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Aim and scope

The Malta Journal of Health Sciences is a peer-reviewed, open access publication that promotes the sharing and exchange of knowledge in Health Sciences. It provides a platform for novice and established researchers to share their findings, insights and views within an inter-professional context. The Journal originates within the Faculty of Health Sciences, University of Malta.

The Malta Journal of Health Sciences disseminates research on a broad range of allied health disciplines. It publishes original research papers, review articles, short communications, commentaries, letters to the editor and book reviews. The readership of the journal consists of academics, practitioners and trainee health professionals across the disciplines of Applied Biomedical Science, Audiology, Communication Therapy, Community Nursing, Environmental Health, Food Science, Health Services Management, Medical Physics, Mental Health, Midwifery, Nursing, Occupational Therapy, Physiotherapy, Podiatry and Radiography.

Submitted manuscripts undergo independent blind peer review, typically by two reviewers with relevant expertise. All manuscripts are reviewed as rapidly as possible and an editorial decision is generally reached within approximately two months of submission. Authors of manuscripts that require revisions will have two weeks to submit their revised manuscripts. No manuscript that has already been published or is under consideration for publication elsewhere will be considered.

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Guest Editorial

Meeting the challenges of person-centredness in mental health care and education

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The provision of mental health care is undergoing significant changes, transitioning from a medical model that focuses on the diagnosis and treatment of mental health conditions to a person-centred holistic approach, that puts the individual at the centre of care. Nonetheless, the narratives of persons with mental health challenges still resonate with experiences of being viewed in terms of *'problems, symptoms and deficits rather than being citizens with strengths and areas of competence'* (Borg & Karlsson, 2017, p.221). Such experiences often result in feelings of isolation, shame and/or stigmatization by others. The experience of stigmatising attitudes has been further linked to diagnostic overshadowing, which can negatively impact access to healthcare within both mental health and general services (Banks, Scerri & Davidson, 2021).

A person-centred philosophy in mental healthcare incorporates an active participatory and collaborative partnership that includes: the person with the mental illness, people significant to them and healthcare providers. It involves creating a safe and non-judgmental space where individuals and others significant to them are treated with dignity and respect. It also emphasises the importance of working with the persons' beliefs and values, involving them in the decision-making process, recognising their uniqueness and value and targeting the whole person, through the integration of psychological, spiritual, developmental, physical, and sociocultural dimensions. It is through such collaborations with persons having a mental illness and their significant others, that care plans which are truly meaningful and relevant to the person are formulated, whilst ensuring that the required support and resources continue to be provided over time.

Despite the many benefits of person-centred care in mental health services, there are also some challenges associated with adopting this approach. One of the main challenges is that person-centred care requires a shift in the way healthcare providers approach care delivery. This requires a significant amount of ongoing training (including self-reflection) and support, to help healthcare providers acquire the skills, attitudes and knowledge needed to deliver person-centred care effectively. The development of care plans that are tailored to the person's unique needs, preferences, and goals may also pose challenges due to the significant amount of time and resources that are also required. This can prove challenging in a healthcare system that is often focused on performance metrics and productivity. It also contrasts with the establishment of '*healthful cultures*' at the workplace, having transformational leaders and where innovative practices, shared decision-making, and collaborative staff relationships are supported and encouraged (McCormack & McCance, 2017).

Nonetheless, the introduction of significant shifts in healthcare delivery also highlights the importance of reforming healthcare education (Cervero & Daley, 2018). The application of a modified version of McKinsey's 7S model (i.e., strategy, structure, systems, shared values; style; skills and staff) (Peters & Waterman, 2004) has

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been found useful when evaluating curricula and in implementing change. The first element, **strategy**, incorporates the unique selling point of the programme, namely the explicit and intentional focus of developing person-centred practitioners. This requires an understanding of person-centredness and encapsulates addressing core constructs such as the macro-context (e.g., policies); prerequisites (i.e., developing professionally competent and reflective mental health practitioners) and the practice environment within the curriculum. The **structural** element highlights the need for the co-construction and evaluation of the curriculum with key stakeholders that includes strategy and policy leaders, students (e.g., through student curriculum evaluation committees), educators (in practice and academic settings) and recipients of healthcare (Cook et al., 2022). This partnership supports continuous evaluation and quality improvement, ensuring that the structure of the curriculum remains responsive and dynamic to changing health and educational demands. Creativity and active learning should also be fostered to enhance the critical and reflective skills required for personal and professional growth in the development of person-centred practice. The **systems** element requires the alignment of teaching, learning and assessment methods with the philosophical principles of personhood (McCormack & McCance, 2017). This can be achieved by immersion in realistic practice environments that provide authentic learning such as simulation and actual mental health settings; the use of various methods of learning and means of assessment including creative modalities (e.g., compilation of portfolios; drama) and the provision of spaces for critical dialogue and reflection, where learners can make sense of their own experiences. The **shared values** component represents the ethos of the programme, where all stakeholders agree on ways of being person-centred in their attitudes with both colleagues and students. This can be exemplified in the co-creation of learning handbooks that incorporate the voices of various stakeholders and facilitates the sharing of values that are espoused in an applied and meaningful way. Another required element is having a transformational leadership **style** that is collaborative, authentic, cooperative, committed to lifelong learning and that encourages critical engagement, and the cultivation of diverse thinking. Persons engaged in curriculum formulation and evaluation should also have the necessary **skills** to create the conditions for learners to flourish. Such conditions include having the necessary skills, expertise, knowledge, and effective communication to create environments where educators and learners function as partners. The creation of a psychologically safe environment is also of benefit where learners can share their experiences and thoughts (Brown & McCormack, 2016) without fear of being judged or discriminated against. Educators should also provide timely and transparent feedback and feedforward and optimum staff-student ratios should be ensured. Investments in **staff** development, both in relation to the diversity of team members and their individual learning needs, are required to ensure that the staff have the necessary attributes to deliver the individual learning needs (Bruggeman et al., 2020). Examples of such staff initiatives that assist in the development of their knowledge, skills and expertise include curriculum design initiation events and evaluation workshops; peer-supported activities and sharing of best practice events (Cook et al., 2022).

In conclusion, person-centredness is an essential aspect of mental health services. It requires a commitment to treating individuals with respect and dignity by recognizing their unique needs and experiences. However, as educators there is an onus on us to develop and evaluate curricula that empower students and staff to flourish and work in person-centred ways. The formulation of any curricula can never represent a 'fait accompli' with educators and stakeholders resting on their laurels for a work well done. Rather, curriculum evaluation should be interpreted as a work in progress since one must remain responsive to the educational, healthcare, and dynamic context in which healthcare practitioners, students, and educators function. The Faculty of Health Sciences at the University of Malta continues to play a vital role in this regard through its contribution towards the development and flourishing of professionally competent healthcare practitioners, who play a vital role in the creation of healthful cultures in the workplace.

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Commentary

Person-centred Care in Rehabilitation: Shall we explore?

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The concept of person-centred care has developed over time due to significant changes in the interactions between patients and physicians in healthcare systems. Over the years, diverse healthcare professions involved in the care of patients have also evolved. It is useful to consider the changes which have occurred in patient care across time, keeping in mind the transition from patient-centred care to person-centred care in diverse social and cultural contexts.

Several conceptualisations have been discussed in healthcare literature regarding the development of interactions between patients and their physicians and other healthcare professionals through time. These interactions have developed greatly from Parson's theoretical analysis of the 'sick role' in 1951. During this period, healthcare was dispensed from the physician to patient according to the patient's medical or surgical needs (Parsons, 1951). The introduction of the biopsychosocial model by Engel in 1977 was the beginning of a revolutionary approach to healthcare, one which attempted to address social and cultural contexts. Later, the interpretative model suggested by Emmanuel in 1992 involved patients in decision-making within their care (Emmanuel et al., 1992), whilst also starting to include an appreciation of patient's values in the decisions made. The relationship between patient and the healthcare professionals involved in his care, including the physician, was transformed in later years, leading to the development of self-management programs, especially for people living with chronic disease. However, Tattersall (2002) highlighted the difficulties in this approach, especially in the evaluation of its efficacy. He noted that the ability for patients to manage and monitor their conditions safely depended on the confidence, skills and education required. Although this sounds perfectly true, Shaw and Baker (2004) challenged these notions, and helped to coin the term "expert patient". They highlighted that all patients are experts regarding their experience of living with their condition, regardless of their medical knowledge or level of education. They claimed that this understanding of the patient's life situation enhanced collaboration between patient and healthcare professional, promoted better adherence to treatment, and led to better outcomes and solutions.

This was easier said than done. Rogers (2009) argued that the effectiveness of the Expert Patient Program introduced in the UK in 2001 was limited. It was intended to enable patients with chronic conditions to work with healthcare providers in managing their conditions. She stated that since self-efficacy was mostly used as an outcome in the evaluation of self-management programs without considering other social needs, social inequalities were not being addressed. This led to poor comparisons in self-efficacy by patients with very little financial means and/or education. Moreover, this outcome of self-efficacy did not include the collective work done by caregivers, including family, friends, and societal networks.

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Since then, there has been a progression within healthcare systems moving from a disease-centred approach, to an illness-centred approach and now a patient-centred approach. This slow progression led to further investigations of the interactions and relationships between patients and the various healthcare professionals entrusted with their care. Research related to these relationships has included topics such as empowerment, autonomy, patient engagement (Jesus &Silva, 2016), patient-centred and person-centred care (Santana et al, 2017), and more recently, patient partnerships (Odero et al, 2020). A distinction between patient-centred care and person-centred care was made by both Ekman et al., (2011) and Starfield (2011). They differentiated between a focus on the patient's symptoms and disease, and a focus on the person's experience and perception of their illness. Although the evaluation of outcomes, impacts and sustainability of person-centred care have been difficult to establish (Santana et al., 2017), several important components have been considered within its conceptualisation. These include communication with patients, listening and sharing of information, discussing care plans and respectful and compassionate care of patients (Santana et al., 2017; Kitson et al., 2013). Arguably, these concepts might appear congruent with healthcare systems today. However, there seems to be a lack of universal agreement globally on how this is achieved at clinical level within diverse social and cultural contexts. The WHO, in its 2015 report 'Global Strategy on people-centred and Integrated Health Services' (WHO, 2015) placed an emphasis on the need for context-specific models of person-centred care. It states that each country needs to "develop its own strategy for integrated and people-centred health services", and that these "must respond to the local context, existing barriers and the values held by people within the state". Whilst emphasising on person-centred care, the WHO also stated that models of care should be specific to the local context, and include values which are important to people of specific states or countries. This must surely highlight the importance of generating data from individual patients within diverse societal and cultural contexts in order to be able to implement and evaluate person-centred care in clinical practice. This would identify specific perceptions and needs for individuals undergoing rehabilitation.

Social contexts and environments, together with levels of education, have been added to definitions of healthcare and rehabilitation for some time – the WHO added 'social well-being' to its definition of health in 1948 (WHO, 1948 cited in Misselbrook D, 2014). This primary idea was added conceptually to any individual's physical and mental health. Further elaborations also included the concepts of communication and negotiation within healthcare as important social determinants, one of which is health literacy (Donkin et al., 2017; Wong Chin et al., 2014). Health literacy involves the individual's capabilities of obtaining and understanding information together with negotiation processes within healthcare systems. The social and cultural aspects within patient-professional interactions, as a form of societal exchange, would therefore be important to identify and interpret (Cordina et al., 2018). One could consider healthcare systems as a social system with a specific purpose in mind – health, disease prevention and treatment, together with rehabilitation. The WHO instilled the importance of social and cultural contexts in its understanding of rehabilitation as the "set of interventions designed to reduce disability and optimising functioning in individuals with health conditions in interaction with their environment" (WHO, 2019). As the participation of patients in their healthcare management appears to be currently an important dimension in current healthcare strategies, (Ramdurai, 2020), exploration of diverse social and cultural contexts within interactions between health care professionals and patients might be important to consider to identify individual needs.

Culture has been described as a 'socially constructed and historically transmitted pattern of symbols, meaning, premises and rules' (Philipson, 1992). It has also been conceptualised as static or dynamic, which implies individual change over time, or predictable and generalisable from individual experiences (Al-Bannay, 2013). The patient participation required during rehabilitation practice suggests the exploration of the conceptualisations of societal and cultural understandings of patient experiences of illness and disability. The Mediterranean context invites this exploration due to the sociocultural nuances present within the Mediterranean Model. Changes in local traditional family structures and values (Abela, 2009) might also be influencing the experience of patients because of social capital and social cohesion offered by robust, or absent, familial, and societal networks.

Current healthcare needs and exigencies might therefore benefit from further exploration of the experiences of patients within rehabilitation in the Maltese context. It has been shown locally that the social determinants of health and well-being appear

to be influenced by social dynamics, including roles of extended family, traditional attitudes towards the institution of marriage, gender roles and religious beliefs (Satariano & Curtis, 2018). This influence of social norms and practices on patient experience could also be addressed. Further exploration of patient experience might shed light on how interactions between patients and healthcare professionals, together with contextual familial and societal networks, influence the process of rehabilitation. Current Maltese healthcare strategies have, in fact, highlighted the importance of person-centred care (National Health Systems Strategy for Malta 2014-2020). Chapter 7 in this report indicates objectives within local health strategies which include the implementation of "the right care at the right place and at the right time" and the inclusion of different aspects of services within this, such as both hospital and community services, with individualised attention where necessary. Research is essential to identify where these objectives need to be implemented in order to achieve person-centred care.

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Undergraduate Graduation Ceremony Oration, November 2022

Environmentally Sustainable Healthcare: Challenges and opportunities

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Graduation ceremonies offer a good opportunity to take a look back, reflect, and then look forward with passion and purpose.

Looking back. The past couple of years, since graduation ceremonies were last held in their full glory, have been particularly difficult for all of us. But we rose to the occasion. Despite the setbacks imposed by the pandemic, our students persevered with their studies, completed their placements, worked on their dissertation...and in the process, undoubtedly developed resilience, adaptability, critical thinking, problem solving and other 21st Century skills that they will definitely utilise in their professional practice and in life in general. After all, as Nora Ephron once remarked, "Your education is a dress rehearsal for a life that is yours to lead." And what a rehearsal it was for your cohort, dear graduands!

As academics, we had to reinvent ourselves and rethink our ways of working and communicating, our methods of teaching and our assessment strategies. We supported our students who needed more time and encouragement to complete their studies. We conducted research during an extraordinarily challenging period.

Universities are often accused of being detached from communities and societies at large. Yet, several lecturers, administrators and students took on an active role in the COVID response team, at testing and call centres, in the vaccine roll out at the University Campus and various other sites.

But we now need to look forward.

As we strive to regain some semblance of normality, we need to make sure to retain the lessons learnt through the pandemic, in terms of flexibility; creativity; sustainability; our use of technology in supplementing (not replacing!) face to face teaching and learning, for instance by redesigning tasks in ways that would have been inconceivable without technology; working in a paperless manner; being more judicious in our travels. Indeed, a recent case study suggested that approximately one third of the carbon footprint generated by academics is related to travel for conferences.[1]

While the coronavirus pandemic was, and still is, a cause for concern, it has also partly diverted our attention from the more catastrophic and long-term effects of global warming, climate change and person-made disasters that are already evident and being felt.

We often – and understandably – focus on the negative impact of deteriorating environmental conditions on our health. Indeed, worsening air pollution and extreme heat increase the risk of non-communicable diseases such as respiratory and cardiovascular disease and cancer. A study published last June in *The Lancet Planetary Health* showed that one in every six deaths occurring globally between 2015 and 2019 was attributable to diseases

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1 Ciers, J. et al. (2019). Carbon Footprint of Academic Air Travel: A Case Study in Switzerland. *Sustainability, 11,* 80; doi:10.3390/su11010080

caused by air pollution.[2] This equates to approximately nine million premature deaths per year being caused by pollution, which exceeds the mortality attributable to drugs, alcohol, war, terrorism and road traffic accidents, and is three times the number of deaths from AIDS, tuberculosis and malaria combined.

However, health and the environment are inextricably linked in the other direction as well. The notion of *Primum non nocere* – first do no harm – has underpinned healthcare delivery for centuries. Yet, according to the Health Policy Partnership (UK), the healthcare sector itself is responsible for almost 5% of global greenhouse gas emissions, and has a carbon footprint equivalent to more than 500 coal-fired power plants. If the healthcare sector were a country, it would be the fifth largest polluter in the world.[3]

By far, the majority (71%) of greenhouse emissions from the health sector consist of indirect – and, therefore, overlooked – emissions, such as those from supply chains. These include the production, transport and disposal of medications, food, medical devices and hospital equipment. This was compounded by the COVID-19 pandemic, which necessitated a tremendous increase in the amount of personal protective equipment and other single-use items to protect staff while caring for patients.

This, dear graduands, is one of the most pressing issues impacting our planet as you formally join the workforce. And unless you – we – challenge the status quo, and radically rethink our way of doing things, emissions from healthcare facilities could triple between now and 2050. As graduates, you are now in a position to influence this, first by raising your awareness on these challenges and ways to address them, and subsequently by improving your own practices, influencing policy and leading by example. To quote the American journalist Tom Brokaw:

> *You may think of (your degree) as the ticket to the good life. Let me ask you to think of an alternative. Think of it as your ticket to change the world.*

Although we can do more, the University is striving to impart the principles of sustainability. For instance, the Department of Nursing, which I form part of, signed up to the *Climate Challenge Europe*, which provides nurses with resources to educate fellow healthcare professionals, students, communities and service users about the health consequences of climate change and the impact of the healthcare sector on the environment.[4] We took an active part in developing the *Nursing School Commitment*, which serves as an opportunity to empower nursing students at all levels to encourage environmental stewardship.[5] And we joined forces with several European universities and healthcare entities in an alliance that seeks to design and deliver a course on planetary health for health science students, with a strong focus on sustainability and climate advocacy within healthcare facilities. Crucially, sustainability is one of the themes of the University's strategic plan (2020-2025) with ambitious but achievable commitments related to waste reduction, reuse and recycling; water conservation; energy efficient measures; sustainable transport; and training and research on sustainability amongst others.[6]

But today is mainly about celebration. So congratulations to you, graduands, on having persisted and completed your studies in more challenging times than usual, and to your parents, family and friends who supported you in this journey. I have no doubt that your journey as undergraduate students has equipped you with several transversal skills, that will enable you to assert yourselves as competent, conscientious and caring professionals.

Needless to say, this is a first step. Keeping abreast with research is not optional. And the sky is the limit in terms of opportunities for further education and training. Of course, these include various postgraduate programmes

2 Fuller, R., et al. (2022). Pollution and health: a progress update. *The Lancet Planetary Health, 6*, e535-47. https://doi.org/10.1016/S2542-5196(22)00090-0

3 Smith, L. (2022). The nexus between climate change and healthcare. *The Health Policy Partnership.* https://www.healthpolicypartnership.com/the-nexus-between-climate-change-and-healthcare/

4 Health Care Without Harm (2021). *Nurses Climate Challenge Europe.* https://eur.nursesclimatechallenge.org/en

5 Heath Care Without Harm (2021). *Nursing School Commitments.* https://eur.nursesclimatechallenge.org/en/school-of-nursing-commitment

6 L-Università ta' Malta (2020). *Strategic Plan 2020-2025: Serving students, scholarship and society, sustainably*. Malta: University of Malta.

and standalone continuing professional development courses offered by our University, including a number of new courses geared at facilitating specialisation that are being offered for the first time this year.

I would like to conclude with a quote from Arie Pencovicie:

> *Graduation is only a concept. In real life, every day you graduate. Graduation is a process that goes on until the last day of your life. If you can grasp that, you'll make a difference.*

On behalf of the University of Malta, I wish you the very best in your professional and personal lives and encourage you to do your utmost to make a difference.