日本生命倫理学会第 33 回年次大会 国際セッション発表者の募集

国際交流委員会

1. 概要

日本生命倫理学会第 33 回年次大会において、「臨床現場の改善とその課題」をテーマとする国際セッションを設けることになりました。このセッションにおいて、英語で発表できる会員を若干名（1-2 名程度）募集いたします。

2019 年度より日本生命倫理学会（以下 JAB と表記する）は、American Society for Bioethics and Humanities（以下 ASBH と略する）会員および The International Association of Bioethics（以下 IAB と略する）会員を対象とするフェローシップ・ファンドを開始しました。コロナウィルス・パンデミックの中、本年度は、ASBH からは 6 の申請、IAB かは 3 の申請があり、その中から JAB 第 33 回年次大会（慶應義塾大学）における国際交流委員会枠国際セッションの発表者として、将来性のある優れた若手海外研究者を、それぞれ 1 名選出しました。本応募は、これらの若手海外研究者と同じ国際セッションで発表できる JAB 会員を募集するものです。

2. 条件・選考方針・募集締切

- **条件**:
  1. JAB 会員であること。
  2. 英語で発表し、英語で質疑応答すること。
  3. 質疑応答を含めて約 30 分の発表ができること。
  4. 国際交流委員会による今年度の国際セッションのテーマである「臨床現場の改善とその課題」に適した内容で、研究発表をすることができる方。または、海外研究者の研究発表の両方または一方にたいするコメント（同じ主題に関する国内の状況の紹介や比較などを含む）のような形式の発表であってもよいものとします。なお、海外研究者の発表の主題は “The business (ethical) case for promoting wellbeing of medical staff” と “Ethics of chronic diseases and long term care” です。それぞれの発表のアブストラクトは以下に示します。
- **選考方針**:

  申込者とその発表内容（アブストラクト）が諸条件を満たしているか、また、それがどれだけ優れていると思われるかといった観点から選考します。
- **締切**:

  2021 年 8 月 10 日。申込みは原則として国際交流委員会が作成した下記の Google フォームからお願いします。

  https://forms.gle/RN5F3TYqo1cS42XL9

3. ASBH／IAB の発表者とアブストラクト

- ASBH

Name	Residence	Affiliation	Title of the paper
Cindy C. Bitter	USA	Saint Louis University	The business (ethical) case for promoting wellbeing of medical staff

Abstract	Introduction: Even prior to the ongoing COVID pandemic, burnout and the related constructs of compassion fatigue, secondary traumatic stress, and moral injury among healthcare staff was a major problem across many disciplines and many countries. The widespread nature of the problem has lead to a realization that burnout is not an individual failing, but is rooted in the systems in which healthcare takes place. The COVID pandemic has placed additional stressors on healthcare staff and, in most studies, has increased burnout. The impact of burnout on healthcare institutions and infrastructure is less explored. Methods: A series of systematic reviews was conducted to explore the prevalence and root causes of burnout among healthcare workers, estimate the effects on patient care and costs to healthcare systems, and evaluate predictors of resilience and proposed strategies to mitigate burnout among healthcare staff. Results: Burnout is prevalent in healthcare workers across nations, disciplines, and specialties. Root causes vary by context but include overwhelming workload, lack of control, inadequate perceived and received support, and disconnect between individual and organizational values. Healthcare staff suffering with burnout are more prone to medical error, practice defensive medicine, provide lower quality of care at higher cost. Physician burnout is estimated to cost $4.6 billion annually in the US alone, not including costs for nursing staff, pharmacists, and other allied health professions. Individual strategies to reduce burnout include mindfulness, cognitive behavioral therapy, development of an internal locus of control, and strengthening relationships. Organizational strategies include transparent and reasonable expectations for productivity, flexibility in performance of tasks, promotion of community, destigmatization of support, and alignment of values. Several of these initiatives have been demonstrated to be cost-effective, and there is evidence that institutions with better employee culture provide higher-quality patient care and have better reputations.

- IAB

Name	Residence	Affiliation	Title of the paper
Francisca Stutzin Donoso	UK		Ethics of chronic disease and long-term treatment
Abstract	Non-communicable chronic diseases are the main disease burden worldwide, accounting for 71% of all deaths globally, 37% of which are considered premature deaths. Estimates show that adherence to long-term treatment for all chronic conditions is around 50% in high-income countries and presumably comparable or lower in low-and-middle-income countries, contributing to the high rates of premature death and poor individual and population health outcomes. Adherence is strongly associated with adjustment to illness, which is commonly defined as the “presence or absence of diagnosed psychological disorder, psychological symptoms or negative mood” or the “healthy rebalancing by patients to their new circumstances”. It is considered a dynamic process, which unfolds over time and is sensitive to fluctuations and prognosis of disease among other variables, such as culture, gender, and socioeconomic status. Although it has been argued that most people adjust to illness, around 30% of people go through an extended period of adjustment that can sometimes be unsuccessful, meaning that some people do not adjust. Still, it is not yet clear which strategies and dispositions are most effective for adjustment of chronic disease, which makes it difficult to know in advance how to better support this specific group of patients to adjust and adhere to treatment. Even if considered dynamic, such perspectives on adjustment are prescriptive because lack of adjustment and poor self-management are seen as failing at something that is expected, considered healthy and, once achieved, must remain stable. Drawing on the original findings of a qualitative study involving 27 adult participants living with different chronic diseases in the United Kingdom, this paper introduces a novel perspective on the dynamic element in adherence to long-term treatment. Living with chronic disease is described as an on-going effort towards balancing different, often competing, demands to live lives people have reason to value. This balance can be more or less precarious as it is closely intertwined with a myriad of variables both disease and non-disease related, and should be thus understood in terms of dynamic		

	equilibrium where new information is constantly being created and nothing is static. In this on-going effort, the chronically ill endure a myriad of challenges and burdens and display several resources and strategies. The empirical findings of this study show how justifiably hard and demanding long-term treatment can be, meaning that it cannot always be prioritised and thus adherence may be hampered. Strategic non-compliance or the chronically ill departing from medical advice to achieve this balance between disease-associated demands and the life they want to live has been described as positive for health outcomes, but this cannot always be the case. Sometimes deviations from medical recommendations may lead to unwanted health consequences, and not all non-adherence are strategic or voluntary, introducing the ethical problem of cumulative disadvantages affecting people who live with chronic diseases.