

移動中の車内にて

- 認知症患者の身体的拘束を日本では入院患者に対し行う傾向があるが海外では原則として行わないというお話をお聞きした
- そこで実際に身体的拘束がどの程度患者にとって不利益となっているか興味をもち、論文”Association of physical restraint duration and undesirable outcomes amongst inpatients comorbid with dementia and pneumonia in acute care settings” を読んだ。

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EMPIRICAL RESEARCH QUANTITATIVE

Association of physical restraint duration and undesirable outcomes amongst inpatients comorbid with dementia and pneumonia in acute care settings

Introduction

- 認知症患者に対し身体的拘束が頻繁に行われており、転倒や自己抜去を防ぐ目的があるとされているが、実際に効果があるかは議論の余地がある。その上身体的拘束は患者の自己決定権や尊厳を損なうという倫理的問題を含んでいる。
- 本論文では入院期間全体にわたる身体拘束が患者の不利益となる最大のリスクであるという仮定のもと研究を行った。