FROM THE THIRD GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE: SPECIAL INITIATIVES FOR PERSON-CENTERED CARE

Bulgarian Person-centered Public Health Project: towards the introduction of the person-centered care model in global medical education politics

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Abstract

According to our analysis, contemporary Global Education Politics (GEP) in Medicine is still dominated by a technocratic cognitive framework and content. For this reason we view it crucial to develop a novel educational framework for graduation in medicine with the Person-Centered Care concept implemented within it, as formulated by Juan E Mezzich and informed by the comprehensive assessment and values-based medical practice, developed by Bill (KWM) Fulford. Some of the outstanding training programs in medicine, dentistry and public health are already designed according to this novel approach. Key elements in the curriculum include:

- Society's Health and Ethics (Ethics and Public Health, pointers of values-based practice, values, evidence and ethics);
- Health research with a major focus on epistemology and methodology;
- Personal Life Psychology (life cycles, relationships, cultural diversity, lifestyle planning, stress management);
- Adverse life events (breaking of bad news, disability, grief and bereavement, euthanasia, suicide);
- The doctor-patient relationship (patient-centered consultation, problem solving and critical thinking, dealing with uncertainty and professional mistakes).

Global medical education may be characterized by progress from facts-based (evidence) to integrative values-and-facts-based clinical education and management. If this is considered with respect to the Bulgarian medical model, which was designed according to German and Russian philosophies in the previous century, then there is a challenging, but nevertheless advantageous opportunity, for a reassessment of the model. In the context of the international movement for person-centered medicine, Bulgarian public health institutions are facing the demand for a proactive adjustment of the medical curriculum with the requirements of the global strategy for an introduction of this model in medical education and postgraduate training.

Keywords

Bulgarian medical model, ethics, formation of physicians, human relationships, medical education, person-centered medicine, evidence-based medicine

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Introduction

Contemporary processes, as well as dynamic innovations in healthcare, introduce a global model based not only on science (evidence) but also on values [1,2]. This emphasizes the need to consider a number of requirements in medical education and training that regard not only the academic achievements of medical students as important, but also that other personal capacities be regarded as

significant features of the medical profession [3]. The World Health Organization (WHO) promotes novel political priorities concerning global revision of the international standards for healthcare practice in two major dimensions: construction of a conceptual platform for introduction of an integral diagnostic and classification system and expanding of the comprehensive assessment as a mainstream for achieving person-centered care [4]. The ICD-11 outline includes prototypes of diagnostic units instead of the current small categories. Thus, emphasis is given to different tools for the humanistic assessment and management of health issues, such as the narrative of the patient.

These global trends, as well as an awareness of the ongoing dehumanization of medicine, impose new models and approaches for the education and training of students in medicine. Accordingly, medical education is at the threshold of a worldwide, large scale reform. The distinctiveness of the medical profession as a humanistic, creative and high risk endeavour, indicates the need for a value program for achievement of a creative and spiritual excellence in medical students. In these contemporary, sophisticated, dynamic and controversial times, it is of the utmost social significance to encourage value formation in medical education. Indeed, the commitment of the medical profession to an humanistic ideal is increasingly questioned [5], necessitating revisions to current educational models, including a higher level of bedside teaching.

The patient and the person-centered approach

Respect for the patient necessarily implies respect for his values, beliefs, desires, expectations and inner needs. The contemporary patient is aware, must be aware, of his rights as well as of the obligations of the physician. Therefore, he must be properly informed and encouraged to take an active part in the recovery process and in the planning of diagnostic and treatment procedures. The person-centered approach provided an opportunity to consider the bio-psychosocial uniqueness of the patient and not simply to treat his "disorder" only. This includes a strong consideration of environment and lifestyle and appropriate training for comprehensive assessment of personal attitudes.

Bringing to life such an educational project demands the capacity for critical reasoning from the medical professional. One possible way to achieve this is to expand training in humanities and social sciences (*philosophy, ethics, psychology, history, pedagogy).*

Clinical practitioners must reflect on the social and community values that are important to patients and these must be given meaning through the contents of the training program and introduced into practice via "values based medicine" tools [6,7]. It is essential that there is an awareness of the interconnection of knowledge and skills in the education process. As we know, there is a serious discrepancy between theoretically learned 'knowledge' and the relevant individual and group capacity for induction and realization in practice. For instance, it is difficult for some clinicians to be tolerant and to develop the ability to respect diversity. The role of humanities in medical education is to create a "shortcut" to the "understanding of meaningful experiences" of the patient. This approach is necessary to reverse the dehumanization of medicine.

Acknowledging patients' perspectives in provided services depends on the motivation and attitudes of the providers. To provide acceptable health services tailored to the needs of patients, healthcare providers must recognize and comply with the specific needs of vulnerable social groups. However, the ideal of health providers being institutionally and culturally compelled to act in the best interests of their patients, discarding their own personal bureaucratic and financial gains, is often contradicted by reality [8].

Ideal models of doctor-patient relationships and roles have to date proved to be unachievable to a great extent because of the traditionally ineffective systems of educational socialization of medical students, with a failure to achieve professional affective neutrality and egalitarian universalism resulting in discrepancies in healthcare delivery and outcomes. Sociologists have long conceptualized the institutional character of medicine as determined by social norms, values and practices, providing blueprints for professional behavior and institutional policies with a special focus on organizational changes in healthcare delivery. The processes of medicalization, depersonalization and fragmentation of healthcare which follow negatively affect patients [9]. Patient experience – and how it differs from illness experience – is another major focus of research in medical sociology, based on the social construction of illness and medical knowledge [10].

This perspective makes understandable the demand for an opening of the educational agenda in medical schools to social sciences and the argument for the adoption of multidisciplinary approaches, defying the dominant and deterministic understanding of disease and illness.

The introduction of such modules, although not always welcomed in the curriculum, has proven effective in nursing education. The experiences of countries where such programs are key components in pre-registration nurse education suggest that it may effectively help in bridging the gap between biomedical and societal perspectives and help students understand the social determinants of health and evaluate their professional roles and responsibilities in a dynamic and challenging environment [11].

The knowledge of 'facts' (or 'evidence-based' knowledge) is undoubtedly important to preserve the social and economic efficacy of education in medical school. Simultaneously, the study of humanities and the social

sciences is a premise for the development of beneficial moral models of behavior in order to "heal" the very system of health services. At the present, as is well known, it is not so much a matter of moral deficit, but rather a substitution of traditional moral values. There is a necessity to form the sense for social and cultural values in medical students, grounded on the authentic interests of the patient himself and society in general.

Didactically, one possible technique for introduction of the person-centered (or person-oriented) approach is problem-based learning and role exercise [12-14]. Problem-based learning gives the medical student the competence to solve high-priority health care problems and to develop critical professional thinking in non-conventional situations in clinical practice [15,16]. In turn, it gives the evolutionary and multi-disciplinary scope of knowledge and understanding of values and fact interference and enables students and clinicians to take responsibility for their professional decisions/mistakes. The introduction of role play exercises is a technique intended to promote learning and to enhance professional motivation and independent reasoning. Thus, role play techniques are regarded as a connection between theory and practice in the process of medical education. Inclusion of role play exercises representing true professional and social communicative roles, provides experience of situations with professional significance and/or value-normative character. The final effect of role play in the training of medical students is that which helps the conceptual consolidation of academic knowledge and information with the immediate personal experience of the trainees. Consequently, there are established opportunities for the formation of physicians with novel capacities to reveal human relationships with a patient and their team workers directed to the improvement of awareness and partnership with respect to human values.

We have previously examined one of the vanguard 'Master Med' programs that take place in the University of Pretoria (courtesy of CW Van Staden) [17]. The educational component of the curriculum: "People and their Environment" might be compared to other extensive modules, e.g. in anatomy or surgery. The topical structure of the program is completely attuned to the modern Global Politics in Healthcare Strategy for comprehensive assessment and person-centered care.

Conclusion

In the context of the above arguments and thanks to the efforts of the Section for Medical Pedagogy and Psychology, Department of Health Care Management, there was recently developed a similar program in the Medical University of Plovdiv, Bulgaria. It was derived from the conceptual prerequisites as previously discussed and based on the template of modern educational frameworks with relevant amendments and adjustments to Bulgarian academic and sociocultural reality. Following the framework of the guidance strategy of WHO, we named it "person-centered practice". Our educational product is geared predominantly to medical students along with such users as healthcare managers, students in sociology, ethnology, psychology and social management, etc. It is divided, as follows, into six modules with contributions from our group in the Faculty of Public Health, University of Medicine in Plovdiv:

- Society's Health and Ethics (Ethics and Public Health, pointers of values based practice, values, evidence and ethics of resource allocation);
- Psychology (communication skills, life cycles, relationships, cultural diversity, life style planning, stress management);
- Adverse life events (breaking of bad news, disability, grief and bereavement, euthanasia, suicide, substance abuse);
- The doctor-patient relationship (patient-centered consultation, problem solving and critical thinking, dealing with uncertainty and professional mistakes);
- Philosophy and view of life: philosophical anthropology and medicine
- Epistemology and research methodology in health sciences

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