How to Be Cooperative in a Competitive System: The Multi-professional and Mul...
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INTERNATIONAL PERSPECTIVE

▲ How to Be Cooperative in a Competitive System:

The Multi-professional and Multicultural Face of European Health Care Education

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Over the past year, the *Journal of Allied Health* has featured two articles about health care in the European Union (EU). While the structure and government of the EU is far different from that of the United States, the EU's experience in integrating diverse cultures into a workable health care system has held lessons for us.

The current article, written by the former president of Cohehre (Consortium of Institutes of Higher Education in Health Care and Rehabilitation in Europe), Dr. Anne Beyers, looks at the nature of health care education. Dr. Beyers discusses the Bologna Declaration, a bold attempt to standardize higher education in EU countries. This would, in theory, facilitate mobility of students and graduates throughout the EU by establishing transferable credits and degree requirements in colleges and universities through the 29 countries signing the document. Education of health care professionals would be part of this system.

Dr. Beyers also discusses a major challenge to implementation of the Bologna Declaration in terms of the manner in which health care professionals are educated. Will education be strictly based on Western ideals of scientific rationality and economic goals (competition), or will it include a humanistic, quality-of-life perspective (cooperation)? One of Cohehre's responsibilities is to grapple with this difficult issue as the EU moves forward with the Bologna Declaration.

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This article discusses the Bologna Declaration, in which 29 European countries have voluntarily committed to standardizing the various systems of higher education, including the education of health care professionals. One of the purposes of the Bologna Declaration is to attract students and income from abroad in order to rival the United States and Australia. An important consideration regarding the impact of the restructuring process is whether it will also contribute to the enhancement of interdisciplinary and intercultural cooperation, which are major factors influencing quality of life for both patients and health care workers.
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TO BECOME a good professional, one needs good training. Until now, every European country has had its own concept of what "a good health care professional" should represent. Most countries have already exchanged ideas, worked on international study programs, and introduced international student and staff exchanges between institutions and diverse disciplines. For many years, the European Commission invested millions of euros on international cooperation in the field of higher education. In June 1999, European countries came to an agreement to restructure the European higher education area to overcome the gap between the integration of the European business market (1992) and the more national-oriented character of educational grades and degree structures. The agreement is called the Bologna Declaration. The Bologna Declaration process represents major changes in the European system of higher education. European higher education will be standardized and packaged to attract students and income from abroad in order to rival the United States and Australia. A flexible system of lifelong learning in the international and multicultural European framework should support and balance employability within the European region and prevent the "brain drain" to other continents that invest more in research and innovation.

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Europe could even become attractive to scientists and specialists from other parts of the world and might contribute to innovation and development on a worldwide scale.

People involved in health care are aware of the fact that health care is closely related to quality of life and human dignity. Therefore, educating health care workers challenges not only the educational system and its educators but the health care system and its health care workers as well. An important question to be put forward is the following: Will the impact of the restructuring process of European higher education (the Bologna process) enable people to not only focus on economic, intellectual, and technological competitiveness, but will it also contribute to the enhancement of interdisciplinary and intercultural cooperation, which are major factors influencing quality of life for both patients and health care workers?

European higher education is based on the Western concept of rationality, intelligence, and competitiveness. In practice, those concepts do not yet focus on cooperation and lifelong learning for all. It provides "best" education for "best" students. Unfortunately, this means that many young people drop out of school at an early stage, without getting many opportunities to complete a full training. Another important issue is the fact that this competitive attitude, in which we are trained so well, leaves the health care worker empty-handed as far as communication and intercultural and interdisciplinary cooperation are concerned. From the moment the well-trained professional starts a professional career, health care practice confronts him or her with many questions and problems that cannot be answered or solved just by using the competitive attitude that made him or her get the degree and grades.

In this paper, I address the conceptual background on which Cohehre keeps aiming for multi-professional, interdisciplinary, and intercultural cooperation. The first section gives an introduction to the Bologna Declaration agreement, and the second section questions the right balance between competitiveness and cooperation.

The European Higher Education System

European higher education is going through a process of transformation. The Bologna Declaration[1] challenges universities and other institutions of higher education to reorganize and tune their curricula in order to cooperate within a conceptualized framework of lifelong learning, inspired by the demands of a European competitive knowledge society. Within the Bologna Declaration, 29 European countries committed, on a voluntary basis, to converge the various systems of higher education. This consensus was reached for mainly three reasons:

1. The experience that large-scale student mobility in Europe clashes with the different structures and educational systems in Europe
2. The growing tension between national systems on the one hand and the internationalization of activities and careers on the other hand
3. The fact that universities in Europe seem to have become less attractive to prospective students when compared with those in the United States and Australia.

Bologna, as the new process is now commonly called, focuses on six action points:

1. Adopting a transparent system to compare degrees from member countries
2. Adopting a system that is essentially based on two learning cycles (bachelor's and master's degrees)
3. Establishing a system of transferable credits
4. Stimulating mobility between countries
5. Stimulating European cooperation in quality health care
6. Stimulating the integration of the European dimension in higher education.

Bologna, however, is not a one-time achievement, but rather a continuous process. The ultimate goal is to create a "competitive European higher education area." The deadline set for the implementation of the Bologna objectives is 2010.

Debate on the Argument

The question to be raised here is focused on intellectual and economic competitiveness and relates to the nonprofit social sector, that is, education and higher education in health care in particular. Health care professions involve scientific observation, intervention, and theory. A well-trained professional will have the right technical knowledge and competencies to deal with health care problems in an adequate way. Yet human suffering is also a daily reality of clinical life; it involves ethical issues as well, by addressing questions and problems of people who might differ fundamentally on what they value in life. Any professional intervention in the lives of others not only affects the technical well-being of the patient involved but also affects the interhuman relationship and the emotional well-being of both the patient and the health care worker. Attempts to codify the relationship between the health care worker and the health care receiver, based on a framework of scientific, economic, and intellectual axioms that are self-evidently true, might lead to a mere quantitative approach of quality-of-life questions for both health care workers and patients. With a focus on higher education in health care, we may presume that the Bologna process can be looked upon as a tool to link education, economics, and health care in a very pragmatic way. However, if lifelong learning in a multicultural Europe only focuses on competitiveness, employability, economic growth, and maximizing profits and does not give the same amount of attention to the importance of adequate interdisciplinary and intercultural communication and cooperation, then one may wonder how long the well-trained professionals will last in their jobs before having to resign, getting ill, or experiencing "burnout." Is it still possible to develop our health care education in a way

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that will benefit interdisciplinary and intercultural cooperation, or will this new Bologna system force us to push the debate about competition to extremes? Will the pursuit of ambitious and noble educational and cooperative communicative goals exist along with rather narrow and one-sided economic criteria and contestable cost-cutting experiments? Economic and intellectual competitiveness, in which both education and health care are increasingly drawn, amounts to the ascendance of a market-oriented economic logic of maximalization, in which quantitative interests tend to overrule the value, dignity, and quality of life of the human being. Further, health care education seems to no longer be primarily interested in the central concerns related to quality of life. The dominating dynamics of economic competitiveness and growth tend to replace the dynamic of human deliberative relationships,[2] in which quality of life and care are also on the agenda and are equally discussed and defended.

If we choose to look at a human being (student, patient, and so on) as a being that has no value except insofar as it can be used as a means to exploit, then principles of instrumentality and utility will dominate as the prevailing principles of our educational and health care policy. The "hurly-burly of clinical practice," as Grant R. Gillet puts it, tends to prevent health care workers from reflecting on "what is so special about human life."[3] One could say that Gillet rings the alarm bell at the introduction of his book. Both patients and health care workers suffer from what he calls "the loss of human dignity," which they experience while having to function in a system that goes along with a pure competitive and technological approach. "Easy life," according to Gillet, brought about by technological advancement, does not always cover the quality-of-life expectations of both patients and health care workers. How does one cope with all this? Posed as an empirical rather than an ethical question, the answer is alarming. Our professions have an inordinately high rate of marital disruption, substance and alcohol abuse, and suicide. However, posed as an ethical question, it directs us toward the moral psychology of human beings in general and health professionals in particular. An "esprit de corps" and institutional mechanisms help us to cope. Gillet further asserts that there is also a culture of medicine, but at times certain elements of that culture seem themselves to be pathological.[3]

Higher Education in Health Care

> Students of today are the professionals of tomorrow. In a world dominated by the power of knowledge, professional experts exercise a crucial influence on the lives and quality of life of millions of citizens. In the future, this will increase under the influence of new (bio) technological and managerial developments. Their implementation by professionals will affect the human and natural environment, the solution of problems with regard to life and death, employment and the quality of information and public office.

With this statement, Johan Verstraeten, director of the European Ethics Network, opens the foreword of the book, *Healthy Thoughts, European Perspectives on Health Care Ethics*.[4]

Education in health care is developing very fast. Standing still is not an option. Not only students but also health care teachers are expected to be in a process of lifelong learning. There is also the role of health care education as such. What is the relevance of health care education in this ongoing process of changes and evolution? What is the social responsibility of health care education schools? How can we decide which direction to go? Universities and university colleges can make a contribution to the education of citizens with a sense of responsibility. The same can be emphasized in looking at the relationship between health care workers and patients.[5] The ongoing learning process invites us to look beyond those dimensions of treatment that are only considered to be relevant according to the premises of a certain technical discipline. As many health care workers and patients can attest, we unfortunately often tend to get stuck in a bureaucracy of technical rationality, with a mentality permeated by instrumental thinking and manipulation. By no means should it be said that scientific interpretations are meaningless or without value. However, through a creative confrontation between various disciplines and cultures, the field of vision can expand from that of narrow scientific interpretations.

Think Global, Act Local

Western education is based on the Western competitive attitude, which is reflected in our Western educational systems. Of course, we have been implementing other educational methods such as problem-based learning, which focuses on cooperative learning in a student-centered approach. However, our Western competitive thinking and acting does not leave much space for a cooperative attitude. It is based on the Western modernistic concept of intelligence, transparency of the subject, and the premise of rationality, which can be linked to the Cartesian concept, "I think, therefore I am." Although Europeans know that they must learn from and cooperate with other non-European cultures such as South Africa, we basically still hesitate to do so. European nations are still inclined to withdraw behind their national borders while, for instance, South Africa could inspire us by the way educators implement problem-based learning into their health care education, starting from a completely different background. After apartheid, the Truth and Reconciliation Committee made quite-clear recommendations concerning the implementation of human rights and ethics in the health care curricula of its schools. Eighty percent of the South African population lives according to the Ubuntu philosophy's cultural background. This concept of Ubuntu signifies the recognition of human worth and respect for the dignity of every person. "Umuntu ngumuntu ngabuntu" ("I am because we are.")

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The Ubuntu concept of being means that to be human is to affirm one's humanity by recognizing the humanity of others, and, on that basis, to establish human relations with them.[6] In its fundamental sense, it translates as personhood and morality. Metaphorically, it expresses itself in describing the significance of group solidarity on survival issues so central to the survival of communities. Its spirit emphasizes human dignity.[7] This cooperative attitude could inspire the West and might add important relational and cooperative competences to our high technologically developed health care system.

Where does the Bologna Declaration leave our attempts to establish patient-centered, multi-professional, and multicultural cooperation in health care? The way in which the health care system and health care education are organized still reflects a top-down structure. In this structure, medical professionals and specialized physicians, those who are most scientifically educated, stand for the "top" of the pyramid. Paramedical or allied health professionals represent the supportive base of the pyramid. Although we all agree that the medical professionals cannot exist without the allied health professionals and vice versa, our educational systems are still struggling with cooperation between medical and allied health professions and do not yet incorporate a cooperative attitude in which the characteristics of the different professions are recognized and respected equally. "Diversity," within the existing framework, is linked to "good, better, and best." We risk adhering to a conceptual framework where the Western scientific concept of objective reason is the dominant value for scientific knowledge and the processes of "illness" and "health." Science intends to start from objective reason and leads to objective knowledge, which in turn leads to judgments that are objective and universally valid. This is what science is good at. Yet what about recognizing the tasks and responsibilities of those who are not only trained in what we call the "exact sciences" and who must deal with health care aspects that are more related to qualities and objectives of the social sciences? In the context of a holistic health care approach, "exact science" becomes not a goal but rather an instrument to use in the multi-professional approach to patients. The narrow and one-sided economic criteria and contestable cost-cutting experiments, which are quantitative measures, will be the input and inspiration for a dominant quantitative and measurable medical scientific approach in health care education. This will not be adequate to prepare professionals for practice.

Even though the problem-based learning approach focuses on multi-professional cooperation, the competitive discussion between "exact science" and more social science-related aspects of care also influences the discussion on what should be incorporated in the health professions curricula and what should not. One could say that there is still a kind of hostility between the diverse discipline-related knowledge systems. They compete for dominance.

Thus, even when we introduce and implement cooperative educational systems, we still compete and fight each other as if every complementary discipline-specific knowledge system is a threatening and inferior system.

What to do? Can we afford to look back 10 years from now and excuse the cooperative bankruptcy of our educational system by saying "we couldn't help it; the use of the Western modernistic rationality concept is in our nature!" Conversely, will we take the risk of taking up the challenge of starting to think globally and to open up our minds toward concepts of cooperation that could be the gateway to understanding cooperative social responsibility?

"Think globally and act locally"; this nice management saying still has a long way to go to be universally accepted. It may be clear that we do not think globally, so it is unrealistic to presume that we act locally with a "global" open mind. The West, with its rich imperialistic past, is still pushing evolution, driven by a technological rationality that, of course, created all possibilities the West knows and "celebrates" at this moment. However, it has not educated us to be cooperative world citizens as yet.

Do we have motives for interdisciplinary and intercultural cooperation in health care or will we continue our work and education in a competitive framework that puts a mortgage on quality of life, not only of that of the patient but also of that of the health care worker?[8] This is a question with which Cohehre must deal.

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