# HUMANITARIAN ISSUES OF MEDICAL EDUCATION IN MODERN RUSSIA

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The article is devoted to the role of humanitarian education in medical universities of Russia. Events of recent years (lack of attention to the value orientation of students and, as a consequence, leaving the profession or feeling unsatisfied with it) that occurred in Russian healthcare determined the interest in this issue. The research data were obtained using the systemic approach. Owing to this, medical education was viewed as a non-integrated set of scientific, clinical proper and humanitarian knowledge and assessments. In this respect, the perspective of using humanitarian expertise of academic courses has been discussed. This was done to coordinate the efforts of socialization agents in development of professional orientation among medical students. A comparative analysis of the effect of High-Hume technologies and mentorship on the positive solution of this problem has been performed. A conclusion about the use of the complementary principle while implementing High-Hume and mentorship has been made. Search for the aggregator of integrative processes in medical and humanitarian preparation enabled to conclude that bioethics is a system-forming factor of developing professional orientation in medical education. Recommendations on the use of scientific and organizational achievements in bioethics in the practice of medical education have been developed.

**Keywords:** professional orientation, medical education, medical humanities, mentoring, High-Hume technologies, knowledge, values, bioethics, orientation, profession, bioethics

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# ГУМАНИТАРНЫЕ ПРОБЛЕМЫ В МЕДИЦИНСКОМ ОБРАЗОВАНИИ СОВРЕМЕННОЙ РОССИИ

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Статья посвящена роли гуманитарного образования в медицинских вузах России. Интерес к данному вопросу определили события в отечественном здравоохранении последних лет — недостаток внимания к ценностным ориентациям студентов и, как следствие, уход из профессии или некомфортное пребывание в ней. Исследовательский материал был получен на основе применения системного подхода, что позволило рассмотреть медицинское образование как неинтегрированную совокупность естественнонаучных, собственно клинических и гуманитарных знаний и оценок. В связи с этим обсуждалась перспектива применения гуманитарной экспертизы учебных курсов, чтобы на основе полученных данных скоординировать усилия агентов социализации в формировании установки на профессию у студентов-медиков. Проведен компаративный анализ влияния High-Hume технологий и наставничества на позитивное решение этой задачи. Сделан вывод о применении принципа комплементарности в использовании High-Hume и наставничества. Поиск агрегатора интегративных процессов в медицинской и гуманитарной подготовке позволил сделать вывод о том, что системообразующим фактором формирования установки на профессию в медицинском образовании является биоэтика. Сформулированы рекомендации по использованию научных и организационных достижений биоэтики в практике медицинского образования.

**Ключевые слова:** установка на профессию, медицинское образование, медицинская гуманитаристика, наставничество, High-Hume технологии, знания, ценности, биоэтика, установка, профессия, биоэтика

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In the post-Soviet era of Russia, medical education suffered certain setbacks. First, sub-internship was cancelled. The reasons were formulated in an unclear way. Then internship was eliminated. Extramural postgraduate training program was cancelled as well. At the same time, the postgraduate program itself became equivalent to the specialist program with research proper being pushed to the background and attending lectures being strictly controlled. Simultaneous, almost twice reduction of the period of study at medical colleges unwittingly suggests an act of intellectual sabotage against medicine.

Not excluding a quite possible implementation of the destructurization plan of Russian healthcare as a social institution, it would be logical to assume that all the enumerated activities were aimed at cost saving, whereas professional damage was not taken into consideration, as a number of subjects was reduced at the expense of non-core disciplines. Temporary transition to remote learning due to adaptation to COVID-19 conditions only made things worse [1]. Especially because this kind of learning of non-core disciplines became permanent. It happened not at every

university and college, but frequent enough not to pay attention to this [2].

This results in an acute shortage of doctors and nursing personnel in Russian healthcare. According to the Federal Compulsory Medical Insurance Fund (FCMIF) [3], the total number of doctors was 145,010 people by the end of June 2022. It was decreased by 1.9 percentage points as compared to the beginning of the year. The total number of nursing personnel decreased by 2.3% and amounted to 371,637 people. This was stated by Chamber of Accounts in the FCMIF budget progress report in 2022 [4].

In fact, the country lost 2,756 doctors and 8,695 nurses within six months of 2022. How could the fact be associated with reduction in the time spent on preparation of medical professionals? Competition in medical educational institutions (both universities, and colleges) is consistently high. Where are the qualified medical personnel then? They master other professions or switch to private medical practice. As private medicine places high demands on professionals, a young graduate can hardly expect a warm welcome. It is known that many part-timers such as doctors and nurses from state and municipal medical organizations are in private practice. Working there has a number of advantages. Thus, private medicine is not at risk of staff shortage. At least, this applies to large network players at the private medicine market [5]. The main reason for leaving the profession or switching from state medicine to private practice is financial one. Other reasons include better labor conditions and possibility of self-realization [6].

All these reasons are obvious enough. However, they are manifested differently for various people. There is, however, an option of leaving state medicine or medicine in general. It occurs when professional orientation is lacking. According to Pavel D. Tishchenko, outstanding Russian scientist in bioethics, healing is practical mercy [7]. Capacity for it is definitely congenital. Nevertheless, it should be executed, developed and fixed, but how exactly?

## RESULTS AND DISCUSSION

### The ratio of medical knowledge and their socio-humanitarian orientation

Gaining professional knowledge is the main objective of medical and other education. Professional teachers deal with this task. In medicine, teachers play a binary role, as they teach both theory, and practice. A special role belongs to those clinicians who supply patients with real medical aid in collaboration with students, residents and postgraduate students. The essence of their professional activity is to develop skills and abilities and provide knowledge to future physicians. However, representatives of non-core, primarily humanitarian disciplines, are responsible for how the knowledge will be used. An adequate professional orientation should be developed to make the obtained knowledge useful but not harmful. Michel Foucault wrote as follows: ‘a physician holds a special place in any society and any civilization: he attracts public attention everywhere and is almost irreplaceable. A physician’s word can’t come ‘from nowhere’: its significance, effectiveness, therapeutic abilities and general conditions of existence, just like the words of medicine itself, can’t be separated from the status of a certain person who articulates, proclaims and confirms the legal right to diminish sufferings and prevent death’ [8, 5].

Underestimation of humanitarian knowledge means that medical teachers distance themselves from transmission of valuable information when communicating with their students by default or just provide short examples of it, which are easy to forget. At the same time, humanitarian teachers are very limited in using medical data that should be analyzed to solidify the system of values. The students do not believe humanitarians who are not medical professionals. Medical teachers try to avoid social issues not because they do not know much about them, but because they are willing to use the class time to ensure better understanding of professional requirements. Thus, it is possible to set a task of integration of special medical knowledge and humanitarian assessment of their use [9, 10]. To determine the ways to solve the task, it is necessary to conduct a preliminary humanitarian expertise of the educational process. It is necessary to find out how they present the social meaning of this profession in the courses of academic subjects at special departments and how the professional context of medical education is presented within a humanitarian discourse.

The method of humanitarian expertise has not been developed enough yet to make the application of certain templates possible. Moreover, polyvariety of humanitarian knowledge implies a difference in explication of its types to the use in relation to medical disciplines. Thus, such a discipline as Public Health and Healthcare Organization considers medicine as a social institute, whereas this approach would be inappropriate for the disciplines of a morphological profile. In this case, philosophical concepts of bios would be useful as basic ones. The philosophy itself would be taught as work-related, i. e., as *philosophy of medicine* [11].

Another very complex issue relates to the criteria of humanitarian expertise. What can be considered useful or doubtful? The requirements are not developed yet. So, it is logical to use the principle of conventionalism. Meanwhile, different educational medical organizations can have a different list of criteria. This approach corresponds to modern requirements of WCF, where universities are granted with extensive rights while taking decisions on compilation of training programs and courses.

A humanitarian expertise should not be a calendar event. Its object can include different structures at different times. It is better to start with learning the views of students and teachers regarding which issues seem more interesting to them in a professional way or in a socio-humanitarian area. The data can be obtained through a simple survey. Depending on the results, it is possible to shift to other stages such as analysis of working programs, determining the areas of behavioral risks, educating teachers (teaching doctors about humanities, and teaching humanitarians about the medical issues that can be useful while implementing academic courses). Medical humanities are a field of doctor-humanitarian joint activity. But this is not a mechanical sum of ‘activities’, this is art, discussion and cooperation. So, such forms of cooperation as elements of web-based learning [12], lectures and practical classes ‘for two’ (lecture as a dialogue between a medical teacher and a humanitarian teacher) are extremely useful. As extracurricular activities used in our universities and colleges are abundant, there is no need to invent new ones, it’s enough to use those available with a focus on medical and humanitarian content.

So, the humanitarian expertise has been conducted, conclusions have been made, and we know what should be done by whom; can our activities help obtain the positive and active orientation to the profession that started it all? The key aspect is interiorization of true knowledge and proper assessments by every student, resident and postgraduate student. It is easier with knowledge, as we can check whether it

is true. But only knowledge is not enough to form an adequate idea of the world and live in it. Orientation in the space of values is required (evaluation activity).

In medical education, axiological plots are mainly presented in human sciences. But there is one thing to mention. Assessments can't be logically deduced from knowledge (unlike new knowledge). Assessments are empirically untestable (only truth/falsity can be tested). Value judgements are not falsified (because they depend on the personality of the assessing person). The assessments are unexplainable (when they are tried to be explained, they stop being assessments and become knowledge). The assessments do not imply direct and indirect empirical confirmation. Hume's principle, stating that assessments and standards can't be deduced from facts, is accepted as an axiom.

Thus, the risk of taking erroneous decisions based on wrong assessments is much higher than the risk of taking erroneous decisions based on false or insufficient knowledge. What can be done about it? More perfect methods of formation of professional orientation associated not with financial considerations, but with the feeling of mercy, compassion and love for the neighbor, are required. But how can novel technologies correspond to humanitarian purposes of medical education?

### Hi-hume-technologies and/or mentor's personality?

A student can be influenced in numerous ways. It is an axiom. The old model of medical education means transition of knowledge and practice organized following the principle of 'Do What I Do'. Nowadays there are methods and techniques that enable to program a future specialist's behavior in accordance with requirements and expectations of the society. Can their inclusion into the educational process bring their orientation into focus and improve effectiveness? The highest expectations can be associated with High-Hume technologies.

'High-humanitarian technologies (High-Hume)' is a new term. There is a connection with an earlier and widely spread 'High-Tech' term. But High-Hume technologies are related not to technological, but to social and psychological resources [13]. The technologies produce a direct effect on consciousness. Initial objective of their development and use included the sphere of consumption of goods and services.

Some researches even believed that they were a tool of marketing. However, the functions changed as soon as they were developed: now, marketing can be a variant of High-Hume. The mechanism of implementation of information and psychological, psychoanalytical, neurolinguistic and similar technologies reminds of logistics of personalized medicine, when an active drug is selected or developed based on individual features of the target typical of a certain group of patients. So, High-Hume technologies focus on group orientation, experience, world view and cultural patterns of a targeted object. Appealing to the basic personality components, the personality is affected using psychological, political, social, culturological and other humanitarian methods. If these technologies have been used for purely commercial purposes, other purposes such as political ones gradually emerged. There is a question: why can't the technologies be used to form respective educational and professional orientation among future doctors? It will be more effective than educating activities or memorization of learning material. Importantly, a student's personality undergoes no changes, it is the emphasis placed on the world-view and behavior that has been changed. The approach of developing professional orientation seems effective. Nevertheless, there is some risk that makes the approach doubtful.

High-Hume technologies have been known for a long time but had another name (behavior modification). They were simpler and more primitive, but still dealt with the same goals as now. Negative attitude to behavior modification was explained by the unwillingness of people to be puppets. Now, they still don't want it. High-Hume tech subjects refer critics to obtaining an informed consent from the involved objects, though the procedure was not processed and is rarely applied, as it can influence the result. It can be said that humanitarian knowledge and their value-based arrangement using High-Hume technologies managed to find their place in medical education. At the same time, they produced a risk of violating the principle of respect for autonomy of not a patient, but of a doctor who teaches and the doctor's students.

Is there an alternative to the High-Hume that addresses the problems of developing the orientation toward the profession of future doctors? Yes, there is. It's called mentorship [14]. The social institute of mentorship as a phenomenon of continuous medical education has been considered in various studies. Now, there is no information in literature stating what is the advantage of this form of interiorization of medical knowledge and values over cutting-edge High-Hume technologies. Comparison can be as follows:

- High-Hume technologies focus on a group consisting of people with similar social and psychological characteristics, whereas mentorship is being implemented through personal communication of two individuals;
- Using digital technologies, High-Hume develops humanitarian standards of professional orientation, mentorship, and unique capabilities, creativity and ability to deviate from standards in favor of a patient;
- High-Hume uses data banks, whereas a mentor utilizes personal exclusive experience;
- High-Hume uses ethical components of a medical profession as a means of orientation development; in mentorship, medical ethics is included into profession and is of a theological nature.

Thus, while preparing future physicians, mentorship is more preferable than High-Hume technologies, mainly for moral reasons. However, mentorship has similar shortcomings. A mentor helps young and untrained doctors. They already have certain orientation, which is difficult to change. That's why mentors should be selected among practical doctors at clinics, where students arrive and get access to the patients. There they interact with a practicing physician who doesn't estimate their knowledge, doesn't introduce to the theory, but just accomplished the work in the presence of a student, shows and explains what has been done, narrates about practical cases and just talks about life.

Shortage of mentors is another challenge. Not every practicing physician can fulfill the function, and some of those who can are not willing to do it. Forcing is not effective in this case, as it is a vicious moral requirement. Thus, staff challenges in mentorship are both of a production, and moral sense. They are not decided yet.

## CONCLUSIONS AND RECOMMENDATIONS

### Integrative function of bioethics in the educational medical space

Ethical parameters of developing a professional orientation are of fundamental importance while selecting the development methods. All the abovementioned issues form a single complex with biomedical ethics being its system-forming factor. First, it is an essential constituent of this profession. Second, professional

orientation has moral content. Thus, we can sum it up and suggest some recommendations.

1. Leaving profession is mainly associated with an unstructured value orientation. So, continuity of ethical content in all studied disciplines and all directions (college, higher education, graduation, residency, postgraduation, continuing medical education) is required. A continuous program of ethical preparation in medical education should be developed and implemented.
2. Among all humanitarian disciplines, only bioethics embraces scientific, clinical proper and humanitarian knowledge and assessments. Moreover, only bioethics can integrate knowledge and assessments. However, only knowledge is given priority in practical medicine (for instance, practice of implementing Clinical Recommendations and their content). So, the system of continuing medical education should contain a course of advanced training in biomedical ethics.
3. Bioethics contains a clear and well-tested system of ethical expertise in medicine [15]. Due to adaptation of the social institute of medicine and healthcare to new realities of science and social life, it became evident that the expert space should be expanded shifting from the ethical expertise proper to the humanitarian expertise. Thus, ethical committees should focus on humanitarian expertise in medicine, reconsider the related Provisions and introduce the article about the status of these Committees into Federal Law No. 323-FZ.
4. Bioethical content of using High-Hume technologies and the institute of mentoring require improvement and social assessment. Thus, it would be useful to conduct ethical expertise of using High-Hume technologies and applied mentoring techniques in medical education to provide the interested subjects with recommendations on their proper and safe usage.

**References**


1. Petrov AV, Donika DA. Eticheskie i pravovye problemy, vyzvannye pandemiej COVID-19. Bioetika. 2020; 14 (2): 29–32. Russian.
2. Sedova NN. Bioetika na «udalenke» ili udalennaya bioetika? Bioetika. 2020; 14 (2): 4–5. Russian.
3. Audit. Schetnaya palata Rossijskoj Federacii (ach.gov.ru). Available from URL: https://ach.gov.ru/ /audit/analysis/. Dostup 27.04.2023. Russian.
4. Chislennost' vrachej v Rossii snizilas' s nachala goda na 2% (vshouz.ru). Available from URL: https://www.vshouz.ru/news/minzdrav/wcs-13060/?ysclid=lh8pmh8dax720470676. Dostup 27.04.2023. Russian.
5. Analiz chastnyh klinik (statprivat.ru). Available from URL: https://statprivat.ru/privateclinics?ysclid =lh8rhb8iyk876508388. Dostup 27.04.2023. Russian.
6. Shagina IR, Smahtina TA, Kubekova AS. Sociologicheskoe issledovanie ocenki otnosheniya vypusknika medicinskogo vuza k vybrannoj professii. Bioetika. 2019; 12 (2): 44–46. Russian.
7. Tishchenko PD, Sedova NN, Petrov KA. Vrachevanie — eto deyatel'noe miloserdie i osnovanie solidarnosti. Diskussiya o proshlom i budushchem bioetiki, priurochennaya k 75-letiyu Pavla Dmitrievicha Tishchenko. Bioetika. 2022; 15 (1): 6–18. Russian.
8. Mishel' Fuko. Arheologiya znaniya. Kiev.: NIKA-CENTR. 1996; 208 s. Russian.
9. Moiseev VI, Moiseeva ON. Sud'ba mediko-gumanitarnogo obrazovaniya v Rossii. Bioetika. 2022; 15 (1): 24–32. Russian.
10. Shkarin VV, Donika AD, Yagupov PR. Volgogradskij opyt gumanitarnogo obrazovaniya v medicinskom vuze. Bioetika. 2020; 13(1): 22–27. Russian.
11. Sedova NN. Filosofiya mediciny: uchebnik. M.: KNORUS. 2023; 193 s. Russian.
12. Petrov VI. Bioetika i setevoe obrazovanie v medicinskih vuzah. Bioetika. 2022; 15 (2): 3–5. Russian.
13. Lysak IV. Hi-Hume tekhnologii i posledstviya ih primeneniya. Sovremennye issledovaniya social'nyh problem. Vypusk № 4 (04). 2010; s. 259–263. Russian.
14. Bykov AV, Myakon'kij RV. Nachinayushchij hirurg i ego nastavnik: monografiya. Volgograd: VolgGMU. 2022;172 s. Russian.
15. Hohlova AL, redaktor. Eticheskaya ekspertiza biomedicinskih issledovanij: rukovodstvo dlya komitetov po etike. M.: Izd-vo OKI. 2021; 792 s. Russian.


**Литература**


1. Петров А. В., Доника Д. А. Этические и правовые проблемы, вызванные пандемией COVID-19. Биоэтика. 2020; 14 (2): 29–32.
2. Седова Н. Н. Биоэтика на «удаленке» или удаленная биоэтика? Биоэтика. 2020; 14 (2): 4–5.
3. Аудит. Счетная палата Российской Федерации (ach.gov.ru). Режим доступа: [Электронный ресурс]. URL: https://ach.gov.ru/ /audit/analysis/. Доступ 27.04.2023.
4. Численность врачей в России снизилась с начала года на 2% (vshouz.ru). Режим доступа: [Электронный ресурс]. URL: https://www.vshouz.ru/news/minzdrav/wcs-13060/?ysclid=lh8pmh8dax720470676. Доступ 27.04.2023.
5. Анализ частных клиник (statprivat.ru). Режим доступа: [Электронный ресурс]. URL: https://statprivat.ru/privateclinics?ysclid =lh8rhb8iyk876508388. Доступ 27.04.2023.
6. Шагина И. Р., Смахтина Т. А., Кубекова А. С. Социологическое исследование оценки отношения выпускника медицинского вуза к выбранной профессии. Биоэтика. 2019; 12 (2): 44–46.
7. Тищенко П. Д., Седова Н. Н., Петров К. А. Врачевание — это деятельное милосердие и основание солидарности. Дискуссия о прошлом и будущем биоэтики, приуроченная к 75-летию Павла Дмитриевича Тищенко. Биоэтика. 2022; 15 (1): 6–18.
8. Мишель Фуко. Археология знания. Киев.: НИКА-ЦЕНТР. 1996; 208 с.
9. Моисеев В. И., Моисеева О. Н. Судьба медико-гуманитарного образования в России. Биоэтика. 2022; 15 (1): 24–32.
10. Шкарин В. В., Доника А. Д., Ягупов П. Р. Волгоградский опыт гуманитарного образования в медицинском вузе. Биоэтика. 2020; 13 (1): 22–27.
11. Седова Н. Н. Философия медицины: учебник. М.: КНОРУС. 2023; 193 с.
12. Петров В. И. Биоэтика и сетевое образование в медицинских вузах. Биоэтика. 2022; 15 (2): 3–5.
13. Лысак И. В. Hi-Hume технологии и последствия их применения.Современные исследования социальных проблем. Выпуск № 4 (04). 2010; с. 259–263.
14. Быков А. В., Мяконький Р. В. Начинающий хирург и его наставник: монография. Волгоград: ВолгГМУ. 2022; 172 с.
15. Хохлова А. Л., редактор. Этическая экспертиза биомедицинских исследований: руководство для комитетов по этике. М.: Изд-во ОКИ. 2021; 792 с.