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Recovery-oriented Medical Training: A Narrative Literature Review for the University of Recovery as a New Concept of Co-learning between Patients and (Future) Healthcare Providers

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d surgical interventions when compared to the general population [3]. T e possible explanations for this disparity include: unhealthy habits (e.g. smoking; lack of exercise); side-e fects of psychotropic medication; delays in the detection or initial presentation of a symptom leading to a more advanced disease at diagnosis; and inequity of access to services partly due to a lack of thorough investigation and poor patient-doctor and doctor-patient communication skills [4-6].

Indeed, di f cult communication, social distance, and the overall poor quality of interactions between healthcare providers and patients with a lower socioeconomic status have been identi fed as barriers to healthcare for such disadvantaged populations [7,8]. Problems with attention and concentration can further harm the understanding of the doctor's explanation, and can a fect adherence to treatment. Also, there is still a stigma surrounding mental illness, o fen worsened when patients present with a psychotropic drug list or an extensive medical history, or when they are known to pay frequent visits to medical services or the emergency departments. T e over attribution of symptoms to an underlying psychiatric condition can thus result in missed diagnoses, the improper management of conditions, and therefore worsened prognostics [9,10].

diabetes being usually increased 2 to 3 fold with them [16]. In e fect,

T e main causes of mortality in patients with schizophrenia, for example, are the same as for the rest of the population (e.g. cardiovascular diseases, cancer, complications of diabetes). Such individuals are prone to many di f erent physical health problems [11]; while these diseases are also prevalent in the general population, their

the association between schizophrenia and diabetes has been known at least since 1879 [17]. It can be explained by potential cellular and genetic links [18,19] or physical inactivity, poor diet, and cigarette smoking [20,21]. Social health determinants, such as income, housing and gender [22] can also contribute, while the uptake of psychotropic medication is particularly associated with Type 2 diabetes [23].

Social determinants are believed to be reasons as to why the prevalence of diabetes is so high among these patients, but there is now a growing argument that emphasizes the interconnectedness of mental and somatic health dimensions [24], with one dimension affecting the state of the other. This relation has been intuitively known for centuries, but unfortunately, modern mental healthcare and physical healthcare are still often working in silos, if not one against the other [25], and with very important, if not tragic consequences in terms of poorer quality of life and shortened lifespan.

Management of chronic physical illnesses in primary care is already very complex [26], even more so when these conditions come in multiple combinations and involve comorbidity with mental illness. Knowing the common causes and disease mechanisms of interactions should allow a more effective and proactive approach in their prevention and treatment. Nevertheless, it is likely that treating psychiatric symptoms on one side alone will not improve life expectancy for those also afflicted by a chronic physical condition, while managing chronic physical illness on the other side separately will not significantly improve the overall outcomes in terms of social inclusion and quality of life, which are key social determinants and predictors of both mental health and physical health [27]. A life-course approach is warranted, much beyond a typically curative approach to illness, since the formative stages of life can affect mental well-being over decades [28,29]. Patients are probably the best placed persons to incarnate such an approach in order to transcend these historic silos, which are artificial from their own daily life-course perspectives and trajectories.

Methods and Materials

Recovery has undoubtedly gained traction throughout the world, and much effort is going into the transformation of mental health policies and systems to achieve recovery-oriented outcomes [30,31]. Generally speaking, two portrayals of recovery stand out amidst the diversity of views: restoration of functioning and deepening wellness [32]. When recovery is mainly seen as symptom management, the primary focus of personal choice and responsibility in the process of recovery becomes seeking and complying with treatment. Such a “clinical” model does include social functions, but from a professional point of view. Instead of focusing primarily on symptom relief and management, a second view casts a wider spotlight on restoration of self-esteem and identity, and on attaining meaningful roles in society

Beentjes et al. [46]	patients (general)	e-mental health	no
Cusack et al. [44]	professionnals (nurses)	communication	no
Eisen et al. [48]	patients (veterans)	peers mentors	no
Hackman et al. [40]	inpatients (general)	satisfaction	no
Kemp et al. [41]	system/institution	advance directives	no
Kidd et al. [42]	systems/institution	engagement	no
Koval et al. [39]	system/institution	nursing	no
Marynowski-Traczyk et al. [49]	emergency department	nursing	no
Morant et al. [35]	providers	shared decision making	no
Munson et al. [50]	youth	engagement	no
Petrik et al. [51]	providers	confidentialty	no
Piat et al. [45]	housing facilities	attitudes	no
Polacek et al. [53]	inpatients	engagement	no
Rabenschlag et al. [47]	patients (general)	peers mentors	no
Rudnick and Eastwood [38]	physicians	attitudes	yes
Salyers et al. [43]	providers	attitudes	no
Sowers and Marin [52]	providers/patients	engagement	yes
Stratford et al. [54]	research community	engagement	yes

Table 1: Results to the search with the key words “recovery-oriented”,

Discussion

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