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Humanitarian competencies of a doctor (cardiologist)

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The article reveals the features of working with the patient as a social and psychological subject, who, in addition to somatic pathology, has an experience of the disease situation. Psychosocial risk factors for cardiovascular (and more generally non-infectious) pathology, as well as social well-being as a component of positive health, are considered as elements of a doctor-patient relationship. Work with a person requires from a doctor competency that differs from working with pathology at a biological level. Perhaps, the time has come to single out "biomedical doctors" and "medical doctors" in clinical medicine, of which the first ones are not required humanitarian competencies. Since non-infectious pathology largely includes psychosomatic features, and mental processes are filled with an experience of social reality, the clinician must have skills of human sciences to work with them. This is especially important in view of the physician's power as an ambassador of medicine and health. The following competencies are discussed: internal work skills, situational search and interpretation, communicative and ethical competence, development of positive health.

Key words: psychosocial risk factors, health, psychosomatics, non-communicable diseases, patient orientation, psychocardiology, medical ethics, continuing education.

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Higher education standards include the concept of general professional and universal competencies. This level of competence combines the knowledge and skills typical of a person with higher education in general and a doctor as a specialist in particular.

Among the universal competences (in the project of Federal State Educational Standard of Higher Education with account of professional standards in the specialty 31.05.01 — Medical Doctor [1]), as well as among general cultural, general professional and professional (in the current FSES HE 31.05.01 — Doctor — medical care [2]) should be highlighted a number of related to humanitarian knowledge (Table 1).

In addition, in the case of primary specialized accreditation in cardiology, the "Communication" station of the objective structured clinical examination includes situations of "difficult" patient" and "bad news" [3].

The doctor is a representative of medicine. Medicine — teaching, private science, practice, cultural phenomenon that has formed in the millennia of confrontation with nature. Its task is to prolong life with maximum quality, to preserve and achieve full health — well-being on the physical, mental and social levels of human being [4].

Man is biosocial in nature. Bioelectricity creates conditions for thinking and communication, which are realized in the form of symbols expressed, perceived and interpreted by people. This is how culture is created — the second nature or everything that is not nature.

Work in medicine requires taking into account 1) the biological side of man, his physiology and pathology, 2) the social and cultural side (worldview, personality, contacts), 3) close two-way relationship between biological and cultural.

The biopsychosocial nature of human beings, as defined in the World Health Organization's definition of health, can be reduced to a biosocial nature without losing meaning. The psychological level in this case (without diminishing the importance of psychology) is the transition level, the door between the biological material processes of the body and the semantic, symbolic reality of society, i.e. communication [4]. The soul, psyche or anima, is processes of body animation, mental functions: thinking, intelligence, memory, emotions, mood, etc. Their filling is somehow symbolic, communicative, and they are realized due to biochemical mechanisms of muscle contraction, isolation of neurotransmitters, bioelectricity.

Medicine of the turn of the XX-XXI centuries was purely biologic [5]. This is easy to understand,

Table 1

Doctor's competencies according to Federal standards (adapted from [1, 2])

Competency level	Formulation
HE FSES project “3 ++” with occupational standards	
Universal	Ability to analyze and take into account the diversity of cultures during intercultural interaction
	Identify and implement the priorities of their own activities and ways to improve it on the basis of self-assessment and lifelong learning
	Maintain an adequate level of physical fitness
Current HE FSES	
General cultural	Ability to use philosophical knowledge to form a worldview
	Ability to take social and ethical responsibility for decisions made
	Willingness to self-development, self-actualization, self-education, use of creative potential
	Willingness to work in a team, to tolerate social, ethnic, religious and cultural differences
General occupational	Ability and willingness to implement ethical and deontological principles
	Ability and willingness to analyze the results of own activities to prevent mistakes
Occupational	Willingness to engage in educational activities to address risk factors and develop healthy lifestyle skills

Note: HE FSES — Higher Education Federal State Educational Standard.

because the rapid development of natural sciences has overshadowed the slow and contradictory growth of human understanding of oneself through philosophy, culturology, sociology, psychology and art. Nevertheless, medicine as an aid to a human being requires work with both biological and cultural parts of it. Within clinical specialties, there is probably a moment of dichotomy: either we persist in developing the humanitarian competence of the physician, or we divide medical practice into two types — one that implies such competencies and the other that does not.

The conservative way in which the scientific and pedagogical community is following now will require a renewal of approaches to the formation of humanitarian competencies among doctors (and among the first — cardiologists taking care of patients with psychosomatic pathology [6]). Another way is to realize that it is impossible to embrace the entire complexity of biosocial interrelationships, and to identify clinicians who are able and unable to work with a person. This recognition of defeat is possible, but maybe it is a requirement of evolution, a new, modern view of medical care. “Medical doctor” and “biomedical doctor”, for example, the names of two types of clinicians that differ by way of working with a patient. The first one suggests a high level of communicative and social skills, the second one — only actions in the field of pharmacology, surgery, diagnostic methods, physiotherapy with minimal and formal communication.

The conservative way is more comfortable. If you follow it, what are the competences of a clinician capable of working with the social self of a patient no less effectively than with the biological processes of his body, taking into account the close relationship between the social and biological aspects?

When interacting with a sick person or a patient as part of primary prevention, the doctor deals with both the "pure" biology and the symbolic reality of this individual. The administration of the drug, not to mention surgical intervention, is nothing but the effect on the biology of the patient. But the psychological processes of experience (negative and positive emotions, mood) are biochemical states. It is associated with a reflection on social life. Cognitive science explores "embodied cognition" [7]. There is plenty of evidence that emotions influence the development of chronic diseases and their exacerbation. Stress is a typical example of a body's biochemical response to understanding social reality: stress factors such as changes in currency exchange rates and job losses.

The biological response is well studied, and it is quite simple in nature. The processes of experience are much more complex — semantic and symbolic processes. They are complicated simply because, unlike biological (natural science) processes, it is impossible to generalize, make a sample and calculate reliability. They are purely individual and require skills of interpretation according to the laws of humanitarian knowledge. Although some natural scientists do not consider humanitarian knowledge to be scientific in principle, it is not so much a matter of designating it as of its essence and practical significance. As such, science itself is only one way to know and change the world [8]. Medicine, on the other hand, is a broader science that has the reality of life with its subject matter, including notions that are imperceptible (fate, god, soul, etc.), but that are important for the patient and, as a result, through experience, affect his or her coping with the disease. Working with a person (alive, in the mind), one cannot help but understand him, decode the factors influencing his adherence to the disease, his attitude to the situation of the disease, his ability to change his lifestyle due to the medical situation.

Psychology is partly responsible for the study of the human being's social. This science has both strict biological fields (neuroscience) and social fields (consultative psychology). Doctor's humanitarian competences are at least psychological competences. But they are not enough for effective work. Moreover, the work with the individual is done with the help of another person, and the clinician cannot abstract his or her personality from the patient's personality, in which case he or she becomes a "biomedical doctor" (see above). Therefore, the key humanitarian competence is the skill and ability to work internally, build awareness, reflexivity, constructive self-criticism, and the ability to change yourself.

Self-identification is a person's experience of the self in relation to social categories. For example, fitness as a muscle building represents the realization of a certain image of body, which is perceived as a standard. And for one man the aim will be the hypertrophy of the muscles as such, for the other — the achievement of "Greek" proportions and relief. In both cases, the processes take place at the somatic level and a person may eventually become a cardiologist's patient due to, for example, arterial hypertension or cardiomyopathy. An even simpler example is

alcohol consumption as a social practice. If a person's self-identification requires recognition in a certain social group, he or she will be forced to consume an excessive amount of alcohol in a feast; the classic situation — "do you respect me? — then drink". When working with such a patient, it is not enough to simply forbid the harmful action, not even to scare with consequences (the reaction may be the opposite, for example, depression, negativism), you need to be able to understand his motivation. Motivation comes from values, value is conditioned by the correlation of the image of the self with the wishful one in the society, and the wishful one is a construct based on the whole human experience.

The above is enough for a somatic doctor to draw a conclusion about the complexity and potential infinity of working with an individual as a person, the social self. But the matter is not in the complexity of this knowledge. The main feature is a qualitative difference of such knowledge. It is non-generatable, unrepeatable, irreplaceable. It is interpretive, and therefore requires tools for analysis: knowledge of history and philosophy of culture, knowledge of psychology, skills to communicate in order to understand the person, not only to collect data. For a "biomedical doctor", pain as a symptom is only a "talking biology," which has a process that manifests itself in complaints of pain. For a clinician, pain is also the patient's experience, his or her perceptions and fears, projection on life, the question "for what?" or "will it always be so now? In doing so, the doctor does not have to suffer pain together with the patient; the ability of a conscious attitude allows one to be involved in person's problem without crossing the boundaries of oneself.

The importance of quality methodology in cardiology was discussed in the article [6]. In fact, this is how the old clinical school returns to a new phase of medical development. Simple references to the full collection of anamnesis, to the correct conversation with the patient, to the consideration of personal traits will sound conservative and sentimental today, if they are not supported by modern ideas about the biosocial relationships, ways to understand the cultural part of the patient, and the doctor himself — to construct his own social identity.

Traditionally, the "non-biological part" of the patient is devoted to the specialty and field of medicine with the word root of "psych-" in its name: psychiatry, psychosomatics, psychocardiology. Although they nominally deal with processes of psychological level, any manifestation of such processes consists in felt, perceived and interpreted symbols. Bio-psychological processes are not available until they are expressed and become psychosocial phenomena. Already V.A. Gilyarovsky said "every epoch has its own psychiatry" [9]. Extrapolating this idea into psychocardiology, stress, harmful habits, and unhealthy lifestyles as cardiovascular risk factors lies in the information environment. It means that the etiopathogenetic tangle has to be unraveled from above. Psychosomatics, psychocardiology, if not redefined, acquire a different level of work. This can be looked at even more widely, because all noninfectious pathology somehow begins with psychosocial risk factors.

Patient-centered care is attached to such doctor's work, with elements of quality methodology. Its simplest attitudes always require positive mood, empathy, respect, constructive communication, joint decision making and tolerant information sharing.

Finally, decision making in ethically complex situations requires the physician to be an ethical subject, i.e. a person capable of understanding and solving each unique situation. Especially if the legal framework is not sufficiently detailed.

Where to find the resource to do this — both formally and substantively? Obviously, it's about humanitarian competencies. Humanitarian — according to the vocabulary definition, refers to society, human beings and their culture (as opposed to the sciences of nature). The following competences can be defined as:

Internal work — the ability to reflect on one's feelings, one's attitude towards another person (colleagues, patients, relatives of patients), to the situation; find the reasons for their attitude to the situation, their feelings, analyze and rationalize them; the tendency to fulfill the postulate "doctor, heal thyself."

Situational search and interpretation — the ability to ask questions about hidden meanings and sources of what is happening — both locally, in the situation of assistance, and globally; to find codes with which the information is presented, its possible distortion and substitution.

Communicative competences — the ability to conduct a dialogue with patients, their relatives, colleagues, in a constructive manner, without creating situations of misunderstanding, conflict; to be aware of their own experiences and meanings generated by communication; to express themselves in the manner necessary for effective communication, taking into account the phenomenon of power of the doctor as a representative of medicine and health care [10].

Ethical competences — the ability to highlight the ethical element of a situation, to distinguish between good and bad, right and wrong; to obtain additional information necessary to make ethically loaded decisions.

Positive health development — understanding of the structure of health (wellbeing) at the socio-cultural level; ability to interpret socio-cultural determinants of disadvantage and find ways to resolve them (it should be added that the considered standards and draft standards of education of the levels of specialization and residency considered do not reveal competencies related to health as an interdisciplinary concept according to WHO).

The development of humanitarian competencies among students and physicians in postgraduate and continuing education is possible with the proper "tuning" of humanitarian and psychological disciplines. The most important is the essential component — the formation of a way to think analytically, to use different points of view to understand the same phenomenon. In today's era of information abundance, the key skill is to preserve one's self-identification as autonomous and independent of external information influences as possible. For a doctor as one of the most important actors in the lives of other people, this is especially important.

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