



World Health
Organization



International Alliance of
Patients' Organizations
A global voice for patients

11th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

Person - Centered Women's Health

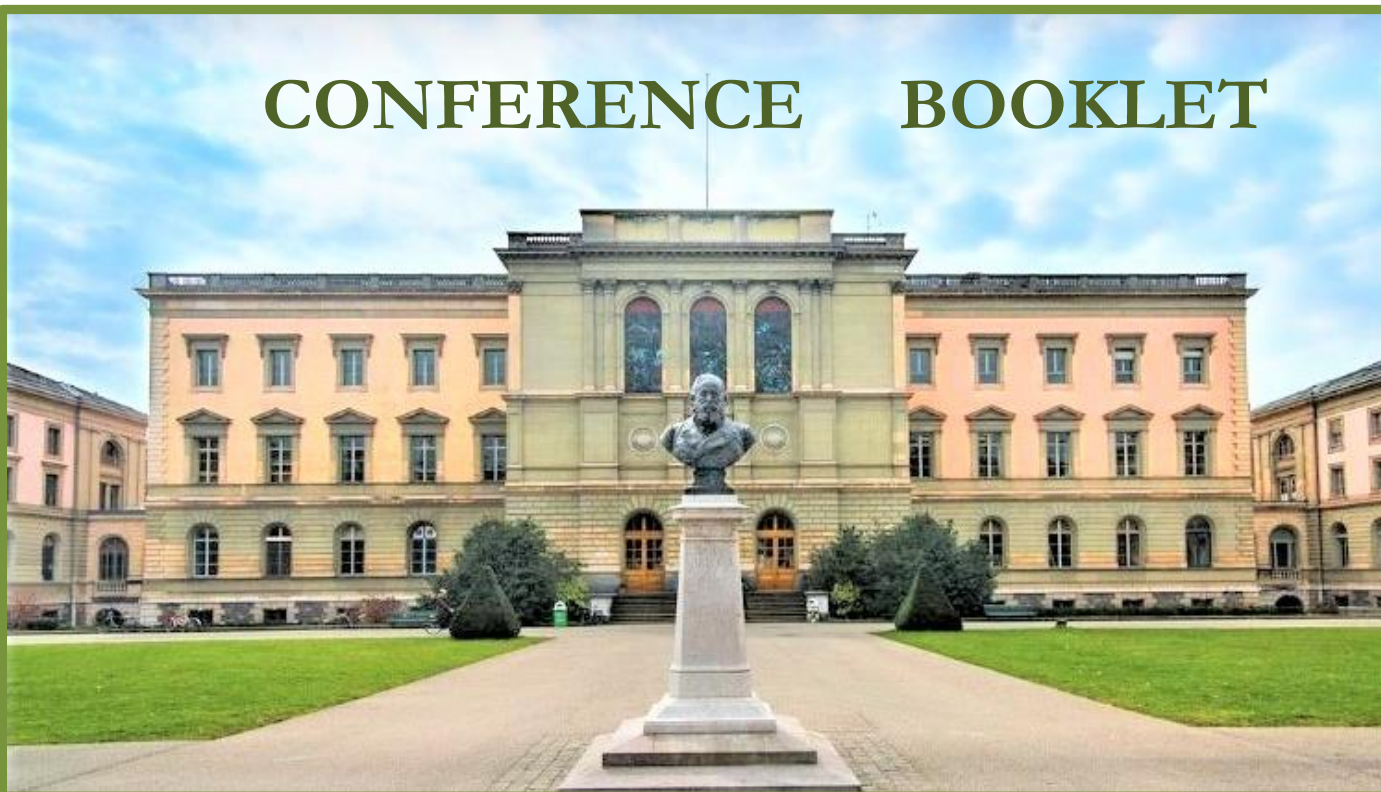
40 Years after Alma Ata

Core Conference 9 – 11 April 2018

Pre-Conference Workmeeting 8 April 2018

Geneva University Hospital and World Health Organization

CONFERENCE BOOKLET



Organization



Program



Presenters



Abstracts



Continuing Professional
Development

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CONFERENCE ORGANIZATION

Organizing Committee: Jon Snaedal (President, International College of Person Centered Medicine, ICPCM), Ruth Wilson (Conference Program Director and WONCA President for North America), Juan E. Mezzich (Secretary General, ICPCM), Wim Van Lerberghe (Former WHO Department Director), Michel Botbol (Secretary for Publications, World Psychiatric Association), Tesfamicael Ghebrehiwet (Former Officer, International Council of Nurses), Hellen Millar (ICPCM Board Director), Ihsan Salloum (World Psychiatric Association Classification Section), Sandra Van Dulmen (Former Officer, European Association for Communication in Healthcare), Jim Appleyard (Former President, ICPCM and World Medical Association).

Collaborating Organizations: The Eleventh Geneva Conference on Person-centered Medicine is organized by the International College of Person-centered Medicine (ICPCM) in collaboration with the World Medical Association (WMA), the World Health Organization (WHO), the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses (ICN), the International Pharmaceutical Federation (FIP), the World Organization of Family Doctors (Wonca), the Council for International Organizations of Medical Sciences (CIOMS), the Latin American Network of Person Centered Medicine (RLAMCP), the World Association for Sexual Health (WAS), the International Federation of Ageing (IFA), the Medical Women's International Association (MWIA), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the Paul Tournier Association, the World Association for Dynamic Psychiatry (WADP), the European Association for Communication in Health Care (EACH), the WHO Collaborating Center at Imperial College London, the International Francophone Psychiatric Federation (ALFAPSY), the French Psychiatric Association, the German Association for Dynamic Psychiatry, San Fernando Medical School of San Marcos National University of Peru, the Universite de Bretagne Occidentale, the Medical University of Plovdiv-Bulgaria, the Belgrade University Institute of Mental Health, and University of Buckingham Press, with the auspices of the Geneva University and its Medical School and Hospital.

Conference Participants are clinicians and scholars in medicine and other health fields as well as other interested individuals. ICPCM Continuing Professional Development (CME) Certificates will be e-mailed upon request to all registered participants. The registration fee is 500 Euros for persons residing in World Bank Group A (High Income Countries) and 350 Euros for persons in other countries. Full time students and official representatives of patient and family organizations pay discounted half rates.

Presentation Formats include Lectures, Plenary Symposia, Parallel Symposia, Interactive Workshops and Brief Oral Presentations.

Conference Secretariat: ICPCM Secretariat at Int'l Center for Mental Health, Icahn School of Medicine at Mount Sinai, Fifth Ave & 100 St, Box 1093, New York NY 10029, USA. E: ICPCMsecretariat@aol.com.

11th Geneva Conference Program

WORKMEETINGS SUNDAY APRIL 8TH 2018 Geneva University Hospital E-Rooms under Marcel Jenny Auditorium

- 9:00 -16:00 Pre-Conference Institutional Work Meetings:
Chairs: Jon Snaedal and Jim Appleyard
- Person Centered Care Educational Programs: *J. Appleyard, J Snaedal, J Mezzich, R Wilson (120 min)*
[11:00 -11:15 AM, Coffee Break]
 - Books on Person Centered Medicine & People Centered Health Systems: *J Mezzich, W Van Lerberghe, J Appleyard, J Snaedal, R Wilson (30 min)*
 - Person Centered Integrative Diagnosis: *J Mezzich, I Salloum, R Cloninger, L Kirmayer M Botbol, W Van Staden (75 min)*
[13:00-14:15 PM, Lunch Break]
 - Membership, Meetings and Fund Raising: *H Millar, M Botbol, J Snaedal, J Mezzich (20 min)*
 - Person Centered Nursing Network: *T. Ghebrehivet, AK Helgesen, V Grondahl et al (15 min)*
 - Person-centered Mental Health Network: *M Botbol (15 min)*
 - Global Research Network and PCI: *I Salloum, L Kirisci, J Mezzich (15 min)*
 - Regional Networks: *O. Cluzet, W Van Staden, V Grondahl, W Van Lerberghe, (25 min)*
[15:45-16:00 PM, Coffee Break]
- 16:00 -17:00 IJPCM Editorial Board Meeting
- 17:00 -18:30 ICPCM Board Meeting

CORE CONFERENCE FIRST DAY, MONDAY APRIL 9TH 2018 Geneva University Hospital Marcel Jenny Auditorium (Plenaries and Sessions A) and E-Rooms (Sessions B)

- 8:00 **Check-in**
- 8:30 -9:00 **Opening Session**
Words of Welcome: *J Snaedal (ICPCM), O Kloiber (WMA), Manjulaa Narasimhan (WHO), Lembit Rago (CIOMS), Bettina Borisch (Geneva University).*
Inaugural Lecture: Person-centered Women's Health 40 Years after Alma Ata: *Ruth Wilson (Kingston, Canada)*
- 9:00 -10:30 **Plenary Symposium 1: Person-centered Care 40 Years after Alma Ata**
Chairs: Chris Van Weel, Helen Millar
- Person-centered care: What Alma Ata meant then and what it means now: *Wim Van Lerberghe (Trieste)*
 - ICPCM Clinical Perspectives: *Robert Cloninger (St. Louis)*
 - Inter-Cultural Challenges: *Laurence Kirmayer (Montreal)*
 - Crossing the 90 biological threshold: The challenge of primary care: *Salman Rawaf (London)*
- 10:30 -11:00 **Coffee Break**
- 11:00 -12:15 **Plenary Symposium 2: Precision Medicine and Whole Person Medicine: Science, Ethics and Society**
Chairs: Jon Snaedal (Reykjavik), Juerg Kesselring (Valens, Switzerland)
- The biological bases of Person Centered Medicine: *Robert Cloninger (St. Louis)*
 - Precision Medicine and Mental Health: *Thomas Schulze (Munich)*
 - Ethical dimensions: *Jim Appleyard (Canterbury, UK)*

- Public Health Perspectives: *Bettina Borisch (UGE, Geneva)*
- Whole Person Medicine Integrative Approaches: *Juan Mezzich (New York)*

12:15 -13:30 **Group Photograph and Lunch (open)**

13:30 -14:45 **Parallel Session 1A: Symposium on Burn-out and Sustaining a Healthy Workforce**

Chairs: Meg Casson (Toronto), Werdie Van Staden (Pretoria, South Africa)

- Wellness and Burnout: *Robert Cloninger (St. Louis, USA)*
- Teaching self-care to the carer in Person Centered Medicine: *Oscar Cluzet (Montevideo, Uruguay)*
- Contributions and challenges for nursing in delivering person-centred women's health: *Ann Karin Helgesen (Halden, Norway)*
- Balancing professional and personal lives: challenges for early career health workers: *Zachary Bordman (Toronto, Canada)*
- Cultivating the primary care workforce: *Chris Van Weel (Nijmegen, The Netherlands)*

Parallel Session 1B: Workshop on Mediation and Collaboration

Aleksandra Weber (Munich)

14:45 -15:15 **Coffee Break**

15:15 -16:30 **Parallel Session 2A: Symposium on Research on Gender and Person-centered Care**

Chairs: Laurence Kirmayer (Montreal), Manjulaa Narasimhan (WHO)

- Diagnostic research for person-centered women's health: *Ihsan Salloum (Miami, Florida, USA)*
- Taking the medical history at first consultation: *Iris Veit (Herne, Germany)*
- Communication research: *Evelyn van Weel –Baumgarten (Nijmegen, The Netherlands)*
- Research on empathy in women's health: *Michel Botbol (Brest, France)*
- Comparative study of Lima hospitals using the Person-centered Care Index: *Alberto Perales (UNMSM, ANM), Levent Kirisci (Universidad de Pittsburgh, USA), Juan E Mezzich (ICPCM), Elard Sánchez (UNMSM), Lorenzo Barahona (UNMSM), Salomón Zavala (UNMSM), Edgar Amorín (INEN)*

Parallel Session 2B: Person-Centred Health Care Beyond Slogans

Chairs: V. Grondahl (Halden, Norway) and Tesfa Ghebrehiwet (Alberta, Canada)

- The influence of technology and standards on healthcare staff's job satisfaction: *V.A Grondahl et al (Halden, Norway)*
- Challenges for female staff in person-centered care for male residents in nursing homes: *AK Helgesen, EA Skang, VA Grondahl (Halden, Norway)*
- A pattern approach to analyzing perceptions of the quality of palliative care and satisfaction: *T. Sandsdalen, VA Grondahl, B. Wilde-Larson (Halden, Norway)*
- How to increase students' practical knowledge of person-centered care in health and welfare education: *L.S. Trette et al (Halden Norway)*

16:30 -17:45 **ICPCM General Assembly** (including a discussion of the 2018 Geneva Declaration)

17:45 -18:45 **Cultural Group Walk** (University of Geneva and Old Town)

19:00 **Conference Dinner** (at *Restaurant des Vieux-Grenadiers*, 92 rue de Carouge; tickets at Conference reception table)

CORE CONFERENCE SECOND DAY, TUESDAY APRIL 10, 2018

Geneva University Hospital Marcel Jenny Auditorium (Plenaries and Sessions A) and E-Rooms (Sessions B)

9:00 -10:15 **Plenary Symposium 3: Gender and Non-Communicable Diseases 40 Years after Alma Ata**

Chairs: Ann K Helgesen (Halden, Norway), Salman Ravaf (London)

- Wonca perspectives: *Ruth Wilson (Kingston, Canada)*
- Dementia and Caregivers: *Jon Snaedal (Reykjavik)*
- Diabetes and Comorbidities: *Helen Millar (Dundee, Scotland)*
- Physical activity and substance abuse in male and female adolescents: *Levent Kirisci (Pittsburgh)*
- The importance of self-care in the new setting: *Austen El-Osta (London)*

10:15 -10:45 **Coffee break**

10:45 -12:00 **Parallel Session 3A: Symposium on Designing Primary Health Care Systems to Meet Women's Needs**

Chairs: Gail Webber (Ottawa), Mohammed Abou-Saleh (London)

- PHC contributions to meeting women's needs: *Chris van Weel (Nijmegen, The Netherlands)*
- Setting health priorities under slow economic growth: *Salman Rawaf (London)*
- Inter-professional collaboration: *Tesfa Ghebrehivet (Alberta, Canada)*
- Person-centered care and inter-sectoral collaboration: *Aleksandra Weber (Munich)*

Parallel Session 3B: Workshop on Clinical Communication

Evelyn Van Weel (Nijmegen, the Netherlands)

12:00 -13:15 **Lunch break (open)**

13:15 -14:30 **Plenary Symposium 4: Respectful Maternity Care**

Chairs: Charlotte Warren (Population Council), Jim Appleyard (London)

- Guidelines for safe maternity care: *Ozge Tuncalp (WHO)*
- Equity and access to respectful maternity care: Between hope and current challenges: *Patricia Perrenoud (Lausanne)*
- Caesarean section by maternal request: A woman-centered dilemma: *Meg Casson (Toronto)*
- Person-centered neonatal health care: *Ornella Lincetto (WHO)*
- Integrative Perspectives: *Ruth Wilson (Kingston, Canada)*

14:30-15:00 **Coffee break**

15:00-16:15 **Parallel Session 4A: Symposium on Education and Research in Woman-centred Reproductive Care**

Chairs: Evelyn van Weel-Baumgarten, (Nijmegen), Ihsan Salloum (Miami)

- User initiated interventions: *Manjulaa Narasimhan, (WHO)*
- Respectful Maternity Care in Tanzania: *Gail Webber (Ottawa)*
- How respectful care has been implemented: Centering group prenatal care: *Rupa Patel (Kingston, Canada)*
- Overcoming implementation challenges for respectful maternity care in Kenya: *Charlotte E. Warren (Population Council, Washington, DC)*
- Safe abortion care: *Bela Ganatra (WHO)*

15:00-16:15 **Parallel Session 4B: Symposium on Human Rights and Women's Health**

Chairs: Aleksandra Weber (Munich), Oscar Cluzet (Montevideo, Uruguay)

- WHO Quality Rights Initiative: Transforming mental health services and promoting rights: *Michelle Funk (WHO)*
- Philosophical perspectives: *Werdie Van Staden (Pretoria, South Africa)*
- Sexual violence against women in conflict situations: *Mohammed Abou-Saleh (London)*
- Impact of socio-economic status on cardiovascular risk and belief among women in Saudi Arabia: *Masha'al Alshaikh (London)*

- Learning for caregivers in Europe: *Spyros Zorbas (Greece)*

16:15-17:30

Parallel Session 5A: Antoine Besse & Jitendra Trivedi Memorial Symposium on Person-centered Mental Health

Chairs: Afzal Javed (Nuneaton, UK), Michel Botbol (Brest, France)

- Preventive Psychiatry and Person-centered Care: *Roy Kallivayalil (Kerala, India)*
- Culture and person-centered psychiatric diagnosis: *Werdie Van Staden (Pretoria, South Africa)*
- Person- Centred Mental Health in England: *Mohammed Abou-Saleh (London)*
- Patient-centered perinatal mental health care in Uganda: *Nandini Sarkar (Antwerp, Belgium)*
- The development of health and personality following an 8-week health promotion intervention: *Julie Jacquet (Grenoble, France)*

Parallel Session 5B: Brief Oral Presentations

Chairs: Hans-Rudolf Pfeifer (Zurich), Zack Bordman (Toronto)

- Biopsychosocial determinants of opioid use disorder and implications for maternal and child health research: *Imelda Medina et al (Miami)*
- Quality circles with self-help groups: *Ottomar Babrs (Goettingen, Germany)*
- Person-centered care and inter-professional collaboration: *Aleksandra Weber (Munich)*
- Development of a Short-form of the Quality from the Patient-Perspective Questionnaire for Palliative Care: *T. Sansdalen et al (Halden, Norway)*
- Operational efficiency of an immunization clinic in North Central Nigeria: A Time and Motion Study: *Ibrabeem Shola Abdulraheem (Amana City, Kano, Nigeria)*

19:30

Networking Dinners (informally organized by interest groups)

CORE CONFERENCE THIRD DAY, WEDNESDAY APRIL 11, 2018
Geneva University Hospital Marcel Jenny Auditorium; last Seminar at WHO Headquarters

8:30-9:15

Paul Tournier Prize Session

Chairs: Jon Snaedal (Reykjavik), Frederic Von Orelli (Basel), Alain Tournier (Geneva), H-R Pfeifer (Zurich)

- *Landatio* for C Robert Cloninger: *Juan Mezrich (New York)*
- 2018 Paul Tournier Prize Lecture: *C. Robert Cloninger (St. Louis)*
- Presentation of the 2018 Paul Tournier Prize Plaque: *Jon Snaedal and Alain Tournier*

9:15-9:45

Coffee break

9:45-11:45

Special Collaborative Session on Empowerment and People-centered Care

Chairs: Manjulaa Narasimhan (WHO), Juan Mezrich (New York)

- Introductory remarks by the chairs.
- Empowering women through person-centered care: *Ruth Wilson (Kingston, Canada)*
Discussion
- Empowering a healthy work force through training on healthy lives and well-being: *Robert Cloninger (St. Louis)*
Discussion
- Empowering the people through self-care: *Manjulaa Narasimhan (WHO)*
Discussion
- Empowering the inter-professional health team: *Howard Catton (International Council of Nurses, Geneva)*
Discussion
- Empowering youth through engagement: *Michalina Drejza (WHO)*
Discussion
- Empowerment through engagement and empathy developments: *Juan Mezrich (New York and Lima)*

- Discussion
 - Session Conclusions: *Manjulaa Narasimhan and Juan Mezzich*
- 11:45-12:30 **Conference Closing Session**
Chairs: Jon Snaedal, Ruth Wilson, Juan Mezzich
- 2018 Geneva Declaration on Person-centered Women’s Health 40 Years after Alma Ata: *Ruth Wilson*
 - Conference Conclusions: *Jon Snaedal*
 - Next Steps: *Juan Mezzich*
- 12:30-13:30 Transfer time from HUG to WHO
- 13:30-15:00 **WHO Seminar on Person/People-centered Neo Natal Health**
Room M-501, M Building Fifth Floor, WHO Headquarters
Chairs: Ornella Lincetto (WHO), Hernan Montenegro (WHO) and Jim Appleyard (London)
- 13.30-13.40 Welcome and introductions: *Ornella Lincetto / Hernan Montenegro/ Jim Appleyard*
- 13.40-13.50 Person/People Centered care: Applying the principles to neonatal health: *Ornella Lincetto (WHO)*
- 13.50-14.00 Midwife-led continuity of care for integrated newborn and mother care: *Fran McConville (WHO)*
- 14.00-14.10 Family centered care in LMICs: Experience from India: *Arti Maria (New Delhi)*
- 14.10-14.20 Family integrated care in HICs: Experience from Canada: *Ruth Wilson (Kingston, Canada)*
- 14.20-14.25 Response: *Laurence Kirmayer (Montreal)*
- 14.25-14.40 Comments: *Werdie Van Staden (Pretoria), Evelyn and Chris Van Weel (Nijmegen) and Nandini Sarkar (Antwerp, Belgium)*
- 14.40-14.55 Discussion
- 14.55-15.00 Conclusions: *Ornella Lincetto, Hernan Montenegro, Jim Appleyard, Juan Mezzich*



ELEVENTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

GALLERY OF PRESENTERS

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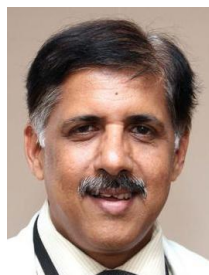


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ELEVENTH GENEVA CONFERENCE ON PERSON CENTERED MEDICINE ABSTRACTS

PRE CONFERENCE INSTITUTIONAL WORK MEETINGS

Person Centered Care Educational Programs

11GC ORGANIZING COMMITTEE EXPECTATIONS

The planning of this WorkMeeting by the 11th Geneva Conference organizing Committee has gradually evolved into two major expectations:

1.The first one involves the Development of an ICPCM Educational Program on Person-centered Clinical Care, building on a long effort most recently lead by Jim Appleyard and Jon Snaedal towards the design of Guiding Principles for Person-centered Clinical Care. The need for having such effort focused on the development of an ICPCM Educational Program has become apparent from recent meetings of the ICPCM Board and also from requests from the Indian Medical Association and the Latin American Network of Person Centered Medicine for collaboration on this topic.

2.The second expectation involves the initial planning of an ICPCM contribution, in collaboration with the WMA and other relevant institutions, to a prospective WHO European Office flagship project for the retraining of the existing workforce related to a major WHO Conference 40 Years after the Alma Ata Declaration.

It is hoped that the substantial time scheduled on 8th April for this important WorkMeeting will allow the presentation and discussion of ideas and recommendations leading to progress on the above two expectations.

PERSON CENTERED CLINICAL CARE: PRINCIPLES AND STRATEGIES TOWARDS EDUCATIONAL PROGRAMS *Juan Enrique Mezzich (New York and Lima) and Alberto Perales (Lima)*

The development of person-centered clinical care is inscribed within an international programmatic movement towards a medicine focused on the totality of the person. This movement, with broad historical bases, has been maturing since 2008 through conferences with global health institutions, research projects and academic publications.

This paper is aimed at elucidating the conceptual principles of person-centered medicine (PCM) and to delineate strategies for the practical application of such principles in clinical care services.

The above objectives have been approached through literature reviews, international consultations, and reflections on the patterns and indications obtained.

The principles identified for person-centered medicine are the following: Ethical commitment, holistic framework, cultural awareness and responsiveness, communication and relational focus, individualized clinical care, common ground among clinicians, patient and family for joint diagnostic understanding and shared decision making, person- and community-centered organization of integrated services, and person-centered medical education and research. Additionally, pertinent strategies have been delineated for the implementation of such principles in clinical care.

The authors conclude that the presented principles and strategies are consistent with suggestions offered in the literature and may serve as bases for the design of educational programs and research instruments. Their continuous refinement is proposed through future international and local studies to clarify the key concepts of the movement as well as strategies for their practical clinical

Books on Person Centered Medicine & People Centered Health Systems

WORKMEETING ON BOOKS ON PERSON CENTERED MEDICINE AND PEOPLE-CENTERED HEALTH SYSTEMS

Juan E. Mezzich (New York and Lima), Wim Van Lerberghe (Trieste), Jim Appleyard (London), Jon Snaedal (Reykjavik), Ruth Wilson (Kingston), Paul Glare (Sydney)

These textbooks would summarize solid evidence on how to go about putting concepts of person-centered medicine and people-centered health systems into practice. They would be multi-editor and multi-author books, engaging some of the principal international clinicians and scholars on the field. They are ben requested by

Springer, which recently published the textbook *Person Centered Psychiatry* [1] prepared under the auspices of the International College of Person Centered Medicine and co-sponsored by the World Psychiatric Association.

The Person Centered Medicine book would tentatively be structured into the following sections:

- A. Principles of Person Centered Medicine (PCM)
- B. Methods for Person Centered Clinical Care (PCCC) (content, structure, processes)
- C. Settings for Clinical Care and Clinical Governance
- D. Clinical Specialties

The People-centered Health Systems book would be structured as follows:

- A. Principles
- B. Policies for People-Centred Health Systems.
- C. Illustrative Country Experiences

Person Centered Integrative Diagnosis

PERSON CENTERED INTEGRATIVE DIAGNOSIS: OVERVIEW AND PROSPECTS

JE Mezzich (New York)

Diagnosis is a fundamental activity in medicine and health care, as it involves developing an adequate informational base to understand a clinical condition and substantiate and guide clinical care. It is argued logically that for practicing Person Centered Medicine (a medicine that places the whole person in context as the focus and goal of clinical care), Person Centered Diagnosis is needed. A theoretical model for person centered diagnosis has been developed and published by the International College of Person Centered Medicine as Person-centered Integrative Diagnosis (PID)[1]. This theoretical model has been applied for the development of the Latin American Guide for Psychiatric Diagnosis (GLADP-VR), published by the Latin American Psychiatric Association (APAL)[2] for the use of health professionals in that continental region. At an earlier Geneva Conference on Person Centered Medicine, a consultational exploration was conducted towards the development of a practical guide for person-centered diagnosis in general medicine, which is expected to move forward.

At the Work Meeting on Person-centered Integrative Diagnosis within the framework of the 11th Geneva Conference on Person Centered Medicine, the following activities are planned:

- Brief overview of the work accomplished so far.
- Review of prospects for the description and classification of diseases in general, including the Wonca classification for primary care and ICD-11 in general.

This Workmeeting will present the above book structures in more detail, list their editors and outline their timetables. Recommendations from meeting participants will be requested concerning the above information and potential chapter authors.

References

1. Mezzich JE, Botbol M, Christodoulou GN, Cloninger CR, Salloum IM (eds): Person Centered Psychiatry. Springer, Switzerland, 2016.

- Review of prospects for advances in the diagnosis of disabilities and quality of life, contributory factors for health, and experience and values for health.
- Review of prospects for enhancing the interview process, engagement and the establishment of empathy.
- Review of prospects for conceptualizing and formulating a basic unit of assessment (CR Cloninger).
- Review of prospects for enhancing the assessment of culture and context: Insights for enactivism (L Kirmayer).
- Other contributions towards enhancing the further development of Person-centered Integrative Diagnosis.

References

1. Mezzich JE, Salloum IM, Cloninger CR, Salvador-Carulla L, Kirmayer L, Banzato CE, Wallcraft J, Botbol M (2010): Person centered Integrative Diagnosis: Conceptual Bases and Structural Model. *Canadian Journal of Psychiatry* 55:701-708.
2. Asociación Psiquiátrica de América Latina (APAL) (2012): Guía Latinoamericana de Diagnóstico Psiquiátrico, Versión Revisada (GLAP-VR). Sección de Diagnóstico y Clasificación, Asociación Psiquiátrica de América Latina (APAL), Lima.

PERSON-CENTERED INTEGRATIVE DIAGNOSIS: WHAT IS THE NATURAL UNIT OF ASSESSMENT?

C Robert Cloninger (St Louis)

Summary for discussion:

- Nearly all genes for human personality have been uncovered along with interacting environmental influences that integrate health as a complex adaptive system
- These genes code for profiles of traits describing the whole person, not for individual traits
- The genes for personality directly influence physical, emotional, and social aspects of health, so these aspects are fundamentally indivisible
- Regulatory processes that integrate functions for adapting to the biopsychosocial milieu orchestrate all the organs of a person as

components of ever larger wholes (community to cosmos) as people develop and evolve in awareness

- Consequently, effective/efficient care needs to be universal, person-centered, people-centered, integrated across sectors of government, and focused on fostering opportunities to develop character strengths
- Social determinants of health like poverty and inequity need to be understood as influences on biopsychosocial processes of adaptation, not something independent of genetics, biology, psychology, or spirituality

CULTURE AND CONTEXT IN PERSON-CENTERED INTEGRATIVE DIAGNOSIS: INSIGHTS FROM ENACTIVISM

L Kirmayer (Montreal)

Culture and context are essential dimensions of person-centered integrative diagnosis (PCID). Cultural identity, knowledge and skills shape illness experience, help-seeking and the response to treatment. Progress has been made in developing interview protocols and assessment strategies to capture aspects of culture and context and there is evidence that the use of these tools and strategies can improve the accuracy of diagnostic assessment. However, the field faces a major challenge in developing systematic ways to incorporate culture in diagnostic formulation. This presentation will suggest ways to advance PCID by incorporating insights from enactivist cognitive science. While previous work in cultural psychology and psychiatry have approached culture in terms of internalized representations, enactivism emphasizes that individuals are in constant transaction with their local environments. These environments constitute ecosocial niches that provide *cultural affordances*, which people use to co-construct personal and collective meanings of health and illness. Experience and adaptation then involve loops of action and perception that include brain, body and the social world. Disease etiology, vulnerability, resilience, healing and recovery can be characterized in terms of the dynamics of these brain/body-person-environment loops. The example of depression will illustrate how an enactivist view can

enrich PCID by formulating health problems in ways that more fully integrate culture and context into assessment, treatment planning, and the ongoing negotiation of the clinical relationship.

References

Kirmayer, L.J. Unpacking the placebo response: Insights from ethnographic studies of healing. In: A. Raz & C. Harris (Eds.) *Placebo Talks: Modern Perspectives on Placebos in Society* (pp. 119-143). New York: Oxford University Press.

Kirmayer, L.J. & Ramstead, M.J.D. (2017). Embodiment and enactment in cultural psychiatry. In: C. Durt, T. Fuchs, & C. Tewes (Eds.) *Embodiment, Enactment and Culture: Investigating the Constitution of the Shared World* (pp. 397-422). Cambridge, MA: MIT Press.

Ramstead, M.J.D., Veissière, S. & Kirmayer, L.J. (2016). Cultural affordances, shared intentionality, and regimes of attention. *Frontiers in Psychology: Cognitive Science*, 7, Article 1090, doi:10.3389/fpsyg.2016.01090

Regional Networks

LATIN AMERICA NETWORK OF PERSON CENTERED MEDICINE

Oscar Cluzet (Montevideo, Uruguay)

BACKGROUND

The foundational event of Latin America activities in Person Centered Medicine (PCM), with Professor Juan Enrique Mezzich's leadership, under the theme of "Toward PCM and Health: an University and National Dialogue" took place in December 2013 (1). The Latin American Network of Person Centered Medicine (LAN-PCM) was founded one year later, at a Lima Symposium 2014, with Professor Alberto Perales as first president.

OBJECTIVES

1. To analyze continental events since 2013 to the present as well as the documents produced in those events.
2. To present the main Latin American contributions to PCM development.

MATERIAL AND METHODS

"Contribution" was defined as an adequate solution to a specific regional problem.

Reference documents produced in each instance: Act of Lima, Declarations of Buenos Aires (2), Declaration of Bogotá (3) and three successive Lima Declarations, were analyzed and their leading contributions are grouped for this event.

FINDINGS AND DISCUSSION

Ten proposals are listed, four of them in educational areas, the last ones coming from Third Latin American Conference of PCM, Lima, 2017.

Finally, forthcoming actions of LAN-PCM planned for this year are listed.

CONCLUSIONS

Despite many difficulties, the level of activity and creativity of Latin American Network of PCM seems high and its contributions to PCM development are solid and consistent but need to be integrated further into a global vision that articulates the best regional solutions.

REFERENCES

1. Perales Cabrera, A: Latin America Development in Person Centered Medicine. Fiftieth anniversary ALANAM. (in Spanish). Bogota, Nov 2017.
2. 2014 Buenos Aires Declaration on Humanism and Science in Latin America for Person Centered Medicine. Accessible 27 March 2018 in: <http://www.personcenteredmedicine.org>
3. ALANAM Declaration on Person Centered Medicine. Produced at the Fiftieth anniversary ALANAM. Bogota, 23-25 Nov 2017. Accessible 27 March 2018 in: www.redalanam.com/

CORE CONFERENCE SESSIONS

Opening Session: Inaugural Lecture

PERSON-CENTERED WOMEN'S HEALTH 40 YEARS AFTER ALMA ATA

Ruth Wilson (Kingston, Canada)

Objectives: To describe the opportunities arising from intersection of three important movements in health—women's health, person-centered medicine, and the renewal the commitment to primary health care described 40 years ago at Alma Ata.

Findings: Over eight hundred women die every day in childbirth. Cardiovascular disease is the leading cause of mortality in women. Sexual and gender-based violence are a reality in to many women's lives. Women's health involves women's emotional, social, cultural, physical and spiritual well-being and is determined by the social political cultural and economic context of women's lives, as well as by biology. This definition of women's health recognizes the validity of women's life experiences and women's own beliefs about and experiences of health.

The Declaration of Alma Ata called for primary health care which at a minimum addressed maternal and child health care, including family planning. It states that this orientation of health care requires and promotes maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care.

Person centered medicine describes health care which is

- of the person (i.e., addressing the whole person's physical, mental, social, and spiritual needs, including strengths and

vulnerabilities, while caring for illness and promoting positive health);

- by the person (i.e., engaging in joint decision making with care-givers, who in turn extend themselves as full human beings);
- for the person (i.e., empowering people to fulfill aspirations for their own health and personal life projects); and
- with the person (i.e., expressing mutually respectful and assertive relationships in which there is co-active communication and joint understanding).

These three movements together can work address the major challenges in women's Health in 2018. Women's empowerment, revitalization of the promise of primary health care, and the promotion of person-centered medicine can work in concert to address the important global challenges for women's health.

References:

1. Declaration of Alma Ata
http://www.who.int/publications/almaata_declaration_en.pdf
2. Geneva Declaration
2014http://www.personcenteredmedicine.org/doc/2014_Geneva_Declaration_Released_May_27.pdf

Plenary Symposium 1: Person-centered Care 40 Years after Alma Ata

ICPCM CLINICAL PERSPECTIVES

Robert Cloninger (St. Louis)

Objectives: To understand how person-centered care can be provided universally, we need to recognize what are the key processes that permit effective health promotion in both developed and undeveloped countries and across inequities in social determinants of health within countries

Methods: review of the ultimate causes of health and well-being, including biological, mental, and social determinants of health

Findings: Access to medical care is a less potent influence on morbidity, mortality, and other health outcomes than psychosocial variables, such as health behaviors, income, education (1). The psychosocial variables that influence health can in turn be understood in terms of profiles of personality variables that account strongly and directly for variability in physical, mental and social well-being (2).

Discussion: Healthy people are responsible, cooperative, and creative persons, and vice versa. Health outcomes depend on

personality organization regardless of socioeconomic circumstances. Genetic, psychosocial, and socioeconomic circumstances do influence the development of healthy or unhealthy personalities.

Conclusions: Effective disease prevention and health promotion depends on policies that promote healthy personality development, which in turn lead to healthy behaviors and appropriate utilization of health care.

References

1. Braveman P, Gottlieb L. The social determinants of health: it's time to consider the causes of the causes. *Public Health Rep.* 2014;129 Suppl 2:19-31.
2. Cloninger CR, Zohar AH. Personality and the perception of health and happiness. *Journal of Affective Disorders.* 2011;128:24-32.

INTER-CULTURAL CHALLENGES FOR PERSON-CENTERED MEDICINE

Laurence Kirmayer (Montreal)

Given the great diversity of experience in families, communities, and societies, every clinical encounter is, to some degree,

intercultural. Even in the same geographic region, people may face very different exposures to risk and protective factors that affect

their health, access to care, and processes of healing and recovery. Understanding these differences requires an intersectionality framework that considers age, gender, social class, education, ethnicity, racialized identity, and other aspects of social position. Major challenges to providing intercultural care include: i) structural constraints of time and resources in the health care system; ii) conceptual limitations of current models of disease, doctor-patient communication, and health care delivery; and iii) the politics of recognition and redistribution in the larger society. Clinicians must attend to the social determinants of health to understand patients' illness experience, communicate effectively, and devise interventions that address key concerns. This requires conceptual models of the ways in which cultural knowledge and social position shape disease etiology, symptoms, help-seeking, illness course, and treatment response. However, the kinds of cultural difference that are recognized and given attention in health care systems and services reflect the local politics of alterity. In the current global context of increased forced migration, politicized anxiety about the other, and reactionary populism, many people are exposed to systemic racism and discrimination. These same issues influence

the clinical encounter and impede communication and recognition of structural inequalities. Person-centered medicine must engage the politics of social marginalization and exclusion to address major determinants of health and provide effective care.

Kirmayer, L.J. (2015). The future of cultural formulation. In: Lewis-Fernández, R., Aggarwal, N.K., Hinton, L., Hinton, D. & Kirmayer, L.J. (Eds.) *DSM-5 Handbook on the Cultural Formulation Interview* (pp. 267-285), Washington: APPI Press.

Kirmayer, L.J., Benneqadi, R. & Kastrup, M. (2016). Cultural awareness and responsiveness in person-centered psychiatry. In: J. Mezzich, M. Botbol, G. Christodoulou, C.R. Cloninger, & I. Salloum (Eds.). *Person-Centered Psychiatry* (pp. 77-95), Heidelberg: Springer Verlag.

Kirmayer, L.J., Kronick, R. & Rousseau, C. (2018). Advocacy as key to structural competency in psychiatry. *JAMA Psychiatry*, 75(2):119-120. doi:10.1001/jamapsychiatry.2017.3897

CROSSING THE 90 BIOLOGICAL THRESHOLD: THE CHALLENGE OF PRIMARY CARE

Salman Rawaf (London)

Introduction

Longevity is a key mark of the 21st century with many people lives over the age of 90. Many of them can enjoy reasonable good health and independence. However, many in this important group of population provide health systems and services with many challenges due to the multiple morbidities and complex interventions they needs. They also require services outside traditional health in term of personal support, mainly from social services. This paper will address the complexity of care in this age group; some of the solutions; and the way forwards, as number (and hence percentage) of this age group will continue to multiply in the future

Methods

1.Review of the current literature on ageing population and what does it mean for health systems

- 2.Analyse the costs of interventions and what does it mean to the health system
- 3.Focusing on some of the good examples exist around the world in addressing this important age group's needs
- 4.Reflect on policies should be developed and how the public and patients should be at the centre of it.

Conclusion

With improved socioeconomic situation around the world, people are living longer and healthier. Many health services are accommodating to this age group needs despite complexity. Health professionals should be aware of this 'new norm' in our society and put in place policies and plan to ensure this age group needs are fully addressed.

Plenary Symposium 2: Precision Medicine and Whole Person Medicine: Science, Ethics and Society

THE BIOLOGICAL BASES OF PERSON CENTERED MEDICINE

Robert Cloninger (St. Louis)

Objectives: To describe the biological bases of Person-centered Medicine

Methods: Review of prior reports and new findings about the genetics and evolution of human personality

Findings: There are three systems of learning and memory that account for human personality development: (1) Habit learning by behavioral conditioning, (2) intentional self-regulation to achieve goals and maintain social relations, and (3) episodic learning and memory, as in autobiographical narratives. These have different psychological properties, unique genetic influences, and distinct brain circuitry and regulate health in general, not only mental health (1).

Discussion: Understanding and caring for persons requires understanding of who the person is as well as cultivation of healthy personality traits (2). Healthy personality traits account for most but not all variability in health outcomes.

Conclusions: PCM integrates humanism with science, and the humanistic aspect depends on the determinants of healthy personality development. Studies of the causes of human personality therefore provide fundamental information about the biological basis of PCM to guide the development of its methods and practices in a coherent way.

References

1. Cloninger CR. The evolution of human brain functions: the functional structure of human consciousness. Australian and New Zealand Journal of Psychiatry. 2009;43:994-1006.

2. Cloninger CR, Cloninger KM. Person-centered therapeutics. International Journal of Person-centered Medicine. 2011;1:43-52.

PRECISION MEDICINE AND MENTAL HEALTH

Thomas Schulze (Munich)

While precision medicine or personalized medicine approaches are widely considered to be driven by biological advancements, they cannot be pursued without person-centered concept of disease and treatment, in particular for psychiatric disorders. To illustrate this, I will present latest findings from (1) one of the largest prospective cohort and biobanking projects in psychosis research, the multi-center PsyCourse initiative (www.psycourse.de) and (2) the international Consortium on Lithium Genetics (www.ConLiGen.org). Using the PsyCourse example, I will show how a systematic longitudinal assessment can help stratify patients according to their course of illness, life events, and/or biological parameters. These stratification approaches delineate highly individualized trajectories of course and outcome that can be used in downstream biological analyses (like generation of induced pluripotent stem cells). Using the unique ConLiGen resource, I will demonstrate how genomic research may eventually advance translational research aimed at personalized prescribing of lithium.

References

Budde, M.; Anderson-Schmidt, H.; Gade, K.; Reich-erkelenz, D.; Adorjan, K.; Kalman, J.L.; Senner, F.; Papiol, S.; Andlauer, T.F.M.; Comes, A.L.; Schulte, E.C.; Klöhn-Saghatolislam, F.; Gryaznova, A.; Hake, M.; Bartholdi, K.; Flatau, L.; Reitt, M.; Quast, S.; Stegmaier, S.; Meyers, M.; Emons, B.; Haußleiter, I.S.; Juckel, G.; Nieratschker, V.; Dannlowski, U.; Schmauß, M.; Zimmermann, J.; Reimer, J.; Schulz, S.; Wiltfang, J.; Reininghaus, E.; Anghelescu, I.; Arolt, V.; Baune, B.T.; Konrad, C.; Thiel, A.; Fallgatter, A.J.; Figge, C.; von Hagen, M.; Koller, M.; Lang, F.U.; Wigand, M.E.; Becker, T.; Jäger, M.; Dietrich, D.E.; Stierl, S.; Scherk, H.;

Spitzer, C.; Folkerts, H.; Witt, S.H.; Degenhardt, F.; Forstner, A.J.; Rietschel, M.; Nöthen, M.M.; Falkai, P.; Schulze, T.G.; Heilbronner, U. A Longitudinal Approach to Biological Psychiatric Research: The PsyCourse Study. Preprints 2017, 2017100169 (doi: 10.20944/preprints201710.0169.v1).

Hou L, Heilbronner U, Degenhardt F, Adli M, Akiyama K, Akula N, Ardau R, Arias B, Backlund L, Banzato CEM, Benabarre A, Bengesser S, Bhattacharjee AK, Biernacka JM, Birner A, Brichant-Petitjean C, Bui ET, Cervantes P, Chen GB, Chen HC, Chillotti C, Cichon S, Clark SR, Colom F, Cousins DA, Cruceanu C, Czerski PM, Dantas CR, Dayer A, Étain B, Falkai P, Forstner AJ, Frisén L, Fullerton JM, Gard S, Garnham JS, Goes FS, Grof P, Gruber O, Hashimoto R, Hauser J, Herms S, Hoffmann P, Hofmann A, Jamain S, Jiménez E, Kahn JP, Kassem L, Kittel-Schneider S, Kliwiczki S, König B, Kusumi I, Lackner N, Laje G, Landén M, Lavebratt C, Leboyer M, Leckband SG, Jaramillo CAL, MacQueen G, Manchia M, Martinsson L, Mattheisen M, McCarthy MJ, McElroy SL, Mitjans M, Mondimore FM, Monteleone P, Nievergelt CM, Nöthen MM, Ösby U, Ozaki N, Perlis RH, Pfennig A, Reich-erkelenz D, Rouleau GA, Schofield PR, Schubert KO, Schweizer BW, Seemüller F, Severino G, Shekhtman T, Shilling PD, Shimoda K, Simhandl C, Slaney CM, Smoller JW, Squassina A, Stamm T, Stopkova P, Tighe SK, Tortorella A, Turecki G, Volkert J, Witt S, Wright A, Young LT, Zandi PP, Potash JB, DePaulo JR, Bauer M, Reininghaus EZ, Novák T, Aubry JM, Maj M, Baune BT, Mitchell PB, Vieta E, Frye MA, Rybakowski JK, Kuo PH, Kato T, Grigoriu-Serbanescu M, Reif A, Del Zompo M, Bellivier F, Schalling M, Wray NR, Kelsoe JR, Alda M, Rietschel M, McMahon FJ, Schulze TG. Genetic variants associated with response to lithium treatment in bipolar disorder: a genome-wide association study. Lancet. 2016 Mar 12;387(10023):1085-1093.

ETHICAL DIMENSIONS

Jim Appleyard (Canterbury, UK)

One of the intentions behind the application of the prefix 'precision' to Medicine was to broaden the discourse from concept of personalized medicine which has the expectation that medicines would be synthesised personally for single patients to the broader concepts of the precise tailoring of therapies to sub categories of disease which are often defined by genomics. Biomedical technologies have enabled a greater understanding of genetic diseases pharmacogenomics and oncology. They have raised new ethical dilemmas particularly for research ethics committees because of the enormous amounts of data generated by clinical whole-genome or whole-exome sequencing and the extent of current uncertainties with respect to data interpretations and disease associations. Among the most ethically challenging issues for clinicians are the complicated informed consent processes, returning results – particularly secondary and incidental findings – and privacy and confidentiality.

The fundamental ethical principles underpinning the practice of medicine provide an essential framework within which these new challenges must be considered so that the safety and best interests of each person are ensured. At the heart of this is the patient physician relationship which is based on the dialogue between the

patient as a person and the physician allowing trust to develop between two individuals so that the best interest of the person can be jointly sought through shared decision making within this clearly understood ethical framework. The key principles are respect for the individual, beneficence, non-maleficence, truthfulness, confidentiality with the protection of privacy, and justice. At times it is enormously difficult to balance these principles as they may internally conflict within the individual circumstances the physician

The physician's professional independence must include the absence of any conflict of interest

These 'principles' need to be 'internalized' and become our **professional conscience**, to act as a compass through the complex scientific and medico social scene

References

Mezzich JE, Appleyard J, Botbol M, Ghebrehiwet T, Groves J, Salloum IM, Van Dulmen S [2013]: Ethics in Person Centered Medicine: Conceptual Place and Ongoing Developments. International Journal of Person Centered Medicine 3: 255-257.
Ashley E A 2015 The Precision Medicine Initiative 1JAMA.,313(21):217

THE PUBLIC HEALTH PERSPECTIVE OF PERSON-CENTERED MEDICINE

Bettina Borisch (UGE, Geneva)

Person-centered medicine (PCM) has become a buzz-word. The individualistic approach and the population-based approach of individualized medicine and the public health (PH) may seem contradictory. This work will present the links and contradictions between the two by using the Global Charter systematic.

Methods

The Global Charter for the Public's Health¹ is a tool-kit used to analyze and facilitate the implementation of public health policies. It was created conjointly by the World Federation of Public Health Associations and WHO. It was created via a world-wide consultation with stakeholders. Since then several countries, institutions and projects are implementing the Charter.

Findings

The person-centered approach needs a local and cultural definition. This being done the obvious contradiction with Public Health is not as clear as hypothesized. On the contrary basic principles of both "disciplines" converge to the same objectives.

Discussion

The main aims of both PCM and public health should be the same: promotion and protection of health and prevention of diseases. There are bridges between the two apparently different approaches. They go back to the Alma Ata declaration and its goals set in this declaration are still valid. The question as why are we not there yet and how can the goals be reached?

Conclusions

The links between to Public Health have to be strengthened as both approaches have complementary views. The use of a framework like the Charter can be of help.

1. A Global Charter for the Public's Health—the public health system: role, functions, competencies and education requirements, *Eur J Public Health* March 8, 2016

WHOLE PERSON MEDICINE INTEGRATIVE APPROACHES

Juan E. Mezzich (New York)

This presentation will formulate and discuss concepts on the theory and practice of Person Centered Medicine (PCM). To this effect, it will build on the various papers presented in this symposium, selected papers published in the *International Journal of Person Centered Medicine* [1-3] and other vehicles as well as major research projects of the ICPCM relevant to the systematic conceptualization and measurement of PCM [4] and the development of a Person-centered Integrative Diagnosis model [5] and its practical application in a Latin American Guide for Psychiatric Diagnosis [6]. Emerging from such analysis are the prospects of a view of PCM involving a holistic dynamic understanding of health and aimed at care informed by bio-psycho-social evidence, experience and values.

References

1. Miles A, Mezzich JE: Advancing the global communication of scholarship and research for personalized healthcare: The *International Journal of Person Centered Medicine* 1: 1-5, 2011.

2. Miles A, Mezzich JE: The care of the patient and the soul of the clinic: person-centered medicine as an emergent model of modern clinical practice. *International Journal of Person Centered Medicine* 1: 207-222, 2011.

3. Cloninger CR, Salloum IM, Mezzich JE: The dynamic origins of positive health and wellbeing. *International Journal of Person Centered Medicine* 2: 179-187, 2012.

4. Mezzich JE, Kirisci L, Salloum IM, Trivedi JK, Kar SK, Adams N, Wallcraft J: Systematic Conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index. *International Journal of Person Centered Medicine*, 6: 219-247, 2016.

5. Mezzich JE, Salloum IM, Cloninger CR, Salvador-Carulla L, Kirmayer L, Banzato CE, Wallcraft J, Botbol M: Person-centered Integrative Diagnosis: Conceptual Bases and Structural Model. *Canadian Journal of Psychiatry* 55:701-708, 2010.

6. Asociación Psiquiátrica de América Latina (APAL) (2012): Guía Latinoamericana de Diagnóstico Psiquiátrico, Versión Revisada (GLAP-VR). Sección de Diagnóstico y Clasificación, Asociación Psiquiátrica de América Latina (APAL), Lima.

Parallel Session 1:

A: Symposium on Burn-out and Sustaining a Healthy Workforce

WELLNESS AND BURNOUT

C. Robert Cloninger (St. Louis)

The problem of burnout is not limited to physicians in the USA.

Burnout is now a worldwide problem encountered in all workers around the world who are treated impersonally like objects as a means to material profit, rather than as human beings with intrinsic dignity worthy of mutual respect.

The fundamental problem is the dehumanization of the human being with a consequent loss of feelings of dignity, trust, hope, and compassion, which are needed to give meaning and purpose to everyone's life.

Therefore, we need to encourage person-centered approaches to medicine. The growing prevalence of burn-out is the Achilles heel of dehumanized approaches to medical care.

TEACHING SELF-CARE FOR THE CARER: ITS PLACE IN PERSON CENTERED MEDICINE

Oscar Cluzet (Montevideo, Uruguay)

BACKGROUND

Caring for who cares represents a real health need recognized for long time and it is expressed in the implementation of various professional welfare programs.

In the PCM, with consequent enhance in the respective commitments, it is foreseeable that need for this care will be increased.

Current medical education doesn't emphasize personal values and choices of the person, which is fundamental in a holistic care paradigm like PCM (1).

Consequently, health professionals should be engaged to become proficient in person centered health systems (2).

OBJECTIVES

1. Contribute to the development of the doctor's wellbeing programs, applied to professionals who perform PCM in medical practice.
2. To train the teacher in the contents and the strategies destined to develop self-care of health personnel that performs PCM in the medical practice.

MATERIAL AND METHODS

Indications of the main international reference document: Statement of the Welfare of Doctors (3) was following.

Then, it tried to establish how the directives of the aforementioned document work in their application to a properly consolidated PCM.

FINDINGS AND DISCUSSION

An attempt is made to establish a Program. The first criterion is that a cultural paradigm change requires integrated educational actions, which are detailed. The second criterion is that each safety objective that has been defined as a healthcare endpoint determines specific actions.

CONCLUSIONS

Guidelines for educational planning following comprehensive principles of safety simultaneously for the patient and the health team are aimed at favoring cultural change that facilitates PCM's consolidation.

REFERENCES

1. Appleyard J, Tesfamichael G, Mezzich JE: Development and Implications of the Zagreb Declaration on Person Centered Health Professional Education. The International Journal of Person – Centered Medicine Vol 4. Issue 1: pp. 8-13.
2. Appleyard J, Botbol M, Caballero E, Tesfamichael G, Mezzich JE, Pérez-Miranda J, Ruiz Moraes R, Salloum IM, Snaedel J, Van Lebergh W: Bases of Person Centered Medical Education to Enhance Health Systems Worldwide. The International Journal of Person – Centered Medicine. 2017. Vol 7. Issue 2: pp. 82-90.
3. Statement of the Welfare of Doctors. Adopted by the 66th General Assembly of the AMM, Moscow, Russia, October 2015. Accessible in: www.un.org/en/ga/64/generaldebate/RU.shtml

CONTRIBUTIONS AND CHALLENGES FOR NURSING IN DELIVERING PERSON-CENTRED WOMEN'S HEALTH

Ann Karin Helgesen (Halden, Norway)

Objectives: The majority of nursing personnel working in nursing homes are women and most of the residents are women. The aim of this study was to explore the experience of nursing personnel with respect to patient participation in special care units for persons with dementia (SCUs) in nursing homes, with focus on everyday life.

Methods: The study has an explorative grounded theory design. Eleven nursing personnel were interviewed twice.

Findings: Patient participation– as far as suitable

Patient participation was described as an important element of the care given in the SCUs. Findings showed that the patient participation had to be adjusted to the individual resident. However, patient participation was often primarily adjusted to suit the nurse's ideas about how to carry out the daily care in the SCU context, and secondly to the individual resident's needs and wishes. Patient participation was described at different levels as letting the resident make their own decisions, adjusting the choices, making decisions on behalf of the residents, and forcing the residents. The educational level and commitment of the nursing personnel and how often they were on duty, impacted on the level that this person applied, as were the ability of the residents to make decisions, and organisational conditions, such as care culture, leadership and number of personnel.

Discussion: Patient participation was often found to be a losing principle in the hectic everyday life on an SCU, in spite of expressed good intentions from the nursing personnel.

Conclusions: To improve patient participation in SCUs for persons with dementia in the future, I suggest that more attention should be paid to creating care cultures with visible leaders who give priority to patient participation. All nursing personnel should be given the opportunity to join discussions about questions such as: 'What does patient participation mean?' and: 'How can we promote an adjusted level of patient participation in our unit?'

References:

1. Gallagher A, Li S, Wainwright P, Jones IR, Lee D. Dignity in the care of older people—a review of the theoretical and empirical literature. BMC nursing. 2008;7(1):11.
2. Welford C, Murphy K, Rodgers V, Frauenlob T. Autonomy for older people in residential care: a selective literature review. International Journal of Older People Nursing. 2012;7(1):65-9.
3. Buron B, Killian TS. Promoting personhood in men in Nursing Homes: The Role of Activity Directors. Annals and Long-Term Care. 2014;3:28-33.

BALANCING PROFESSIONAL AND PERSONAL LIVES; CHALLENGES FOR EARLY CAREER HEALTH WORKERS

Zachary Bordman (Toronto, Canada)

Balancing one's personal and professional life is essential to maintaining wellness and preventing burnout. This is important not only for the physician and their long-term health, but also directly impacts patient outcome¹. Early career physicians and other healthcare workers face unique challenges to balancing their lives, including poor habits that are developed in residency or training². To combat this, many training programs are developing and implementing a range of wellness programming into their curriculum. The cultural shift towards awareness of the importance and

promotion of personal wellness will play a significant role in maintaining a healthy medical workforce in the future.

1. Oberg EB, Frank E. Physicians' health practices strongly influence patient health practices. *J R Coll Physicians Edinb* 2009; 39(4): 290–1

Williams AS, Williams CD, Cronk NJ, Kruse RL, Ringdahl EN, Koopman RJ. Understanding the Exercise Habits of Residents and Attending Physicians: A Mixed Methodology Study. *Fam Med* 2015;47(2):118-23

CULTIVATING THE PRIMARY CARE WORKFORCE

Chris Van Weel (Nijmegen, The Netherlands)

Background, Objective: Most countries around the world experience problems in their health systems to meet and finance the health needs of their populations. Primary health care is considered a key factor in solving this problem: health systems with community based primary health care as a core component focus on individuals and populations in their bio-psycho-social context; and have better population health at lower health expenditure.

Health reforms towards primary health care are further bolstered by the pursuit of universal health coverage. Yet, the expanding role of primary health care has often to be realized under conditions where the political, educational and scientific agendas continue to focus on organ- and disease centered interventions. This miss-match between health policy aspirations and its actual management is a threat for the wellbeing and functioning of primary health care professionals.

Methods: This presentation reviews experiences of success in developing primary health care and identify strategies that have empowered the cultivation of a competent, self-confident primary health care workforce, acknowledged by the public, patients, policy makers and academic leaders.

Findings, discussion and conclusions: Three strategies come forward:

1. The identification of the core values that determine the effectiveness of primary health care: bio-psycho-social integration, continuity of care, person- and population centeredness based on a relation of trust.
2. Building of professionalism through teaching and training, based on these core values.
3. Development of indicators for performance review and remuneration, that capture these core values.

Currently, development of primary health care sensitive indicators is the biggest challenge.

Weel C van. Primary Health Care and Family Medicine at the Core of Health Care: Challenges and Priorities in How to Further Strengthen Their Potential. *Front. Med.* 2014; doi: 10.3389/fmed.2014.00037

Stigler F, Macinko J, Pettigrew LM, Kumar R, van Weel C. No universal health coverage without primary health care. *The Lancet* 2016; 387: 1811.

1B: Workshop on Mediation and Collaboration

PERSON-CENTERED CARE AND MEDIATION

Aleksandra Weber (Munich)

*Health is not everything,
but everything is nothing without being healthy.*
Arthur Schopenhauer

Person-centered care is a collaborative effort in a sector of unique complexity with a variety of players, professionals and interest groups interacting transdisciplinary and cross boarder in order to support health of the individual and the society in general. Sector closely interacts with social, cultural, ethical, political and economic aspects of the society and is the essential part of it. Expanding costs, technological progress with new options for diagnostic and treatment, strong cost cutting pressure, aging of the society and turbulences in the global economy are some of the topics causing tension around the globe. The main challenge for healthcare sector is bridging individual health and social responsibility through integrative cooperation of all participants. The overall potential for

misunderstandings and conflicts within the sector is extremely high on all levels of interactions. The purpose of this study is to explore the use of mediation in person-centered care, share personal experiences from consultations in the medical field and raise the awareness for effective communication and dispute resolution. It has been suggested in the selected literature, that mediation skills may optimize the process of person-centered care. Mediation as an autonomous process for conflict solutions bears a facilitating power in dealing with most critical issues, dilemmas and challenges. It is an integrative process of mutual decision making in order to solve problems effectively and harmonize relationships sustainably, thus sparing our most valuable resources. Mediation is relationally oriented and goes beyond than being just a technical tool by including cultural values, traditions, individual minds sets and life principals of the disputants. Mediation, conducted by a neutral third party can be easily applied in the clinical practice to involve all

stakeholders in diagnostic and treatment processes and catalyze collaboration. There is a strong need for a comprehensive conceptual framework with core elements of person-centered communication including empowerment and recognition of all active participants. Healthcare mediation teams should be set up at individual facilities to provide education and consultation services to frontline staff and patients. The key idea is to raise the awareness of implementing mediation skills in a daily practice of person-centered care, lay the foundation for future innovative research in this field and also implement this aspect in educational programs. The participants will have the opportunity to actively collaborate on a case study.

Parallel Sessions 2 :

A. Symposium on Research on Gender and Person-centered Care

TAKING THE MEDICAL HISTORY AT FIRST CONSULTATION

Iris Veit (Herne, Germany)

In Germany a consultation at doctor's office lasts 7 minutes. On average general practitioners have more than 250 contacts with patients per week. This is frustrating for them and their patients. To invest more time in the first consultation will be useful to reduce frequent consultations and to establish a cooperative relationship of truth between doctors and their patients.

This is the aim of a now official recommendation of the German Society for general practitioners and family medicine DEGAM concerning the take of medical history.

This recommendation has been created by more than 30 general practitioners, female and male, from Germany and Austria, who work in their own office and also teach medical students, linguistic and sociological experts and psychotherapists. The process lasted several years and included during three workshops the discussion of videotapes of doctor-patient interactions at their first consultation

References:

Howe EG: How mediation (and other) approaches may improve ethics consultations' outcomes. The journal of clinical ethics 2011 Vol 22, Issue 4, pp 299–309

Mezzich J et al: Systematic Conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index. The International Journal of Person Centered Medicine 2016 Vol 6 Issue 4, pp 219-247

Neveloff Dubler N, Liebmann CB: Bioethics Mediation – Guide to Sharping Shared Solutions. Vanderbilt University Press, 2011

and a literature review. Besides research documented in literature this recommendation is founded in the experience of medical practitioners.

The results of their discussion will be presented.

Taking the medical history is a process in time with ongoing steps. These steps range from an introduction to documentation including listening, clarifying, summing up and enquiring the psychological and social context of complaints and biographical background.

Every step includes verbal interventions which are described word by word to be easily used in daily work.

We hope that the recommendation "Taking the medical history at first consultation" will influence daily work of general practitioners as well as undergraduate and postgraduate training.

COMMUNICATION RESEARCH: EVIDENCE FOR THE IMPORTANCE OF PERSON CENTERED COMMUNICATION

Evelyn van Weel –Baumgarten (Nijmegen, The Netherlands)

Background: Research and teaching of communication have been receiving attention for some time now, however patients still encounter many problems when they visit clinicians because of health problems. This research show that along with knowledge and practical skills, adequate patient centered communication is essential in realizing optimal health outcomes in patients, and improves their well-being.

Objectives: To provide an overview of the impact of adequate person centered clinical communication and highlight its key elements and the importance of the patient perspective.

Methods: This presentation will subsequently present research about patient experiences and highlight outcomes of various types of research on the relation between person centered communication and health outcomes. It will discuss key elements of patient centered communication for effectiveness such as finding common ground, and include a discussion and specific focus on gender and more vulnerable groups.

Findings, discussion and conclusions: person centered communication matters and makes it possible to capture the full story and the patient perspective. This is necessary to build a trustful relationship and to find common ground and helps with shared decision and adherence to treatment. This in turn leads to improved outcomes and well-being.

References:

Zill JM, Scholl I, Harter M, Dirmaier J. Which dimensions of patient-centredness matter? Results of a web-based expert Delphi survey. PLoS One 2015;10 (11):e0141978

Weel-Baumgarten, E van. Is linking research, teaching and practice in communication in health care the way forward? Patient Education and Counseling 99 (2016) 1441–1445

COMPARATIVE STUDY IN LIMA HOSPITALS USING THE PERSON-CENTERED CARE INDEX

Alberto Perales (UNMSM, ANM), Levent Kirisci (Universidad de Pittsburgh, USA), Juan E Mezzich (ICPCM), Elard Sánchez (UNMSM), Lorenzo Barahona (UNMSM), Salomón Zavala (UNMSM), Edgar Amorín (INEN)

Antecedents: In the First Latin American Conference on PCM held in Lima, Peru (December, 2015) it was strongly recommended to collect, through scientific research, a more systematic and valid data to evaluate the real development of PCM in Latin America (1). Following this indication, the present study was organized and carried out.

Methodology: Explorative transversal survey study. **Instrument:** The Person-centered Care Index (PCI) is an instrument designed by Mezzich et al. (2) useful to evaluate how closely health care systems follow the essential concepts of Person Centered Medicine. Its structure includes 8 major item categories and 33 sub-items, that offer a global score on PCM basic concepts: 1°) Ethical Commitment, 2°) Cultural Sensitivity, 3°) Holistic scope, 4°) Relational Focus, 5°) Individualized Care, 6°) Common Ground for Collaborative Diagnosis and Care, 7°) People-centered Systems of Care, and 8°) Person-centered Education and Research. Its Cronbach's alpha is 0.95, its factor structure is unidimensional, and indications of its reliability and content validity are available.

Procedures: Following the training of a group of evaluators, they engaged groups of physicians and nurses to apply the PCI to their own hospital services (surgical and medicine). Engaged for the study were four hospitals belonging to three different Peruvian health care systems: two public hospitals (one general and one oncological), one Social Security hospital, and one private hospital. Across hospitals, 240 health professionals were involved in rating the medical or surgical services of the hospital where each worked. This represented a total of 120 physicians and 120 nurses; 50% belonging to Medicine Services and 50% to Surgical Services. The

Project was approved by the Ethics Research Committee of the School of Medicine of San Marcos National University in Lima.

Results: It was found that the private hospital was rated highest with the PCI, followed by the oncological and the general public hospitals, with the social security hospital being rated lowest. No significant differences were obtained between surgical and medicine services nor between the ratings made by nurses and those made by physicians. The raters with fewer years of experience tended to rate the hospitals higher.

The content validity of the PCI was rated by the evaluators around the substantial level.

Conclusions: The application of the PCI to four prototype hospitals in Lima yielded interesting inter-hospital comparative results and substantial content validity ratings for the PCI. The findings suggest the value of the PCI for clinical and health service evaluations and research on person centered care in Latin America.

REFERENCES:

1. Perales A. Desarrollo Latino Americano de la MCP y el entorno médico-paciente. Presentado en las "Jornadas Latino Americanas de Medicina Centrada en la Persona: Del concepto a la acción". Lima, Diciembre 18-19, 2015.
2. Juan E Mezzich, Levent Kirisci, Isahn M Salloum, Jitendra K Trivedi, Sujit Kumar Kar, Neal Adams and Janet Wallcraft. Systematic conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index. The International Journal of Person Centered Medicine, 2016 Vol 6, Issue 4: pp 219-247

2B. Symposium on Person-Centred Health Care Beyond Slogans

THE INFLUENCE OF TECHNOLOGY AND STANDARDS ON HEALTHCARE STAFF'S JOB SATISFACTION

V.A Grondahl et al (Halden, Norway)

Objectives: There is an increase in utilising information and communication technology (ICT) in hospitals, including a standardization of work processes (1). Previous research shows that satisfied nurses (RNs) have a positive impact on patients' care quality perceptions (2). The aim of the study was to explore differences in job satisfaction among healthcare staff from an old to a new high-tech hospital in Norway.

Methods: A cross-sectional design was used. Using the questionnaire Emotional Stress Reaction Questionnaire (ESRQ) including items concerning the staff's workplace and work, data were collected in 2015 (old hospital) and 2016 (high-tech hospital), with respectively 985 and 1289 respondents. Comparative statistics were used to test for differences between job satisfaction from old to new high-tech hospital, and to explore the impact of ICT and standardization of work processes on job satisfaction ($p \leq .05$).

Findings: The majority of the healthcare staff is satisfied with their workplace. Nevertheless, there was a significant negative correlation between job satisfaction and a perception of control through technology and standards. In addition, analyses indicate

differences across staff's perception of technology and standards on their work. RNs were more likely to agree that technology and standards control their job than physicians. A majority of RNs disagreed that technology open up for an increase in person-centered care.

Discussion: It is likely that technology and standards increasingly intertwine with professionals' work, and that RNs may find themselves captured by standards and feel a time consuming effect of technology, obstructing them from having contact with patients. Perhaps RNs need more time to familiarize with the use of technology. An increase in ICT might also give the administrators an opportunity to reduce the number of positions in hospital.

Conclusions: Administrators and staff need to highlight person-centered care parallel to the development and use of technology and standardization.

References:

3. Russel, B., Trusson, C. and De, S. (2016). *The ambiguities of 'managed professionalism': working in and with IT*. IN: Wilkinson,

A., Hislop, D. and Coupland, C. (eds.) *Perspectives on Contemporary Professional Work: Challenges and Experiences*, Cheltenham: Edward Elgar Publishing, pp. 165-186.

4. Kutney-Lee, A., McHugh, M. D., Sloane, D. M., Cimiotti, J. P., Flynn, L., Neff, D. F. & Aiken, L. H. (2009). Nursing: A key to patient satisfaction. *Health Affairs*, 28(4), 669-677.

CHALLENGES FOR FEMALE STAFF IN PERSON-CENTERED CARE FOR MALE RESIDENTS IN NURSING HOMES

AK Helgesen, EA Skaug, VA Grondahl (Halden, Norway)

Objectives: The aim of this study was to explore the female personnel's experiences with the implementation of an activity program for male residents in municipal care services.

Methods: This study was inspired by a grounded theory approach according to Strauss and Corbin. Data were collected by means of two focus interviews with 11 staff in total.

Findings: The findings showed that the female personnel experienced that continuity was a prerequisite to being and remaining motivated when taking part in the activity program. Therefore, a lack of continuity was an obstacle. The categories 'to be prepared', 'to be responsible for a sense of fellowship', and 'to gain new perspectives' illuminate the personnel's experiences. Different conditions had an impact on how the personnel experienced the implementation of the activity program and whether they stayed motivated for being a part of the program in the future.

Discussion: The study showed that it was significant for the female personnel to feel prepared when taking part in the activity program,

and a lack of knowledge about the activity leader role was highlighted as a huge challenge.

Conclusions: This study has highlighted the importance for the personnel of continuity in performing the activity leader role and the importance to be prepared for the role. Furthermore, the personnel's knowledge of the men is essential for facilitating not only a sense of fellowship, but also individual care during the activity program. More attention should be given to ward routines that, with only minor changes, may strengthen the activity leader role.

References:

1. Buron B, Killian TS. Promoting personhood in men in Nursing Homes: The Role of Activity Directors. *Annals and Long-Term Care*. 2014;3:28-33.
2. Moss SZ, Moss MS. Being a man in long term care. *Journal of Aging Studies*. 2007;21:43-54.

A PATTERN APPROACH TO ANALYZING PERCEPTIONS OF THE QUALITY OF PALLIATIVE CARE AND SATISFACTION

T. Sandsdalen, VA Grondahl, B. Wilde-Larson (Halden, Norway)

Objectives: The aim was to explore the profiles of patients in palliative care with respect to: patients' perception of the quality of palliative care and patient satisfaction, and to describe and compare person related conditions and organization related conditions that characterize the patient profiles. **Methods:** A cross-sectional study, including 140 patients from four different palliative care contexts. The Quality from the Patient's Perspective questionnaire for Palliative Care is based upon a person-centered theoretical framework, was used [1]. Satisfaction was measured by the Emotional stress reaction questionnaire [2]. Person- and organization-related conditions were measured. Hierarchical cluster analysis, General Linear Model and Pearson Chi-Square Test were used. **Findings:** Three unique clusters of patients with different patterns of perceptions of quality of care and satisfaction were identified. Patients in cluster 1 (30%) had best perception of care quality and were more satisfied, Patients in cluster 2 (25%) had better perceptions of care quality and were most satisfied and patients in cluster 3 (18%) had worst perceptions of care quality and were less satisfied. The clusters were characterised by person related conditions (e.g. patients' sense of coherence and

perceptions of subjective importance) as well as organisation related conditions (e.g. physicians' competence and type of care services). **Discussion and conclusions:** One may assume that perceptions of quality if care and satisfaction is positively associated, however the result shows that this relationship is more complex. The results provides healthcare personnel with important knowledge to tailor quality work initiatives and improve person-centered care for different groups of patients in the palliative care contexts.

1. Sandsdalen, T., Rystedt, I., Grøndahl, V.A., Hov, R., Høye, S., Wilde-Larsson, B. (2015). Patients' perceptions of palliative care: adaptation of the Quality from the Patient's Perspective instrument for use in palliative care, and description of patients' perceptions of care received. *BMC Palliative Care*, 14:54(54)
2. Larsson, G., & Wilde-Larsson, B. (2010). Quality of care and patient satisfaction: A new theoretical and methodological approach. *International Journal of Health Care Quality Assurance*, 23(2), 228-247.

HOW TO INCREASE STUDENTS' PRACTICAL KNOWLEDGE OF PERSON-CENTERED CARE IN HEALTH AND WELFARE EDUCATION

L.S. Tvete et al (Halden Norway)

Objectives: Health and welfare students learn about person-centered care in their theoretical studies. During their practical training, they are expected to develop person-centered care skills,

but research shows a gap between theory and practice (1). The aim of the study was to increase students' competence on person-

centered care in psychiatric wards, in substance abuse treatment and in nursing homes

Methods: Person-centered care was operationalized into one intervention: one-to-one contact (patient/resident – student). The intervention was systematically conducted during the students' practical studies (8 weeks). The students were responsible for two patients/residents at all time. One student should spend 30 minutes twice a week alone with one patient/resident. This form of companionship comprised activities such as talking, watching TV and going for a walk. Focus group interviews are conducted prior to the practical studies, and immediately after. Content analysis will be performed.

Preliminary findings: The students had learned of person-centered care, and their previous experiences suggested that person-centered care was something special. Special as in only performed when there was time to do it. The students were eager to perform the one-to-one contact. During the practical training, the students to some extent found it difficult to conduct the intervention. The difficulties were caused by the heads in their practical

placements who assessed the patients/residents to be too frail for person-centered care.

Discussions: There seems to be a need for educating health and social care workers in person-centered care, and perform intervention studies involving both the personnel and their administrative leaders (2).

Conclusions: The education need to involve students in intervention studies, to increase the students' practical knowledge on person-centered care.

References:

1. Monaghan, T. (2015) A critical analysis of the literature and theoretical perspectives on theory–practice gap amongst newly qualified nurses within the United Kingdom, 35 (8) 1–7
2. Grøndahl, V. A., Fagerli, L. B., Karlsen, H., Hansen, E. R., Johansson, H, Mathisen, A. G., & Helgesen A. K. (2018). The impact of person-centered care on residents' perceptions of care quality in nursing homes: an intervention study. *International Journal of Person Centered Medicine*. Vol 7, No 2 ›

Plenary Symposium 3: Gender and Non-communicable Diseases 40 Years after Alma Ata

WONCA PERSPECTIVES ON GENDER AND NON-COMMUNICABLE DISEASES 40 YEARS AFTER ALMA ATA

Ruth Wilson (Kingston, Canada)

Objectives: To describe the opportunities arising from intersection of three important movements in health—women's health, person-centered medicine, and the renewal the commitment to primary health care described 40 years ago at Alma Ata.

Findings: Over eight hundred women die every day in childbirth, yet cardiovascular disease is the leading cause of mortality in women. Improving the health of women requires a broader view of women's health than reproductive care alone. How can health systems best provide preventive and curative care for women with non-communicable diseases?

The primary care paradox is that that compared with specialty care or with systems dominated by specialty care, primary care is associated with the following: (1) apparently poorer quality care for individual diseases, yet (2) similar functional health status at lower cost for people with chronic disease, and (3) better quality, better health, greater equity, and lower cost for whole people and populations.

The Declaration of Alma Ata called for primary health which “should be sustained by integrated, functional and mutually supportive referral systems, leading to the progressive improvement of comprehensive health care for all, and giving priority to those most in need”

Family Physicians are well-trained generalists, based in the community they serve, working in teams, and oriented to both high quality interpersonal interactions as well as ascertaining the most pressing health challenges of the defined population they serve. As such a well equipped and supported Family medicine workforce can make a transformative contribution to addressing NCDs in women, both at an individual and community level.

References:

3. Declaration of Alma Ata
http://www.who.int/publications/almaata_declaration_en.pdf
4. Stange K, Ferrer R. The paradox of primary care. *Ann Fam Med* July 1, 2009 vol. 7no. 4 293-299

PERSON CENTERED CARE IN DIABETES & COMORBID SEVERE MENTAL ILLNESS: ACTING TOGETHER TO DELIVER AN INTEGRATED PERSON-CENTERED APPROACH

Helen Millar (Dundee, Scotland)

Background

Adults with severe mental illness die on average 25 years earlier than the general population. Much of the premature death is related to comorbidities such as diabetes which is more common amongst this population. There is a need to move towards a more integrated approach to health care including not only a more collaborative integrated working approach between specialities and psychiatry but also a broader focus on self management interventions to improve overall health outcomes.

Aim and Methods

Review the current literature on Diabetes and co-morbid severe mental illness including the current challenges and bidirectional connections between these co-morbidities. Disparities in health care and the gender gap issues were reviewed and the ongoing developments aimed at managing these challenges.

Findings

- (i) The literature highlights the burden of Diabetes and severe mental illness linked to premature mortality
- (ii) There is a growing body of literature supporting person centered interventions and the implementation of more integrated models of care to improve healthcare outcomes in this population.

(iii) Pilot programmes and data collection for health care improvements are currently underway which highlight patient empowerment and a structured collaborative approach to make a person centered care approach for those with diabetes and severe mental illness a reality.

Conclusions

The burden of diabetes and severe mental illness is a major challenge for our current health care systems. Providing person centered integrated care is essential to address this challenge to achieve better health outcomes and overall improve the mental and physical wellbeing of this population. The interplay between empowerment of the person and improved demonstrable person centered outcomes is a further step forward in providing evidence of the need to utilise a more person centered model of care for comorbidities such as Diabetes and severe mental illness.

References

1. Mezzich J. E. and Salloum I. M. (2009). Comorbidity, positive health, and integration of services. *Psychiatric Diagnosis: Challenges and Prospects*. J. M. IM Salloum. Oxford, UK, Wiley-Blackwell.
2. Millar H.L. and Abou-Saleh M. T. Multimorbidity in Mentally Ill People: The Need for a Person-centered Integrated Approach. *The International Journal of Person Centered Medicine* 2015 Vol5 Issue 1 pp28-33
3. Frayne S. M. (2005). Disparities in Diabetes Care; Impact of Mental Illness *Arch Intern Med*/Vol 165.
4. Miyamoto S et al. (2018). mHealth Technology and Nurse Health Coaching to Improve Health in Diabetes: Protocol for a Randomised Controlled Trial. *JMIR Research Protocols*.

THE IMPORTANCE OF SELF CARE IN THE NEW SETTING

Austen El-Osta (London)

Indeed, there is much scope to develop person-centred medical practices that lead to happier patients and better outcomes. Collaborative care and self-management of chronic conditions strongly merit further development. There is also a great deal of focus and attention today on health equity and the rights that people around the world have (or should have) in health and healthcare services. Unfortunately, this has inadvertently diverted attention away from the fact that rights generally come with responsibilities. As noted in the Alma-Ata Declaration: "People have the right *and duty to participate individually* and collectively in the planning and *implementation* of their health care". The primary beneficiary of self-care is the self-carer themselves. The primary loser of a failure to self-care is that same person. And the consequences of failure or inability to self-care is the epidemic of chronic 'lifestyle' diseases facing the world today, which impacts, directly or indirectly, on everyone. Aside from simple self-interest

we each have a moral imperative based on responsibility towards other users of precious public health resources, and towards future generations, including our own children. In sum, there is an important societal balance to be struck between rights to health and healthcare, and responsibilities towards one's own health and to the consequences of poor lifestyle choices. There is a major opportunity and need to promote public dialogue and understanding in this area. Recognising the importance of self-care in the new setting, Imperial College London, the International Self Care Foundation (ISF) & the Self Care Forum (SCF) UK spearheaded a strategic collaboration resulting in the establishment of the Self Care Academic Research Unit (SCARU) at Imperial. This lecture will raise awareness about the singular importance of self-care and shared care in the new setting and will stimulate discussion regarding this contemporary issue.

Parallel Sessions 3:

A: Symposium on Designing Primary Health Care Systems to Meet Women's Needs

SETTING PRIORITIES UNDER SLOW ECONOMIC GROWTH

Salman Rawaf (London)

Introduction

Almost all health systems worldwide are under financial pressure mainly due to population growth, ageing population and technological advance. With many competing priorities a well defined approaches are needed to identify these priorities and how to target it through service redesign and innovation without losing the focus on patients and centre services around needs. Furthermore, with defined priorities health professional have to change their practices and shift emphasis from disease to health model. This paper logical approaches to priority setting and bring some examples from countries in upper, middle and low income supported with international and national data.

Methods

1. Review of the current literature on population dynamic and technology and their impacts on health
2. Focusing on some of the good examples exist around the world
3. Reflect on policies should be developed and how the public and patients should be at the centre of it.

Conclusion

In modern health services the role of policy makers and senior managers is not only complex but also very challenging. They have to juggle with many priorities in shrinking health finance (inflation, capital costs, salaries etc). Re-designating services and innovating to provide alternative and different settings are some of the options to meet population health needs.

INTERPROFESSIONAL COLLABORATION AND COMMUNICATION

Tesfa Ghebrehiwet (Alberta, Canada)

Objectives

The presentation aims to highlight key issues in interdisciplinary collaboration and communication as underlying factors for effectiveness of health teams in providing person-centred care and improved patient outcomes.

Methods

The presentation is based on literature review.

Findings

Coordination of care and teamwork reduce medical errors; improve quality of care, patient outcomes, and patient safety (Institute of Medicine 1999). On the other hand ineffective health team collaboration is the root cause for nearly 66 percent of all medical errors (Institute for Health Communication, 2011).

Furthermore, the evidence indicates that there are positive relationships between a healthcare team member's communication skills and a patient's capacity to follow medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors (Institute for Health Communication, 2011). And when communication about tasks and responsibilities are done well, there is a significant reduction in staff turnover and improved job satisfaction, because it facilitates a culture of mutual support (Lein & Wills, 2007).

Discussion

In today's complex health systems it is impossible for a single health professional group to provide a continuum of person-centred and cost-effective care. Interdisciplinary collaboration and communication are largely achieved through interprofessional education during certain periods of their training.

Conclusion

Team approach - with collaboration and communication at its core - offers a viable solution to the service delivery challenges facing health care systems worldwide.

References

- [1] Institute of Medicine (1999). Institute of Medicine. *To Err Is Human: Building a Safer Health System*. Washington, DC: National Academy Press
- [2] Laschinger, H.K.S, Almost, J, & Tuer-Hodes, J. (2003). Workplace Empowerment and Magnet Hospital Characteristics: Making the Link. *JONA*, 33 (7/8)
- [3] Institute for Health Care Communication. Impact of Communication in Healthcare. Available at: <http://healthcarecomm.org/about-us/impact-of-communication-in-healthcare/>

PERSON-CENTERED CARE AND INTER-SECTORAL COLLABORATION

Aleksandra Weber (Munich)

Person-centered care is a collaborative effort and at its core an integrated health service. The health is determined not only by health sector activities but also by social and economic factors. Intersectoral collaboration of stakeholders and interest groups such as policy-makers, decision-makers, providers, researchers, education, finance and industry is essential for comprehensive services and continuum of care. All of them provide a wide range of services and have at least one common goal: improving and sustaining health. Coordination and integration of human services as a comprehensive intervention by public, not-for-profit, private and financing sector is a common problem internationally. The purpose of this study is to raise the awareness for the importance of effective communication and complex interactions through the process since effective intersectoral collaboration is one of the essential pillars of a fully integrated person-centered care. There are tremendous macro and micro changes taking place in the complex healthcare sector around the globe challenging all providers not only because of technological advancements transforming the entire healthcare industry. The focus here is on comprehensive knowledge synthesis and integration of services through strategic alliances along a continuum of care. Essential are meaningful partnerships based on common objectives and joint ownerships through strategic and operational dialogue. Only a small number of valid and reliable tools such as questionnaires and checklists have been identified to measure intersectoral relationships, collaboration and progress and also to capture key dimensions and principles of integrated care. The variables identified to measure intersectoral collaboration and the scope and depth of integration include identifying structures between parenting organizations, level of connectivity representing cooperation and coordination as well as collaboration and consolidation. Other variables include looking at social networks

capturing in quantitative terms both intra- and intersectoral service integration. Some key questions to be discussed: How to improve intersectoral communication to create sustainable partnerships? How can capacity for collaborative action be ensured? What to do when partnerships are stuck at different levels from local to global, governmental to private? Which options are available to find a common ground and move forward? The key idea is to develop a framework for future research, stimulate intersectoral communication and collaboration, provide a blueprint and inspire all the participants actively involved in the process of person-centered care.

References:

- Browne G, Roberts J, Gafni A, Byrne C., Kertyzia J, Loney P: Conceptualizing and validating the human services integration measure. *International Journal of Integrated Care*. 2004 Apr-Jun; 4: e03
- Mezzich J et al: Systematic Conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index. *The International Journal of Person Centered Medicine* 2016 Vol 6 Issue 4, pp 219-247
- Neveloff Dubler N, Liebmann CB: *Bioethics Mediation – Guide to Sharpening Shared Solutions*. Vanderbilt University Press, 2011
- Oelke ND, Stiphout ML, Suter E, Hepp S, Rostami M, Birney A, et al.. Measuring intersectoral collaboration in a health care setting: A knowledge synthesis. *International Journal of Integrated Care*. 2016;16(6):A11. DOI: <http://doi.org/10.5334/ijic.2954>

3B: Workshop on Clinical Communication

CLINICAL COMMUNICATION SKILLS: WHAT AND HOW TO TEACH OBSTACLES AND SOLUTIONS FOR TRANSFER TO CLINICAL PRACTICE.

Evelyn Van Weel (Nijmegen, the Netherlands)

Background: Person centered communication is a key element of person centered care. Even though the evidence shows that adequate person centered communication is necessary to achieve optimal health outcomes, patients still encounter many problems in that respect when they visit clinicians for health problems. Because of its importance and the fact that not every healthcare professional is a good communicator by nature, these skills need to be trained, maintained and implemented in clinical practice.

Objectives: To provide knowledge and practice effective person centered communication skills; to highlight and discuss the problems of implementation in clinical practice and offer some suggestions to solve the problem.

Methods: In this workshop a variety of interactive small group exercises will be mixed with mini presentations in plenary. The exercises will include 'what' to teach (skills and models that can be used to ensure capturing both medical and patient perspective) and 'how' to teach communication skills (methods including effective feedback) and use brainstorming, video and role-play. The

presentations will include evidence about the impact of person centered communication as well as about effective teaching methods in under- and postgraduate training. This will be followed by an interactive discussion about what can be done to improve transfer of what has been taught into clinical practice, highlighting the problem, as well as brainstorming about and offering some solutions.

Conclusions: The workshop will finish with participants generating take home points.

References:

E. van Weel-Baumgarten et al. Bridging the gap: How is integrating communication skills with medical content throughout the curriculum valued by students? *Patient Education and Counseling* 90 (2013) 177–183

E. van Weel-Baumgarten. Is linking research, teaching and practice in communication in health care the way forward? *Patient Education and Counseling* 99 (2016) 1441–1445

Plenary Symposium 4: Respectful Maternity Care

GUIDELINES FOR SAFE MATERNITY CARE

Ozge Tuncalp (WHO, Geneva)

This presentation will give an overview of WHO's work on quality of care for maternal and newborn health and highlight new guidelines

on antenatal care and intrapartum care for positive pregnancy and childbirth experience.

EQUITY AND ACCESS TO RESPECTFUL MATERNITY CARE: BETWEEN HOPE AND CURRENT CHALLENGES

Patricia Perrenoud (Lausanne)

Objectives: This presentation will question the equity of access to respectful maternity care and highlight current challenges faced by policy makers and health care professionals in this regard.

Methods: The reflection will rely on a narrative literature review and on research results extracted from an anthropological fieldwork held in Switzerland.

Results: The knowledge on maternal experience and respectful care has been augmented since the emergence of Evidence-Based Medicine and the ensuing structuration of knowledge production and circulation. However, efficient interventions and respectful care still do not reach women on an equitable basis, leaving some women, e.g. those with an immigrant background or low SES, more often as the recipient of substandard care. This is especially the case when best practices on collaboration with community interpreters are not met, in the presence of pre-existing maternal diseases as well as around transition care.

Discussion: Since the 1980s, social scientists have questioned the reductionist approach health professionals may use in care, i.e. the

difficulty to account for social determinants of health and to address problems related to these determinants. Hospital-based practice or in town medical offices, as well as contemporary cultural conceptions of the individual, can be a barrier towards an understanding of the social circumstances that interfere with the experience of maternity. Thus, important needs can be overlooked, leading to substandard care and its sometimes serious if not tragic consequences.

Conclusions: Respectful care implies kindness, access to information as well as choice, but it is also rooted in the delivery of adequate care that targets actual maternal needs. In high-income countries, the equitable delivery of adequate care is yet to be achieved due to the presence of cultural and structural barriers. Triangulation of different types of Evidence, from research and practice, can inform policy makers and professionals and help tackle these important issues.

CAESAREAN SECTION BY MATERNAL REQUEST: A WOMAN-CENTERED DILEMMA

Meg Casson (Toronto)

The rate of Caesarean section (CS) deliveries worldwide have increased steadily over the past 60 years.¹ While there is considerable variation both between and within countries, most surpass the WHO recommended rate of 10-15% of births by CS.² The reason for this trend is multifactorial; changing maternal and fetal characteristics, improvements in delivery and access to surgical services, and increasing numbers of non-medically indicated CS or CS by patient request all likely large contributors.

Caesarean section by maternal request (CSMR) is a caesarean delivery performed because the mother requests this method of delivery in the absence of conventional medical or obstetrical indications for avoiding vaginal birth. The incidence of CSMR is not well documented but is estimated to be between 1-8% of all Caesarean section.³ The provision of CSMR is a matter of global debate without clear guidelines for patients or practitioners. The rise in CSMR highlights the complex interface between system-level

use of resources and technology, ethically grounded and patient autonomy.

Through a reflection on recent CS trends, and country specific approaches to CSMR, it is evident that the dilemma of non-medically indicated CS is enhanced by a woman-centered lens.

References

1. Betran et al. The Increasing Trend in Caesarean Section Rates: Global, Regional and National Estimates: 1990-2014. *PLOS Medicine*. 2016, <http://doi.org/10.1371/journal.pone.0148343>.
2. WHO Statement on Caesarean Section Rates (2015). Available at http://apps.who.int/iris/bitstream/10665/161442/1/WHO_RHR_15.02_eng.pdf?ua=1
3. Barber et al. Contributing Indications to the Rising Cesarean Delivery Rate. *Obstetrics & Gynecology*, 2011, 118(1): 29–38.

PERSON-CENTERED NEONATAL HEALTH CARE

Ornella Lincetto (WHO, Geneva)

Objectives: promote person-centered models of newborn care

Methods: To advance newborn care in low and middle-income countries (LMICs), informal consultations took place with ENAP partners to define current status of inpatient newborn care, health system challenges to scale-up WHO recommended interventions, and standards of quality newborn care services.

Findings: Newborn babies, particularly when born preterm or sick in many parts of the world are not receiving the care they need. Their immediate needs, love from mother father family and health professionals in the form of dignity and respect, warmth, freedom from infection, good nutrition and support for breathing are not met. Poor quality of care impacts on mortality, morbidity, growth and brain development. Challenges in LMICs include lack of services, poor quality of care, insufficient skilled health providers and limited family involvement in the care of the baby. Person-centered models of care built on newborn needs and rights, such as NICU family-integrated care and kangaroo mother care are very promising and can address the complex needs of the newborn, family and health system.

Discussion: To improve neonatal outcomes and reach UHC services for the small and sick newborn should be built up from person-centered needs and rights considering the individual infant,

the mother, father and the wider family in the context of the local community and based on a shared vision of health care providers and the community.

Conclusions: Newborn services should be designed to support the best start in life with the newborn and the family at the center of care.

References

1. Moxon SG, Lawn JE, Dickson KE, Simen-Kapeu A, Gupta G, Deorari A, Singhal N, New K, Kenner C, Bhutani V, Kumar R, Molyneux E, Blencowe H. Inpatient care of small and sick newborns: a multi-country analysis of health system bottlenecks and potential solutions. *BMC Pregnancy Childbirth*. 2015;15 Suppl 2:S7. doi: 10.1186/1471-2393-15-S2-S7. Epub 2015 Sep 11.
2. O'Brien K, Robson K, Bracht M, Cruz M, Lui K, Alvaro R, da Silva O, Monterrosa L, Narvey M, Ng E, Soraisham A, Y Ye X, Mirea L, Tarnow-Mordi W, and Lee SK. Effectiveness of Family Integrated Care in neonatal intensive care units on infants and parents outcomes: a multicentre, multinational, cluster-randomised controlled trial. *Lancet Child and Adolescent Health* 2018. Published online February 7, 2018 [http://dx.doi.org/10.1016/S2352-4642\(18\)30039-7](http://dx.doi.org/10.1016/S2352-4642(18)30039-7)

Parallel Sessions 4:

A. Symposium on Education and Research in Woman-centred Reproductive Care

PROMOTING RESPECTFUL MATERNITY CARE IN RURAL TANZANIA: NURSES' EXPERIENCES OF THE "HEALTH WORKERS FOR CHANGE" PROGRAM

Gail Webber (Ottawa)

Objectives: Disrespectful and abusive care of women during their pregnancies has been shown to be a barrier for women accessing health care services for antenatal care and delivery. As part of an implementation research study to improve women's access to health care services in Rorya District, Mara, Tanzania, we

conducted a pilot study training reproductive health care nurses to be more sensitive to women's needs based on the "Health Workers for Change" curriculum (1).

Methods: Six series of workshops were held with a total of sixty reproductive health care nurses working at the hospitals, health centres and dispensaries in the district. The participants provided comments on a survey and participated in focus groups at the conclusion of the workshop series. These qualitative data were analyzed for common themes (2).

Findings: The participants appreciated the training and reflected on the poor quality of health care services they were providing, recognizing their attitudes towards their women patients were problematic. They emphasized the need for future training to include more staff and to sustain positive changes. Finally, they made several suggestions for improving women's experiences in the future.

Discussion and Conclusions: The qualitative findings demonstrate the success of the workshops in assisting the health care providers

to become aware of their negative attitudes towards women. Future research should examine the impact of the workshops both on sustaining attitudinal changes of the providers and on the experiences of pregnant women receiving health care services.

[1] Fonn S, Xaba M. Health Workers for Change: A Manual to Improve Quality of Care. Geneva: UNWP, World Bank, WHO Special Project for Research and Training in Tropical Diseases and Women's Health Project; 1995. http://apps.who.int/iris/bitstream/10665/63192/1/TDR_GEN_95.2.pdf [Accessed September 4, 2017].

[2] Webber G, Chirangi B, Magatti N. Promoting Respectful Maternity Care in Rural Tanzania: Nurses' Experiences of the "Health Workers for Change" Program (2018, submitted for publication)

HOW RESPECTFUL CARE HAS BEEN IMPLEMENTED: CENTERING GROUP PRENATAL CARE

Rupa Patel (Kingston, Canada)

Objectives:

1. Review of the models of group prenatal care, particularly the Centering Pregnancy Model.
2. Discuss the literature documenting outcomes of group prenatal care
3. Reflect on the personal experience of implementing this style of prenatal care
4. Review the concept of respectful maternity care in this model

Group prenatal care is a novel approach that has been gaining popularity in practice and research. In particular, the Centering Pregnancy program is a model of group prenatal care that has been well described in the literature.

Much of the literature focuses on measurable outcomes such as preterm birth rates, birth weights, gestational weight gain, breastfeeding rates. These outcomes have shown to be improved in the group prenatal care model. In addition, other outcomes such as patient satisfaction and postpartum contraceptive adherence are also improved. Some of the studies have been done in high risk populations such as adolescents and minority groups and have shown increased prenatal visits when compared to usual care.

The literature review shows that group prenatal care is a valid and exciting new option for the medical care of pregnancy. The Centering Pregnancy program places great emphasis on facilitative leadership rather than the usual didactic education that take place in traditional medical care. This technique engages women and supports discussion of concerns that are relevant to them. The atmosphere encourages discussion, sharing of group wisdom and development of social connections. Implications for respectful maternity care will be discussed.

1. A systematic overview of the literature regarding group prenatal care for high-risk pregnant women. Byerley BM; Haas DM. BMC Pregnancy & Childbirth. 17(1):329, 2017 Sep 29
2. Group prenatal care: review of outcomes and recommendations for model implementation. [Review] Tilden EL; Hersh SR; Emeis CL; Weinstein SR; Caughey AB. Obstetrical & Gynecological Survey. 69(1):46-55, 2014 Jan
3. Group prenatal care versus individual prenatal care: a systematic review and meta-analyses. Ruiz-Mirazo E; Lopez-Yarto M; McDonald SD. Journal of Obstetrics & Gynaecology Canada: JOGC. 34(3):223-229, 2012 Mar.

OVERCOMING CHALLENGES IN RESPECTFUL MATERNITY CARE IN KENYA

Charlotte E. Warren (Washington, DC)

Background: Despite decades of growing concern about women experiencing mistreatment during facility based childbirth, there are limited interventions that specifically focus on addressing issues to promote respectful maternity care (RMC). An evidence-based participatory implementation research (IR) study was conducted in Kenya. It engaged a range of community, facility, and policy stakeholders to address the causes of mistreatment during childbirth and promote RMC.

Methods: We used the consolidated framework for IR (CFIR) as an analytical lens to describe a complex, multifaceted set of interventions through a reflexive and iterative process for triangulating qualitative data. Data from a range of documents, and interviews were collected throughout the intervention. Assessment

of data used software to inductively derive codes for themes at different time points. We generated categories of themes for analysis found across the intervention design and implementation stages.

Results: The implementation process, intervention characteristics, individual champions, and context influenced both successes and challenges. Success stemmed from readiness for change at multiple levels, constant communication between stakeholders, and perceived importance to communities. The relative advantage and adequacy of implementation of an RMC package was meaningful within Kenyan politics and health policy, given the timing and national promise to improve quality of maternity care.

Conclusion: Despite the relatively nascent stage of RMC IR, this study is an important start to understanding interventions that can begin to address issues of mistreatment in maternity care; replication of these activities is needed globally to better understand if the process can be successful in different countries and regions.

References:

Dr. Timothy Abuya, Population Council, Nairobi, tabuya@popcouncil.org
Dr. Pooja Sripad, Population Council, DC psripad@popcouncil.org

4B. Symposium on Human Rights and Women's Health

THE WHO QUALITY RIGHTS INITIATIVE

Michelle Funk (WHO, Geneva)

WHO QualityRights is an initiative which aims to promote integrated people-centered care, recovery and human rights for people with mental health conditions and psychosocial disabilities throughout the world. QualityRights uses a participatory approach to achieve the following objectives:

- Build capacity to understand and promote recovery and human rights in mental health

- Create community-based, integrated people-centred and recovery-oriented services that respect human rights
- Improve the quality and human rights conditions in existing mental health and related services
- Develop a civil society movement to conduct advocacy and influence policy-making
- Reform national policies and legislation in line with the CRPD and other international human rights standards

PHILOSOPHICAL PERSPECTIVES

Werdie Van Staden (Pretoria, South Africa)

Objective: This presentation draws connections between Person-Centered Medicine (PCM) and human rights for advancing women's health. **Method:** Conceptual means are used to make clear the connections, and examples are presented by which the kind of relations are demonstrated. **Findings:** Some of the human rights as articulated in the Universal Declaration of Human Rights by the United Nations in 1948, can serve as support for PCM. Examples relate to the recognition of being a legal person; dignity of the person; liberty and freedom; a standard of living adequate for health and well-being including food, clothing and housing; protection of privacy, honour, reputation, and a right to work; a cultural life of a community; and sharing in scientific advances. These human rights may be deployed as a rights-informed pursuit of PCM, also concerning women's health. This pursuit, however, should also account for its limitation as being partial in scope, for a mere pursuit of human rights or gender issues may overshadow

and even defy the values and interests of the person that are not a matter of rights or gender. The focus on human rights, or gender, in PCM may thus push the person into the background. **Conclusion:** PCM is supported by the pursuit of human rights, but in PCM the person should remain more important than his or her rights or gender.

References:

- 1) United Nations General Assembly. The Universal Declaration of Human Rights – Resolution 217 A of 1948.
- 2) Christodoulou GN, Van Staden CW, Jousset D, Schwartz M, Mishara A, Mezzich JE. Ethics in Person-Centred Psychiatry. In Person-Centered Psychiatry. Mezzich JE, Botbol M, Christodoulou G, Cloninger CR, Salloum I (Eds). Heidelberg: Springer Verlag. 2016.

SEXUAL VIOLENCE AGAINST WOMEN IN CONFLICT SITUATIONS

Mohammed Abou-Saleh (London)

Sexual violence (SV) is common particularly in conflict situations. In recent decades, human rights groups have campaigned for sexual violence to be recognised as a crime and a tactic/weapon of war culminating in a summit convened in June 2014 by the UK "to end sexual violence in conflict", with up to 148 countries participating.

In early 1990s, appalling sexual violence occurred in two conflicts: during the dissolution of Yugoslavia, Serbian militias rounded up tens of thousands of Bosnian Muslim women and raped them systematically or sexually enslaved them, both to terrorise their people and as a policy of forced impregnation and during the 1994 genocide against the Tutsi in Rwanda, at least 100 000 women were raped and sexually tortured by the militias as part of their broader campaign of ethnic cleansing. The UN report documented massive abuses in 20 countries including Syria and the complex and long-lasting consequences for victims' physical and mental

health. Each year an unknown number of people are injured and traumatised by such violence, subject to unwanted pregnancies, exposed to sexually transmitted infections, and left to cope with potentially profound challenges to their mental health (Alcorn, Lancet, 2014). The health consequences are often unreported by victims for the stigma surrounding SV.

The international community and UN have taken action: recognising it as a global problem that needs legal and healthcare provision.

The WHO has introduced guidelines for medico-legal care for victims of SV and for strengthening health systems to respond to women subjected to SV and a manual for health managers.

The scope of the presentation will cover the health consequences of SV focusing on mental health issues in conflict situation

highlighting the dearth of research in this area; review the evidence base for healthcare interventions and the need for the medical and legal sectors to collaborate for the provision of appropriate medical care to victims and for documenting SV for prosecution of the perpetrators. The challenges for implementation of global and local actions are formidable but where there is a will there is a way.

Alcorn T. Responding to sexual violence in armed conflict. Lancet. 2014 Jun

14;383(9934):2034-7.

International Protocol on the Documentation and Investigation of Sexual Violence in Conflict Best Practice on the Documentation of Sexual Violence as a Crime or Violation of International Law Second Edition: March 2017 https://iici.global/0.5.1/wp-content/uploads/2017/08/International_Protocol_2017_2nd_Edition.pdf

LEARNING FOR CAREGIVERS IN EUROPE

Spyros Zorbas (Greece)

Carers or caregivers can be defined as persons who provide assistance or support to another family member or friend. They carry out, often regularly, significant or substantial caring tasks, and assume a level of responsibility which would usually be associated with an older person. The person receiving care is often a parent but can be a sibling, grandparent or other relative who is disabled or has some chronic illness, mental health problem or other condition connected with a need for care, support or supervision.

Within the Learn4Carers project we will target carers and professionals working for carers of every age group. Research shows and service providers tell us that carers are a minority group, but that their presence in European families is very common.

For instance, in Ireland the questions on caring, in the 2016 census showed a total of 195,263 persons (4.1% of population) were providing unpaid assistance to others, an increase of 8,151 (4.4%) on the 2011 figure of 187,112. Women made up just over 6 in 10 carers (60.5%, 118,151 carers) with 77,112 (39.5%) men.

There were 3,800 children under 15 years engaged in providing care to others, accounting for 1.9 per cent of all carers.

Mr Zorbas is a caregiver of a person with mental health problems. Mr. Zorbas is a Board member of WFMH (World Federation for Mental Health) and a Board Member of EUFAMI, the European Federation of Associations of Families of People with mental illness. He is working on collaborative projects with European Institutions to bring awareness in the topic of mental health. He has participated in several meetings in the European Parliament, in collaboration with other umbrella associations (Mr. Zorbas is vice president of the organization COFACE Disability). He supports the movement of family and patient associations for the proper conduct of advocacy activities within EU institutions.

In 2016, Mr. Zorbas developed the association EPIONI (www.epioni.gr) to support informal carers in Greece, irrespective of their age or the particular health need of the person they are caring for.

Parallel Sessions 5:

A. Antoine Besse & Jitendra Trivedi Memorial Symposium on Person-centered Mental Health

PREVENTIVE PSYCHIATRY AND PERSON-CENTERED CARE

Roy Kallivayalil (Kerala, India)

Preventive Psychiatry has a very important leadership role to foster mental health in modern world. Person centered Psychiatry and care are integral to this. Unlike the west, developing countries face massive constraints- lack of facilities, inadequate manpower, poor resource allocation etc. Hence strategies need to be different in the various parts of the world. The establishment of large number of General Hospital Psychiatry Units in countries like India has helped to foster person centered care.

Looking ahead, integrating mental health in primary care is an ideal way forward. What is necessary is a public health approach relying on primary prevention which promotes individual responsibilities. Tackling inequalities and fostering resilience are essential. Existing services need to be sustained to achieve our goals. National Mental Health Programmes will make minimum mental health care available and accessible to all. Teaching Psychiatry in

undergraduate medical training, training lay counselors and social workers, co-operation with NGOs, planning special programmes for children, women and the elderly, increased use of psychosocial methods in treatment and continuous monitoring and evaluation will make person centered care in preventive psychiatry more relevant and meaningful.

References:

1. Agarwal SP, Goel DS, Ichhpujani RL, Salhan RN, Shrivatsava S: Mental Health- An Indian perspective(1946-2003), Directorate General of Health Services, Ministry of Health and Family Welfare, New Delhi.2004.
2. Patel V, Maj M, Flisher AJ, MJ DES, Koschorke M, Prince M: Reducing the treatment gap for mental disorders: a WPA survey. World Psychiatry 2010;9(3):169-176.

CULTURE AND PERSON-CENTERED PSYCHIATRIC DIAGNOSIS

Werdie Van Staden (Pretoria, South Africa)

Objective: This presentation examines the conceptual scope of culture in the practice of making person-centered psychiatric

diagnoses. **Method:** Conceptual means informed by philosophical value theory are used to make clear the scope of the concept of

culture in person-centered psychiatric diagnosis. Examples are provided to underscore the importance of accounting for culture in its full scope. **Findings:** A person-centered approach to cultural values uncovers the natural tendency to have blind-spots for these values. Two kinds of blind-spots are apparent: a) having a blind-spot for one's own culture and ascribing culture merely to someone else, whether in theory or clinical practice; and b) not recognizing the scope of culture in theory and practice. Regarding the former, we spot cultural values relatively easy when they are different and even in conflict, whereas cultural values are less apparent when shared. Regarding the scope of the concept of culture, a person-centered approach to psychiatric diagnosis recognizes culture in the various *practices* of people rather than taking 'culture' as if designating merely identity or a group of particular locality. **Conclusion:** A remedy for the natural tendency to have blind-spots

for culture is sensitivity and sophistication that account for both cultural uniformity and diversity in theoretical discourse and in clinical practice.

References:

- 1) Rashed MA, Du Plessis RR, Van Staden CW. Culture and Mental Health. In: Psychology: Themes & Variations, South African Edition. W Weiten, J Hassim (Eds.). Cengage: Boston. 2016
- 2) Van Staden CW, Fulford KWM. The indaba in African values-based practice: respecting diversity of values without ethical relativism or individual liberalism. In Oxford Handbook of Psychiatric Ethics. JZ Sadler, CW van Staden, KWM Fulford (Eds). Oxford: Oxford University Press. 2015

PERSON- CENTRED MENTAL HEALTH IN ENGLAND

Mohammed Abou-Saleh (London)

Person-centred healthcare is enshrined in the NHS Constitution, uniting patients and staff in a shared vision, mission and values of working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives and everyone counts. The NHS over seven decades has faced many challenges and undergone much reorganization. However, it has maintained its person and people's centeredness.

A recent key development was the establishment of the Care Quality Commission (CQC), the independent regulatory body for all health and social care providers guided by core principles that services should be Safe, Effective, Caring, Responsive and Well led.

The other key development was the establishment of the National Institute for Health and Care Excellence (NICE) that has adopted person-centred care as the prime principle for optimal health care.

In this presentation, key strategic developments and achievements are highlighted with reference to mental health in the NHS and charitable providers: parity of esteem between physical and mental health; Five Year Forward View for Mental Health; The Mental

Health Workforce Plan for England; Personalization of Care; English Improving Access to Psychological Therapies (IAPT) service; Mental Health Core Skills Education and Training Framework. IAPT delivers psychological therapies recommended by NICE for depression and anxiety disorders to more than 537 000 patients in the UK each year with good outcome (Clark et al, 2017).

The WPA-Lancet Commission on the Future of Psychiatry (2017) addressed priority areas that represent opportunities and challenges. Its prime conclusion is that the therapeutic relationship remains paramount for achieving optimal mental health. It is important that psychiatrists remain professional, maintain professional values in addition to being skilled, competent and collaborative.

Bughra D et al, The WPA-Lancet Psychiatry Commission on the Future of Psychiatry Lancet Psychiatry. 2017 Oct; 4(10):775-818.

Clark DM et al, Transparency about the outcomes of mental health services (IAPT approach): an analysis of public data. Lancet. 2017 doi: 10.1016/S0140-6736(17)32133-5.

PATIENT-CENTERED PERINATAL MENTAL HEALTH CARE IN UGANDA

Nandini Sarkar (Antwerp, Belgium)

Objectives: The aim of this session is to present a situational analysis of an existing local health system in its ability and scope to provide integrated, equitable, and patient-centered perinatal mental health coverage in resource-constrained rural Uganda.

Methods: As part of a larger PhD research on the challenge of equitable mental healthcare at Local Health System level in low-resource, rural Ugandan settings (2015-2017), a qualitative enquiry consisting of 81 in-depth interviews and 9 focus-group discussions was conducted with a variety of local health system actors and key informants involved in maternal and perinatal mental healthcare. Data analysis was conducted via emergent, thematic content analysis using NVivo 11.

Findings: Overall analysis indicates that local, grounded conceptualisations of perinatal mental health issues, as well as related health-seeking behaviours, are socio-cultural in nature, rather than bio-medical. Patient-centeredness and interpersonal

aspects of quality of basic perinatal care and service delivery are largely perceived as lacking in this setting. Regarding integrated provision of both perinatal biomedical and mental healthcare, larger systemic issues were viewed as barriers, including unstable and insufficient referral practices, excessive staff workloads and overburden, and inadequate training in patient-centeredness and mental health.

Conclusions: The growing appreciation for the unspoken and unaddressed needs of perinatal women and communities, yet ineffective and unintegrated systemic and structural dimensions of perinatal healthcare, highlight both the imperative and the complexities in providing integrated and women-centered perinatal healthcare at the local health system-level in rural Uganda.

References:

1.Prof. Dr. Bart Criel. Department of Public Health, Institute of Tropical Medicine, Antwerp, Belgium BCriel@itg.be

2.Dr. Florence Baingana. MHPSS Lead, WHO Sierra Leone Makerere University School of Public Health, Kampala, Uganda bainganaf@who.int

THE DEVELOPMENT OF HEALTH AND PERSONALITY FOLLOWING AN 8-WEEK HEALTH PROMOTION INTERVENTION

Julie Jacquet (Grenoble, France)

Health has been defined as a state of physical, mental, social and spiritual well-being, and not merely the absence of disease or infirmity (OMS, 1946; Cloninger, 2007). Many health promotion interventions have been recently developed in order to improve health and well-being. However, underlying mechanisms responsible for the personal growth and inter-individual differences are seldom considered. In addition, common factors such as the working alliance between the therapist and the client and therapist related characteristics are usually not included in the analyses. The present study aims at understanding several factors and mechanisms that could explain the development of health and well-being, when participating to a health-promotion intervention. The factors considered are related to the person, to the specific intervention, and to common factors among therapies. Ninety-five participants and seven health-care professionals were included in the study. Participants were randomly assigned to either a positive psychology intervention (i.e. CARE, Shankland, Kotsou, Durand & André; University of Grenoble) or a mindfulness-based intervention

(i.e. MBCT, Seagal, Williams & Teasdale, 2002). Each intervention was delivered in group, and consisted of 8 weekly sessions of two hours each. Both participants and therapists completed the Temperament and Character Inventory (Cloninger et al., 1993). They also completed measures related to health, working alliance, and practice. Findings are being analyzed and will be discussed.

References

- Cloninger, C. R. (2007). Spirituality and the science of feeling good. *South. Med. J.* 100, 740–743. doi:10.1097/SMJ.0b013e318070d177.
- Cloninger, R. C., Svrakic, D. M., and Przybeck, T. R. (1993). A psychobiological model of temperament and character. *Arch. Gen. Psychiatry* 50, 975–990.
- Segal Z. V., Williams J. M. G., et Teasdale J. D. (2002). *Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse*. New York: Guilford.

5B. Brief Oral Presentations

BIOPSYCHOSOCIAL DETERMINANTS OF OPIOID USE DISORDER AND IMPLICATIONS FOR MATERNAL AND CHILD HEALTH RESEARCH

Imelda Medina et al (Miami)

Background: Opioid abuse is on the rise among women of reproductive age in the United States of America (USA), contributing to a marked increase in the incidence of adverse consequences on maternal and child health (MCH) in the last decade.

However, little is known about the biopsychosocial determinants of opioid abuse in MCH populations and their role in the current opioid abuse epidemics.

Aims: To examine the epidemiology of opioid use disorders in the USA and develop a biopsychosocial research model of opioid abuse among women of reproductive age.

Methods: Utilizing a scoping review methodology, a systematic search strategy was implemented on MEDLINE/PUBMED, Integrated Library searches, and Google Scholar. Scholarly/peer-review articles published up to July 2017, in English, and restricted to populations in the USA were eligible for inclusion in the study. A qualitative synthesis of the selected studies was performed to summarize study findings.

Results: There is evidence for the role of multiple factors at every level of the biopsychosocial model in opioid use disorders—from

molecular (genetic, epigenetic), cellular-tissue, organ system, the person (psycho-affective, cognitive, and behavioral), relationship-based (family, peers), community environments, healthcare-related, and policy levels.

Conclusions: Important research gaps at each level remain, highlighting the need for multiple-level biopsychosocial research in this area to enhance our understanding of the nature, extent, distribution, etiology, and consequences of opioid use disorders among women of reproductive age. Our biopsychosocial model of opioid abuse can be used to guide innovative MCH epidemiology research.

References

- Salihu HM, Mogos MF, Salinas-Miranda AA, Salemi JL, Whiteman VE. National trends in maternal use of opioid drugs among pregnancy-related hospitalizations in the United States, 1998 to 2009. *American journal of perinatology*. 2015;32(3):289-98.
- Smith R, Fortin AH, Dwamena F, Frankel RM. An evidence-based patient-centered method makes the biopsychosocial model scientific. *Patient education and counseling*. 2013;91(3):265-70.

GOING FOR JOINT TREASURE HUNTING – QUALITY CIRCLES WITH MEMBERS OF SELF-HELP GROUPS

O Bahrs, N Krüger, J Müller, M Röslen, (Goettingen, Germany)

Quality circles (QuiG®) are an established method for bottom-up quality development. A quality circle consists of 8 – 12 people who want to increase the quality of their health-related work with reference to their own experiences, supported by a moderator. Up to now, the focus was on improving the quality of care provided by health professionals (“experts”).

Our project is different. We invited members of self-help groups to develop knowledge and skills concerning risks, resources and potentials for health promoting behavior. In order to enhance their quality of life and thereby the conception/perception of their disease and treatment, our focus was on the patients’ side and the expertise deriving from their lived condition. The members of the quality circle were asked for biography based case-presentations within the group and joint reflections of their history of disease and illness from the perspective of the personal life history.

In 2014 8 members of self-help groups (6 women, 2 men) agreed to participate in our project. They were between 40 and 80 years old and organized in very different groups (heart diseases, COPD, MS, mourning parents, highly sensitive persons). They chose the topic “coping with stressful situations” for their 1 ½ years of work. Each of the 10 group sessions lasted about 2 ½ hours. Each participant

held a case presentation and in the following group discussions resources were emphasized and adjustments for further improvements suggested. At the last meeting the group work was summarized and evaluated by all participants.

In our presentation, we will describe the group work and give an overall impression of the project. The group atmosphere was extraordinary good, the high attendance continuity noteworthy. It should be emphasized that almost all participants wanted to continue the group work and are interested in a follow-up project that specifically addresses the work of group leaders of selfhelp groups. The learning processes are examined in detail in the doctoral thesis of Ms. Krüger and Mrs. Müller. Further participatory research is needed.

References: 1. Bahrs O (Ed.): Qualitätszirkel in der Gesundheitsförderung und Prävention – Handbuch für Moderatorinnen und Moderatoren; BzgA, Köln 2005 2. Röslen M, Bahrs O (2013): Qualitätszirkel Hypertonie; „Druck im Leben – Druck in den Gefäßen?“, Auf dem Weg vom interprofessionellen Qualitätszirkel QuiG® zum Patientenzirkel mit Expertenbeteiligung; Der Mensch – Zeitschrift für Salutogenese und anthropologische Medizin, 46, ISSN 1862, S. 52-58

PERSON-CENTERED CARE AND INTER-PROFESSIONAL COLLABORATION

Aleksandra Weber (Munich)

Person-centered care is a collaborative and integrative process. The purpose of this study is to identify key features of teamwork and explore the impact of leadership on effectiveness of interprofessionall collaboration. It is also a personal reflection from consultations in the medical field. Selected literature suggests that interprofessional teams in healthcare may offer advanced person-centered care through cooperation in a shared decision-making process. Essential components here are: team member characteristics, professional background, common task, communication, cooperation, coordination, responsibility, participation, staff satisfaction, patient safety and satisfaction and efficiency with the focus on complex interventions. It is also shown that healthcare providers face weekly, if not daily significant challenges in form of misunderstandings and conflicts. Therefore, optimizing the communication process goes beyond the patient-physician dyad and includes actively all stakeholders in the process within the patient-centered care context. Shortage of resources and international migration as global phenomena put responsible clinical leaders under substantial pressure. The emphasis is on Integrated Team Effectiveness Model for improvements in person-centered care and organizational effectiveness. Actively implemented communication, collaboration, conflict resolution, participation and cohesion are more likely to influence staff satisfaction and strengthen the team coherence. Proactive leadership interventions facilitate effective communication and collaborative working and also create safety culture based on trust. The key idea is to actively implement curriculum change and leadership initiatives to address the complexities inhibiting collaborative working relationships. Strengthening the leadership can act as a significant catalyst for

patient safety and culture improvement and can also have a crucial impact on team sustainability over time. Suggested is a close cooperation and supervision of the Core Workgroup and the Consultation Group to improve the competence of the interprofessional collaboration. This might be a foundation for future innovative research in exploring relationships between team context, structure, processes and outcomes in a person-centered care and also regarding interprofessional educational programs for collaborative patient-centered practice.

References:

Effectiveness of Multi- Professional Team Working (MPTW) in Mental Health Care. National Institute for Health Research Service Delivery and Organization Programme. Published October 2012. http://www.netscc.ac.uk/hsdr/files/project/SDO_FR_08-1819-215_V01.pdf

Laurenson M, Heath T, Gribbin S: Intervention in health care teams and working relationships. Journal of Healthcare Leadership, Vol 2012, Iss default, Pp 117-2012

Mezzich J et al: Systematic Conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index. The International Journal of Person Centered Medicine 2016 Vol 6 Issue 4, pp 219-247

Lemieux-Charles L., McGuire W.L.: What do we know about health care team effectiveness? A review of the literature. Med Care Res Rev, 63 (3) (2006), pp. 263-300

DEVELOPMENT OF A SHORT-FORM OF THE QUALITY FROM THE PATIENT-PERSPECTIVE QUESTIONNAIRE FOR PALLIATIVE CARE

T. Sandsdalen et al (Halden, Norway)

Objective: Patients' views on the quality of palliative care are important to improve person-centered palliative care. It is desirable that palliative care can be assessed using short, yet valid and reliable instruments. The aim was to develop a short form of the Quality from the Patient's Perspective questionnaire for Palliative Care (QPP-PC). **Methods:** Cross-sectional study, including 128 patients in four different palliative care contexts. The QPP-PC [1], based upon a person-centered theoretical framework, comprises 4 dimensions: medical-technical competence, physical-technical conditions, identity-oriented approach, and socio-cultural atmosphere, 12 factors (49 items), 3 single items and is answered by a 4-point Likert-type scale. Confirmatory factor analysis and Cronbach's alpha was used. **Preliminary findings:** The short form of QPP-PC consists of 20 items and 4 single items comprising the theoretical framework. The psychometric evaluation showed a stable solution with a Root Mean Square Error of Approximation (RMSEA) value of 0.109. The reliability coefficients ranged between 0.59 and 0.86 for most dimensions on the perceived reality and the subjective importance scales of QPP-PC. **Discussion and**

preliminary conclusions: The development of the short form of QPP-PC were in line with steps described by Goetz et al. [2]. However, the RMSEA value was slightly above the recommended level. The short form of QPP-PC shows promising results and may be used to patients in a late palliative phase. However, the short version of QPP-PC needs to be validated in new samples of patients.

1. Sandsdalen, T., Rystedt, I., Grøndahl, V.A., Hov, R., Høye, S., Wilde-Larsson, B. (2015). Patients' perceptions of palliative care: adaptation of the Quality from the Patient's Perspective instrument for use in palliative care, and description of patients' perceptions of care received. *BMC Palliative Care*, 14:54(54)
2. Goetz, C., Coste, J., Lemetayer, F., Rat, A.-C., Montel, S., Recchia, S., . . . Guillemin, F. (2013). Item reduction based on rigorous methodological guidelines is necessary to maintain validity when shortening composite measurement scales. *Journal of Clinical Epidemiology*, 66(7), 710-718.

OPERATIONAL EFFICIENCY OF AN IMMUNIZATION CLINIC IN NORTH CENTRAL NIGERIA: A TIME AND MOTION STUDY

Ibraheem Shola Abdurraheem (Kano, Nigeria)

Background: Nigeria is currently having health manpower shortage and overburdened health system problem. In recent years, healthcare enterprises all over the world have begun applying time and motion studies and system analysis tools to improve their operations and overall efficiency 1. Since the tasks carried out in immunization clinics are already structured and defined, a time – motion study is ideal for evaluating its efficiency 2.

Objective: The objectives of the present study were: 1). to study the operational efficiency of an immunization clinic. 2). to identify deficiencies in the organization of immunization clinic and barriers to client flow.

Methods: An observational cross-sectional study was conducted between November 2015 to February 2016. The study is composed of two stage evaluations, a passive observation and a time and motion study. Systemic random sampling method was used to select 1055 mothers/caregivers attending the immunization clinic. **Results:** The study participants spent 67.3% of their total time in waiting. The average total time spent at the clinic by the clients was

103 mins (25–138min). Adults had an average total time of 84 min (19–146 min) and children 95min (32–156 min). The average waiting time (48 min) is more than the average time used (17 min) in receiving service. Health worker's attitude is a significant predictor of clinic organization and client flow.

Conclusion: This study showed a high waiting time for receiving immunization service. Innovative operational research is therefore needed to decrease waiting time, increase consult times and improve health system responsiveness.

REFERENCES

1. Palmer D. Tackling Malawi's human resources crisis. *Reprod Health Matters*. 2006; 14(27):27–39.
2. Finkler SA, Knickman JR, Hendrickson G, Lipkin Jr M., Thompson WG, "A comparison of work- sampling and time and- motion techniques for studies in health services research," *Health Services Research*, 1993; 28 (5): 577–597.

THE IMPACT OF THE SOCIO-ECONOMIC STATUS ON CARDIOVASCULAR RISK AND BELIEF AMONG WOMEN IN SAUDI ARABIA

Mashaal Alshaikh (London)

Background

Cardiovascular disease (CVD) is a significant public health problem in Saudi Arabia, not only of its impact on morbidity and mortality but also because of its financial liability on health budgets. Data from our latest systematic reviews highlights the prevalence of CVD risk among women in Saudi Arabia. Most of the reported risks are related to behavioural factors, i.e. physical inactivity, low consumption of fruits and vegetables. However, there has been little discussion about the impact of socio-economic status on CVD risk and belief.

Aim

This study aims to assess cardiovascular health beliefs and to investigate the impact of the social economics position on CVD risks and believes among Saudi women attending the Primary care clinics

Method

A cross-sectional study designed to include women attending the primary care clinics at King Saud Medical city, Riyadh. Validated

tools were used to assess health beliefs related to CVD risk behaviour i.e. physical activity and healthy diet. Sociodemographic and personal information was collected.

Findings

A total of 503 women participated in this study, 75% were older than 45 years old. Only 1.4% were consuming five portions of fruits and vegetables per day, 13.1 % of participants exercised more than three times per week, while 63.1% were physically inactive. Obesity remains higher among women with hypertension or diabetes ($P<0.001$, $P<0.071$). Half of the participants educational

background was below high school and more than 68% were housewives. There was a significant difference in the Framingham mean score and CVD health beliefs in all the different socio-economic determinants (income, education, occupation, marital status).

Conclusion

This study highlights the importance of patient-centred approach, focusing on individual women, especially those in low socio-economic positions and considering their health beliefs as CVD risk determinants.

Paul Tournier Prize Session

THE SCIENCE OF WELL-BEING AND TOURNIER'S MEDICINE OF THE PERSON

C. Robert Cloninger (St. Louis)

The principles of the Science of Well-being (Cloninger 2004 et seq) are described and compared to those of Tournier's Medicine of the Person (Tournier, 1977). There is a strong correspondence that is seen in the work of many philosophers of well-being and physicians dedicated to health understood as physical, mental, social and spiritual well-being.

References

Cloninger CR (2004). *Feeling Good: The science of well-being*. New York, Oxford University Press.

Tournier P (1977). *The Best of Paul Tournier*. New York: Iverson-Norman Associates.

WHO Seminar on Person/People-centered Neo Natal Health

MIDWIFE-LED CONTINUITY CARE FOR INTEGRATED NEWBORN AND MOTHER CARE

Fran Mcconville

Objective:

To provide the evidence on the midwifery model of care (MLCC) for integrated newborn and mother care.

Findings

Midwife-led continuity of care (MLCC) describes a model of care where one midwife, or a group of midwives working together, provides care to a woman, newborn and her family throughout the antenatal, intrapartum and postnatal continuum. This differs to "medical-led" care, or care that is "shared" between medical staff and midwives. MLCC is associated with improved outcomes for the majority of women and babies at low risk of developing complications. Adverse outcomes are comparable to medical-led care. Studies to date indicate MLCC probably reduces the risk of preterm birth and perinatal mortality

When MLCC is provided women are more likely to experience spontaneous vaginal birth and experience fewer interventions

including episiotomies and instrumental births. Women are also more likely to be satisfied with their care.

Discussion

The evidence demonstrates that 87% of service need can be delivered by midwives, when educated to international standards;³ and that 56 maternal and neonatal outcomes are improved through midwifery practice and philosophy of care;² Whichever model of care is used, team work, coordination, communications and support between all staff is critical. WHO recommends that MLCC should only be introduced where there is a well-functioning midwifery programme with sufficient numbers and quality of midwives, educated and regulated to international standards.

Conclusion

Women value supportive, caring relationships with one, or a group of, midwives and appreciate a consistent and unhurried women-centred approach to care for them and their babies.

FAMILY CENTERED CARE IN LMICS: EXPERIENCE FROM INDIA

Arti Maria

The concept of parental involvement in NICU was tested initially in 2007 to overcome severe HR constraints at a Neonatal Intensive Care Unit of north India. However multiple fringe benefits were observed with this intervention! A randomized controlled trial¹ (2010-12) demonstrated improvement in exclusive breast feeding rates with no increase in infection rates in the intervention group.

Adapting and translating principles of family centred care (FCC) into a discrete implementable framework of a respectful collaborative partnership between the provider and receivers of care for care of their sick neonate and delivered through a culturally sensitive, structured, audio-visual training tool to build capacity of P-A to care for their sick neonate was demonstrated to be feasible and

acceptable. Additionally, FCC addresses unmet developmental needs of a sick neonate as well as psychosocial needs of the stressed family². After the successful initial pilot at 5 districts, Government of India MOHFW has recently approved countrywide FCC scale up to Special Newborn Care Units settings of India.

FCC marks a paradigmatic shift in neonatal care to improve quality of care and health care experience of all stakeholders. Through enhancing competencies of the family, FCC serves as a cornerstone for continuum of care at home, thus likely to bridge the gap between facility and home based newborn care. Through enhanced society's capacity to act for improving newborn health, FCC seems to hold a promise for affecting a sustainable healthcare solution for improving newborn care survival and outcomes³.

References

1. Family-Centered Care to Complement Care of Sick Newborns: A Randomized Controlled Trial
<http://indianpediatrics.net/june2017/455.pdf>
2. <http://indianpediatrics.net/june2017/451.pdf>
Quality, Equity and Dignity for Preterm Infants Through Family-centered Care ANTHONY COSTELLO Director, Department of Maternal, Child and Adolescent Health, World Health Organization, Geneva, Switzerland. costelloa@who.int
3. <http://www.healthynewbornnetwork.org/blog/family-centered-care-sick-newborns-paradigm-social-collaboration-improve-maternal-newborn-health-outcomes/>



**International College of Person Centered Medicine (ICPCM)
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Dates	Session Periods	Session Titles	Session times and credits earned	Check-off attendance
9.04.2018	8:30 – 9:00	Inaugural Lecture	30 minutes, 0.50	
	9:00 -10:30	Plenary Symposium 1	90 minutes, 1.50	
	11:00 -12:15	Plenary Symposium 2	75 minutes, 1.25	
	13:30 -14:45	Parallel session 1(A)	75 minutes, 1.25	
		Parallel session 1(B)	75 minutes, 1.25	
	15:15 -16:30	Parallel session 2 (A)	75 minutes, 1.25	
		Parallel session 2 (B)	75 minutes, 1.25	
10.04.2018	9:00 - 10:15	Plenary symposium 3	75 minutes, 1.25	
	10:45 -12:00	Parallel session 3 (A)	75 minutes, 1.25	
		Parallel session 3 (B)	75 minutes, 1.25	
	13:15 -14:30	Plenary symposium 4	75 minutes, 1.25	
	15:00 -16:15	Parallel session 4 (A)	75 minutes, 1.25	
		Parallel session 4 (B)	75 minutes, 1.25	
	16:15 -17:30	Parallel session 5 (A)	75 minutes, 1.25	
		Parallel session 5 (B)	75 minutes, 1.25	
11.04.2018	8:30 – 9:15	Paul Tournier Prize Lecture	30 minutes, 0.50	
	9:45 -11:45	Special Collab. Session	120 minutes, 2.00	
	13:30-15:00	WHO Seminar	90 minutes, 1.50	
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