2022년도
제4회 간호윤리 교육자 세미나

한국간호윤리학회
The Korean Society for Nursing Ethics

간호에서의 윤리적 가치
: 어떻게 협력해 나갈 것인가?

2022. 06. 11. (토) 09:30~12:30

ZOOM 온라인 세미나

프로그램

한국간호윤리학회
The Korean Society for Nursing Ethics

시간	내용	비고
09:00~09:30	등록	
		사회자: 김상희 교육이사(연세대학교 간호대학)
09:30~09:40	개회사 및 인사말	**이순행 회장**(서울아산병원)
09:40~10:20 (40분)	Keynote Ⅰ **의료인의 사회적 책임, 윤리, 협력**	**안신기 교수** (연세대학교 글로벌사회공헌원,제중원 보건개발원장)
10:20~10:30 (10분)	Break	
10:30~11:10 (40분)	Keynote Ⅱ **임상윤리집담회(Ethics Grand Round, EGR)에서의 간호사의 역할과 경험**	**최원호 간호사** (서울대학교병원 완화의료.임상윤리센터)
11:10~11:20 (10분)	Break	
11:20~12:00 (40분)	Keynote Ⅲ **상급 종합병원에서의 다학제 윤리 교육**	**김해정 간호사** (가톨릭중앙의료원 의료윤리사무국)
12:00~12:30 (30분)	종합토의	
12:30~	폐회	

한국간호윤리학회
The Korean Society for Nursing Ethics

개회사 및 인사말

한국간호윤리학회
The Korean Society for Nursing Ethics

Keynote I

의료인의 사회적 책임, 윤리, 협력

안신기 교수
연세대학교 글로벌사회공헌원,제중원 보건개발원장

YONSEI UNIVERSITY

의료인의 사회적 책무, 윤리와 협력

Social Accountability of Healthcare Professionals, Ethics and Collaboration

Shinki An, MD, PhD, Mdiv.

연세대학교 의과대학 의학교육학교실 | 내과 | 인문사회의학교실

연세대학교 의료원 제중원보건개발원장

YONSEI INSTITUTE FOR GLOBAL HEALTH

Medical & Nursing Education for the Future in Uzbekistan

강의 제목의 재해석

의료인의 사회적 책무: 윤리와 협력

Social Accountability of Healthcare Professionals: Ethics and Collaboration

Shinki An, MD, PhD, Mdiv.

연세대학교 의과대학 의학교육학교실 | 내과 | 인문사회의학교실

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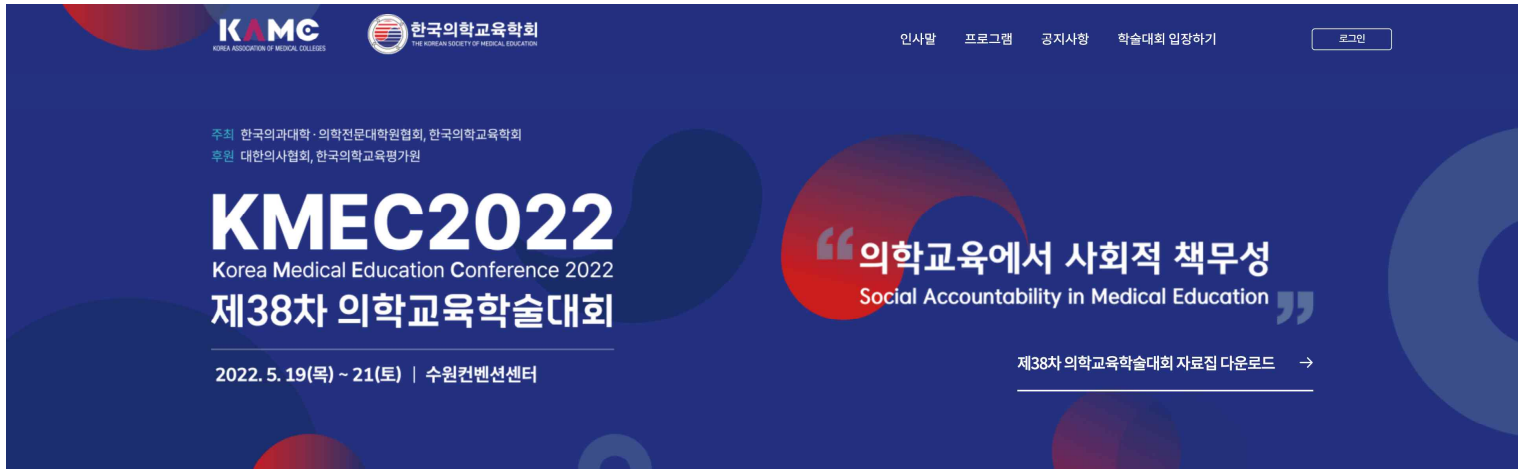
YONSEI INSTITUTE FOR GLOBAL HEALTH

Medical & Nursing Education for the Future in Uzbekistan



Responsibility → Responsiveness → Accountability

Social needs identified	Implicitly	Explicitly	Anticipatively
Institutional objectives	Defined by faculty	Inspired from data	Defined with society
Educational programs	Community-oriented	Community-based	Contextualized
Quality of graduates	« Good » practitioners	Meeting criteria of professionalism	Health system change agents
Focus of evaluation	Process	Outcome	Impact
Assessors	Internal	External	Health partners

Charles Boelen. **Why should social accountability be a benchmark for excellence in medical education?** Educacion Medica. 2016. http://dx.doi.org/10.1016/j.edumed.2016.06.004

Health as the GLOCAL reality
의료는 국지적이고 국제적이다.

UN Secretary-General António Guterres

...developed countries must assist those less developed, or potentially "face the nightmare of the disease spreading like wildfire in the global South with millions of deaths and the prospect of the disease re-emerging where it was previously suppressed".
Let us remember that **we are only as strong as the weakest health system in our interconnected world.**

JOHNS HOPKINS UNIVERSITY & MEDICINE | CORONAVIRUS RESOURCE CENTER

Home | Topics | By Region | Events & News | About | Search Data by Region...

Tracking Home | Data Visualizations | Global Map | U.S. Map | Data in Motion | Tracking FAQ

COVID-19 Dashboard by the Center for Systems Science and Engineering (CSSE) at Johns Hopkins University (JHU)

Last Updated at (M/D/YYYY)
2022. 6. 11. 오전 3:21

Total Cases	Total Deaths	Total Vaccine Doses Administered
534,528,610	6,307,388	11,534,575,429
28-Day Cases	**28-Day Deaths**	**28-Day Vaccine Doses Administered**
14,224,580	42,674	405,102,098

Cases | Deaths by Country/Region/Sovereignty

US
28-Day: 2,967,800 | 9,393
Totals: 85,407,783 | 1,010,972

Taiwan*
28-Day: 2,122,917 | 2,616
Totals: 2,762,080 | 3,797

Germany
28-Day: 1,076,692 | 2,381
Totals: 26,738,530 | 139,729

Australia
28-Day: 1,074,747 | 1,241
Totals: 7,571,837 | 8,957

Japan
28-Day: 739,400 | 872
Totals: 9,010,943 | 30,864

Brazil
28-Day: 721,720 | 2,916
Totals: 31,360,850 | 667,790

Portugal
28-Day: 687,805 | 961
Totals: 4,917,127 | 23,531

France
28-Day: 657,580 | 1,553
Totals: 29,946,697 | 149,749

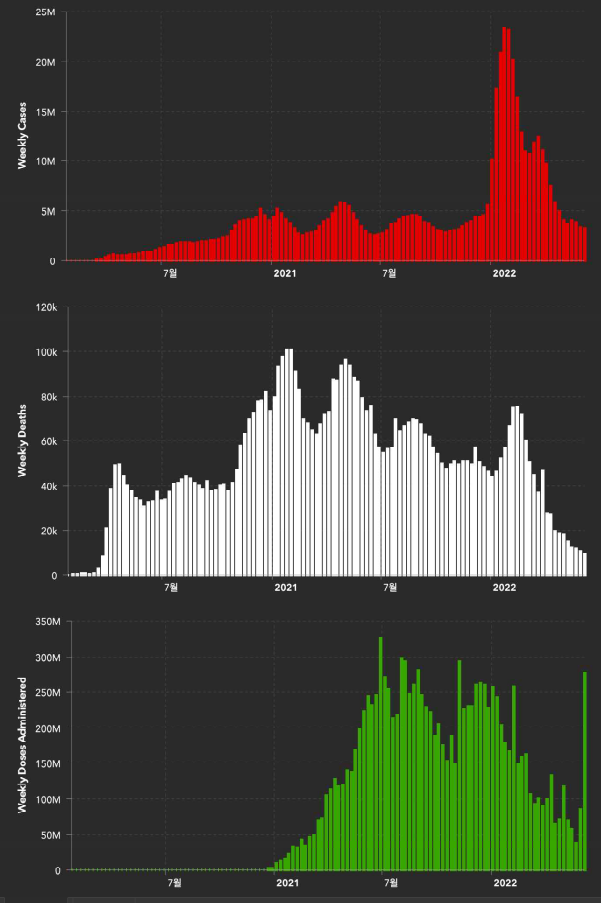
Italy
28-Day: 634,811 | 2,277
Totals: 17,609,537 | 167,308

Korea, South
28-Day: 482,564 | 735
Totals: 18,209,650 | 24,341

Spain
28-Day: 377,650 | 1,791
Totals: 12,478,994 | 107,108

United Kingdom
28-Day: 207,658 | 2,080
Totals: 22,571,880 | 179,884

New Zealand
28-Day: 197,776 | 355
Totals: 1,233,895 | 1,248

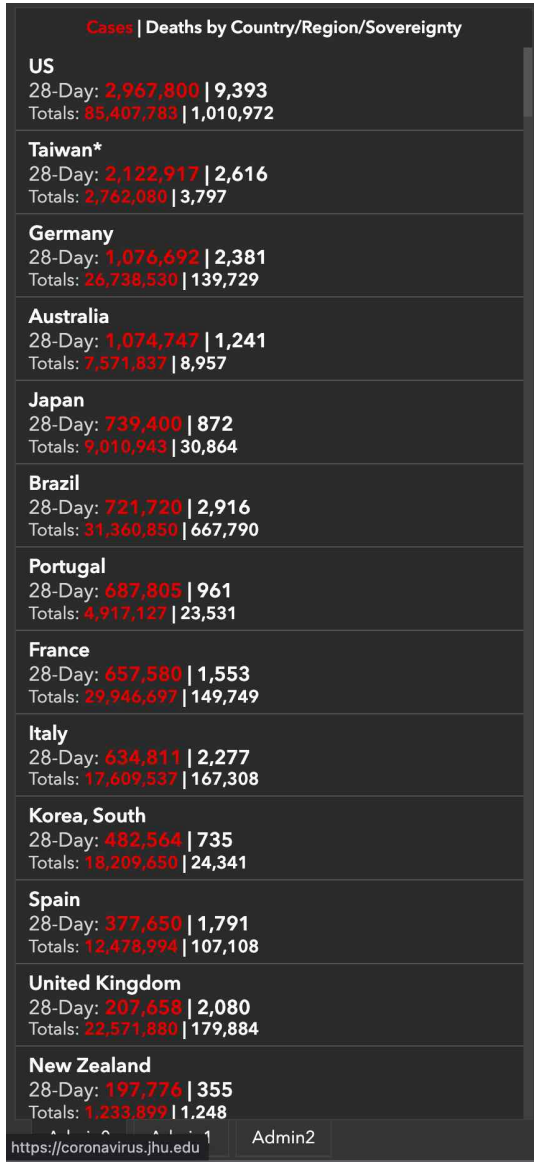


Admin2 | 28-Day | Totals | Incidence | Case-Fatality Ratio | Global Vaccinations | US Vaccinations | Terms of Use | Weekly | 28-Day

https://coronavirus.jhu.edu

Medical & Nursing Education for the Future in Uzbekistan

YONSEI UNIVERSITY



the Epochal Experience
COVID-19 Reflections

1. OECD 선진국의 감염과 사망율의 의미?
2. K-방역의 결국

엄중한 사회적 통제 vs 시민의 자유
발달한 의료의 수준이 곧 보건안전은 아니다.

우리가 살고 있는 세상은 어떤 세상이었고
또 어떤 세상이 될 것인가?

COVID-19 Reflections

미세먼지는 위험하다

SCIENCE ADVANCES | RESEARCH ARTICLE

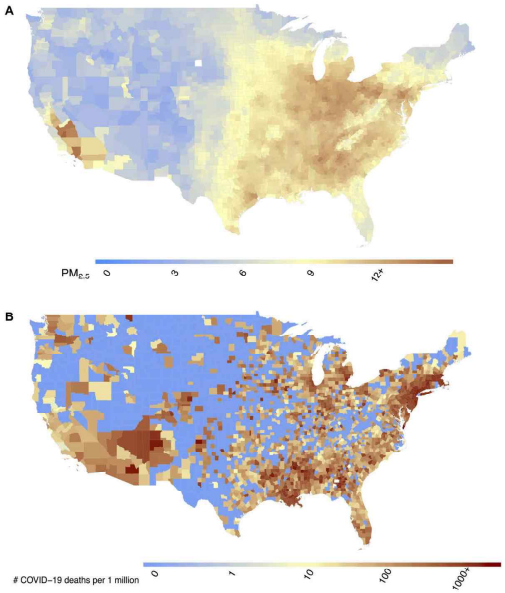


Fig. 1. National maps of historical $PM_{2.5}$ concentrations and COVID-19 deaths. Maps show (**A**) county-level 17-year long-term average of $PM_{2.5}$ concentrations (2000–2016) in the United States in $\mu g/m^3$ and (**B**) county-level number of COVID-19 deaths per 1 million population in the United States up to and including 18 June 2020.

인간의 활동이 미세먼지를 만든다

Then and now: Pandemic clears the air

By Mark Kinver
Environment reporter

1 June 2021

Climate change

In our monthly feature, Then and Now, we reveal some of the ways that planet Earth has been changing against the backdrop of a warming world. Air pollution has long been one of the biggest killers. claiming an estimated seven million victims annually. However, the Covid-19 global pandemic showed how quickly we could clear the air once we cut the number of journeys we made...

Air quality at India Gate in Delhi

Drag the button to see the shift from smog to clean air

Images: Reuters

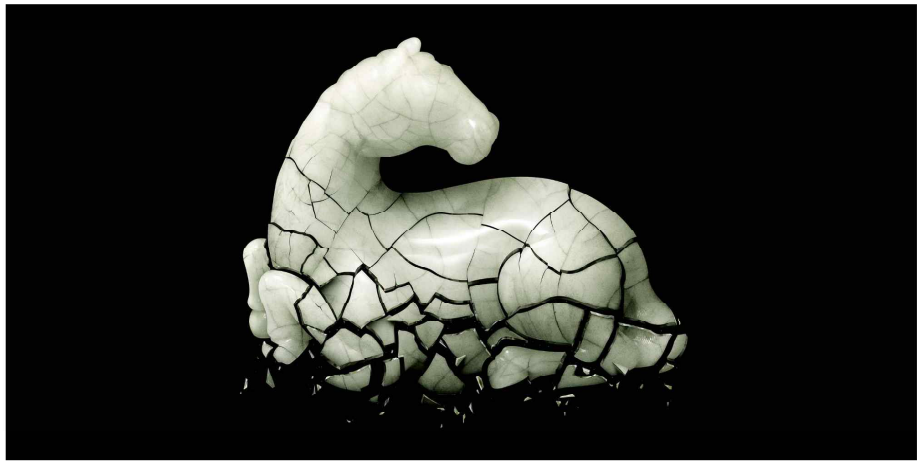
세계의 생산기지 중국, 인도 싸게 생산한 물건의 비싼 댓가

Globalization

The Strategic Challenges of Decoupling

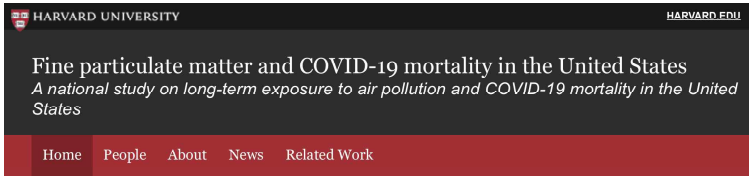
by J. Stewart Black and Allen J. Morrison

From the Magazine (May–June 2021)



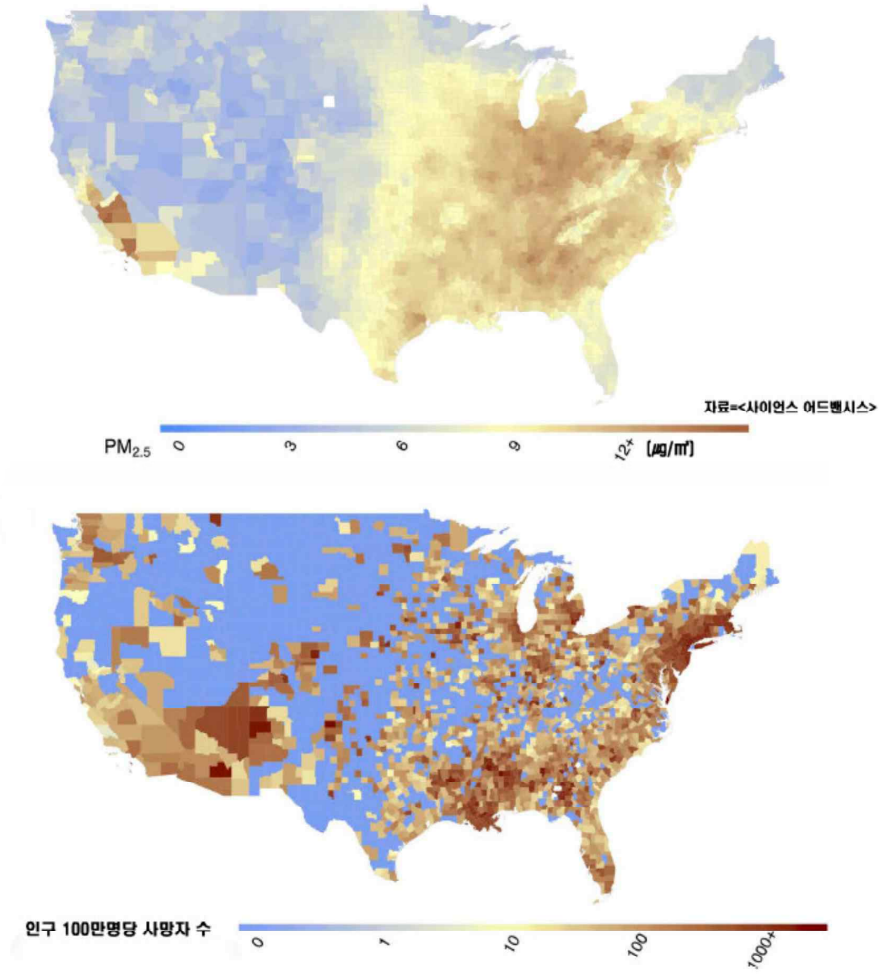
Bartholomew Cooke/Trunk Archive

1μg/m³ - 11%



한편 하버드대 보건대학원 연구팀은 미국 카운티 단위의 장기간 미세먼지 농도가 1㎍/㎥ 증가할 때마다 코로나19 사망률은 11%(신뢰도 95%, 범위 6~17%)가 증가한다고 결론을 얻었다고 밝혔다.

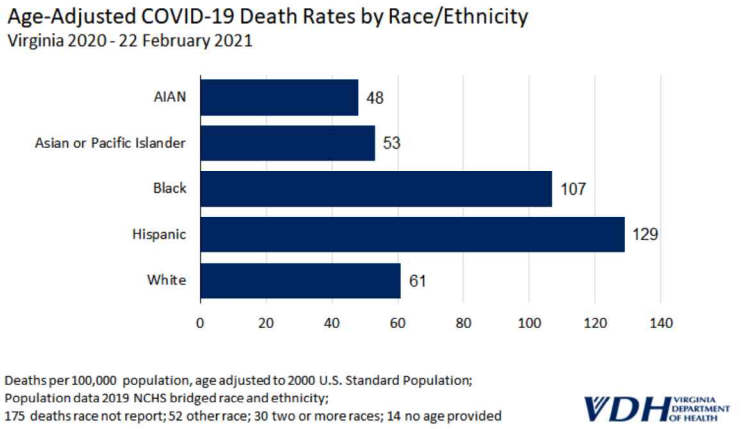
□ 미국 미세먼지 농도(위)와 코로나19 사망률(아래) 비교

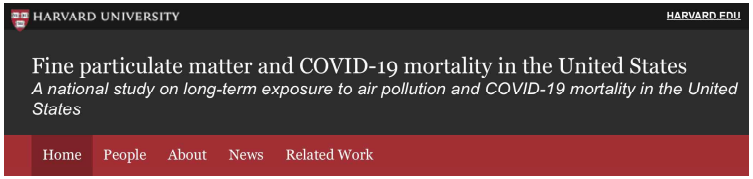


※ 위 : 미국 3089개 카운티의 2000~2016년 17년간 미세먼지(PM2.5) 일 평균 농도
아래 : 올해 6월18일까지 코로나19 사망자 11만6747명의 카운티별 분포

1μg/m³ - 11%

14.1% - 49%





YONSEI UNIVERSITY COLLEGE OF MEDICINE

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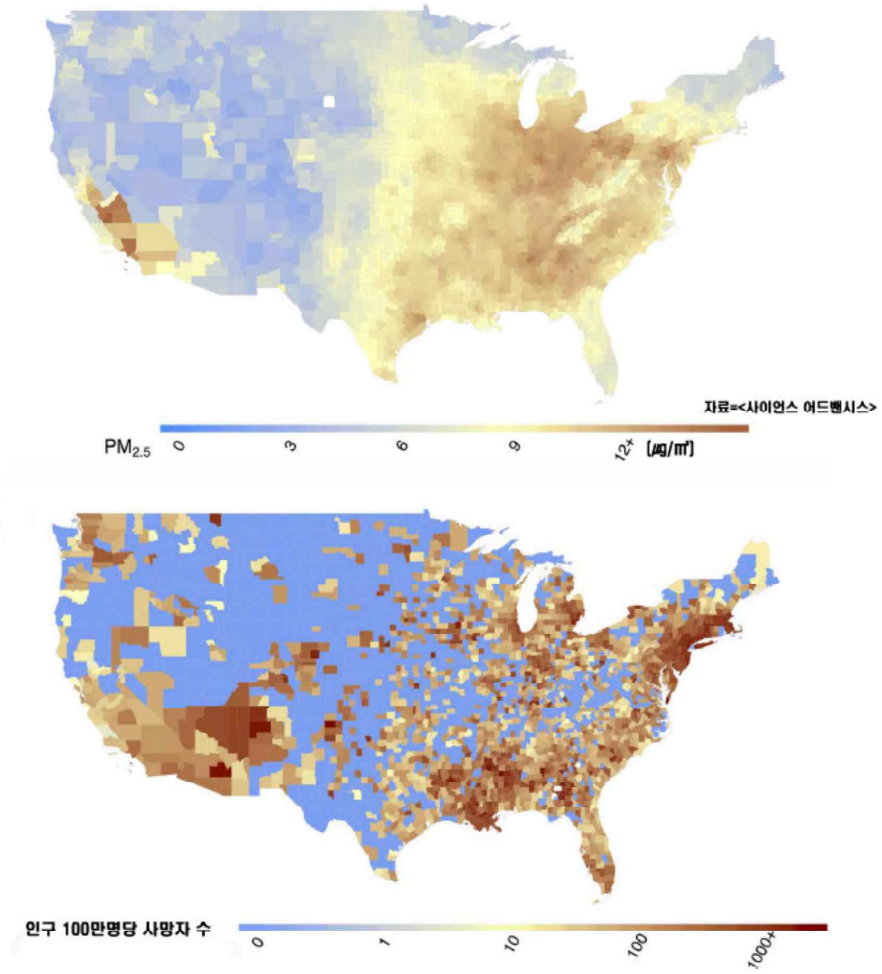

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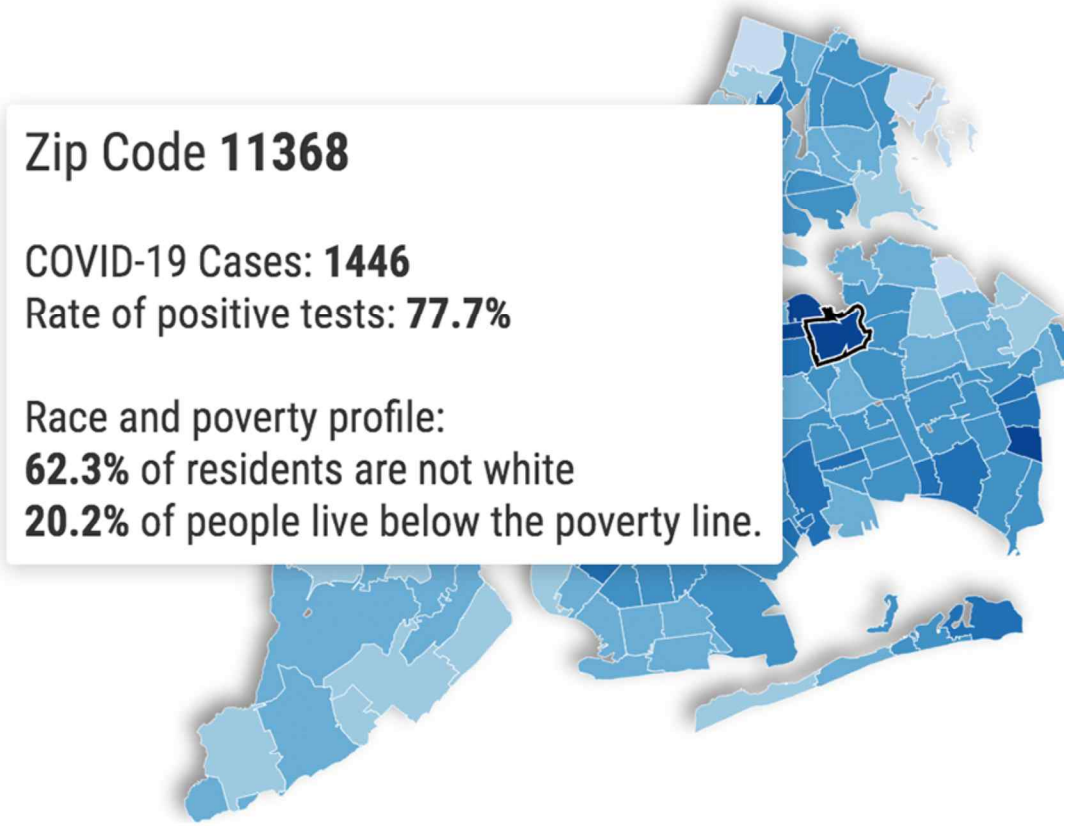
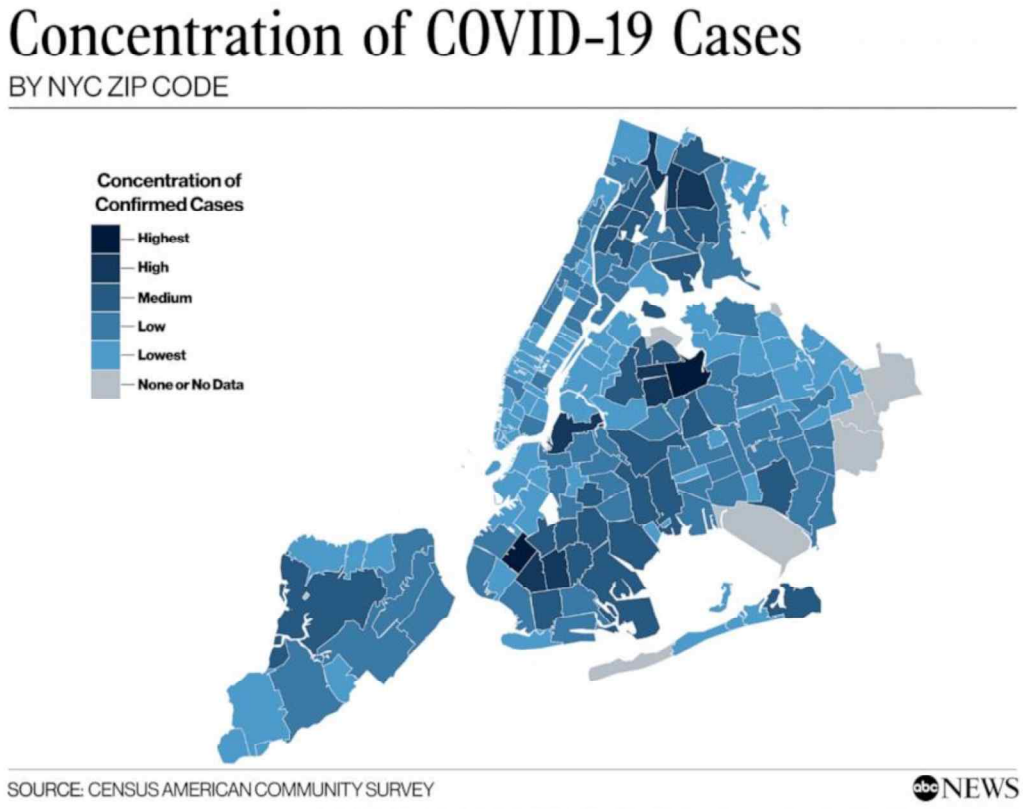
코로나의 사회학: 왜 우편주소마다 다를까?





동일한 생물학적 특성을 가진 바이러스에 왜 흑인노동자가 더 위험했을까?

COVID-19 DEATHS

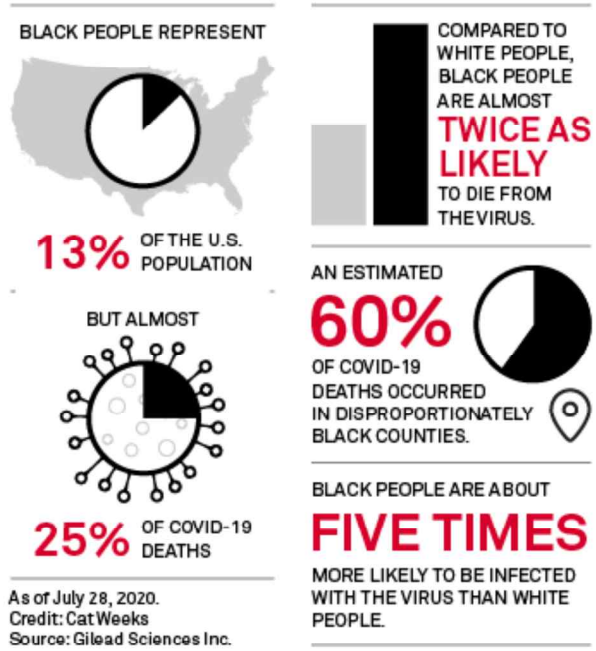
Rich and Poor, New York City

New York City population by annual household income (%)

	Less than $25,000	More than 240,000
65 years and older	10.7	21.6
Hispanic	59.4	6.4
African American	38.6	2.1
Anglo	15.0	83.0

	Less than $25,000	More than 240,000
Median death rate per 100,000	221.8	85.7

COVID-19 inequity in the US, by the numbers



As of July 28, 2020.
Credit: Cat Weeks
Source: Gilead Sciences Inc.

COVID-19 & BLACK WORKERS

Black workers are at greater risk from COVID-19 than their white peers.

More likely to have
- Preexisting health conditions
- Limited access to health care

More likely to live in
- Multi-generation households
- Dense housing

More likely to work
- In front-line industries
- Without health insurance
- Without paid sick days
- Without the ability to work at home

Economic Policy Institute | Learn more: go.epi.org/covidrace

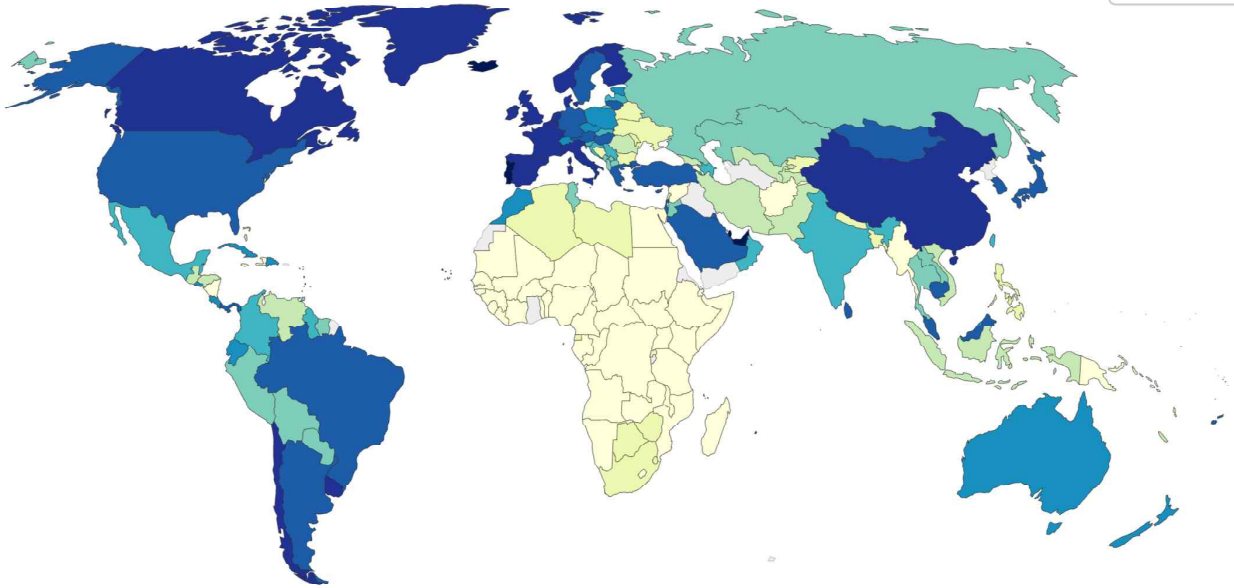
Source: Economic Policy Institute

Share of people who received at least one dose of COVID-19 vaccine, Sep 11, 2021

Our World in Data

Total number of people who received at least one vaccine dose, divided by the total population of the country.

World



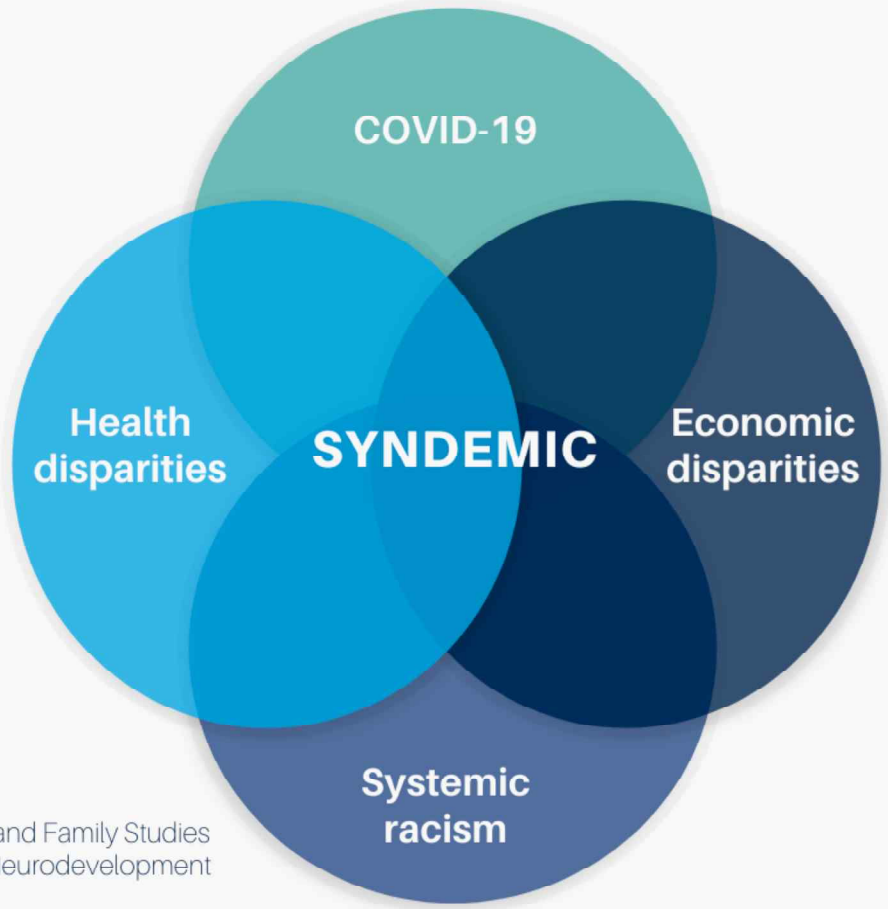
Source: Official data collated by Our World in Data.

CC BY

Dec 1, 2020 — Sep 11, 2021

CHART | MAP | TABLE | SOURCES | DOWNLOAD

PREVENTION SCIENTISTS
must mitigate the impacts of the
SYNDEMIC
on marginalized populations



DR. DIANA FISHBEIN
Senior Research Faculty, Department of Human Development and Family Studies
Director, Program for Translational Research on Adversity and Neurodevelopment
The Pennsylvania State University

Syndemics

a convergence of biosocial forces that interact with one another to produce and exacerbate clinical disease and prognosis

Syndemics and the biosocial conception of health

Merrill Singer, Nicola Bulled, Bayla Ostrach, Emily Mendenhall

The syndemics model of health focuses on the biosocial complex, which consists of interacting, co-present, or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction. This emergent approach to health conception and clinical practice reconfigures conventional historical understanding of diseases as distinct entities in nature, separate from other diseases and independent of the social contexts in which they are found. Rather, all of these factors tend to interact synergistically in various and consequential ways, having a substantial impact on the health of individuals and whole populations. Specifically, a syndemics approach examines why certain diseases cluster (ie, multiple diseases affecting individuals and groups); the pathways through which they interact biologically in individuals and within populations, and thereby multiply their overall disease burden, and the ways in which social environments, especially conditions of social inequality and injustice, contribute to disease clustering and interaction as well as to vulnerability. In this Series, the contributions of the syndemics approach for understanding both interacting chronic diseases in social context, and the implications of a syndemics orientation to the issue of health rights, are examined.

Lancet 2017; 389: 941–50

This is the first in a **Series** of three papers about syndemics

See **Editorial** page 881

See **Comment** pages 888 and 889

Department of Anthropology (Prof M Singer PhD) **and Department of Community Medicine** (Prof M Singer), **University of Connecticut, Storrs, CT, USA; Division of Interdisciplinary & Global Studies, Worcester Polytechnic Institute. Worcester. MA. USA**

Panel 1: The syndemic lexicon

Syndemic
Population-level clustering of social and health problems. The criteria of a syndemic are: (1) two (or more) diseases or health conditions cluster within a specific population; (2) contextual and social factors create the conditions in which two (or more) diseases or health conditions cluster; and (3) the clustering of diseases results in adverse disease interaction, either biological or social or behavioural, increasing the health burden of affected populations.

Syndemic vulnerability
Integration of epidemiological and experiential levels of analysis of multiple, overlapping social and health problems that increase morbidity and mortality as a result of syndemic clustering of social and health conditions within a certain context.

Syndemic interaction
The co-occurrence of social and health conditions, including social–psychological, social–biological, and psychological–biological interactions, which worsen the condition of the person or population afflicted.

Syndemic risk factor
Social, political, economic, and environmental factors that increase the risk for clustering of two or more diseases.

Syndemogenesis
The processes, pathways, and stages of syndemics development involving a disease–social context and disease–disease interactions.

Iatrogenic syndemic
A syndemic interaction caused or exacerbated by medical treatment, as occurred in Egypt with campaigns to inoculate against schistosomiasis using hepatitis C virus-infected intravenous tartar emetic;[9] or, medical treatment for one disease is weakened by the actions of another disease.

Countersyndemics
When one biological trait, disease, behaviour, or social condition provides a protective benefit against other disease interactions, as seen in the protection from potentially lethal Rocky Mountain spotted fever that can be conferred after exposure to *Rickettsia amglyommii*.[10]

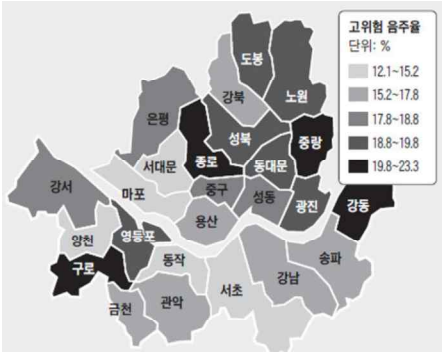
Unintended countersyndemic
When efforts to treat one disease improves the elimination of another.

Eco-syndemics
Extreme weather contributes to severe conditions that foster migration, the breakdown of built environments, and metabolism of pathogenic organisms that result in increased rates of growth and cell division, as well as other interactions.

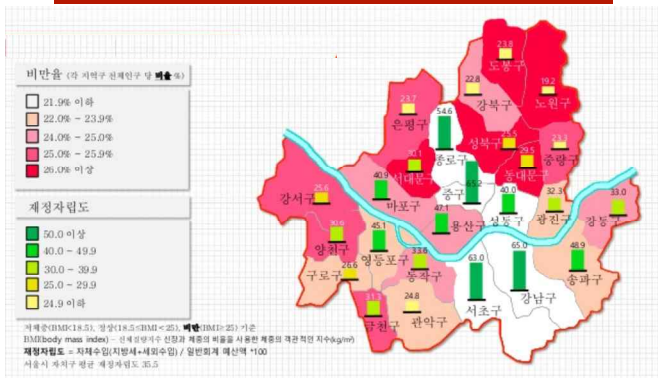
Syndemics of war
War and conflict are traumatic biosocial events that compromise existing conditions and health-care access, thereby increasing the likelihood of disease clustering and syndemic interaction.

서울이 같은 서울이 아니다?

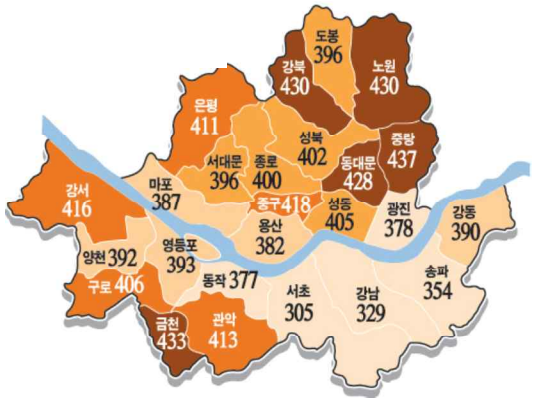
자치구별 음주율



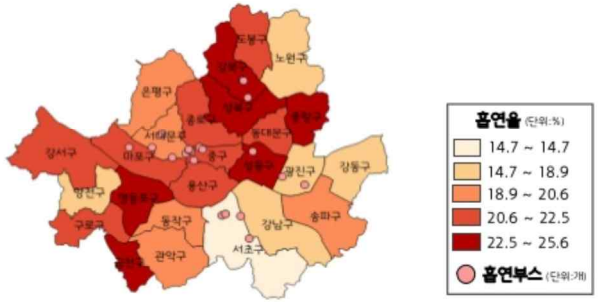
자치구별 비만율과 재정자립도



자치구별 사망율

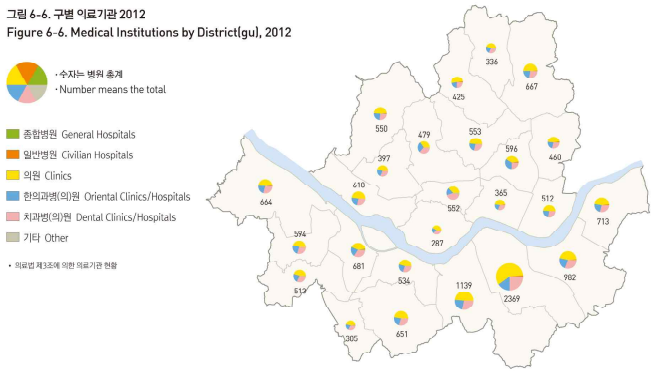


자치구별 흡연률

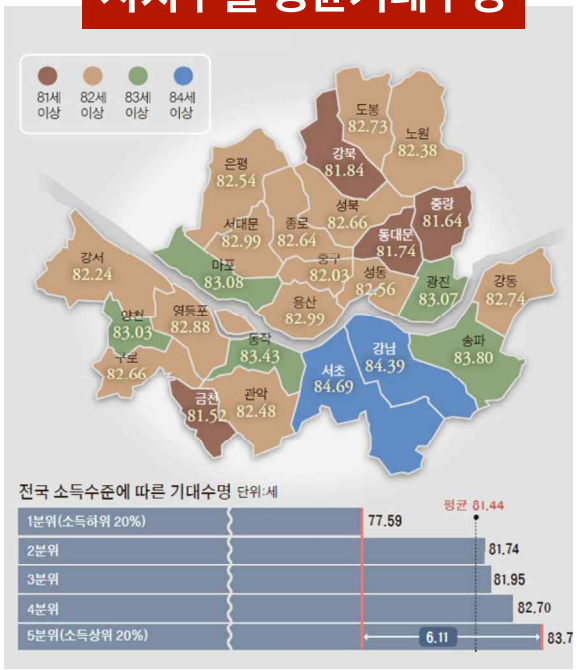


* 서울시의 흡연부스는 26개에 불과하고 높은 흡연율을 보인 6개 지역구에도 단 3개 뿐
* 흡연자들을 위한 실외 흡연구역이 **매우 부족** → 실외 흡연구역 추가 설치 필요
* 서울시, "실외 흡연구역을 만들 계획은 가지고 있지 않다" → **간접적 해결 방안** 필요

자치구별 의료기관



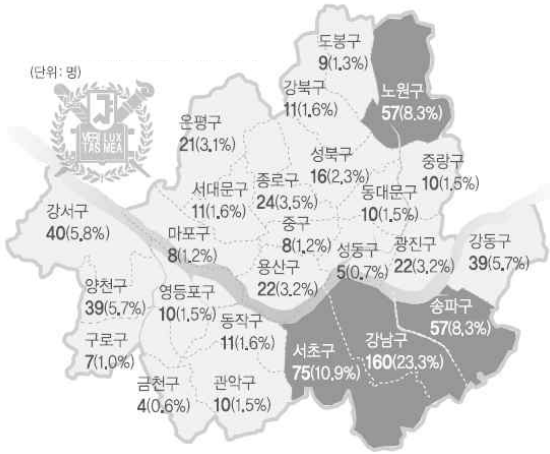
자치구별 평균기대수명



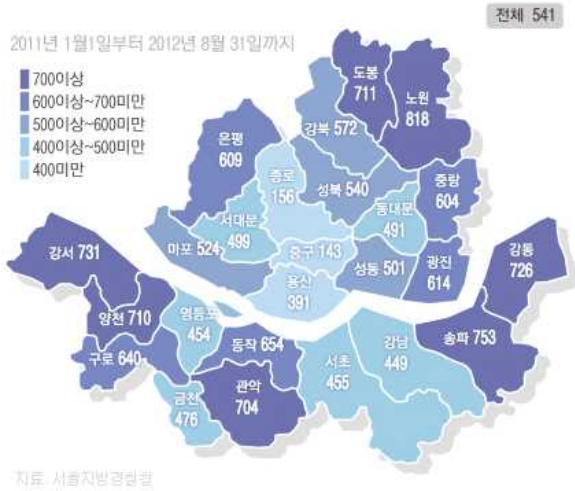
서울이 같은 서울이 아니다?

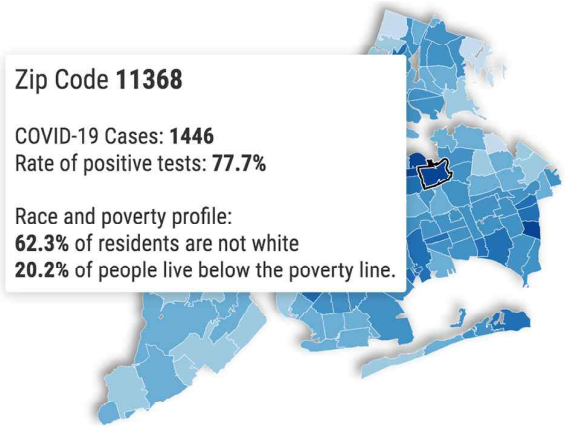
자치구별 재정자립도

자치구별 서울대 합격자수



자치구별 경찰1인당 인구비율

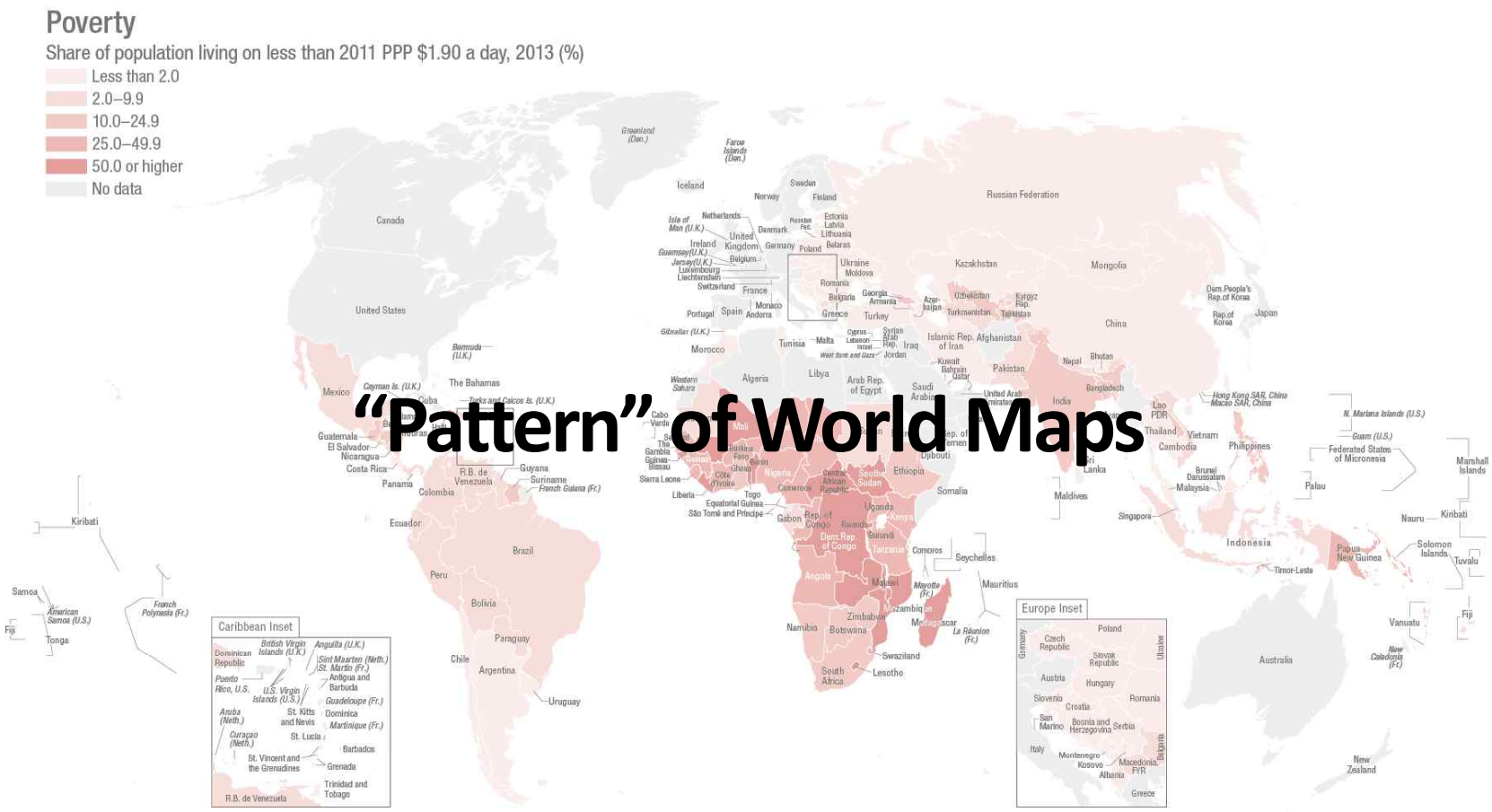




YONSEI UNIVERSITY COLLEGE OF MEDICINE

건강한 삶은 어떻게 결정되는가?

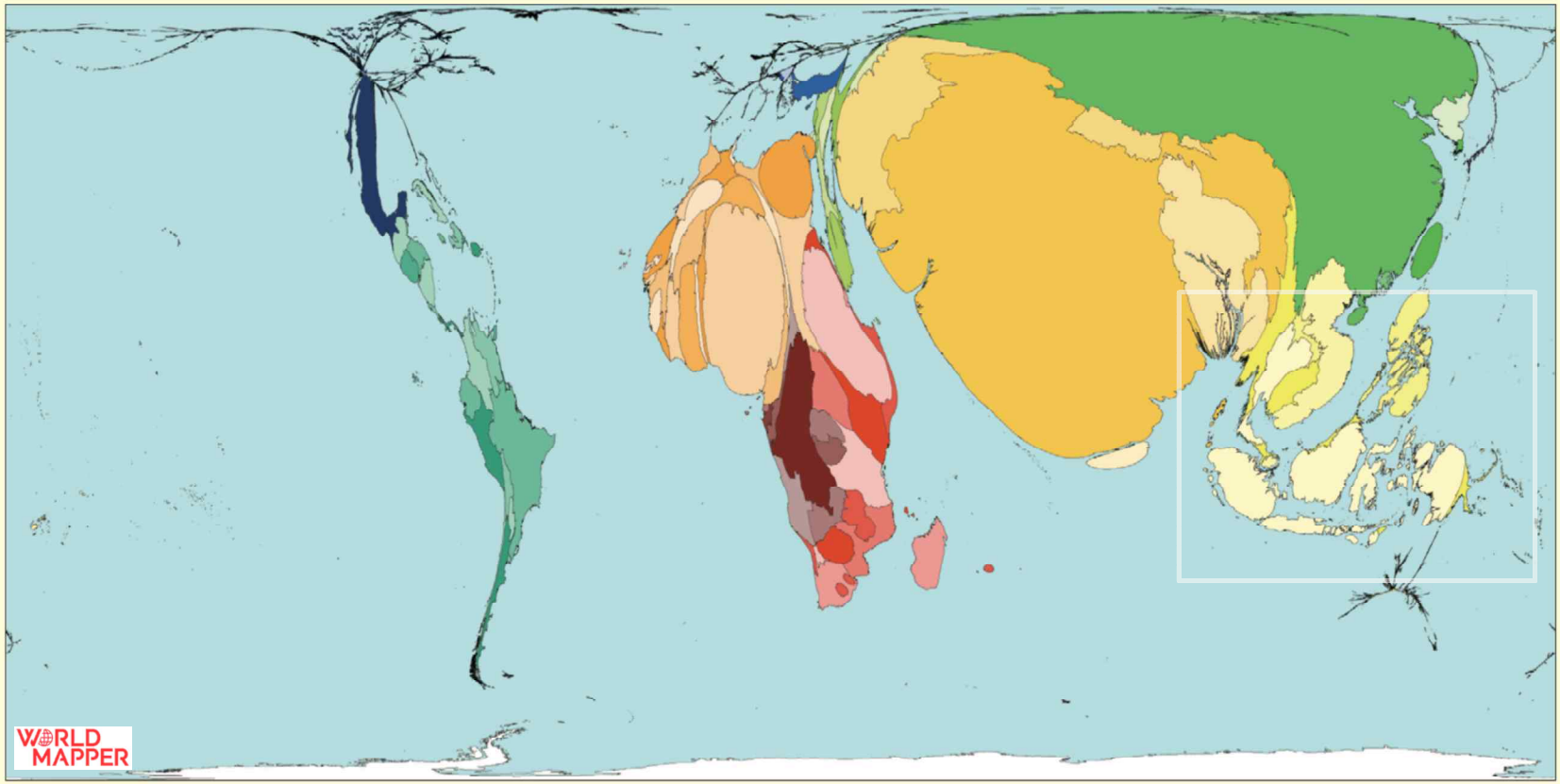
공동체의 건강은 나의 건강과 연관되고,
사회가 지속가능해야 나도 지속가능하다.



"Pattern" of World Maps

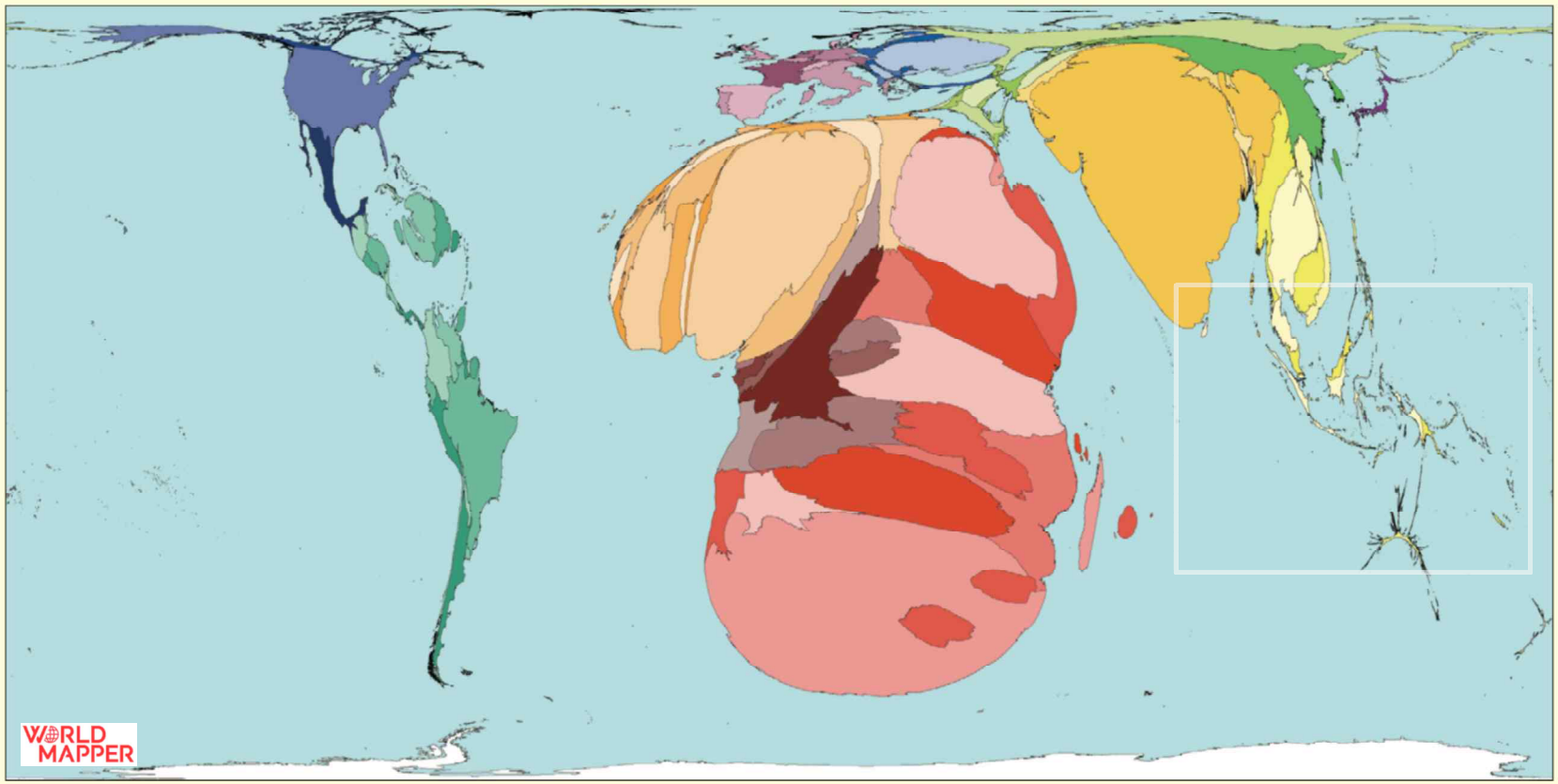
Source: World Bank

Absolute Poverty



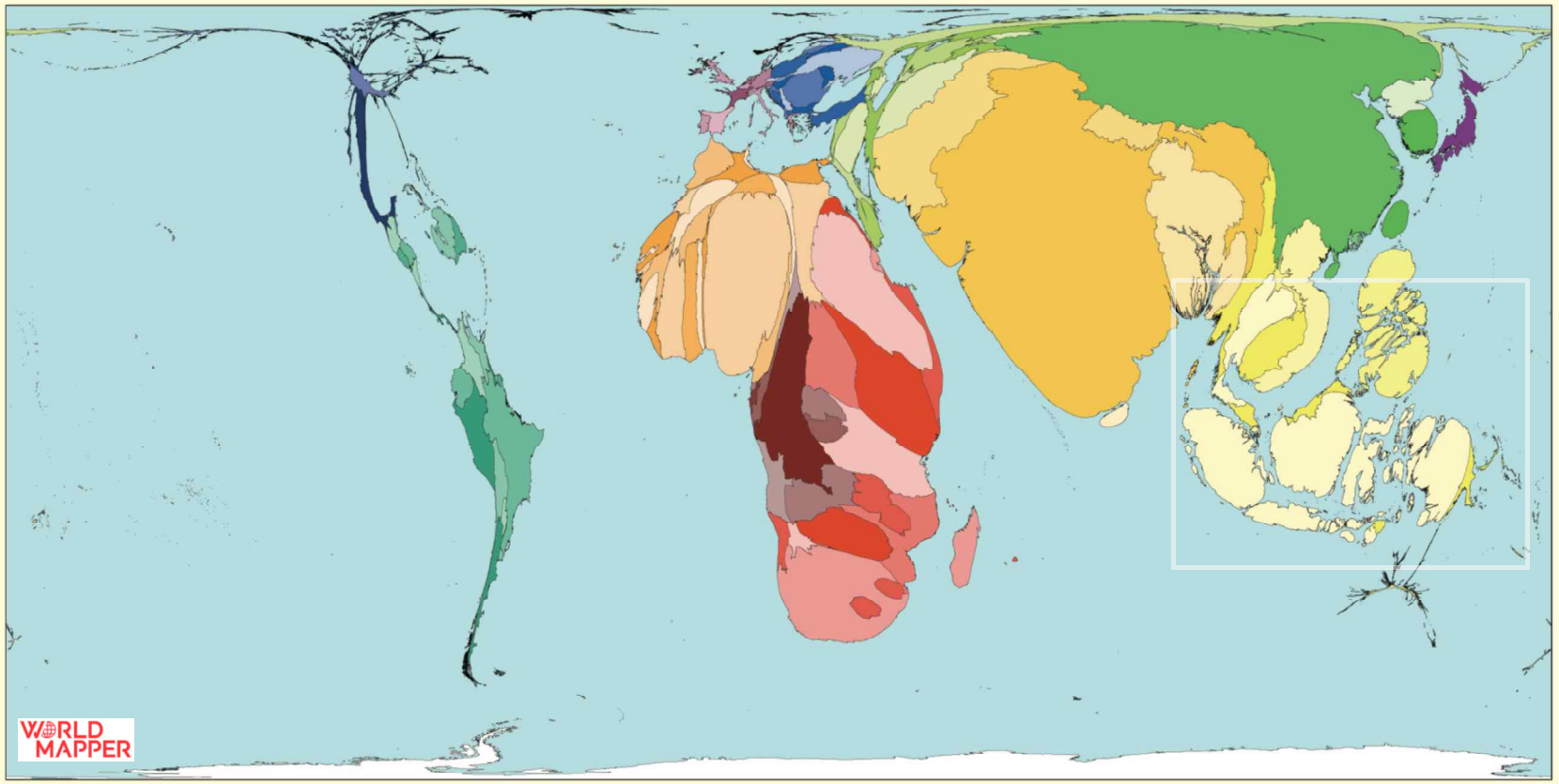
Source: World Mapper
www.worldmapper.org/display.php?selected=180

HIV Prevalence



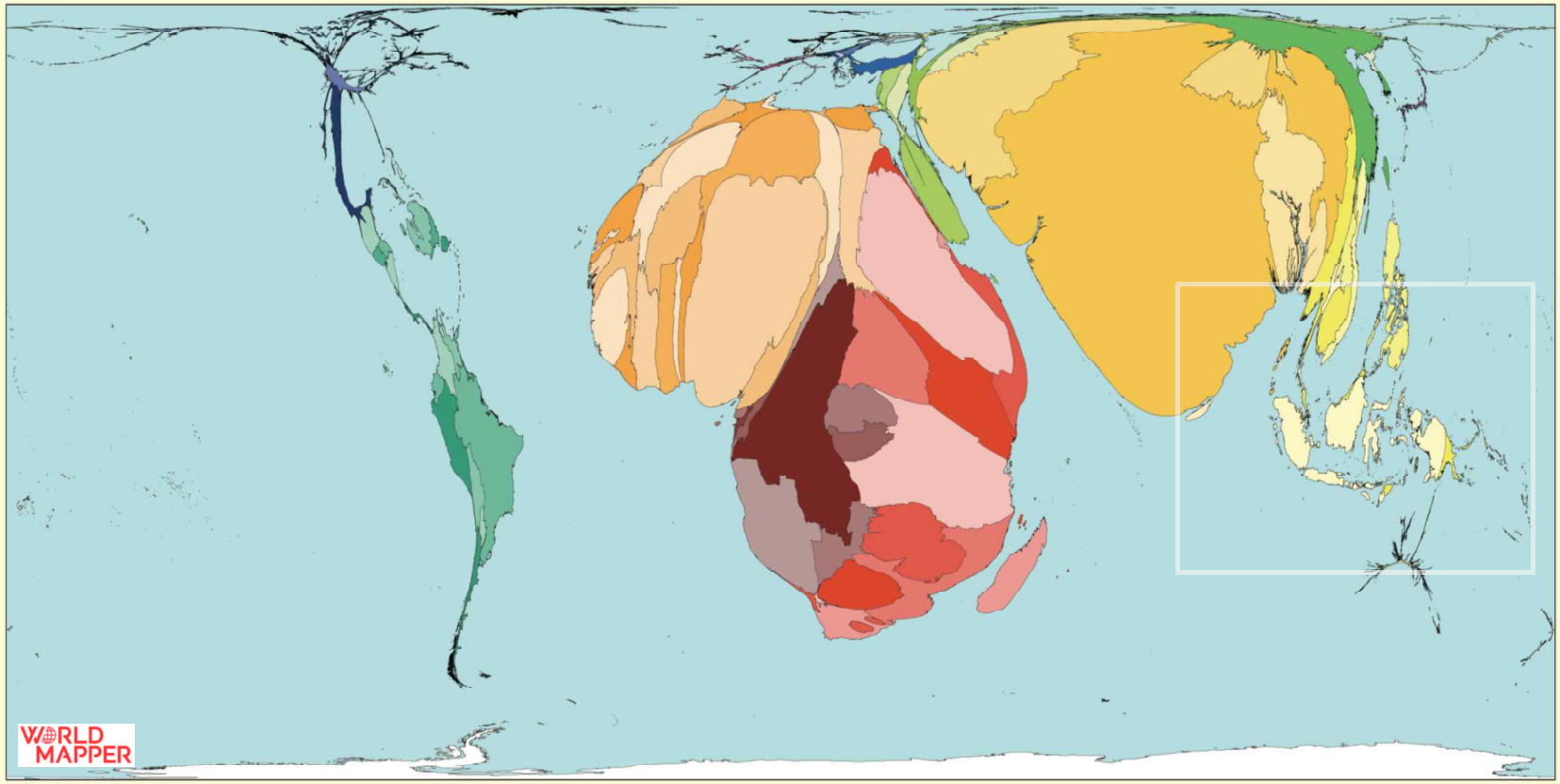
Source: World Mapper
www.worldmapper.org/display.php?selected=227

Tuberculosis Cases



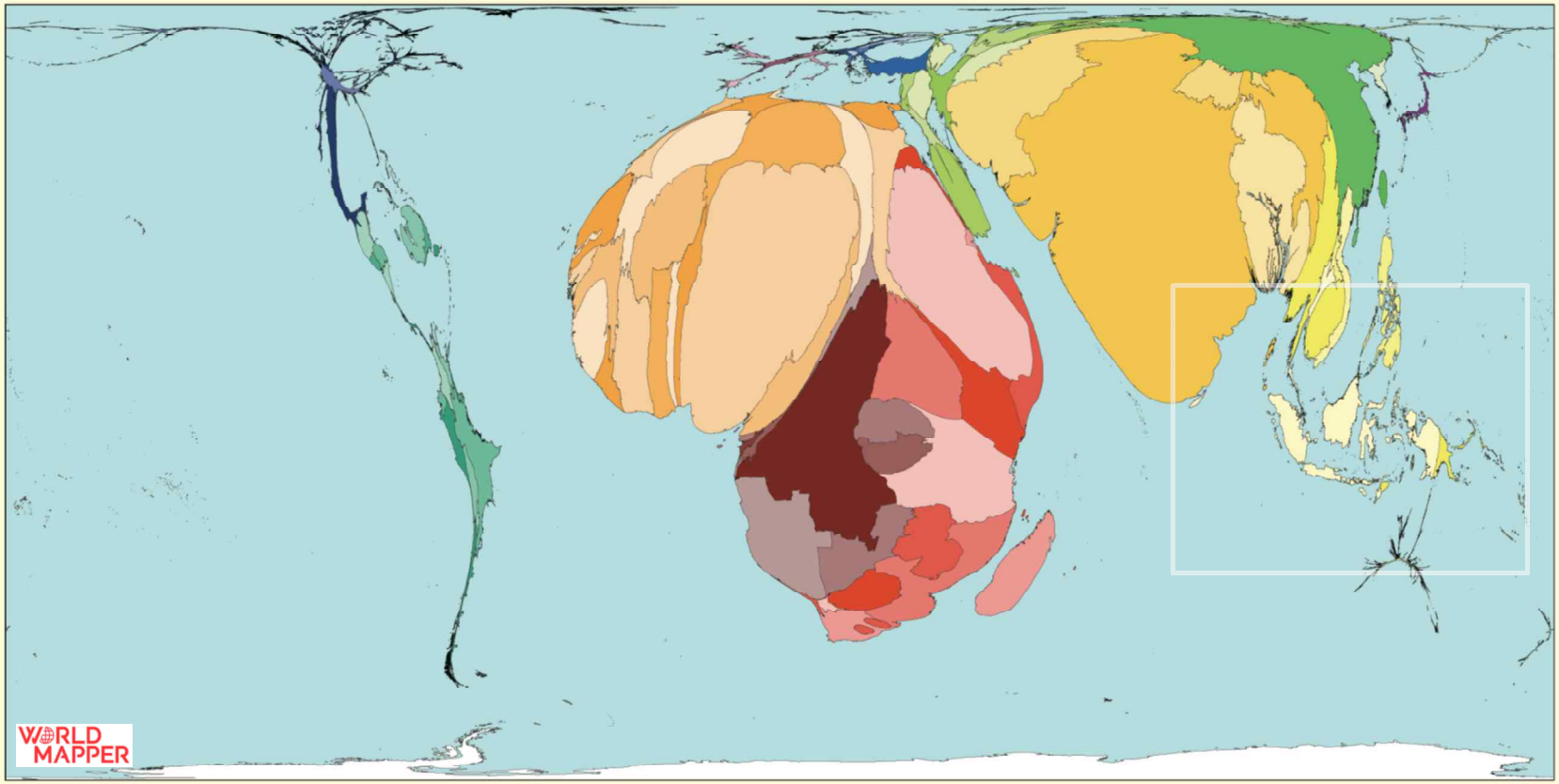
Source: World Mapper
www.worldmapper.org/display.php?selected=228

Maternal Mortality



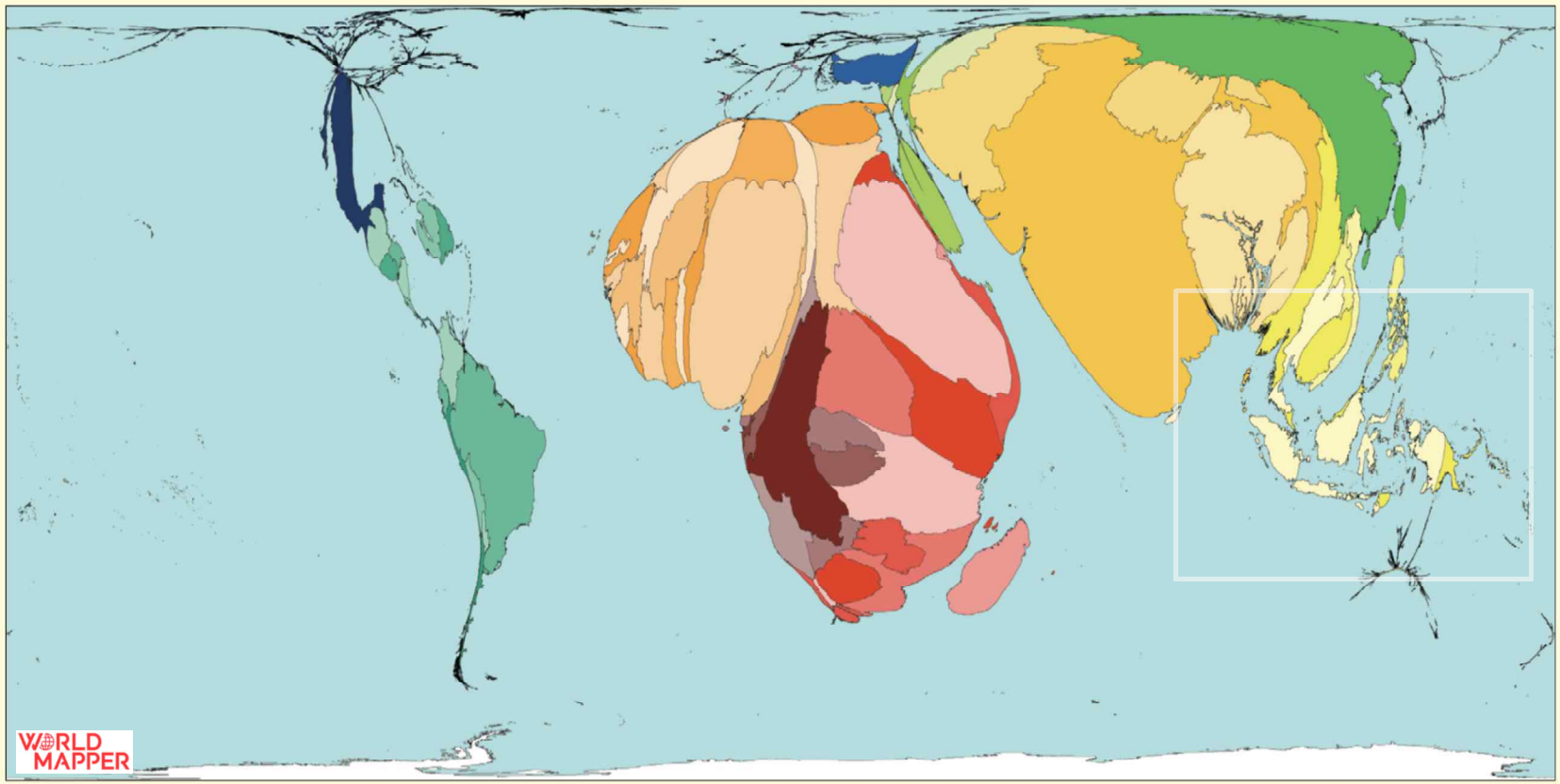
Source: World Mapper
www.worldmapper.org/display.php?selected=258

Mortality 1-4 Year Olds



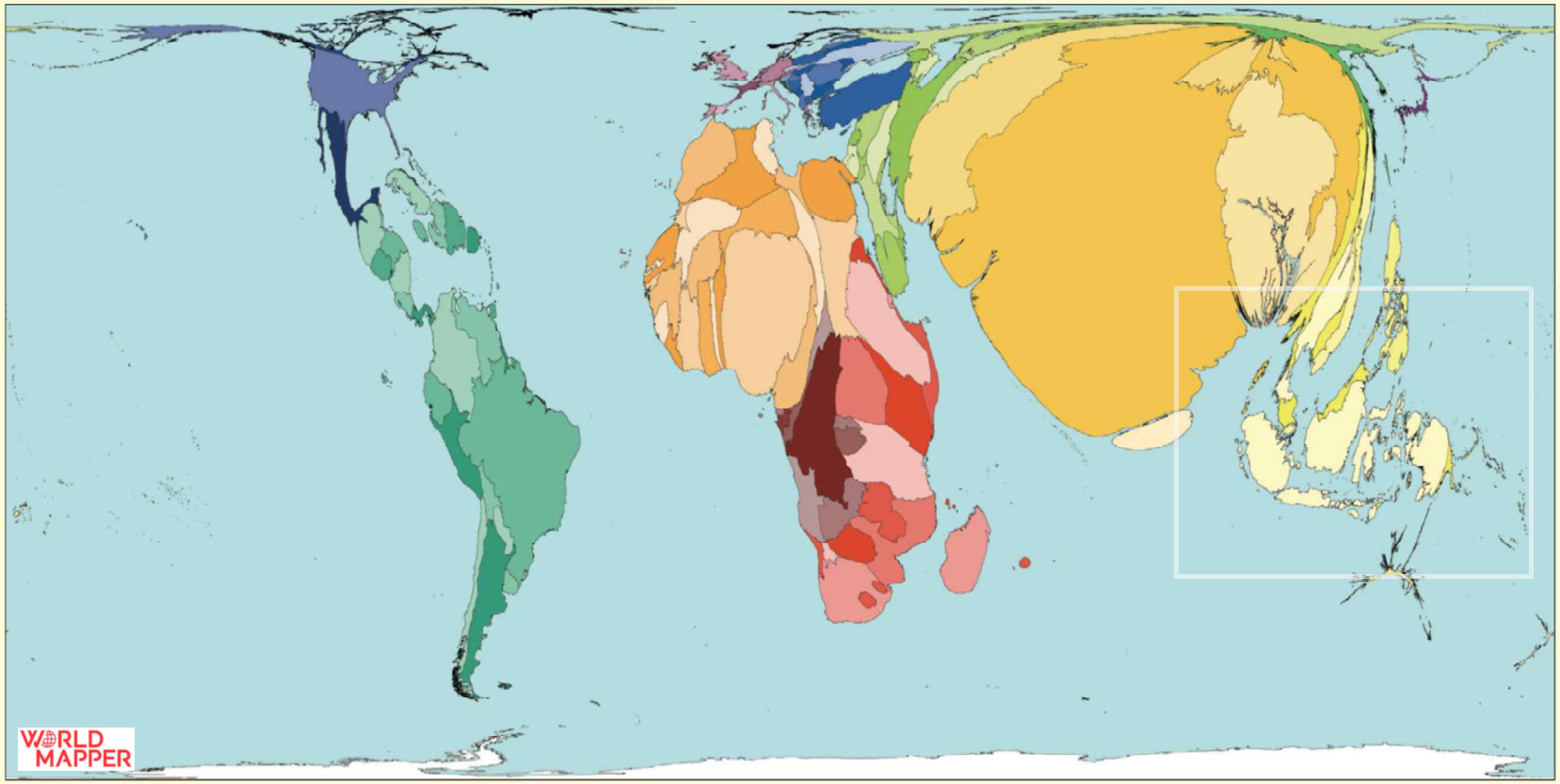
Source: World Mapper
www.worldmapper.org/display.php?selected=263

Child Labour



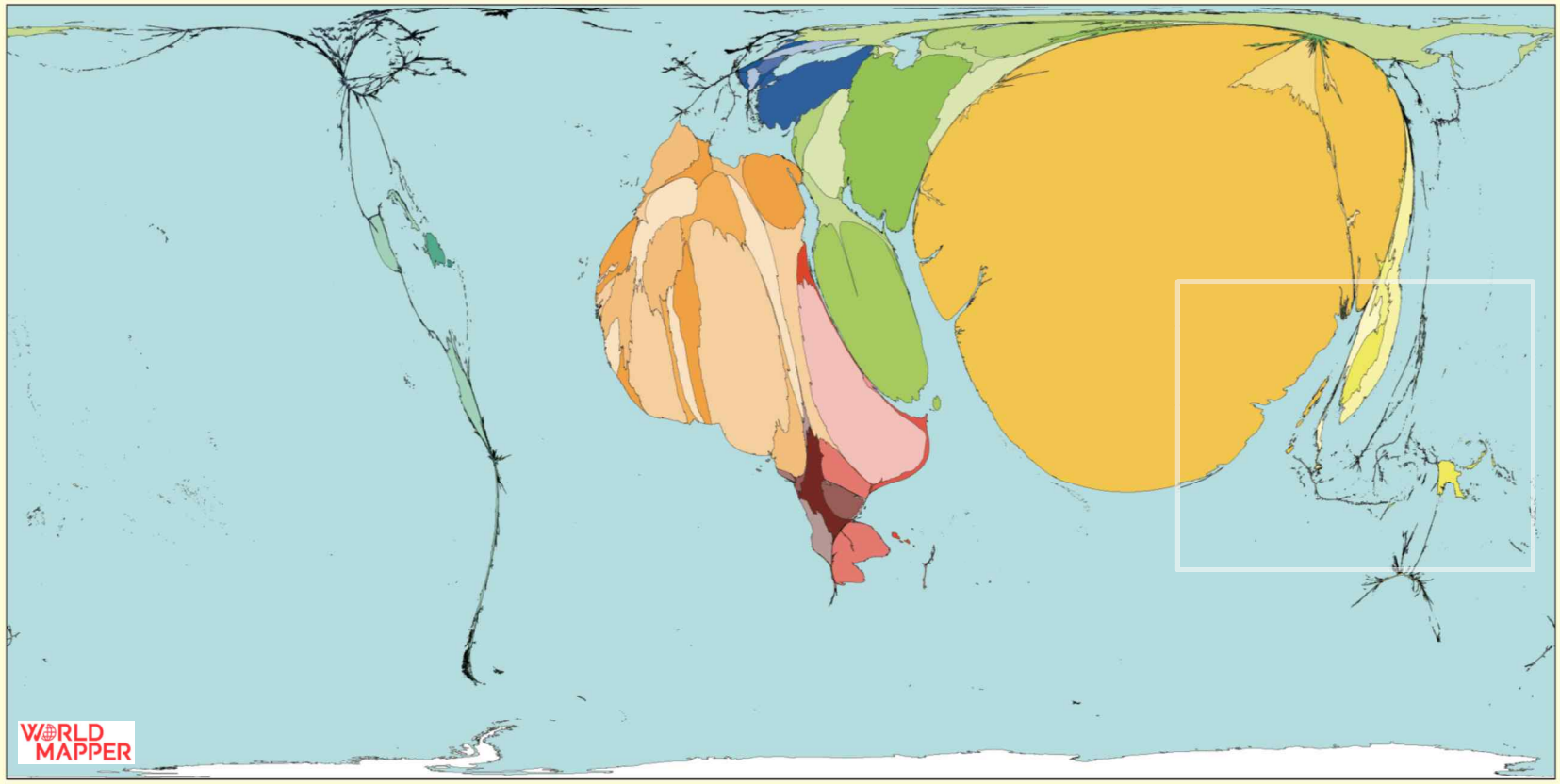
Source: World Mapper
www.worldmapper.org/display.php?selected=135

Teenage Mothers



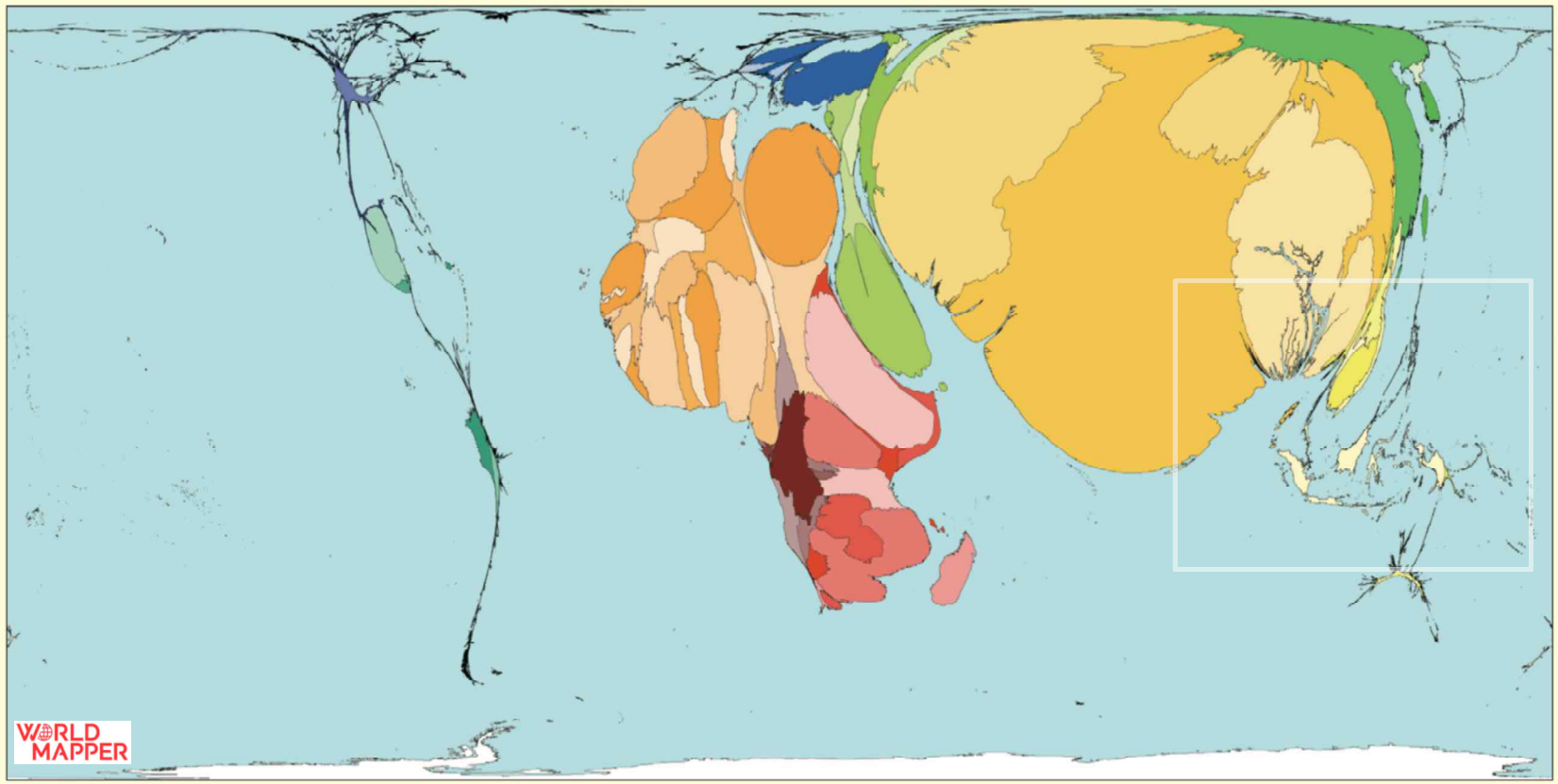
Source: World Mapper
www.worldmapper.org/display.php?selected=136

Girls not at Primary School



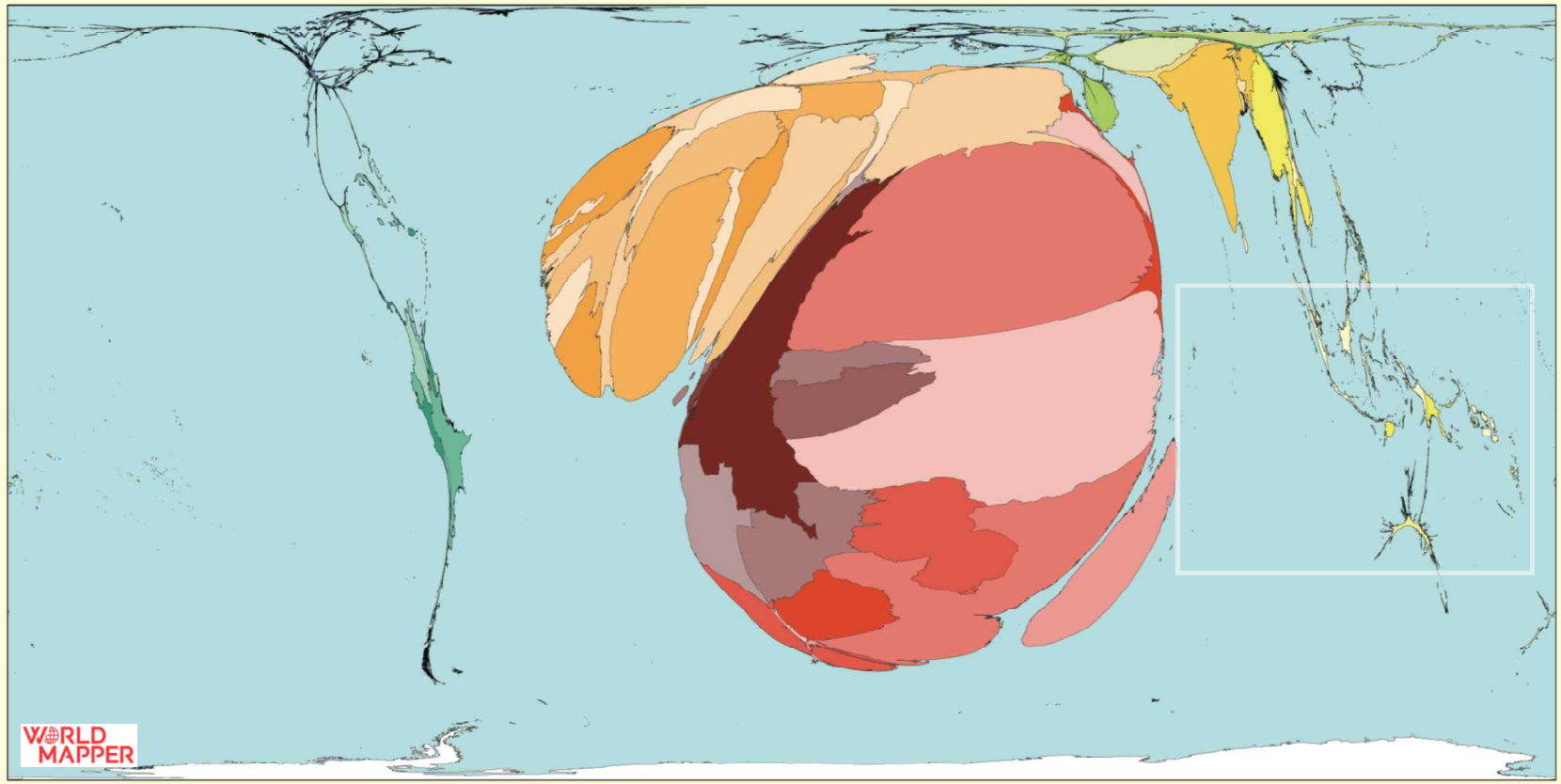
Source: World Mapper
www.worldmapper.org/display.php?selected=201

Illiterate Young Women



Source: World Mapper
www.worldmapper.org/display.php?selected=197

Malaria Cases



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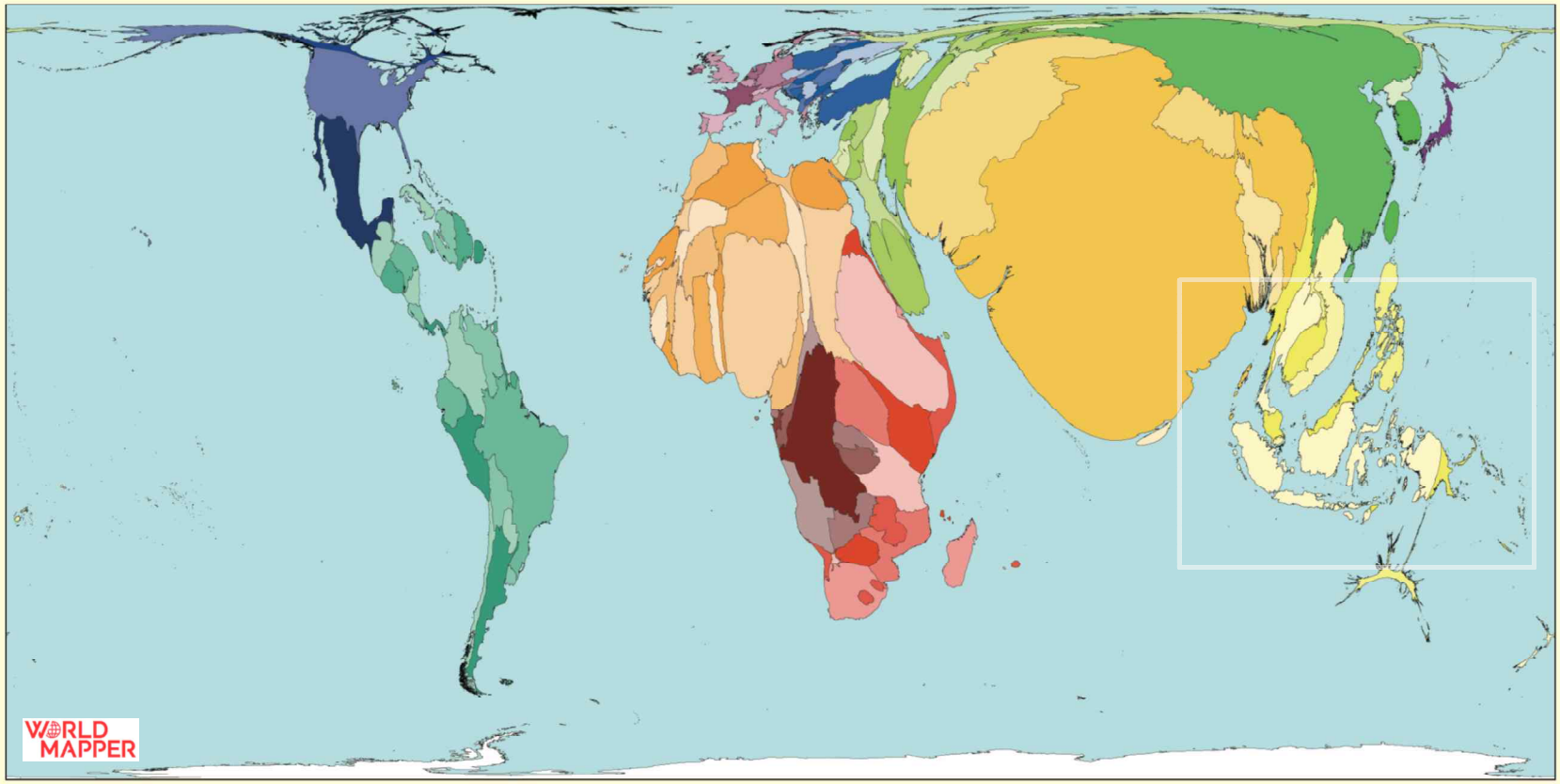
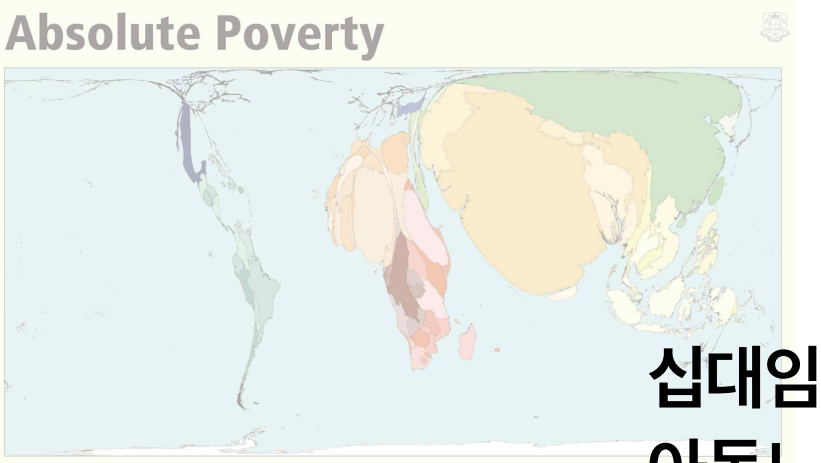
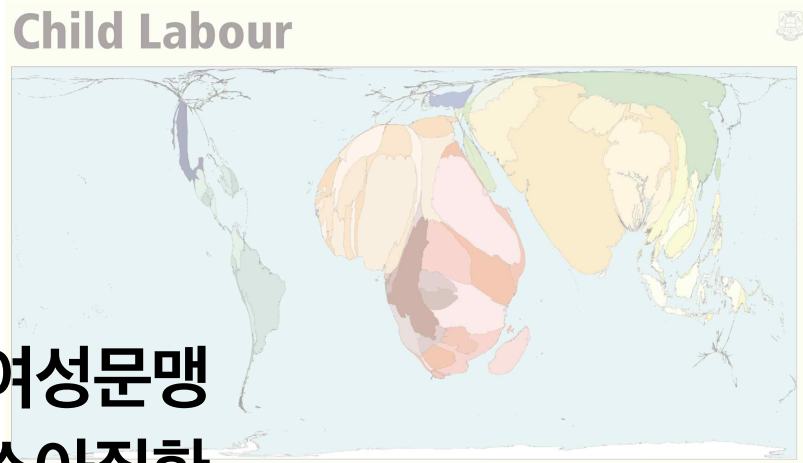
Childhood Diarrhoea



www.worldmapper.org/display.php?selected=233

“Pattern” of World Maps

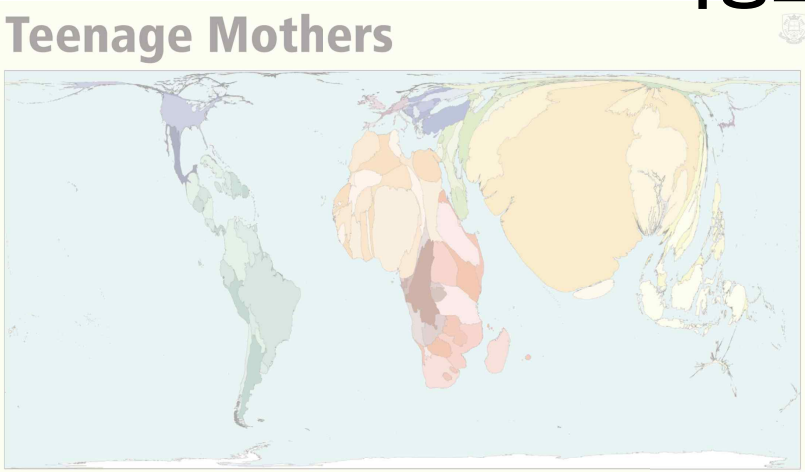


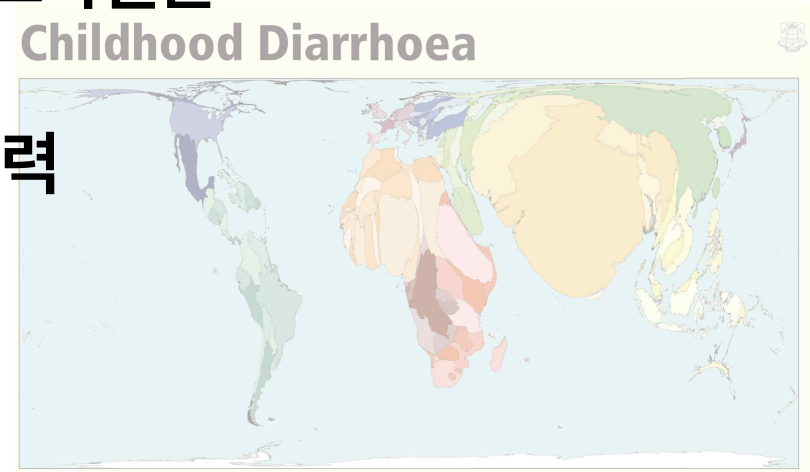


절대빈곤

십대임신-모성사망율-여성문맹

아동노동-아동사망율-소아질환





특정질환-의료인력

“Pattern” of World Maps

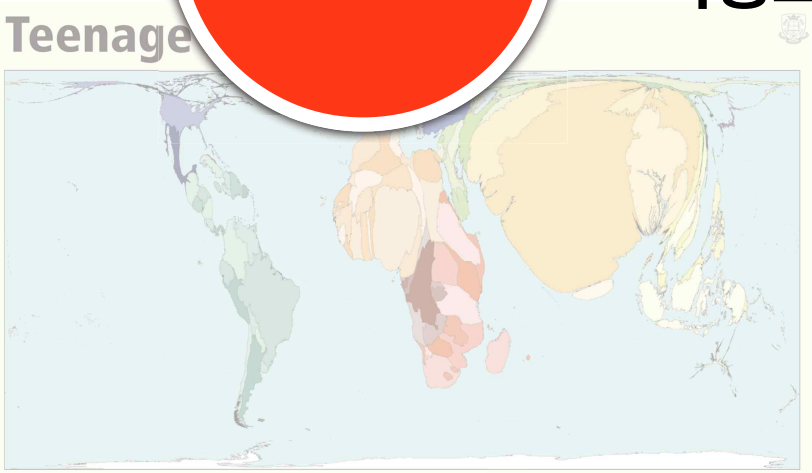
여성

절대빈곤

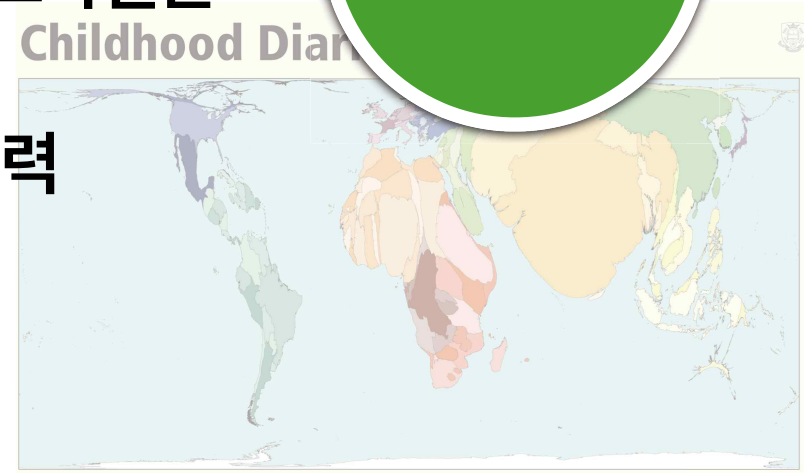
십대임신-모성사망율-여성문맹

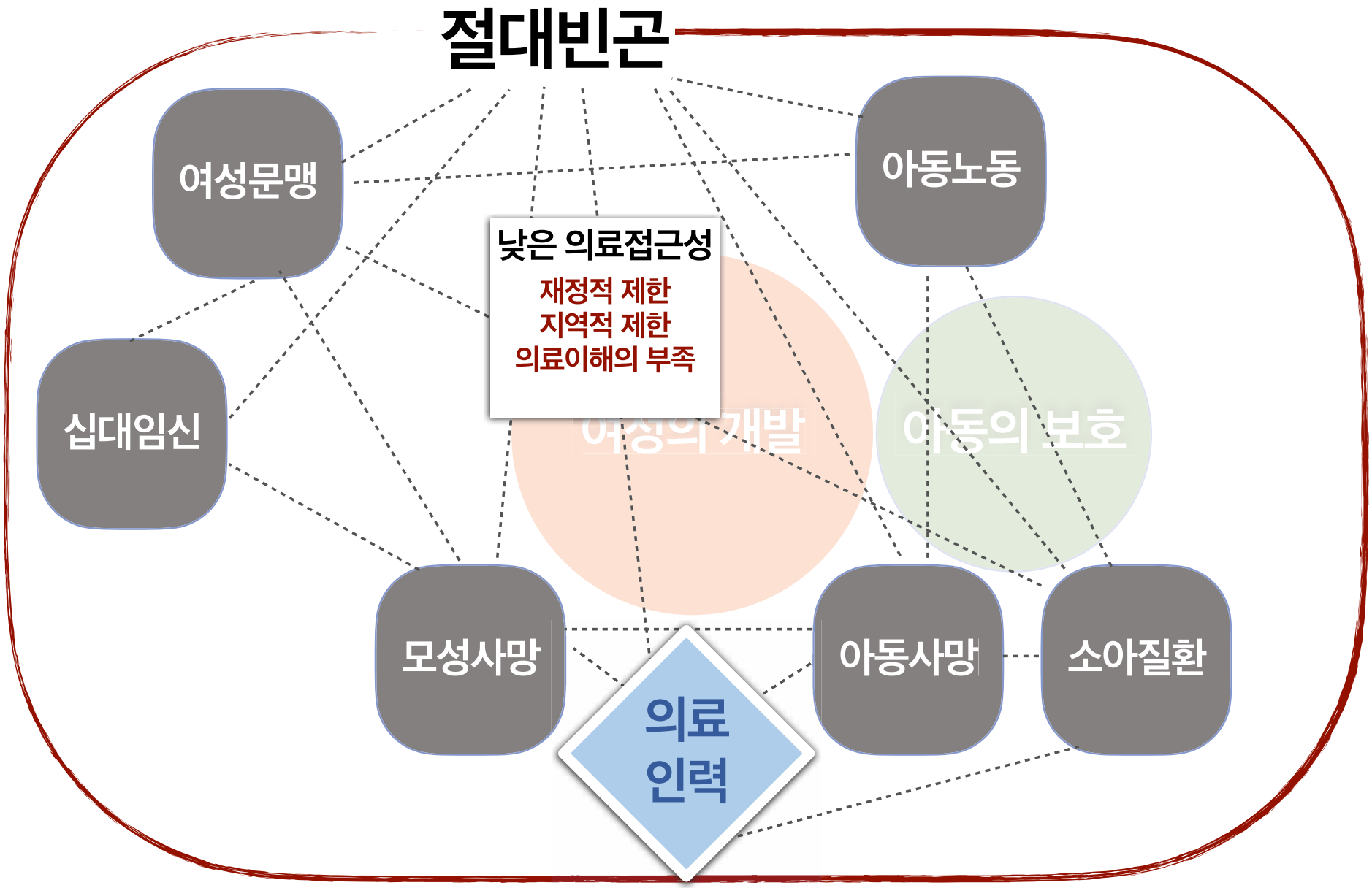
아동노동-아동사망율-소아질환

아동



특정질환-의료인력




절대빈곤
여성문맹
아동노동
낮은 의료접근성
재정적 제한
지역적 제한
의료이해의 부족
십대임신
여성의 개발
아동의 보호
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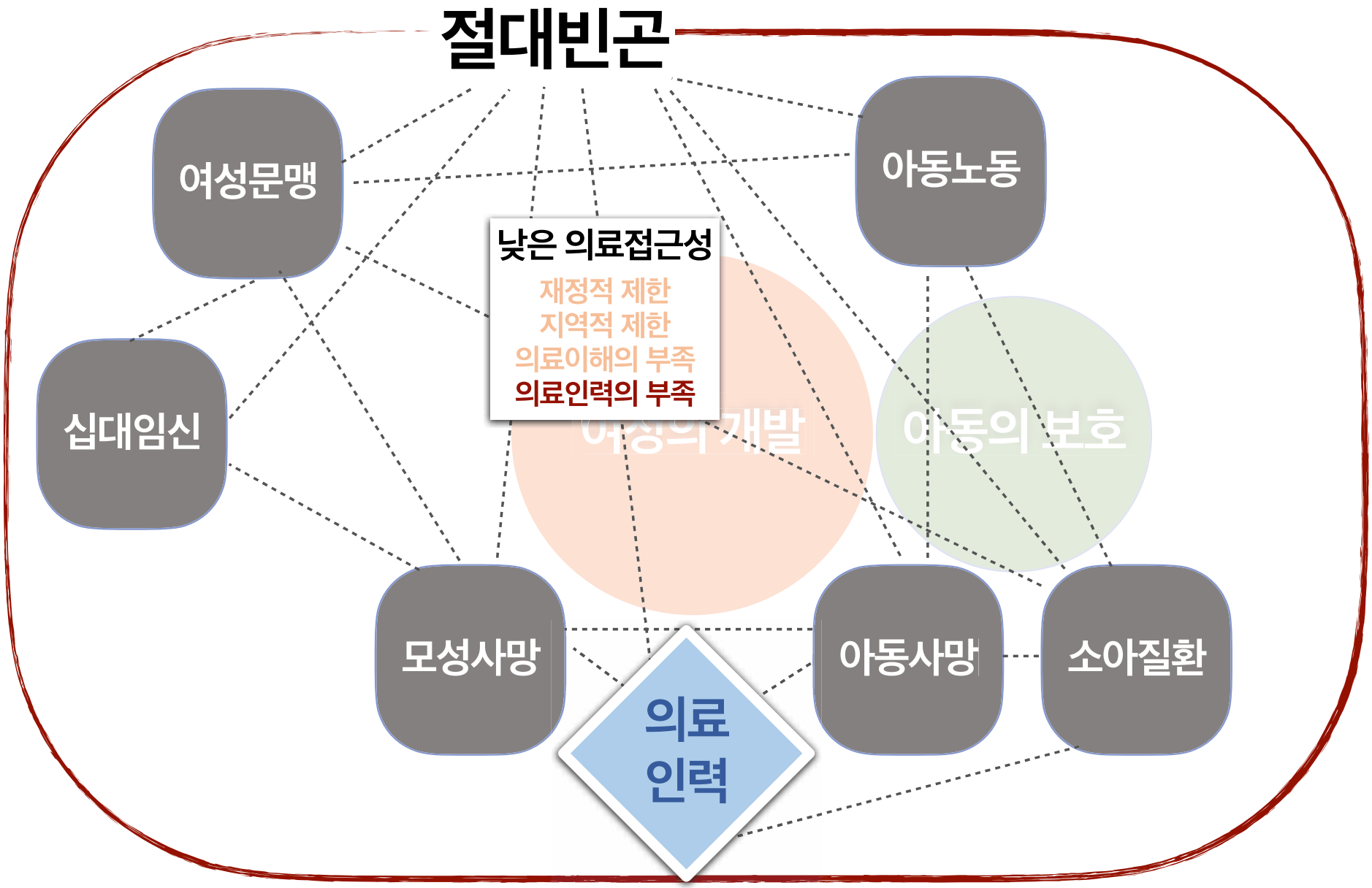
소아질환
의료
인력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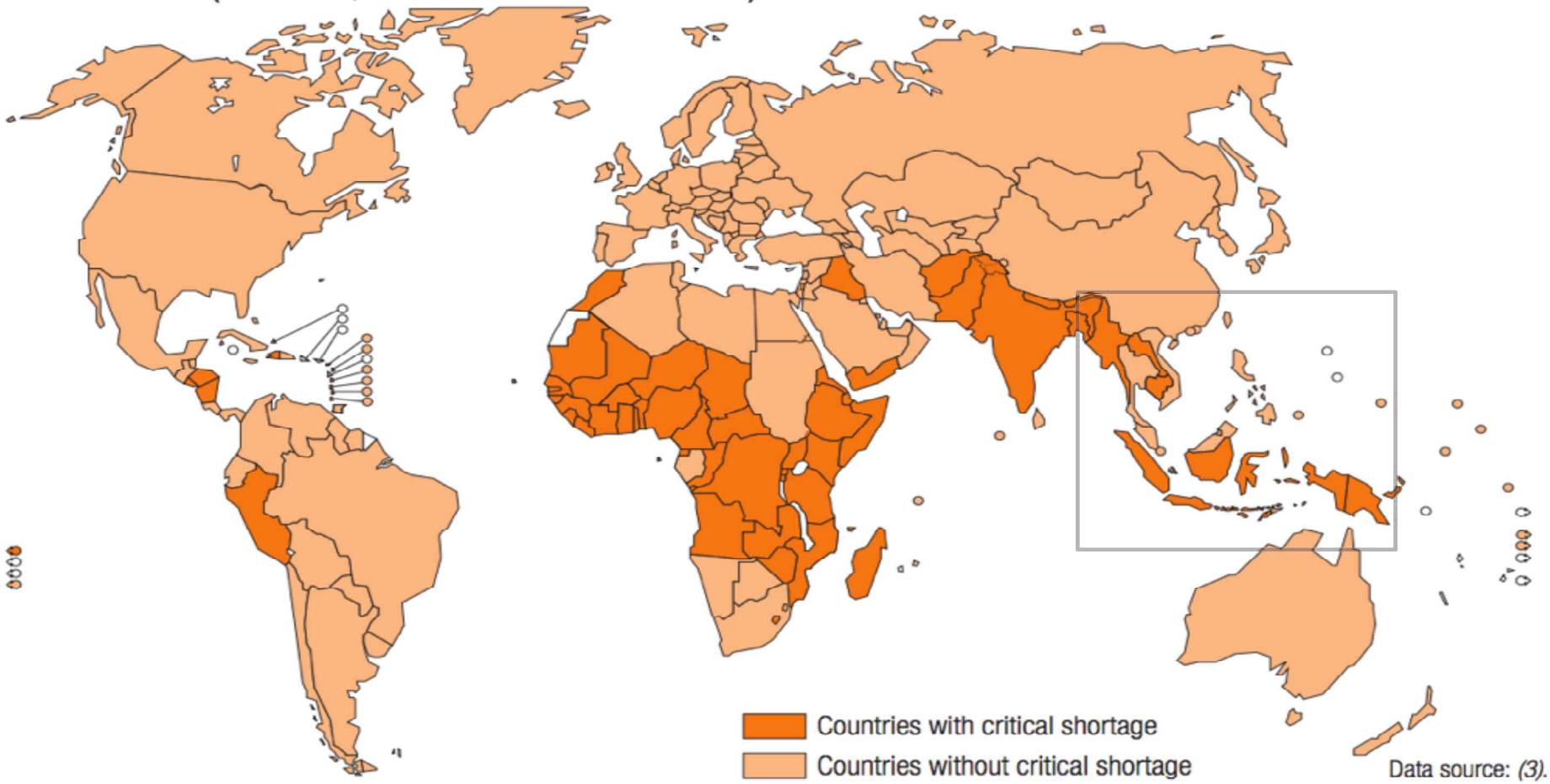
아동사망
소아질환
의료
인력

Figure 1.5 Countries with a critical shortage of health service providers (doctors, nurses and midwives)

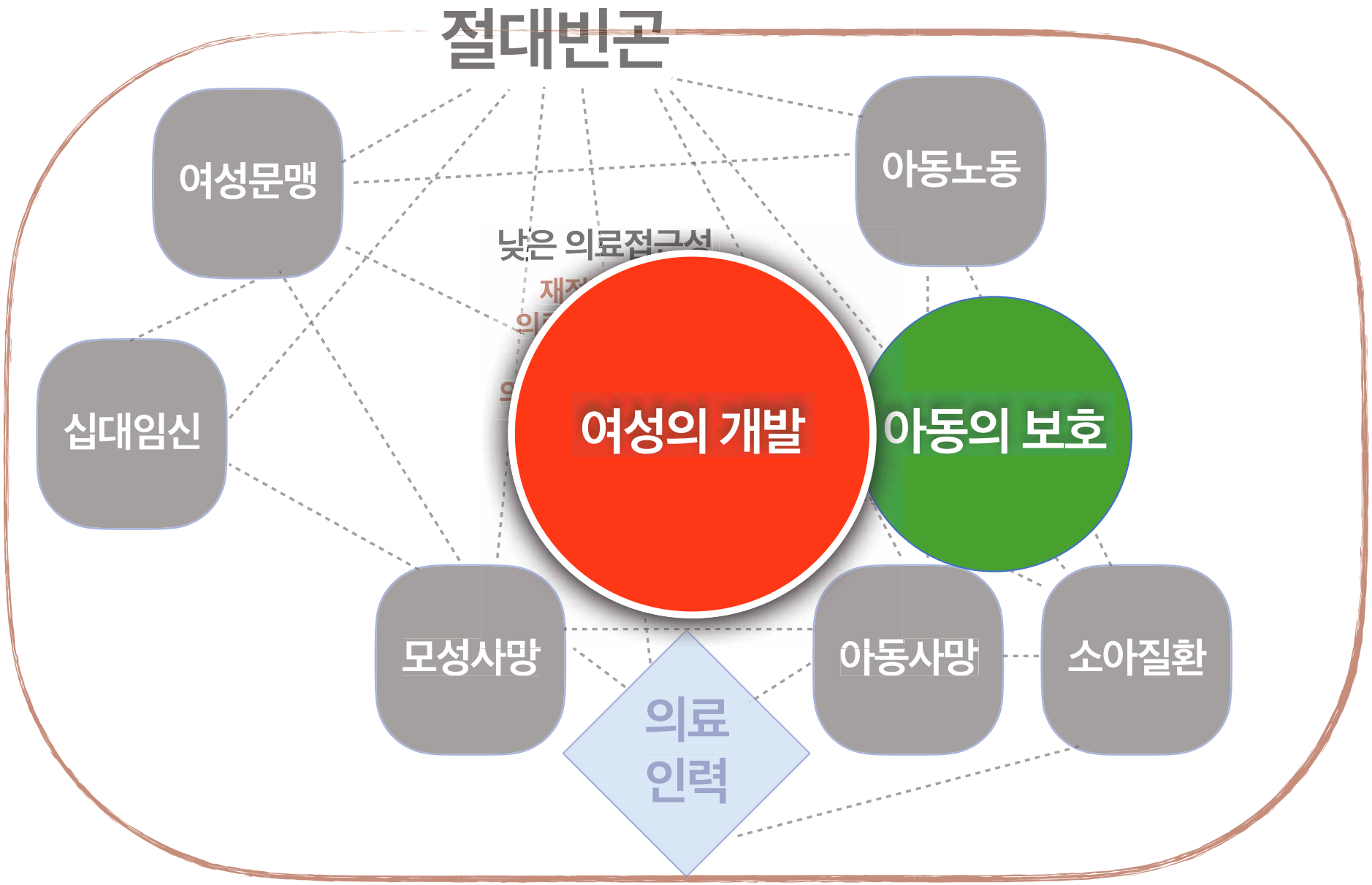


A UNIVERSAL TRUTH:

NO HEALTH WITHOUT A WORKFORCE

There is a current deficit of about 7.2 million skilled health professionals. A projection model driven by population growth would lead to a global deficit of about 12.9 million by 2035.

숙련된 보건 전문가들의 부족은
현재 720만명 정도이다.
인구성장을 고려한 예측모델에 의하면
2035년까지 전세계적으로
약 1,290만명이 부족하게 될 것이다.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아동사망
소아질환
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인력