

Resolving this deep-seated contradiction requires a comprehensive approach, since it is impossible to change the cultural code simply by issuing new orders.

The primary avenue for resolving this contradiction is a comprehensive transformation of educational approaches.

The methodology for teaching communication skills makes it clear that partnership does not mean leaving the patient alone to make a choice (“choose for yourself”), but rather carefully facilitating their vulnerable autonomy.

Objective

In this context, it is important to identify the types of perspectives through which a specialist understands their role, their authority, and their relationships with patients, which in turn influences their willingness to learn medical communication that offers tools for partnership-based interaction.

Materials and Methods

The study employed a comparative analysis to contrast the value-and-meaning matrices of different worldviews held by medical professionals and to identify areas of axiological conflict with the value-and-meaning foundations of partnership.

Results

The study resulted in a typology of healthcare professionals' worldview perspectives and their influence on communication with patients. This typology is based on the professional stance of the healthcare professional, which is determined by their attitude toward the structure of life, the patient's role in the interaction, and their perception of non-standard situations when providing medical care.

1. A mindset focused on chance and fate, in which the medical professional tends to minimize efforts to build relationships, perceiving any difficulties as inevitable. Partnership seems pointless: “nothing can be changed anyway.”
2. A mindset focused on inherent superiority and self-interest, in which partnership is perceived as an encroachment on status. Questions are interpreted as mistrust, and discussing options as doubting the healthcare professional's competence.
3. A focus on rules and “penalties,” which boils down to “adhering to the rules of interaction.” If the patient does not follow the “correct script,” they are labeled “wrong,” which intensifies the conflict.
4. A focus on exchange and transactions, where partnership is understood as a bargain. If the patient does not “pay” with the expected loyalty, the healthcare professional feels deceived and reduces their level of engagement.
5. A focus on illusion and “emotional comfort,” where the healthcare professional offers only formal participation in the discussion without genuine involvement. Partnership is perceived as a “ritual” that does not affect the essence of the process.
6. A mindset focused on professional responsibility and reflection, where partnership is not perceived as a threat but as a tool for achieving better outcomes.

The healthcare professional does not view maintaining authority as a goal; rather, authority emerges naturally as a consequence of competence and the ability to engage in dialogue, rather than through hierarchy.

Worldview attitudes shape the “perspective” of the dialogue with the patient: five of the six attitudes discussed tend to perceive partnership as a threat, while the sixth views it as an opportunity.

Discussion

Professionals' attitudes toward fatalism, superiority, or bargaining increase tension within the system. A doctor or nurse with a superiority-oriented attitude may interpret any nonlinear behavior on the part of the patient as a lack of trust and react involuntarily with irritation.

A professional with a mindset of reflection will see the same patient behavior not as an attack but as a warning sign and will offer a clear risk assessment protocol, thereby strengthening cooperation.

Thus, a “threat to authority” is not an objective loss of status, but a subjective experience linked to how a healthcare professional interprets the need to negotiate with the patient.

Conclusions

By focusing on the physician's legal vulnerability, the paternalistic model completely ignores the patient's existential responsibility.

The proposed typology can serve a diagnostic and motivational function for instructors of medical communication, as well as for healthcare professionals themselves in honestly identifying their own type, and demonstrates that without an evolution of one's own worldview, it is impossible to expect effectiveness from communication skills. It is necessary to seek ways to reduce feelings of threat and, conversely, to draw from the partnership resources that contribute to satisfaction with the provision of medical care among both patients and healthcare professionals themselves.

Partnership does not negate professional authority — it changes the interpretation of its nature. Authority ceases to be a given based on position and instead becomes the result of competence, empathy, and the ability to engage in dialogue.

The goal of medical education and simulation-based training methodology is not to impose a “correct worldview,” but to foster reflexivity: the ability to recognize one's own fears and preconceptions, understand their impact on practice, and consciously choose professional strategies.

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THE ALL-RUSSIAN SURGERY OLYMPIAD FOR RESIDENTS AND STUDENTS, NAMED AFTER ACADEMICIAN E.A. WAGNER AND FEATURING INTERNATIONAL PARTICIPATION, MARKS A NEW STEP IN IMPROVING THE TRAINING PROCESS FOR SURGICAL SPECIALTIES

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Abstract. Bringing together residents and students in a single forum — the All-Russian Olympiad for Residents and Students in Surgery with International Participation named after Academician E. A. Wagner — made it possible to intensify the process of teaching surgical skills and knowledge to both groups of trainees. Participation in the Olympiad contributed to the development of their surgical techniques, brought together young physicians and students, and facilitated the transfer of professional experience. The Olympiad served as a powerful motivator for the active training of both students and residents.

Scientific specialty: 3.2.3. Public Health and Health Care Organization, Sociology and History of Medicine.

Relevance

The surgical Olympiad movement in our country has reached an extremely high level: virtually every medical university has a surgical team, and there is a vast number of Olympiads ranging from intra-university competitions to large-scale international events. However, most of these competitions are aimed at developing students' professional skills, with no involvement whatsoever of surgical residents. This seems problematic, since one of the factors driving continuous progress is the ongoing refinement of surgical techniques, including within a competitive environment. Undoubtedly, the professional community is aware of this issue and is working to create competitions for surgical residents. An example of such a competition is the All-Russian Surgery Competition for Residents in Memory of A. A. Vishnevsky, traditionally held at the A. V. Vishnevsky National Medical Research Center for Surgery. Perm State Medical University named after E. A. Wagner has also established a large-scale competitive event bringing together students and young physicians — the All-Russian Olympiad in Surgery for Residents and Students with International Participation, named after Academician E. A. Wagner. This collaboration served as a powerful motivator for the active training of both groups of students.

Objective

To present the results of the All-Russian Olympiad for Residents and Students in Surgery with International Participation Named After Academician E. A. Wagner.

Materials and Methods

The All-Russian Olympiad for surgical residents and students with international participation named after Academician E. A. Wagner was first held in 2024. Since then, the Olympiad has become a tradition. Every year, 15 teams from various cities in Russia, Kazakhstan, Uzbekistan, and Kyrgyzstan — composed of medical students and surgical residents — participate in the competition.

Results

The idea of creating an Olympiad for surgical residents originated while working with the university's student team. Young surgeons who had gone through the Olympiad training program often expressed a desire to continue their competitive careers at a more mature age. When communicating with teams from other universities,

it also became clear that this desire was shared by both medical school graduates and the mentors of surgical residents.

When creating the competition series, our goal was to design unconventional, more complex competitions that would require not the routine repetition of surgical techniques, but a combination of clinical reasoning and flawless surgical skill. At that point, the decision was made to divide the competitions into two major categories — "Oncology" and "Military Field Surgery." Examples of competitions in the first category include "Proximal gastrectomy with D2 lymph node dissection and double-tract reconstruction," "Extended left pneumonectomy with resection of the tracheal bifurcation, mediastinal lymph node dissection, and anastomosis between the right main bronchus and the trachea"; In the second block, the procedures that drew particular interest were "Laparoscopic small bowel anastomosis" and "Cardiac anastomosis." The total number of competitions was 16–17.

While preparing for the competition, many teams faced the challenge of involving residents in the training process. Clinical residents are constantly engaged in the work of surgical departments, whose chiefs are reluctant to release trainees for competitions. As a result, they have far fewer opportunities to devote the necessary amount of time to honing their techniques in the training operating room compared to students. This prompted us to revise the competition format: to form mixed teams consisting of students and residents. The new format brought a fresh perspective to the competition's concept — bringing together future surgeons of different statuses — which created a conducive environment for the exchange of professional experience.

Our surgical competition featured several scoring categories: individual scores for each event, scores for the "Oncology" and "Military Field Surgery" event blocks, and the traditional overall score, which is the sum of points from all competition events. Since some teams consisted of a large number of students and a small number of residents, while others were composed almost entirely of residents, the teams varied in skill level. To level the playing field, it was decided to divide the overall standings into two categories: one for teams consisting primarily of students, and another for senior teams composed of a large number of residents. The main individual prize of the Olympiad is the Academician E. A. Wagner Cup, awarded to the resident with impeccable surgical technique.

Every year, the All-Russian Olympiad for Residents and Students in Surgery with International Participation, named after Academician E. A. Wagner, brings together about 120 residents and 110 students from Russia and other countries.

Discussion

Currently, the Olympic movement focuses on the professional development of students. However, every surgical resident is much closer to independent practice than even the most promising student. This necessitates the creation of an environment specifically designed to develop the surgical skills of surgical residents. One way to motivate young physicians to improve their manual skills is to prepare them for surgical competitions, which under-

scores the need to establish competitions specifically for surgical residents.

Conclusions

The All-Russian Olympiad for Surgical Residents and Students with International Participation, named after Academician E. A. Wagner, serves as an example of creating a supportive competitive environment for the professional development of surgical residents. The experience of holding an Olympiad of this format will be useful for developing similar surgical competitions for young physicians.

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SIMULATION TECHNOLOGIES IN THE COURSE "PROPAEDEUTICS OF INTERNAL MEDICINE" FOR NURSES WITH HIGHER EDUCATION

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Abstract. The following working hypothesis was formulated in this study: the use of highly realistic simulation technologies in the process of studying the course "Propaedeutics of Internal Medicine" contributes to a more pronounced increase in the level of theoretical knowledge, the development of clinical reasoning, an increase in students' subjective satisfaction with the educational process, and the formation of professional confidence compared to traditional teaching methods.

Scientific specialty: 3.2.3. Public Health and Health Care Organization, Sociology and History of Medicine.

Relevance

Modern healthcare places increasingly high demands on the practical training of nurses with higher education. Simulation technologies have now taken on an important role in modern medical education because they can model clinical situations, allowing students to practice optimal protocols in a safe environment. It has been proven that their use contributes to the development of practical skills and the ability to make decisions in complex medical scenarios.

Objective

To integrate simulation technologies into the course "Propaedeutics of Internal Medicine" for nurses with higher education.

Materials and Methods

To determine the extent to which simulation-based training influences the quality of practical skill acquisition in the "Respiratory System" section of the "Propaedeutics of Internal Medicine" course, a two-stage assessment was conducted for participants in the experimental group (EG) and the control group (CG).

The first assessment was conducted before the start of the targeted simulation cycle (pre-test), and the second immediately after the completion of all training sessions (post-test). The control group consisted of third-year students who studied the same material using traditional

teaching methods and did not participate in the simulation training sessions.

As part of the study, a structured checklist was developed and applied, which allows for a standardized assessment of the completeness and accuracy of the physical examination of a patient's respiratory system.

The tool includes 39 assessment steps, each of which reflects the sequence of a healthcare professional's interaction with the patient: from establishing contact with the patient to formulating the correct conclusion.

Results

The study showed that the introduction of simulation technologies and a simulation module into the course "Propaedeutics of Internal Medicine" for nurses with higher education is accompanied by a statistically significant improvement in the quality of physical examinations of the respiratory system and the development of critical thinking (the average final score in the experimental group was 87.1%, and in the control group, 77.1%).

High results were achieved in areas closely related to compliance with safety protocols, including hand hygiene, proper waste disposal, and the formulation of conclusions. The simulation environment effectively fosters adherence to SOPs (standard operating procedures). This is due to the repeated practice of actions, the analysis of errors, and the receipt of feedback during debriefing.

Discussion

An analysis of the results from the experimental part of the study identifies the key conditions necessary for achieving high outcomes in the educational process when studying the course "Propaedeutics of Internal Medicine":

1. Regularity and appropriate frequency of simulations. This entails conducting 3 to 5 sessions followed by debriefing.
2. The creation of highly realistic scenarios that closely resemble situations likely to occur during clinical practice. These include palpating the patient (veins during intravenous injection, the pulse when measuring heart rate).
3. A safe learning environment in which the learner can experiment and repeat their actions from one cycle to the next.
4. Individualized pace of learning. This implies the opportunity for each learner to repeat a procedure for as long as needed to master it to the point of automaticity.
5. Barriers faced by instructors when using traditional teaching methods: a lack of feedback, which means the inability to review one's mistakes either on video or through a structured analysis of each step of the algorithm.
6. A lack of time for the practical component. Lectures and seminars effectively do not include time for high-quality practice of manual skills. Often, no more than 10% of instructional time is allocated to practical training.
7. Fear of real patients is one of the most common factors hindering the effectiveness of training. Even with