



Faculty Building for Personalized Medicine and Care

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ABSTRACT

Personalized medicine and care always places the patient at the center and requires psychosocial interprofessional skills. Using the example of personalized care, which is conceived as clinical, biopsychosocial work in an interdisciplinary, care-relevant manner, it is shown why comprehensive and differentiated abilities are required for this activity. According to grounded theory methodology, an interview-study with several experts in the field was carried out in a cyclical research design. As a result, problem definitions and solution concepts suggested to focus existing and development of new curricula or curriculum elements, to focus training processes and students' qualification profiles for the respective personell-, organizational-development and faculty building. The qualification profile, definitions of learning objectives, as well as their effective implementation and didactic mediation possibilities are empirically reviewed and presented in an overview and exemplary manner. The training is designed to be practice-relevant, patient-centered with sufficient personal reflection skills, which are conveyed through teaching in continuous small groups. Selection procedures and internships take into account the requirements of psychosocial care and academic standards. Workplace-based examinations and case-oriented feedback develop the trainees into professional workers. A priori necessary basic competencies are presented and discussed in order to further elaborate empirical research and curricular strategies. Therefore, the respective faculty building can be derived.

Keywords: qualification profile, internships, didactics and learning objectives, metacompetencies, admission, approbation.

INTRODUCTION

Considering the requirements for personalized care-related work, we first have to focus the patients, their needs according to the biopsychosocial paradigm. Precision medicine offers clear insights in to the molecular, genetic, biological base of illnesses. For the psychosocial part a problem definition is necessary:

Nationally, 23.8% of the Austrian population suffers from mental illnesses, with only 14% covered by the current care system. Only 3.8% of the Austrian population currently receive psychotherapeutic treatment. The economic damage caused by mental illness amounts to €13.9 billion per year, corresponding to 4.3% of gross domestic product [1,2]. In terms of prevalence, current studies [3,4] show that 40% of the population suffer from a mental illness at least once in their lifetime. These include, in particular, anxiety, depression, addiction and somatic

symptom disorders. These mental disorders have overtaken somatic illnesses in the ranking of the most common illnesses and clinical complaints in Austria [5].

At European level, the one-year prevalence of depressive symptoms in the European Union was 6.6% in 2019, with a prevalence rate of 4.3% in Austria [6]. The EU comparison is led by Luxembourg with 10.0%, followed by Germany with 9.2%, where there is a disproportionately high rate of 11.5% compared to the EU average of 5.2%, especially among younger patients [6]. Depression plays a leading role in the globally calculated burden of disease, with major depressive disorder accounting for 8.2% of years lived with disability worldwide in 2010, just behind the leading chronic back pain [7]. The illnesses from the schizophrenic spectrum are characterised by their frequent psychic comorbidities such as depression, personality disorders, stress disorders, anxiety disorders and sleep disorders [8], but addiction disorders account for the highest comorbidity rates at 50-80% [9], which is just as high as the underlying somatic illnesses in hospitalised schizophrenic patients [8]. The mortality rate is 2.6 times higher compared to healthy collectives [10]. This is due to accidents, suicides, addictions or the often poorly treated underlying somatic diseases [8]. Even with optimal therapeutic treatment, 10% of the suffering patients are considered permanently disabled and over 80% of the patients are either not in employment or not fully employed, which means that there is a very great need for public support for this patient group [8]. A large-scale analysis of epidemiological studies in the EU (1990-2010) on a wide range of mental and neurological disorders with "best estimates" for one-year prevalence showed that at least 164.8 million of the total 510 million EU citizens suffered from one or more brain disorders (mental and neurological disorders) in the past year [11].

Globally, the burden of disability due to mental and neurological disorders is greater in the EU than in other regions of the world: in terms of disability-adjusted life years (DALYs), they were estimated to account for 26.6% of the total DALY burden (all causes) (30.1% for women, 23.4% for men) and 42% of all diseases in terms of years lived with disability (YLD). The largest proportion (60-70%) of the DALY burden from "diseases of the brain" was attributed to mental disorders in this study. The study found no evidence of increasing or decreasing rates of mental disorders overall when looking at the same diagnoses with an overall prevalence of 27.4% in 2005 compared to 27.1% in 2011. Cross-sectionally, many cases with a mental disorder have more than one disorder - the comorbidity rates increase with age. Only 14-36% (depending on the country) of all patients with mental disorders are in contact with professional health services. Only half of them receive reasonably adequate treatment (treatment rates are highest for psychotic and eating disorders; 72% and 61% respectively). In contrast to the high direct treatment costs for various neurological disorders, mental disorders cause high indirect costs (e.g. absence from work) that can be directly linked to inadequate treatment services. A recent analysis of the DALY burden is based exclusively on data from the Global Burden of Disease - Global Burden of Disease study [11] and indicates a much higher proportion for the burden, as in addition to the impact of mental disorders, the close relationship between somatic (e.g. COVID-19) and mental health has been further explored in recent years, which can be expected to increase the need for mental health care [12].

WORK IN THE PSYCHOSOCIAL FIELD

Psychiatry, psychotherapy, psychotherapeutic medicine and psychiatric-psychotherapeutic care in the broader sense are a rapidly growing professional field. Psychiatric treatments are

proving to be just as effective as those for other medical conditions. Treatment strategies and care approaches have been completely revolutionised, the emphasis is now on outpatient care in the community, from rehabilitation to early diagnosis, and it is clear that many strategies for the prevention of psychiatric illness are within reach. Psychiatric research has experienced an unprecedented boom due to advances in neuroscience, and progress in understanding mechanisms and causes is multiplying and accelerating thanks to neuroimaging and genomics. Technological advances go hand in hand with the ever-increasing drive towards a more personalised medicine, where psychiatry and psychotherapy can make significant contributions to mental health. The above comments make it clear that there is also a need for increased measures to improve psychosocial care and prevention.

The knowledge, on which this field of work is based, is traditionally departmentalized or “compartementalised”, developed and researched according to the various disciplines, and the requirements as well necessary skills for working in the psychosocial field are considered in each discipline separately. However, multi-professional care and interdisciplinary collaboration are essential in the care of people with mental illnesses [13].

CONCEPTS FOR THE TREATMENT

The harmonisation of psychiatric and psychotherapeutic care and standards for mental health care in Austria, as well as compliance with European training standards for the medical specialty of psychiatry and psychotherapy, is essential for integrated care. Improving the training of mental health professionals and non-mental health professionals, promoting the exchange of best practice between countries, improving working conditions for mental health professionals and exploring new working models, including changing roles and multidisciplinary, are essential (see Figure 1).

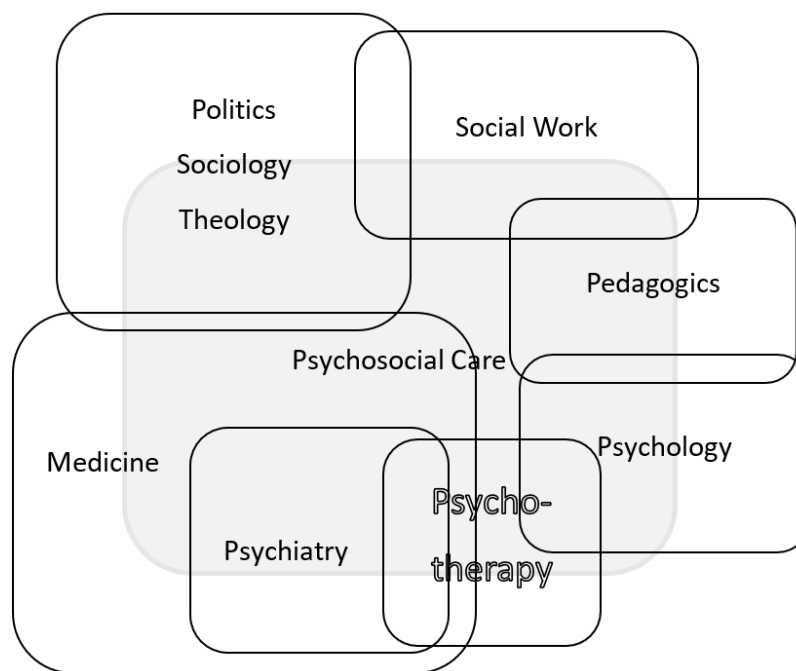
By promoting exchange/collaboration between healthcare professionals, ethical and human rights standards (cf. destigmatisation campaigns), mental health care and prevention, as well as access to psychiatric and psychotherapeutic care can also be supported.

New responses to an evolving world must be found by exploring the challenges and opportunities of digitalisation, AI, climate change, urbanisation and migration, especially in terms of their impact on mental health, particularly among young people. Improving crisis response capacity, implementing public mental health and prevention measures, providing adequate funding for research in the fields of psychiatry and psychotherapy, public mental health and prevention strategies must be addressed as well as strategies for health in all policy areas.

Although it is already known that interdisciplinary collaboration improves patient care [13], descriptions of the necessary skills and studies on the effectiveness of interdisciplinary collaboration are rare [14]. For this reason, the Medical University of Vienna attached great importance to interprofessional education and training in its "White Paper on Teaching" (2018) [15]. Medicine and also the field of psychotherapy have a specific catalogue of competence levels [16,17], which includes a qualification profile for interdisciplinary collaboration in the psychosocial field. From this, the derivation of learning objectives for clinical work [16], a corresponding didactic concept along Bloom's taxonomy and the requirements for strategic curriculum-development, higher education didactic or personnel development effects for

interdisciplinary teaching and professional socialisation characterised by respect, trust and empathy can be clearly derived [18].

Developments, results and trends in psychotherapy research suggest that clear consequences should be drawn for the conceptualisation of training of personalized care. Particularly in connection with universities, which are committed to research-led teaching, a meta-discourse has been introduced that enriches both areas - training and psychotherapy research - and represents an enormous potential for development in order to fill research gaps. At a curriculum-strategic level, a psychotherapy portfolio consisting of several courses has been established at the Medical University of Vienna since 2013, some in cooperation with other educational institutions. On the medical didactics side, a number of employees have completed a Master of Medical Education (MME) programme on the topic of interprofessional teaching. Human resources development has also taken up interprofessional collaboration and offers courses on psychosocial skills together with continuing education, meaning that chairs in research areas related to the medical health professions are slowly being established.



SPECIFIC QUALIFICATIONS

In order to generate a stronger social orientation and an assessment of the qualification profile with regard to its treatment efficiency despite intensive regional anchoring, content-related discussion and empirical research in the direction of institutional research are necessary. Since the patient is always at the center of integrated care, psychosocial interprofessional competence and its mediation is always linked to a care plan, legally covered and coordinated with the respective providers. This strategy, which must be strictly adhered to, inevitably results in a socially relevant agenda. HealthCare research and training research on didactic issues are necessary:

In order to understand the challenging efforts to implement the idea that within psychosocial care the subjective meaning is essential for treatment processes, we conducted an interview

study that showed us the necessity to go deeper into the question of care in a systems-theoretical way.

Investigation

An interview study was conducted in a cyclical research design [19] with experts from different disciplines and domains responsible for health care, who had already been involved in questions on public mental health care planning, effectiveness for chronically and severely disturbed patients or ethics of care in their area of responsibility (e.g., medical education, curricular development, design of health care pathways, etc.). Material was analyzed according to the thematic coding paradigm.

As a result, contexts and problems of action were mentioned (Tab.1) suggesting to focus timely mandatory organisational development and faculty building strategies; equality of treatment, care ethics, multiplication and collaboration, inclusion of all stakeholder, patients, their relatives and the respected advocacy, were seen as facilitators for implementation. Patient-, stakeholder- and students' involvement was mentioned as strategy to build up structures, also toward new curricula of psychotherapy. An overview of condensed themes is given in Table 1.

Table 1: Code family: Contexts and problems of action according to expert perspectives

Thematic Codes	Perspectives											
	Health Policy Advice	Health Care Administration	Health Insurance	Social security & health policy employer perspective	Health policy employee perspective	Health Care Research and Health Policy Advice	Health Care Research and Psychosocial Strategy Development	Psychotherapy Care and Professional Representation	Psychosocial Services and Professional Representation	Legal protection	Patient Advocacy	Patient (Representation)
Planning & lobbying	19	14	4	6	29	3	13	19	3	5	3	16
Readiness	9	7	4	7	23	3	16	6	2	4	4	10
Organizational responsibility	4	7	2	10	17	3	11	2		6	16	
Complaints & advocacy	1	5		1	10			8	1	1	16	1
Professional development policy	4				18	1	4	7		1		3
Self-help & representation of affected persons	5			1	3		4				2	19
HealthCare research & scientifically based support		2	1	5	7	1	9	2			3	2
Relatives & relatives' representatives					4			1	1	1	5	9
Health policy responsibility	4	1		1	5	2	2	1		2	3	
Visibility	1	1	2	1	4		2	1		3	4	1
Ignorant environments	2	1	1	4	1		4		6		1	
Control within the legal framework	1	8	1		6							1
Relevance of the person or being networked			1		4			3	3		2	4

Networking	2	1	4		2	3		5	1	1		1
Legal protection					3					10		1
Patient representation					2	.		1		6	4	1
Political will fixation	1	1		1		1	2				1	
Conflict management		3									1	1

Legend Table 1: The numbers show the amount and frequency of the codes mentioned.

SKILLS PROFILE

Every training effort and curriculum is based on a qualification profile. The core competence for the treatment of the mentally ill [20] is mentalisation competence [21]. In addition to the therapeutic relationship, which in turn is influenced by the attachment capacity or ability to bond, empathy is one of the general factors for psychotherapeutic effectiveness. The latter is closely linked to factors that are considered essential for the psychotherapeutic profession: Openness and curiosity, humanity and attentiveness, integrity and social as well as multicultural sensitivity, patience and tolerance, etc. [22].

The core competence of mentalisation skills is closely related to empathy skills and interprofessional competence and has already been investigated with regard to its trainability in various professional groups in the care context [23,24]. In order to develop an institutional research agenda from regional research work, international networking is essential:

The experiences and approaches presented here should be seen in the context of a project that has been running since 2011 and is being conducted worldwide by the Society of Psychotherapy Research Interest Section on Therapist Training and Development (SPRISTAD) [25,26,27]. In the globally different training programmes, the qualification profiles (ability to reflect, interdisciplinarity, etc.) were similar and the definition of criteria for the selection of applicants was also the most uniform result across countries: the admission criteria focused mainly on personal qualities (empathy, self-awareness and good mental health), supplemented by the assessment of relevant intellectual qualities (psychological thinking, theoretical interest), as well as the commitment to relationship-based experiential learning. Because of this research-based approach, there is potential for development and implementation at several universities.

DIDACTICS

I As the focus of the training is on clinical practice, the teaching of theory is linked to specific case material. The ongoing group work enables a detailed study of cases (problem-oriented, patient-centred) with a review of the relevant literature [25,28]. The small group works at the beginning and end of a module/topic block, or fortnightly over 3 or more years in the case of longer topic blocks. As part of bedside teaching, students work on and discuss their own cases [29] under supervision on a weekly basis in the advanced course so that the theory can be learnt and consolidated in everyday working life [30].

In terms of didactic considerations, the concept of the "flipped classroom", the teaching of theory over long periods of self-study, case-oriented teaching [29], the teaching of applied knowledge via simulated patients [31] and learning using scenarios, integrated thematic instructions [28], as well as the promotion of polythematic network and cross-linking thinking through routine team meetings are important. Reflection skills are required and promoted

through a "learning diary" in the "Empathy Lab" [24] and in the plenary discussion by naming the challenges and opportunities of interprofessional collaboration (similar to a SWOT analysis) [23,32]. Interactive questions in e-CBBL lessons [28,29], the students' own case presentation and attitude reflection have so far proven to be the most beneficial measures for learning progress in interdisciplinary work [33]. The evaluation (case control study) using a questionnaire on interprofessional socialisation is ongoing.

Didactic concepts and considerations for admission have been developed with the target planning of the meta-competences to be achieved: resilience, self-organisation, self-reflection, basic digital competence, communication and learning competence.

INTERNSHIPS

The duration of the internships in inpatient and outpatient facilities corresponds to international guidelines [18,25] and is linked to the regular review of the number of cases treated in each facility with regard to training sovereignty. The practical activity includes case work, case reports, case studies, case series and, furthermore, the development of a concrete research design in the professional field. The academic examination (e.g. also in the form of a Master's thesis) therefore includes data from the student's own professional field/organization, provided that empirical scientific research designs are chosen. If field research methods, interview methods or grounded theory methods are chosen, the Master's thesis contains narratives or individual case descriptions that are processed anonymously in accordance with "good scientific practice". In all cases, the guidelines of research ethics must be observed. Here, too, the focus is on interdisciplinarity at the practice level and also at the research level, which is integrated into treatment plans (including diagnostics, indication procedures) [30].

RESUME

Interdisciplinary work is essential for university development, curriculum design, research strategy and personnel development in the face of increasing specialization, individualization and the enormous growth in knowledge. A bio-psycho-social approach in the sense of an integrated approach is indispensable, especially when working with and treating the mentally ill. Since university development is always a research-led process, evidence-based management can benefit from the experience of psychotherapy, interdisciplinary work in integrated care and its didactic concepts and mixed-methods research perspectives that integrate multi- and interdisciplinary findings from biomedicine, psychology, statistics, social and behavioral sciences, education, social work, sociology, politics as well as the perspectives and experiences of non-scientific actors. An "integrated interdisciplinarity", which overcomes the typical additive character of current interdisciplinary work and can better grasp the inherent complexity of public health, can provide impetus for several universities, as shown here. Systems science thinking approaches as useful metatheoretical, self-reflective approaches to integrated competence development have been proposed here. Developments, results and trends in psychotherapy research suggest that clear consequences should be drawn for the conception of psychotherapeutic training. The didactic models presented here reach far into several disciplines and universities that focus on the treatment of people and are committed to relationship-based experiential learning. Since the patient is always at the center of integrated care, psychosocial interprofessional competence and its mediation is always linked to a care

plan, legally covered and coordinated with the respective providers and stakeholders. This strategy, which must be strictly adhered to, inevitably results in a socially relevant agenda.

The practice of "integrated interdisciplinarity", which is made possible by systems thinking, allows an understanding of the treatment of the mentally ill in the field of public health. The educational field of psychotherapy was chosen as an example, as this discipline has a long tradition of research-led interdisciplinary collaboration. This forms the basis for more holistic university strategic responses that also involve society as a whole in a critical dialog in order to jointly develop and shape actions, measures and strategies.

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