

SECOND GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

ABSTRACTS

SESSION 1 International Organization Perspectives and Activities on Person-centered Medicine

S 1.1

IAPO PERSPECTIVE ON PERSON-CENTRED MEDICINE

Jeremiah Mwangi, Senior Policy Officer

Patients', families' and carers' priorities are different in every country and in every disease area, but from this diversity there are some common needs. Health systems in all world regions are under pressure and cannot cope if they continue to focus on diseases rather than patients; they require the involvement of individual patients who adhere to their treatments, make behavioural changes and self-manage.

The International Alliance of Patients' Organizations (IAPO) supports and encourages the role of patients' organizations in promoting patient-centred healthcare as an appropriate way to improve health outcomes for patients². Engaging patients and the organizations that represent them – patients' organizations – in health policy decision-making helps to ensure that policies reflect patient and caregiver needs, preferences and capabilities and provide the most appropriate healthcare.

IAPO's origins stem from the realisation that patients' organizations all face some common healthcare issues, regardless of their countries of origin and disease area. In the global context issues of access to treatment, patient safety, patient involvement in health policy, health communication and information are key to patient-centred healthcare.

This presentation will demonstrate how a person-centred approach compliments IAPO's vision of patient-centred healthcare as outlined in IAPO's Declaration for Patient-Centred Healthcare and the five principles essential for patient-centred healthcare, which resonate with patients' organizations globally: 1 Respect for individuals' unique preferences and needs; 2 Choice and empowerment; 3 Patient involvement in health policy; 4 Access and support; and 5 Information that is accurate and presented in an appropriate way. Bringing **people and patients** to the centre of health care, with a focus on the whole person, not just the disease, and on the **people that deliver** healthcare, is necessary to help align healthcare systems with the needs of patients.

¹ IAPO is a patient-led global alliance of 200 organizations. Our full members are patients' organizations. Together our members represent at least 365 million patients worldwide.

² There is growing evidence that patient-centred healthcare promotes greater patient responsibility and optimal usage which ultimately leads to improved health outcomes, quality of life and patient satisfaction (see IAPO (2005) What is Patient-Centred Healthcare?: A Review of Definitions and Principles available online at www.patientsorganizations.org/pchreview).

³ Available online at www.patientsorganizations.org/declaration.

S 1.2

PERSPECTIVES OF THE INTERNATIONAL NETWORK FOR PERSON-CENTERED MEDICINE

Juan E. Mezzich M.D., Ph.D.

A brief review of historical and conceptual aspirations, involving an encompassing notion of health, constitutes a critical background for a person-centered approach to medicine and health care. On these bases, an expansion of the focus of medicine from disease to patient to person appears compelling. Also stimulating at this stage is the consideration of pioneering early efforts and the emerging responses of global health and medical organizations, such as the WMA, Wonca, and WPA. Building on them, the first Geneva Conference on Person-centered Medicine was organized in May 2008. Extending its impact, a monograph with the

papers presented there as well as a joint editorial authored by the leaders of the main institutions organizing it are being completed. The same group, with the support of an enlarged set of international medical and health associations have organized the Second Geneva Conference on Person-centered Medicine. Emerging from this work process is the International Network for Person-centered Medicine (INPCM), aimed at coordinating future steps towards the scientific and humanistic development of concepts and procedures to enhance the fulfillment of medicine's fundamental soul and purposes.

S 1.5

PERSON CENTERED MEDICINE IN THE CONTEXT OF PRIMARY CARE – A VIEW FROM THE WORLD ORGANIZATION OF FAMILY DOCTORS (Wonca).

Prof. Chris van Weel, President of Wonca

Professor of Family Medicine, Radboud University Medical Centre, Nijmegen, The Netherlands.

Family physicians are responsible for the most important health needs in the community they serve. As a consequence, family practice is engaged in the large majority of illness patients seek care for, with the hospital sector only accounts for a minority of cases. A broad range of acute and chronic diseases are presented to the family physician, that involve all patient groups and all body systems. This is testimony of the nature of family medicine of care for unselected health problems. The clinical uncertainty of family medicine is underlined by the large variation in the 'natural' course of this illness. A substantial part of the acute diseases are infections of a self-limiting nature. But the most frequent chronic diseases reflect the main burden of illness that impacts on the community in terms of mortality and quality of life [1].

This paper explores the concepts of family medicine to be able to provide evidence-based, high quality, care for patients and communities around the world. The 'ecology of health care' [2] illustrates empirically the central position of primary care, as the interface between population and the health care system. Persons/patients present unselected health problems and in order to find the most relevant response, the personal context must be taken into account.

Family practitioners and other primary care providers work within an established partnership with patients over time (continuity of care), and as a consequence encounter over time various illness and diseases in the same individual. This, again, stresses the orientation on patients as individuals, rather than diseases as stand-alone issues. This is, however, by and large *experiential* knowledge and wisdom, with limited scientific

basis. Although there is hard evidence that strong primary care improves individuals' and populations' health, the mechanisms behind it are poorly understood – a 'black box' [3]. To explore this black box, the *paradigms* of family medicine come into play [4]:

- personal, patient-centred, care
- continuity of care
- care in the context of the family and social environment.

Gaining more insight in person centered medicine will make it possible to further strengthen the evidence base for family medicine, to provide health care at the grass roots of society, responsive to individual needs, based on the two moral principles: that (1) all patients are equal and equally entitled to the best care available; while yet (2) each patient is unique, and should be approached in acknowledgement of their singularity.

S 1.7

INTERNATIONAL COUNCIL OF NURSES PERSPECTIVES ON PERSON-CENTRED CARE

Tesfamicael Ghebrehiwet, RN, PhD

Consultant, Nursing and Health Policy, International Council of Nurses

ICN's commitment to person-centred care is embodied in its policy statements, guidelines and the ICN Code of Ethics for Nurses which affirm respect for human rights, including the right to life, dignity and to be treated with respect as inherent to nursing. ICN's policy statementsⁱ and ICN's Framework of Competencies for the Generalist Nurse outline key concepts in person-centred care. A recent ICN initiative – the Patient Talk – provides a good example of person-centred approach to information, education and empowerment.

ICN locates person centred care within the larger context of family and community in a dynamic and interactive state. Person centred care is broad in scope and requiring a set of skills of nurses and other members of the health team. Key components of person-centred care include:

- Identifying and respecting the person's preferences, values, and differences and expressed needs.
- Coordinating continuously and timely care.
- Relieving pain and suffering.

References

1. Weel C van, Grauw WJC de. Family practices registration networks contributed to primary care research. *J Clin Epidemiol.* 2006; 59(8):779-83.
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3. van Weel C. Steadfast flexibility – supporting good care. *New Zealand Family Physician* 2006; 33: 234-238.
4. Wonca Europe. *The European definition of general practice/family medicine.* Wonca Europe 2002.
[The European Definition of General Practice/Family Medicine](#) (accessed February 14th, 2007).

- Listening and communicating.
- Providing education and information.
- Sharing decision-making and management.
- Promoting wellness and healthy lifestyles.

Person-centred care improves care outcomes including satisfaction with care and adherence to therapeutic regimens. Person-centred care strengthens the role of patients and their families and supports them to become experts in their own care and needs. In person-centred care, people shift from passive recipients of care to active participants and decision-makers in matters affecting their health and wellbeing.

ⁱ . Continuing Competence as a Professional Responsibility and Public Right. ICN Position Statement, 2006.

ⁱⁱ . Cultural and Linguistic Competence. ICN Position statement.

SESSION 2 Special Initiatives Relevant to Person-centered Care

S 2.2

INTERNATIONAL ASSOCIATION OF MEDICAL COLLEGES (IAOMC) PERSON-CENTERED PERSPECTIVES ON DISTANCE LEARNING.

Prof. James Appleyard

Hon Secretary to the IAOMC Board

Computer based learning (CBL) is well established in medical education. Distance learning (DL) has developed into a useful tool to teach medical students and is commonly used in medical schools with multiple campuses

The goal of the International Association of Medical College (IAOMC) founded in 2005 is to serve society by enhancing the quality of undergraduate medical education worldwide. It is committed to peer evaluation of the education provided by individual medical schools anywhere in the world in a transparent way and available to the public to inspire confidence in the integrity of the findings

The IAOMC's first task was to develop global accreditation standards, building on The World Federation for Medical Education's recommended International Standards for medical education and the Liaison Committee on Medical Education of the American Medical Association and the Association Of American Medical Colleges. (www.iaomc.org)

.Medical practice is by definition a vocation whose core element is work based upon the mastery of a complex body of *knowledge* and *skills* and whose members 'profess' a *commitment* to competence, integrity, morality, altruism and the promotion of the public good within their domain

The study of medicine thus requires the assimilation of the core professional values that underpin the moral standards of physicians and the acquisition of the skills to implement those values in clinical practice. These standards are based on the Hippocratic tradition of medical ethics placing the individual person in the centre of the physician's concerns. This ethical framework should inform all clinical decisions throughout each physicians career and must remain the essential core component of any medical curriculum.

With this person based ethical structure in mind, a sub- committee of the IAOMC's Advisory Council has reviewed studies on computer based learning (CBL) and distance learning with a view to incorporating new standards into the IAOMC's accreditation process.

Some of the advantages and disadvantages of the impact of Distance Learning on the core standards of educating physicians to embrace an ethical framework built on the best interest of each individual person were considered and will be discussed.

The Sub Committee has concluded as an 'interim' report that + Distance learning (DL) has developed into a useful tool to teach medical students and is commonly used in medical schools with multiple campuses

- + Some core component parts of medical education require skills and hands on experience (*the traditional clinical method*) that cannot be provided by distance learning
- + Patient contact is irreplaceable. (*i.e. practical learning about the needs of each individual patient*) Distance learning may help to a limited degree as a supplement
- + A blend of distance learning along with traditional methods is usually the most efficacious
- + Faculty oversight of students is essential for them to master a common foundation of knowledge, skills, attitudes and values to include altruism and response to duty (*i.e. the practical reinforcement of shared professional values*)

- + It must be realized that to effectively evaluate this rapidly evolving pedagogical tool the accreditation process must be modified
- + As the field of computer based learning is developing rapidly an advisory council subcommittee of medical educators should supplement the IOAMC's standards, data base and standards to determine to validity of any schools distance learning programme
- + Further the evaluator should refer an applicant's information concerning distance learning to this committee for their recommendations and instruct the site visitors.

Your comments and criticisms to inform the continuing discussion are welcome.

S 2.3

BRINGING TOGETHER VALUES-BASED AND EVIDENCE-BASED MEDICINE: UK DEPARTMENT OF HEALTH INITIATIVES IN THE 'PERSONALISATION' OF CARE'

Prof. Bill (KWM) Fulford

Fellow of St Cross College, University of Oxford, and Professor of Philosophy and Mental Health, University of Warwick
Paper presented by: Dr. Jan Wallcraft

Values-based practice is a new skills-based approach to balanced healthcare decision-making where complex and conflicting values are involved. Together with evidence-based practice, values-based practice has been the basis of a number of training and policy initiatives in mental health from the UK government's Department of Health in London. This

paper outlines some of these initiatives and indicates the challenges in developing similar values-based approaches in other areas of medicine. Combining values-based with evidence-based practice could make a key contribution to developing a medicine for the 21st century that is not only science-based but also patient-centered.

S 2.4

EUROPEAN PREVENTION MANUAL PROJECT (IMHPA)

Dr. Evelyn. M van Weel-Baumgarten, Department of Primary and Community Care,
Radboud University Nijmegen Medical Centre, The Netherlands

Background

In primary care many patients present with emotional symptoms. Even though the prevalences of depressive and anxiety disorders are high, interventions to prevent mental disorders are not used regularly in this setting. In a European Commission funded project a specialised training manual was developed with interventions aiming at prevention of mental illness in patients at risk.

The manual was well received in both countries. Two days were sufficient to learn the basic principles but the participants indicated more time for practice and feedback advisable. Trainers experienced differences between the 2 countries in pre-existing knowledge and skills, and in acceptance of the teaching methods. Furthermore Dutch GP's expected a problem in finding enough time to use the interventions in every-day practice, the Slovenian's expected difficulty with patients acceptance of 'psychological treatments' rather than medication.

Manual

The manual contains a two-day program, in English, to train primary health care professionals in several techniques for prevention of depression and anxiety. There is also a focus on patient centered communication skills. Patient empowerment is a key issue in Brief Problem Solving (BPS), the intervention aiming at prevention of depressive illness. This intervention is trained in a way it can be managed within a 10 – 15 minute appointment system. Other interventions in the manual are 'education and reassurance, reattribution, simple exposure and managing insomnia. The materials were tested in 2 successive pilots for general practitioners in Europe: The Netherlands and Slovenia.

Conclusions: The training programme is considered relevant, but the program should be adjusted to individual needs of the various European countries. Translations and training in one's own language will have to ensure that all health care professionals benefit optimally from the content. Small changes will also have to be made to adapt the manual to the cultural setting of the countries who want to use it in the future. Although BPS is derived from the effective intervention Problem Solving Treatment, future research should test the efficacy of all person centered interventions in the manual to find out if they prevent emotional symptoms developing into disorders in the primary care setting.

S 2.6

EUROPEAN FEDERATION OF ASSOCIATIONS OF FAMILIES OF PEOPLE WITH MENTAL ILLNESS (EUFAMI) INITIATIVES ON PERSON CENTERED CARE

Sigrid Steffen, President, EUFAMI

There is a definite need for a new care environment – away from the conventional long term hospital model to a more community and mobile care centred model, which includes psychiatric departments in regional hospitals instead of large psychiatric clinics in crisis situations. In addition, there is a need for a more total holistic encompassing all aspects of the patient's health. With concepts like Empowerment and Recovery new responsibilities and roles arise, for clinicians, users, cares and public policy. This implicates new requirements to the abilities and possibilities of these affected parties.

EUFAMI is leading the campaign to ensure that families are listened to and that the large knowledge base which families has built up from years and years of 'on the spot' experience of living with mental illness is shared by all of the care team; hence the need to have families officially as an integral part of any care team.

Also there is a need for a review of how professional staff are trained in order to include 'family training' on the official training curriculum. EUFAMI would contend that a seed change in training and training

methods for psychiatry is required. Firstly shift the emphasis from the illness to the person with the mental illness. In other words, training should be patient focused.

This shift could be achieved by updating the current standards for the curriculum. New modules need to be introduced to cover human aspects related to the user and family, which will result in a seed change, and thereby allow all interested parties to fully participate in the care team on the road to recovery. Also the most important parties, namely the people with mental illnesses and their families, will feel valued and not feel mere onlookers.

S 2.7

INTERNET-BASED INITIATIVES FOR PERSON-CENTERED MEDICINE

Prof. R. Montenegro (Buenos Aires)

Once the 2008 First Geneva Conference on Person-centered Medicine was closed, we thought it was necessary to have a site in which the richness of the topic, the discussions held and the material presented could be displayed. Besides the publication of the Conference papers and editorials in various international journals, and the organization of symposia on Person-centered Medicine at major events in international forums, it was only natural for us to think of the Internet as the best place to lodge an easily accessible meeting point for all those interested in this topic.

Thus, we started building the personcenteredmedicine.org site. The process included consultation with several outstanding colleagues who are fully involved in this matter, including WMA and Wonca leaders, who play an important role in these Conferences. The resulting site was publicly

A better and easier life for all concerned – the ill person will feel more involved and take ownership; the medical profession will feel more relaxed and life will be easier as there will be more dialogue; the family member will feel valued and a reduction in isolation.

Finally, there is a critical need for information to help understand the illness, support and education to help develop one's coping skills, to name just a few issues. Also, a very negative result of someone being diagnosed as suffering with a mental illness is the onset of feelings of stigmatization, discrimination and isolation.

posted on the Internet in mid April, just in time to publicize the Second Geneva Conference which is now taking place. The site will grow as the program on Person-centered Medicine develops, giving it wide visibility. We plan further initiatives to follow, such as intranet communication to support the efforts of our various workgroups; communication with external related organizations and programs; internet-based surveys; development of an electronic journal on person-centered medicine; public education and information. All the institutions involved in such development are invited to actively participate in it. We expect this to result in the development of an international entity, with an informationally and interactively rich internet platform, to move forward our initiatives on person-centered medicine.

S 2.8

ANTHROPIEDIA'S INITIATIVE TO PROMOTE PERSON-CENTERED CARE BY EMPOWERING INDIVIDUALS AND COMMUNITIES

Dr. S. Kedia (Denver, USA) and Dr. L. Munsch (St. Louis, USA)

The Anthropedia Foundation (APF) is dedicated to empowering communities and individuals of all ages to reach their fullest potential for health and well-being. APF recognizes that existing biomedical approaches to illness prevention and treatment often fail to address the complex relationships between a person's body, mind, and social context. Additionally, the current healthcare system provides little opportunity for people to receive the attention, personalized care, health education resources, lifestyle counseling, and support necessary to foster long-term health and happiness. APF goes beyond the modern medical practice of focusing on illness and aims to prevent disease and promote health by advancing a comprehensive integrative approach to healthcare that encourages health professionals to consider and care for the *whole* person (body, mind, and psyche) within their social context. APF's Initiative to

promote Person Centered Care will be accomplished in four ways: (1) by advancing research and professional awareness on how to help individuals improve their lifestyles and grow in self-awareness and character development (via conferences and research); (2) by developing and providing multi-media courses in well-being that individuals can use on their own; (3) by developing and providing evaluation tools for professionals and individuals to become aware of a person's own temperament and character, emotional tendencies, and higher cognitive processes; (4) by distributing, to health care providers, educational resources to promote health and well-being in their practice. Increasing the accessibility (for patients, professionals, and communities) of educational resources that teach ways to develop and sustain health and happiness will help individuals to reach their personal capacity for well-being.

SESSION 3

Concepts and Meanings of Person-centered Medicine

S 3.1

THE PERSON IN MEDICINE

Prof. E. Cassell (New York)

A brief description of what is a person is followed by a brief description of what sickness is. It is apparent that virtually every aspect of the person is altered to some degree by serious illness. It is a circumstance of the ascendant theory of sickness ('when a person is sick it is because of disease'), history, and a result of the development of science that the physical manifestations of sickness are so prominent. Because persons are of a piece, whatever happens to one part happens to the all. Because of this, if a determinant of the illness is personal, psychological, social, or

spiritual there will necessarily be physical manifestations as well. If these are given the most attention (as at present) that might not be true to the patients experience or offer the best opportunities for intervention. Sickness makes itself known by interferences in function that prevent persons from pursuing their goals and purposes. Healing should be directed toward restoration of function and a consequent return of well-being.

S 3.2

IDENTITY, EMPATHY AND ENGAGEMENT IN PERSON CENTRED MEDICINE: THE SOCIOCULTURAL CONTEXT.

John L. Cox. Professor of Mental Health. University of Gloucestershire;
Professor Emeritus University of Keele, UK.

This paper is partially derived from two recent reports relevant to understanding the changing sociocultural context of Person-Centred Medicine: 'A Good Childhood: searching for values in a competitive age' (Layard and Dunn 2009) and 'Guidelines on spirituality for staff in acute care services' (2009). Compassionate empathy and a sense of self are core requirements for engagement in person-centred medicine. An understanding of continental philosophers (Levinas, Merlau-Ponty) can also assist to develop a more adequate conceptual basis.

The paper will conclude with an appraisal of the Bio-psycho-social model (Engel 1977), and will suggest that this model is re-fashioned for a

contemporary multi-ethnic society. It is proposed that a Bio-social / psycho-spiritual (BSPS) **approach** to a person-centred and relationship-based medicine might be considered.

References:

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S 3.3

LIFE EXPERIENCE AND MEDICINE OF THE PERSON.

Prof. B. Rüedi, M.D.

Medicine of the person, as proposed by Paul Tournier, attempts to offer the patient the best's available therapeutic means, in a personal therapeutic relationship. Such attitude may require a sharing of life experiences between the patient and his doctor. The indispensable requirements are time, limited by its cost, and a climate of reciprocal confidence, unfortunately often replaced today by a climate of reciprocal defiance.

The life experience is perceived by the person like the meaning given to his

or her life by all his or her lived experiences. When shared in a therapeutic relationship, it will help to take the right decisions, not only to cure the diseases of a human organism, but to heal a suffering person and promote a creative health. But the image of a healthy person is changing, expecting an everlasting youth, enhanced performances, delayed death, offering the opportunity of new biological and emotional experiences. In this context, medicine will have to redefine its role.

SESSION 4 Procedures for Person-centered Diagnosis

S 4.1

MULTILEVEL EXPLANATIONS AND DIAGNOSIS IN MEDICINE:

Prof. Kenneth F. Schaffner, M.D., Ph.D. (Pittsburgh, USA)

This presentation outlines an account of diagnosis as a multilevel search for multilevel medical and psychiatric explanations. The talk starts with a brief summary of the PID generalized concept of diagnosis [1], and then describes the first stage of data collection and problem formulation in the diagnostic process. I stress significant roles for values at this very beginning of the diagnostic process in identifying what is relevantly abnormal, and thus what falls in the purview of the diagnostic process – therefore, ultimately, what will need to be treated. The structure of the diagnostic process discussed in the remaining parts of the talk draws on analyses and empirical studies done in the logic [2-3] and psychology of clinical reasoning [4-6] over the past forty years, and identifies several lessons learned from these accounts. One of these lessons is the importance of creating multiple prototypical "illness scripts" as well as more detailed "exemplars" (medical and/or psychiatric cases) – but scripts and exemplars which encompass *all levels* of PID content. I propose that a series of such scripts and exemplars be developed by several PID

subcommittees, and then be made available for further general discussion and clinical teaching.

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3. Schaffner KF. Medical informatics and the concept of disease. *Theor Med Bioeth* 2000 Jan;21(1):85-101.
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6. Dhaliwal, G. "Clinical Decision-Making: Understanding how Clinicians Make a Diagnosis, in Saint, S. et al, *Clinical Problem Solving*. New York: McGraw-Hill, 2006.

S 4.2

THE PERSON-CENTERED INTEGRATIVE DIAGNOSIS MODEL

Ihsan M. Salloum, M.D., M.P.H. (University of Miami, USA)

As diagnosis is a critical first step for clinical care, it was early recognized that an appropriate diagnostic model was necessary as informational basis for person-centered clinical care. The design of a Person-centered Integrative Diagnosis (PID) model was based on literature reviews and workmeetings in London, Paris, Geneva, Preston, U.K., and Uppsala, Sweden over the past two years.

The current PID model covers both ill-health and positive health through the following three levels: Health Status (from illness to

recovery/disorderlessness and from disabilities to adaptive functioning), Experience of Health (cultural factors and values concerning ill health and positive health), and Contributory Factors (including internal and external risk and protective factors). Each of these domains will be evaluated with standardized categories and dimensions as well as narratives. Specific attention is paid to evaluators (clinicians, patient, family and other carers) and the interactive evaluation process.

References:

Mezzich JE, Salloum IM: Towards Innovative International Classification and Diagnostic Systems: ICD-11 and Person-centered Integrative Diagnosis. Acta Psychiatrica Scandinavica 116: 1-5, 2007

Salloum IM, Mezzich JE (eds): Psychiatric Diagnosis: Challenges and Prospects. Chichester, UK, Wiley-Blackwell, 2009

S 4.3

PROSPECTS FOR PERSON-CENTERED DIAGNOSIS IN GENERAL MEDICINE

Prof. M. Klinkman, MD.MS (Ann Arbor, USA)

Everywhere in the world, from highly developed health care delivery systems to developing regions, primary health care has same purpose – to meet the needs of persons living in the community. This is by nature a person-oriented task. This discussion will focus on prospects for person-centered diagnosis and treatment in the general medicine setting.

Primary care currently operates under major time and resource constraints, and the range and complexity of tasks continues to increase. Clinicians often follow a “satisfying” strategy to cope with the workload, and employ person-centered care in an informal and/or inconsistent way. Several examples from my own practice will highlight the difficulties of maintaining a person-centered approach in everyday practice.

Advances in health information technology and the rediscovery and promotion of the concept of the Patient Centered Medical Home (PCMH) in

the US provide a tremendous opportunity to integrate person-centered care into routine primary care practice. Some foundational work has already been accomplished. However, there are four key areas in which much more work is needed:

- (1) development of a patient-centered “primary care data model”
- (2) identification of the key domains and data elements of the “patient side” of care
- (3) collaboration with EHR – and PHR - vendors to implement standards
- (4) thinking far beyond the clinical encounter as the unit of health care delivery

If we can develop and articulate a simple and robust approach to person-centered care, we will be able to integrate it into the expanded model of primary health care delivery represented by the PCMH. We must find a way to bring the patient’s own voice into our work.

S 4.4

PERSON-CENTERED DIAGNOSIS

Session Discussant - Sigrid Steffen, President of EUFAMI

Sigrid will discuss a number of aspects that arise as a consequence of an individual’s diagnosis and how such a diagnosis affects the wider family unit.

From the family perspective, the onset of any mental illness is very traumatic and frightening. Consequently a sense of relief prevails when a diagnosis is made. But soon the realisation of the longer term effects and changes becomes clear. A lifetime sentence looms for many.

There is a critical need for information to help understand the illness, support and education to help develop one’s coping skills, to name just a few issues Sigrid will deal with.

It is important to understand that the overall life situation has to be incorporated in the diagnoses and, additionally to medication the persons’ positive skills or abilities should be strengthened from the beginning of the treatment process. This will help the patients to find new perspectives for their future lives.

SESSION 5

Panel on Programmatic Contributions to Person-centered Medicine

S 5.1

WORLD FEDERATION FOR MENTAL HEALTH

J. Copeland, WFMH President

The World Federation for Mental Health has a mission to promote mental health awareness, prevention, advocacy and best practice recovery worldwide. With organizational members in over 100 countries and consultative status with the United Nations there is major interest in the welfare of consumers and families and their advice should be at the centre of all health care. The tendency for services under pressure to be

orientated around health workers instead of consumers must be reversed. However, many areas of the world and some specialized services e.g. for disaster victims, have little mental health provision of any kind. WFMH is therefore keen to support consumer participation in both development and administration of services.

S 5.2

WORLD ASSOCIATION FOR SEXUAL HEALTH: SEXUAL HEALTH FOR THE MILLENNIUM

Ruben Hernandez, Past-President World Association for Sexual Health

Until recently and due to WAS work, University Departments, and AIDS Pandemia, global increase in sexual violence, cyber sexophilia, new discoveries on medications to treat sexual problems, overcoming stigma and myths about human sexuality, increase in media covering of sexual issues, conferences, congresses, books, papers, new advances in measuring human sexual response and many other factors the importance of SEXUAL HEALTH has been on the table for Quality of Life Issues.

The involvement of WHO, PAHO, and many ONG’s around the world had a land mark in defining sex, sexuality, sexual health, and sexual rights.

Valencia in 1997, Hong Kong in 1999, Antigua in 2000, Geneva in 2004, Montreal in 2005 produced Declarations and Documents (www.worldsexualhealth.org) that shape the current movement in defense and integration of sex in productivity and happiness of human beings,

We will present a brief summary of the main issues looking at the future, following the most recently Document WAS-WHO Sexual Health for the Millennium. The Person Centered Medicine Program is advancing coherently with these world wide documents.

S 5.3

INTERNATIONAL ASSOCIATION OF MEDICAL COLLEGES

J. Appleyard, IAOMC Secretary General

The International Association of Medical Colleges' goal is to enhance the quality of undergraduate medical education by developing shared global accreditation standards. Central to these is the Hippocratic tradition of medical ethics which places the individual person in the centre of the physician's concerns and provides the framework for the assimilation of

the core professional values that should underpin the moral standards of physicians worldwide. It is committed to peer evaluation of the education provided by individual medical schools worldwide in a transparent way and available to the public to inspire confidence in the integrity of the findings.

S 5.4

EUROPEAN FEDERATION OF ASSOCIATIONS OF FAMILIES OF PEOPLE WITH MENTAL ILLNESS

Sigrid Steffen, President EUFAMI

In her contribution, as a discussant, at the Panel Discussion Sigrid will briefly summarise the three main initiatives which are being promoted and tried by EUFAMI members in an effort to change to the deliver of care from a symptom based one to a person centred methodology. It is

EUFAMI's strong belief that if these three initiatives are embraced by the wider medical professional community, then a lot will have been achieved in pursuit of a new care model.

S 5.5

PAUL TOURNIER ASSOCIATION (PTA)

Dr. Hans-Rudolf Pfeifer

Paul Tournier (1898-1986) from Geneva has inspired many professionals and laymen by his vision of a «Médecine de la Personne» (Medicine of the Whole Person), expressed in his 20 books on existential themes (translated in over 20 languages), his speeches and regular conferences. Viktor E. Frankl called him "the pioneer of Person-Centered Medicine". The Paul

Tournier Association will contribute by networking and providing resources, deepening and widening reflection and furthering the practical application of a person-centered medicine. The Association was founded in 1998 and works in close cooperation with the International Group Medicine of the Person.

S 5.6

INTERNATIONAL GROUP OF MEDICINE OF THE WHOLE PERSON

Prof. Dr. Méd. Bernard Ruedi

As a member of the « International Group of Medicine of the Whole Person », I would like to share my present, primary concern about the future of medicine.

experiences in true personal dialogues? Or will he become a highly performing organism, reaching for ever more life experiences, with the expectation to enlarge constantly the biological limits of his life?

What kind of man is our society already programming with its biotechnologies? Will he still be a person, able to share enriching life

I am worried about how frightfully naive and unconscious we are concerning our present responsibilities.

S 5.7

LATIN AMERICAN PSYCHIATRIC ASSOCIATION

Prof Roger Montenegro, APAL Past President

Latin America is a region which covers 20,500,00 km², which are inhabited by 540,000,000 people, among whom there are 25,000 psychiatrists.

The national associations in our region are deeply interested in the person-centered medicine project, so activities about this topic are constantly taking place at our congresses.

APAL is a regional psychiatric association which was originated in 1950, during the 1st WPA World Congress of Psychiatry, which was held in Paris. The Latin American delegates felt the need to create an association through which all the Latin American countries could contribute to the study of psychiatry and that of the Latin American man. APAL was officially founded in September 1960, in Cuba. It is made up of 21 societies of psychiatry and it is an Affiliate Association of the WPA. Every society organizes annual congresses which display the high professional level of its members and which are very well attended. The first APAL Congress was held in 1961 in Caracas. These Congresses are now held every two years.

There were similar activities in Argentina, Bolivia, Peru, Venezuela, etc. in 2007, and this also happened during the XXVI Brazilian Congress of Psychiatry (Brasilia, Brazil, October 2008), where I personally participated of various activities. Prof Mezzich held a symposium on "New International Systems of Diagnosis: ICD-11 and Integral Person-centered Diagnosis" in Mar del Plata, Argentina, last April 2009, during the Association of Argentine Psychiatrists annual congress. Next July I will attend the 10th National Psychiatric Congress in Cochabamba, Bolivia, with the central theme: "Towards the Promotion of Mental Health at a time of Social Change", just to mention a few.

Indicated by historian Garrabe, person-centered concerns were present since the beginning of WPA (and therefore of APAL). The themes of several Congress themes in Latin America in recent years have focused on the person, e.g. the Brazilian in 2007 (Psychiatry and the Person: Embracing Plurality).

Among the potential contributions of APAL to Person-centered care is the GLADP-2 in preparation by APAL, which plans to use a personalized diagnostic model.

APAL website regularly gives visibility to the person-centered medicine project. www.apalweb.org

S 5.8

SOUTH ASIAN ASSOCIATION FOR REGIONAL COOPERATION

Prof. Roy Abraham Kallivayalil,
Founding Secretary General SAARC Federation

SAARC (South Asian Association for Regional Co-operation) includes seven countries: India, Pakistan, Bangladesh, Nepal, Sri Lanka, Bhutan and Maldives representing 1.5 billion people, about ¼ of humanity. Most people share common heritage and culture and their problems too are nearly similar. Person Centered Medicine has special relevance here

because women, children, elderly, the refugees and displaced persons are especially vulnerable. The region can contribute by participating in person-centered diagnostic developments, preparing educational curricula for person-centered clinical care and emphasizing on integrating mental health care with general health care

S 5.9

EASTERN EUROPEAN PSYCHIATRY: ITS RELEVANCE TO THE PERSON-CENTERED APPROACH

Professor George Christodoulou
President, Psychiatric Association for Eastern Europe and the Balkans

The Psychiatric Association for Eastern Europe and the Balkans (www.paeeb.com) was established in March 2005 in Athens following the Craiova Declaration of December 2004 and the decision to promote its evolution from a WPA Institutional Program to an independent WPA – affiliated Association.

Eastern European Psychiatry in the recent past reflected the prevailing political and socio-economic conditions in the countries of the region. In the majority of Eastern European countries, individualized and personified

psychiatry was not encouraged. For example, psychotherapy, a highly personified treatment method, especially that of psychodynamic direction, was practically abandoned and the **person** has hardly been in the focus of attention of mental health professionals.

Things are changing, however, and the leadership of the Association feels that emphasis on the person and to person-linked concepts like recovery, resilience and positive health will contribute a lot to a change in the provision of not only psychiatric but also medical services in the region of Eastern Europe.

S 5.10

HELLENIC MEDICAL SOCIETY OF NEW YORK

George John Tsioulis, MD, PhD, FACS
President, Hellenic Medical Society of New York

Hellenic Medical Society of New York address to the participants of the Second Geneva Conference on Person-Centered Medicine:
Esteemed Colleagues:

We salute and fully support your noble initiative to bring the human being as a person back to the center of modern medicine. Assembly-line health care and overregulation have created an impersonal and detached way of practicing medicine that degrades the human existence and trivializes our profession. Our Society, faithful to the anthropocentric Hippocratic oath,

the cornerstone of Greek Medicine, Ancient and Modern, will join in your efforts to revive the person-centered medicine. We wish you all success in your endeavors and looking forward to future collaboration.

With our kindest regards,

George John Tsioulis
President, Hellenic Medical Society of New York

S 5.11

FRENCH PERSPECTIVE ON PSYCHIATRY FOR THE PERSON

Dr. Michel Botbol
President of the Association of WPA French Member Societies

In the 50s, French psychiatry has been very much involved in the creation and development of International bodies to represent World Psychiatry. This important move was successful in many aspects but had two related side effects: division of French psychiatry's representation in these bodies weakening the overall influence of the French perspective on Psychiatry, and as a consequence, a drastic reduction of French psychiatrists' involvement in international psychiatry. The three main French Societies created recently the Association of WPA French member societies to overcome these weaknesses with the objective to give more visibility to the French psychiatric model. This model is based on two main specificities: the space it gives to psychodynamic psychotherapy in private and public practice, the strength of the "secteur" model in the organization of psychiatric public services. It is based on a strong focus put on clinical

practice stressing the importance of patient-therapist relation rather than disorders only. As a consequence, French Psychiatry tend to need a higher number of psychiatrists and to discredit reductionist approaches adopted in the more reductionist conceptions of EBM. Psychiatry for the person movement was then seen as the long waited for opportunity to find international support to this clinical perspective. They find in this important move a reason to reinvest the international bodies where they thought this perspective has been too radically absent for the last twenty years. In line with this perspective, French psychiatry is particularly involved on three axes: Classification with the Global Network, "Practice based" studies, and promotion of psychiatry for the person's conceptual and practical thinking through publication and congresses.

S 5.12

PERSPECTIVES AND POTENTIAL CONTRIBUTIONS OF THE INTERNATIONAL FRANCOPHONE PSYCHIATRIC ASSOCIATION AND THE FRENCH ASSOCIATION OF PRIVATE PRACTICE PSYCHIATRISTS

Dr. Antoine Besse
President Elect, International Francophone Psychiatric Association

- The clinical framework of the psychiatrist in private practice?

A liberal practice is based on the encounter with an ailing person in a confidential setting. This framework favors the expression of the patient's innermost thoughts. This encounter aims at the same time therapeutic and diagnostic. The psychotherapeutic dimension may or may not be enhanced by the prescription of psychoactive drugs. The psychotherapeutic process is based on the idea that the symptoms send a message to the patient and to those around him (Freud spoke of an unconscious knowledge). For the psychiatrist, the question is then to identify what the "the subject and his mind" need to know about this message, about its place in the patient's life experiences as a person and about his psychic functioning.

- **Direct access to the psychiatrist** is then an essential issue for the private practice in psychiatry. Solutions exist to make it economically feasible.

- The solitude of the private practice psychiatrist?

The setting's adaptability and the informal ties it allows to other local professionals (GPs, psychologists, etc.) contrast with the more complex organization of public services. However, he **can be involved in clinical research** based on his personal expertise and on his participation in peer groups as shown by the one that we recently completed in France (Publication in the journal "*Psychiatries*".)

- **Following Dakar Congress**(in march 2009)approached the evolution of the African woman status, the International Francophone Psychiatric Association(ALFAPSY) develop in emergent country involvement of the person centered psychiatry through private practice.

SESSION 6 Procedures for Person-centered Treatment and Health Promotion

S 6.1

PERSON-CENTERED INTEGRATIVE CARE

C. Robert Cloninger, MD

The practice of person-centered medical care requires physicians to examine basic questions about the scope of medical responsibility, the nature of the therapeutic doctor-patient relationship, and the types of procedures that are appropriate in treatment and health promotion. Once well-being is recognized as an integral part of health care, then health promotion must address the whole art and science of living well. Human beings only flourish when they are self-directed, cooperative, and self-transcendent (Cloninger 2004). Each human being has an intrinsic dignity as a result of their capacity for self-awareness and self-actualization. Consequently the person-centered physician becomes a consultant and adviser to assist people in their quest to live well.

What procedures can the person-centered physician apply that are practical and effective? First, the physician must understand the personality of the individual including their emotional style, their goals and values, their strengths and weaknesses physically, mentally, socially, and spiritually. Second, there must be a therapeutic alliance in the sense of a relationship of mutual trust and respect in which the physician and patient agree to work together toward common goals. Third, physicians need to

communicate in a reassuring and hopeful manner. Fourth, once a person is calm, they can face and accept unpleasant facts, such as information about a possible disease or abnormal test results. Fifth, it is empowering for a person to take responsibility and act in ways that are purposeful and resourceful to improve their lifestyle to promote health.

These procedures embody the three key elements of effective person-centered psychotherapy: (1) respect or unconditional positive regard, (2) empathy, and (3) genuineness (Rogers 1980). They also correspond to the three general practices for developing well-being: (1) Letting go, which fosters self-directedness, hope, and respect, (2) Working in the service of others, which fosters cooperativeness, compassion, and empathy, and (3) Awareness, which fosters genuineness or authenticity (Cloninger 2004). Given the frequency of stress-related complaints in medicine, it is likely that the practices of well-being are broadly applicable in medicine.

Cloninger, C. R. (2004). *Feeling good: The science of well being*. New York, Oxford University Press.

Rogers, C. R. (1980). *A way of being*. Boston, Houghton Mifflin.

S 6.2

THE PERSON CENTERED MEDICAL HOME IN THE INFORMATION AGE IN THE UNITED STATES

Ted Epperly, M.D.

Program Director and C.E.O.

Family Medicine Residency of Idaho – Boise, Idaho

1. The Future of Family Medicine charge is to, "develop a strategy to transform and renew the specialty of family medicine to meet the needs of people and society in a changing environment."
2. The new model of family medicine incorporates a personal medical home with patient-centered care, team approach, elimination of barriers to access, advanced information systems, redesigned offices, whole-person orientation, care provided within a community context, emphasis on quality and safety, enhanced practice finance, and commitment to provide family medicine's basket of services¹.
3. The Patient Centered Medical Home involves both a place and process of care.
4. The Patient Centered Medical Home is about practice designation. It's not about person designation. This designation is done by the National Committee for Quality Assurance (NCQA).
5. The seven joint principles of the Patient Centered Medical Home are: 1) each patient has an ongoing relationship with a personal physician; 2) a physician directed medical practice; 3) whole person orientation; 4) care is coordinated and integrated across all elements of the complex health care system and in the patient's community; 5) quality and safety; 6) enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff; and 7) payment reform.
6. Three useful websites to find out more about Patient Centered Medical Homes are: TransformMED (www.transformed.com); NCQA (www.ncqa.org); and AAFP (www.aafp.org).
7. The current amount of money spent in the United States per year on health care is \$2.3 trillion, which is 16% of the nation's gross domestic product (GDP).
8. America's current health care rankings are: number one in health care dollars spent per capita; number one in health care technology dollars spent per capita; number one in research dollars spent per capita; number 20 in health care outcomes (e.g., life expectancy, infant mortality, and immunizations); number 37 for our health care system's efficiency and effectiveness; and number 54 for being a fair, just, and equitable system².

9. Despite the money spent on health care in our country the United States has one of the worst primary care infrastructures in the world.

¹ The Future of Family Medicine - Annals of Family Medicine - 2004

² Lebow R. Health Care Meltdown: JRI Press: 2002 World Health Organization Data

10. The value of family medicine is continuity, comprehensiveness, coordination, and integration of care.

S 6.3

PERSON-CENTERED HEALTHINESS, SOCIAL DETERMINANTS AND HEALTH PROMOTION

Dr. Eugenio Villar

Coordinator

Department of Ethics, Equity, Trade and Human Rights (ETH), Information Evidence and Research (IER), WHO

The approaches and concepts of Person-centered medicine (PCM) are analyzed through the lenses of the recent developments on the social determinants of health (SDH) following the publication of the Report of the Commission of Social Determinants of Health in August 2008. Several dimensions are addressed including the possible contributions a SDH approach could offer in explaining the complex determination social, economic and ideological/political factors contributing to health and disease and consequently how PCM can broaden its already holistic

approach both in terms of diagnosis and treatment. Within this framework health promotion, as conceived in the Bangkok Conference, will be discussed around the PCM approach. In order to ensure a coherent and comprehensive analysis, reference is also made on the relationship between PCM and the Primary Health Care strategy (as renewed in the World Health report 2008), especially on the reforms referring to public policies for the public's health (which is instrumental to the implementation of the SDH approach) and putting people's first.

SESSION 7

Person-centered Medicine for Children and Older People

S 7.1

PERSON CENTRED PEDIATRIC CARE

Prof. James Appleyard

IAOMC Secretary General

Each child is a unique individual - mentally, physically, intellectually emotionally and spiritually – as he or she grows and develops toward adulthood.

- ❖ a safe and secure environment;
- ❖ the opportunity for optimal growth, development; and education
- ❖ access to preventive and curative health services
- ❖ opportunities for continual improvement into the future from evidence-based research

Different physiological, psychological and pathogenic features occur at the different ages from the premature newborn infant through adolescence.

To reach their potential, children need to be respected as developing 'persons' who require

This paper will explore some of the issues raised by this person centered approach both globally and individually as members of families and local communities

S 7.2

PERSON CENTERED MEDICINE FOR OLDER PEOPLE

Dr. Jon Snaedal

Geriatrician

Immediate Past President of the WMA

The geriatric patient is distinctive from younger patients on several accounts. The geriatric patient commonly has multiple health problems and he generally is treated for most of them creating the problem of polypharmacy. Furthermore, the symptomatology of the diseases that occur in the geriatric patient are more vague than in younger patients and sometimes misleading. Last but not least, the person behind the symptomatology is more unique than in other age groups as his/her life style and former diseases make each patient more special than is the case in younger patients.

but other health professionals have their own responsibility. To treat the geriatric patient successfully the team needs to know the background of the patient, not only his social status and his circumstances but also his life history and personality. The successful treatment also depends on the patient's family and the dynamics inside the family. Even in the face of dementia, all these facts matter but in these cases the information must to great extent be given by the next of kin. In all but the most severe cases of dementia, the personal preferences of the patient must be the main focus of treatment even though that is very often not the case in reality. This fact is one of the many challenges that are facing those that care for older patients.

The means by which the geriatric patient is treated by the geriatrician is classically by team work. The doctor is typically the leader of the team

SESSION 8

Training and Research on Person-centered Medicine

S 8.1

DEVELOPING A CURRICULUM FOR PERSON-CENTRED CLINICAL CARE

Prof. Tom Sensky

Professor of Psychological Medicine, Imperial College London

Progress will be reported on the development of a core curriculum for person-centred clinical care. The curriculum is being developed iteratively by a group of clinicians, from a variety of cultural and clinical backgrounds. The conceptual basis for the curriculum is the framework for person-centred clinical care developed to date by the WPA Institutional Programme on Psychiatry for the Person. Currently, four key domains

have been identified (1) clinical expertise/clinical decision-making, (2) communication, (3) collaboration and partnership, and (4) professional responsibility and standing. Twelve themes have been identified within these key domains, and relevant key knowledge proposed within each of these themes. Examples will be offered of the themes and their proposed contents.

S 8.2

ASSESSMENT OF PERSON CENTERED MEDICINE AND PERSON CENTERED CLINICAL METHOD TEACHING IN THE AMBROSIANA UNIVERSITY MILAN SCHOOL OF MEDICINE

Prof. Giuseppe R. Brera

Rector, Ambrosiana University;

Director, The Milan School of Medicine and the European School of Medicine

Person-Centered Medicine and PCCM are born as a new paradigm for Medical Science from a criticism to the imperialism of a bio-molecular and technological paradigm confuted by interactionism evidenced by base experimental science and teleonomy of human nature revealed by research in Medical Psychology, Psychology and humanities.

Person Centered Medicine teaching structured procedures were introduced into physicians' educational curricula in the Ambrosiana University Academic Year 1998-1999 after the formal presentation of Person Centered Medicine in the 1998-1999 academic opening and the publication in the same year of "Person centered Medicine paradigm", where the epistemological principles of PCM have been determined. The teaching procedures were partially inspired to the previous and contemporary teaching procedures of Medical Counseling, the precursor of Person-Centered Medicine, born in 1991 and developed in the period 1991-1998.

Educational structures of courses, the learning objectives in Milan School of Medicine courses in MCP and MCCC and Person Centered Clinical Method teaching method and a pilot study on its results will be presented.

ⁱ Brera G.R. Epistemological aspects of medical science . *Medicine and Mind*. 1992 VII, Jan . 1-2 :5-12,

ⁱⁱ Liu D., Dorio J., Tannenbaum J. Maternal care, Hypocampal Glucorticoid Receptors and Hypotalamic-Pituitary-Adrenal Responses to stress. *Science*. 1997; 277:1659-166

ⁱⁱⁱ Laundeslangers M.L., Ryan S.M., Drugan S.F.F et al.. Coping and immune-suppression: inescapable but not escapable shock suppresses lymphocytes proliferation. *Science*. 1983; 221:568-570

^{iv} Sterling P. Principles of Allostasis: optimal design, predictive regulation, pathophysiology and rational therapeutics in "Allostasis, homeostasis and the cost of adaptation.(J.Schulkin ed) ; Cambridge University Press 2004

^v Wilet C. Walter. Balancing Life Style and Genomic Research for Disease Prevention. *Science*. 2002; 296:695-699

^{vi} Università Ambrosiana- Offerta formativa 1998-1999- Archivio

^{vii} Brera G. R, The manifesto of Person-Centred Medicine. *Medicine, Mind and Adolescence* 1999.XIV, 1-2:7-11

^{viii} Brera G.R. Brera G.R. Person -centered medicine and medical education in the third millennium, IEPI & UA Pisa, 2001

S 8.3

RESEARCH ON THE VALUE OF COMMUNICATION FOR PERSON-CENTERED CARE OUTCOMES

Sandra van Dulmen, PhD.

Netherlands Institute for Health Services Research, Utrecht, the Netherlands

When entering a consulting room a person becomes a patient with double needs, i.e. the need to feel known and understood and the need to know and understand, also referred to as affective and instrumental needs, respectively. The fulfilment of these needs highly depends on the communication skills of both doctor and patient which help to bridge the inherent distance that exists between these two persons. There is ample evidence that this bridge becomes stronger the more the communication is tailored to the person behind the patient. Research shows that this so called tailored communication contributes to patient outcome known to be crucial for recovery and quality of life, i.e. recall, medication compliance,

self-management, reassurance and need fulfilment. Being a natural skill, communication is at the same time easy and difficult to adjust to circumstances and patient characteristics. Easy because communication is a tool that is generally always present, difficult because most persons usually do not communicate in a conscious way. My presentation aims to provide evidence for the value of tailored communication for patient outcome as well as give a case example of how to communicate in a purposeful way while at the same time respecting patients' values and feelings.

S 8.4

RESEARCH ON PERSON-CENTRED CLINICAL CARE

Arnstein Finset, PhD

Dept. of Behavioural Science, Institute of Basic Medical Sciences, Faculty of Medicine, University of Oslo

A number of different terms have been applied to characterize person centred clinical care, such as the patient perspective, and patient centred as well as narrative medicine. Different ways to operationalize person centred care in empirical studies will be reviewed, including health provider exploration of patients' cues and concerns and empathic responses to emotional needs, the ability to establish common ground and a trusting relationship, and a positive approach emphasizing the effect of illness on patients' life and health promotion. A number of studies have documented significant associations between some of these aspects of person centred

clinical care and different outcome variables, such as patient satisfaction, patient adherence, health care utilization, malpractice litigation, and health outcome. Different aspects of person centeredness are found to be differentially related to outcome measures. Another line of studies is the research on the effect of communication skills training. Although results are mixed, a number of studies indicate that a person centred approach to clinical care may be learned, and that the skills acquired by health care providers after communication skills training may impact patient outcome.

S 9.1

PEOPLE-CENTRED MEDICINE AND WHO'S RENEWAL OF PRIMARY HEALTH CARE

Dr. Yongyuth Pongsupap & Dr. Wim Van Lerberghe
World Health Organization, Geneva, Switzerland

When people are sick they are a great deal less concerned about managerial considerations of productivity, health targets, cost-effectiveness and rational organization than about their own predicament. Each individual has his or her own way of experiencing and coping with health problems within their specific life circumstances (1). Health workers have to be able to handle that diversity. For health workers at the interface between the population and the health services, the challenge is much more complicated than for a specialized referral service: managing a well-defined disease is a relatively straightforward technical challenge. Dealing with health problems, however, is complicated as people need to be understood holistically: their physical, emotional and social concerns, their past and their future, and the realities of the world in which they live. Failure to deal with the whole person in their specific familial and community contexts misses out on important aspects of health that do not immediately fit into disease categories.

People want to know that their health worker understands them, their suffering and the constraints they face. Unfortunately, many providers neglect this aspect of the therapeutic relation, particularly when they are dealing with disadvantaged groups. In many health services, responsiveness and person-centredness are treated as luxury goods to be handed out only to a selected few.

Over the last 30 years, a considerable body of research evidence has shown that person-centredness is not only important to relieve the patient's anxiety but also to improve the provider's job satisfaction (2). The response to a health problem is more likely to be effective if the provider understands its various dimensions (3). For a start, simply asking patients how they feel about their illness, how it affects their lives, rather than focusing only on the disease, results in measurably increased trust and compliance (4) that allows patient and provider to find a common ground on clinical management, and facilitates the integration of prevention and health promotion in the therapeutic response (2, 3). Thus, person-centredness becomes the "clinical method of participatory democracy" (5), measurably improving the quality of care particularly in the industrial world (2), the success of treatment and the quality of life of those benefiting from such care: improved treatment intensity and quality of life (6); better understanding of the psychological aspects of a patient's problems (7); improved patient confidence regarding sensitive problems (8); increased trust and treatment compliance (4); better integration of preventive and promotive care (2).

Person-centred care has also been applicable in developing world as part of the characteristics of "good" quality of care as well as its measurement (9). In Thailand, different domains of person centred care were measured by using a method of simulated patient survey: waiting time at all stages (at reception, between reception and consultation, at the cashier following consultation, and to obtain medication); politeness (frequent use of the politeness particles 'khrub' and 'khaa'); duration of consultations (disaggregated for the time patients are allowed to express their problems, the time is allocated to physical examination, the time the doctor is talking to the patient, and the time the doctor spends writing or dealing with the nursing and administrative staff); responses to different categories of patient-centredness (requests for information, empathy, anxiety relief); medicalisation (prescribed drugs and suggested investigations); and costs (cost of drugs; consultation fee, cost of recommended investigation, and cost to state) (10, 11).

In practice, clinicians rarely address their patients' concerns, beliefs and understanding of illness, and seldom share problem management options

with them (12). They limit themselves to simple technical prescriptions, ignoring the complex human dimensions that are critical to the appropriateness and effectiveness of the care they provide (13).

Thus, technical advice on lifestyle, treatment schedule or referral all too often neglects not only the constraints of the environment in which people live, but also their potential for self-help in dealing with a host of health problems ranging from diarrhoeal disease (14) to diabetes management (15). Yet, neither the nurse in Niger's rural health centre nor the general practitioner in Belgium can, for example, refer a patient to hospital without negotiating (16) (17): along with medical criteria, they have to take into account the patient's values, the family's values, and their lifestyle and life perspective (18).

Few health providers have been trained for person-centred care. Lack of proper preparation is compounded by cross-cultural conflicts, social stratification, discrimination and stigma (17). As a consequence, the considerable potential of people to contribute to their own health through lifestyle, behaviour and self-care, and by adapting professional advice optimally to their life circumstances is underutilized. The current payment systems and incentives in community health-care delivery often work against establishing this type of dialogue (19). Conflicts of interest between provider and patient, particularly in unregulated commercial settings, are a major disincentive to person-centred care. Commercial providers may be more courteous and client-friendly than in the average health centre, but this is no substitute for person-centredness.

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S 9.3

THE PERSON IN HEALTH CARE POLICY DEVELOPMENT

Dr. Jan Wallcraft

Programme Consultant, UK Department of Health, London, UK

This presentation will briefly outline the historical and sociological changes in the late 20th Century which led to involvement of the person in health policy. It will touch on philosophical and ethical reasons for bringing the person into healthcare policy, and then go on to the more practical and pragmatic reasons in decision-making theory, and research which shows

the advantages to public health of empowerment and choice. Finally examples will be given of how person-centred health policy can lead to better public health, more responsible citizenship and better health economics.