



## FOURTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

*Articulating Person-centered Clinical Medicine and People-centered Public Health*

Core Conference on May 2 – 4, 2011

Pre-Conference Workmeeting on April 30-May 1, 2011

*Geneva University Hospital and World Health Organization*

# CONFERENCE BOOKLET

- Conference Program
- Gallery of Participants
- Conference Abstracts

L' Auditoire Marcel Jenny, Geneva University Hospitals

Executive Board Room, World Health Organization

[www.personcenteredmedicine.org](http://www.personcenteredmedicine.org)



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*Organized by the International Network for Person-centered Medicine (INPCM), the World Medical Association (WMA), the World Organization of Family Doctors (Wonca), and the World Health Organization (WHO), in collaboration with the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses (ICN), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the Council for International Organizations of Medical Sciences (CIOMS), the International College of Surgeon's (ICS), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the International Federation of Gynecology and Obstetrics (FIGO), the Medical Women's International Association (MWIA), the World Association for Sexual Health (WAS), the World Association for Dynamic Psychiatry (WADP), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAMC), the International Federation of Medical Students' Associations (IFMSA), the International Federation of Ageing (IFA), the European Association for Communication in Health Care (EACH), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), Ambrosiana University, Buckingham University Medical School, and the Paul Tournier Association, and with the auspices of the Geneva University Medical School and Hospitals.*

## CONFERENCE PROGRAM

**Organizing Committee** J.E. Mezzich (President, International Network for Person Centered Medicine), J. Snedal (World Medical Association President 2007-2008), C. van Weel (World Organization of Family Doctors President 2007-2010), M. Botbol (World Psychiatric Association Psychoanalysis in Psychiatry Section Co-Chair), I. Salloum (World Psychiatric Association Classification Section Chair), and W. Van Lerberghe (WHO Health Systems Governance and Service Delivery Director).

**Conference Participants** Physicians and other health professionals and interested persons. INPCM Continuing Professional Development (CME) Certificates will be e-mailed upon request to all registered participants. Registration fee: 300 Euros for persons residing in World Bank Group A (High Income) Countries (see list on the Registration Form); 200 Euros for persons from other countries. All Conference Participants must complete the Registration Form.

**Conference Secretariat** International: INPCM Secretariat at Int'l Center for Mental Health, Mount Sinai School of Medicine, Fifth Ave & 100 St, Box 1093, New York NY 10029, USA. E: [INPCMsecretariat@aol.com](mailto:INPCMsecretariat@aol.com), [www.personcenteredmedicine.org](http://www.personcenteredmedicine.org). Local: WMA Secretariat, Ferney-Voltaire, France, [wma@wma.net](mailto:wma@wma.net) T: 33-4-5040-7575. WHO Secretariat: [pcc\\_conference@who.int](mailto:pcc_conference@who.int)

April 26, 2011

**PRE-CONFERENCE WORKMEETINGS, SATURDAY APRIL 30 AND SUNDAY MAY 1:**  
**Venue: Geneva University Hospital Auxiliary Halls adjacent to Main Auditorium,**  
**Rue Micheli du Crest 24, 1205 Geneva, Switzerland.**

**Organizational Note: The Workmeetings will typically include a Lead presenter followed by contributions/comments from other workgroup members. Workgroups will have individualized sessions during the Pre-Conference Workmeetings and joint sessions with related Workgroups the afternoon of May 2.**

SATURDAY APRIL 30

1:00 – 2:30 PM

INPCM Workmeeting on Informational Framework:

Chair: *Jon Snaedal (Reykjavik)*

Co-chair: *John Cox (Cheltenham, UK)*

- International Journal of Person Centered Medicine (IJPCM): *Andrew Miles (Lead)(London, UK)*
- Upgrading the institutional website and interactions with related ones (Journal and GLADP websites): *Roger Montenegro (Lead)(Buenos Aires), Christopher Woodhead (Buckingham, UK)*
- Bibliographical Clearinghouse and Data Base: *Levent Kirisci (Lead)(Pittsburgh), Janine Hayes (Pittsburgh)*

2:30 – 2:45 PM

Coffee Break

2:45 – 6:00 PM

INPCM Workmeeting on Person-centered Clinical Care Guidelines

Chair/Moderator: *Michel Botbol (Paris)*

Co-Chair/Rapporteur: *Neal Adams (Berkeley, USA)*

Lead presenter: *Jon Snaedal (Reykjavik)*

Workgroup Discussants: *James Appleyard (London), Chris Van Weel (Nijmegen, Netherlands), Roger Montenegro (Buenos Aires), Arnstein Finset (Oslo), Elena Gayvoronskaya (Voronezh, Russia), Nikos Christodoulou (London), Jeremiah Mwangi (London), Janet Wallcraft (London), Sigrid Steffen (Salzburg), Michaela Amering (Vienna), Edmond Pi (Los Angeles, USA)*

6:15 – 7:45 PM

*International Journal of Person Centered Medicine* Launching Reception and Editorial Board Meeting

SUNDAY MAY 1

9:00 AM – 12:30 PM

INPCM Workmeeting on Person-centered Integrative Diagnosis  
(Coffee Break at 10:45 AM)

Chair/Moderator: *Juan E Mezquich (New York)*

Co-Chair/Rapporteur: *Luis Salvador (Cadiz, Spain)*

- Current status of PID development: *I. Salloum*

- Diagnostic Assessment Procedures (categories, dimensions, narratives): *M Botbol (Lead), C Banzato, L Salvador*
- Evaluators and Assessment Process (interactions among clinicians, patients and carers): *J Wallcraft (CoLead), M Amering (CoLead), S Steffen, I Salloum*
- Disorders and Comorbidity: *C Banzato (Lead), M Abou-Saleh, V. Krasnov, I Salloum*
- Disabilities and Functioning: *L Salvador(Lead), J. Saavedra*
- Positive Health and Well-being: *R Cloninger (Lead), I Salloum, J Mezzych*
- Towards a Formulation on Experience of Illness and Health: *J Mezzych (Lead), S Barnhielm et al*
- Contributors to Illness and Health: An Overview: *W Rutz (Lead), E Villar*
- Etiopathogenic and Risk Factors: *I. Salloum (Lead), J Saavedra, M Botbol, L Salvador*
- Strengths and Protective Factors: *J Wallcraft (Lead), R Cloninger, E Gayvoronskaya, I Salloum*
- Diagnostic Summary, Treatment Planning and Case Illustration: *N Adams (Lead), I Salloum, J Mezzych*
- Validation of the PID Model and Guide: *K Schaffner (Lead), I Salloum, J Saavedra*

12:30 – 1:30 PM

Lunch Break

1:30 – 4:30 PM

INPCM Workmeetings on Person Centered Special Developments  
(Coffee Break at 3:15 PM)

Chair: *Chris van Weel (Nijmegen, Netherlands)*

Co-Chair/Rapporteur: *Ihsan Salloum (Miami)*

- Mexico-INPCM Collaborative Project on Person-centered Care for Chronic Diseases: *Armando Barriguete (Lead) (México D.F.), Jose Angel Cordova (México D.F.), Michel Botbol (Paris).*
- Pediatric Diagnostic Model: *James Appleyard (Lead)(London), Michel Botbol (Paris). Eyal Shemesh (New York).*
- Latin-American Guide of Psychiatric Diagnosis Project: *Javier Saavedra (Lead)(Lima), Juan E. Mezzych (New York), Elvia Velasquez (Medellin), J. Armando Barriguete (Mexico City), Michel Botbol (Paris), Luis Salvador (Cadiz, Spain), Claudio Banzato (Campinas, Brazil).*
- French Diagnostic Project: *Michel Botbol (Lead)(Paris), Antoine Besse (Paris), Paul Lacaze (Montpellier).*
- Person Centered Partnership Project: *Janet Wallcraft (CoLead)(London), Michaela Amering (CoLead)(Vienna), Jeremiah Mwangi (London), Arnstein Finset (Oslo), Sigrid Steffen (Salzburg), Terry Bamford (London).*
- South Asian Project: *Jitendra Trivedi (Lead)(Lucknow, India), Roy Kallivayalil (Cochin, India), Yongyuth Pongsupap (Bangkok)*
- World Federation for Mental Health-INPCM Project: *Mohammed Abou-Saleh (Lead) (Doha and London), George Christodoulou (Athens), Roger Montenegro (Buenos Aires), Helen Millar (Dundee, Scotland)*
- Person Centered Care for People Abusing Substances: *Ralph Tarter (Lead), Levent Kirisci, Ty Ridenour, Deborah Bogen (Pittsburgh)*
- Person-centered Young Health Professionals Group: *Nikos Christodoulou (Lead)(London)*

5:00 – 7:00 PM

INPCM Board Meeting

**CORE CONFERENCE FIRST DAY, MONDAY MAY 2, 2011**  
**Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls**

**Organizational Note for Symposia and Workshops.** *Unless otherwise noted, each session will have chair and cochair, three or four brief presentations (15-10 minutes each), ample general discussion time, and a 5-minute conclusions/rapporteur's summary. Each session will focus on what we know and what gaps we have, what should we achieve, and how to do it in different settings).*

- 8:00 – 8:30 AM Registration and check-in
- 8:30 – 9:00 AM Conference Opening (*Master of Ceremony: Hans-Rudolf Pfeifer, Zurich*)
- Welcoming words: *Prof. Panteleimon Giannakopoulos (Geneva University Medical School Vice Dean), Dr. Carissa Etienne (WHO Assistant Director General).*
  - International Network for Person-centered Medicine: Achievements and Horizons: *Juan E. Mezzich (New York)*
- 9:00 – 10:30 AM Plenary Symposium on Person-centered and Contextualized Study of Disease
- Chair: *Jon Snaedal (Reykjavik)*  
Co-Chair: *Andrew Miles (London)*
- Epistemological Perspectives: *Ken Schaffner (Pittsburgh)*
  - Primary Care Perspectives: *Stephen Buetow (Auckland, New Zealand)*
  - Public Health Perspectives: *Eugenio Villar (Geneva)*
  - Understanding Dementia and the Person Behind: *Dawn Brooker (Worcester, UK)*
- 10:30 – 10:45 AM Coffee Break
- 10:45 AM – 12:15 PM Plenary Symposium on the Components of Care in Person-centered Medicine
- Chair: *Chris van Weel (Nijmegen, Netherlands)*  
Co-Chair: *Max Downham, International College of Surgeon's (ICS, Chicago)*
- Understanding and Support: *Janet Wallcraft (London)*
  - Education and Counseling: *James Appleyard (London)*
  - Illness Treatment: *Jon Snaedal (Reykjavik)*
  - Prevention and Health Promotion: *George Christodoulou (Athens).*
- 12:15 – 1:30 PM Lunch (open) and Poster Session
- 1:30 – 2:45 PM First Parallel Sessions:
1. Interactive Workshop on Enhancing Person-centeredness in Diagnosis and Treatment Planning (Main Auditorium)
- Chair: *Michel Botbol (Paris)*  
Co-Chair: *Jeremiah Mwangi International Association of Patients' Organizations (IAPRO, London)*
- Personalizing Diagnosis in Mental and General Health: *Ibsan Salloum (Miami)*
  - Personalizing Treatment Planning in Mental and General Health: *Neal Adams (Berkeley, USA)*

2. Interactive Workshop on Conducting Research on Clinical Communication (Larger Auxiliary Hall)

Chair: *George Christodoulou (WFMH, London)*

Co-Chair: *Wolfgang Holzgreve International Federation of Gynecology and Obstetrics (FIGO, Basel)*

- How to Conduct International Research on Clinical Communication: *Arnstein Finsent (Oslo)*
- Addressing the Pros and Cons of Observational Research: *Sandra van Dulmen (Nijmegen, Netherlands)*

2:45 – 3:00 PM

Coffee Break

3:00 – 4:15 PM

Second Parallel Sessions

1. Interactive Workshop on the Person with the Disease at the Center of Teaching (Main Auditorium)

Chair: *Michel Vallotton, Council of International Organizations of Medical Sciences (CIOMS)*

Co-Chair: *Olivier Bugnon, International Pharmaceutical Federation (FIP)*

- Western European Approaches: *Salman Rawaf (London, UK)*
- Eastern European Approaches: *Elena Gayvoronskaya (Voronezh, Russia)*
- North-American Approaches: *Ted Epperly (Boise, Idaho, USA)*

2. Interactive Workshop on Advancing Wellbeing and Health Promotion (Larger Auxiliary Hall):

Chair: *Alexander Bischoff, International Council of Nurses (ICN, Basel)*

Co-Chair: *Terry Bamford, International Federation of Social Workers (IFSW, London)*

- Well-being and Person-centered Medicine: *Robert Cloninger (St. Louis)*
- Promoting Well-being in Disabled Persons: *Luis Salvador Carulla (Cadiz)*
- Advancing Health Promotion in Low-resource Countries: *Yongyuth Pongsuap (Bangkok)*

4:15 – 4:30 PM

Coffee Break

4:30 – 5:45 PM

Third Parallel Sessions

1. Session on Oral Contributions to the Advancement of Person-centered Care (Main Auditorium)

Chair: *Bernard Ruedi (Paul Tournier Association, Neuchatel)*

Co-Chair: *Hans-Rudolf Pfeifer (Zurich)*

- Person-Centered Medicine Must Be Context-Dependent and Method-Based: *M. Schwartz (Austin, USA)*
- Person-Centered Care in Cyprus' Medical Education: the STD experience.: *G. Lavranos, N. Papanephytous, N. Christodoulou, S. Kyriakides, S. Michaelidou, M. Antoniadou, E. Malekou, S. Fetta. (Larnaca)*
- Project PARIS: Parents and Residents in Session-Studying the teaching of person and family-centered care in a residency program. *C. Low, R. Annunziato,*

*E. Shemesh, E. Bauml, E. Goodman, S. Church, S. Brown, D. Rode, J. Forman. (New York)*

- *A Personal Experience with Person-centred Medicine: M. Abou Saleh (Doha and London)*
- *Combating Health Care Fragmentation through Integrated Health Services Delivery Networks: H. Montenegro (PAHO, Washington, D.C.)*
- *Patient-Centered Care in Primary Health Care in the East Mediterranean Region: N. El Kurashi (Dammam, Saudi Arabia)*
- *Relation of People-centred Public Health and Person-centred Health Care Management: a Case Study: D. Stoyanov (Sofia), R. Cloninger (St. Louis).*
- *Moving towards patient-centred care: How to get there? The case of Dutch fertility care: J.W.M. Aarts (Nijmegen, Netherlands)*
- *Person-centered psychiatry: how to reach it? V. Krasnov (Moscow)*
- *Person centred perinatal psychiatry (PCPP): research and clinical challenges: J. Cox (Cheltenham, UK), P. Verhagen (Ermelo, Netherlands)*
- *People-centered Mental Health Care in Rwanda: A Multisectoral Approach: Y. Kayitesbonga (Kigali, Rwanda)*
- *The Octogonal Personality Assessment: Update of a Puerto Rican Person-centered Mental Health Evaluation System: E. Ramirez (San Juan)*
- *Young Professionals' Perspectives on the Significance of Person-Centred Medicine for Future Directions in Healthcare: N. Christodoulou (London)*

2. Parallel Session on Workgroup Meetings (Large and Small Auxiliary Hall)(Sessions intended to round up the work of Pre-Conference Meetings through publications projects or progress reports)

- *Diagnostic Projects (PID, GLADP, French Project, Pediatric Project): Ihsan Salloum (Lead) (Miami), Juan Mezzich (New York), Javier Saavedra (Lima), Chris Van Weel (Nijmegen), Robert Cloninger (St. Louis), Claudio Banzato (Campinas, Brazil), Luis Salvador (Cadiz, Spain), Ken Schaffner (Pittsburgh), James Appleyard (London), Michel Botbol (Paris), Antoine Besse (Paris), Paul Lacaze (Montpellier), Elvia Velasquez (Medellin), Armando Barriguete (Mexico City), Eyal Shemesh (New York).*
- *Clinical Care Guidelines: Jon Snaedal (Lead)(Reykjavik), Neal Adams (Berkeley, USA), Roger Montenegro (Buenos Aires), Arnstein Finset (Oslo), Nikos Christodoulou (London), Elena Gayvoronskaya (Voronezh, Russia), Jitendra Trivedi (Lucknow, India), Roy Kallivayalil (Cochin, India), Yongyuth Pongsupap (Bangkok), Edmond Pi (Los Angeles, USA).*
- *Person Centered Partnership Project: Janet Wallcraft (CoLead)(London), Michaela Amering (CoLead)(Vienna), Jeremiah Mwangi (London), Terry Bamford (London), Sandra van Dulmen (Nijmegen, Netherlands), Sigrid Steffen (Salzburg)*
- *World Federation for Mental Health-INPCM Project: Mohammed Abou-Saleh (Doha and London), George Christodoulou (Athens), Helen Millar (Dundee, Scotland).*

6:00 – 7:15 PM

INPCM General Assembly (Main Auditorium)

7:30 PM

Conference Dinner (Downtown)

**CORE CONFERENCE SECOND DAY, TUESDAY MAY 3, 2011**  
**WHO Executive Board Room**

**9:00 AM – 12:00 Noon Plenary Session on Making Progress in People-centered Care: Country Experiences**

Chair: *Wim Van Lerberghe (WHO, Geneva)*

Opening Remarks: *Carissa Etienne (WHO Assistant Director General)*

Country experiences with people-centered care

- New Zealand: *Don Matheson (Wellington)*
- Spain: *Rafael Bengoa (Basque Region)*
- India: *Sanjay Kumar (Bihar)*

10:20 – 10:30 AM

*Coffee Break*

Country experiences with people-centered care

- Chile: *Ricardo Fabrega (Santiago)*
- Uganda: *Robinah Kaitiritimba (Kampala)*

Lesson and way forward – *Hernan Montenegro (WHO, Regional Office for the Americas)*

- Discussion

12:00 – 1:30 PM

Lunch (open)

1:30 – 3:40 PM

**Plenary Session on Measuring Progress towards People-centered Care**

Chair: *Somnath Chatterji (WHO, Geneva)*

- INPCM-WHO Project on Developing Measures to assess progress towards People-centered care: *Juan E Mezzich et al (New York)*
- The PC-HC National Indicators Project: *Vivian Lin (Victoria, Australia)*
- People-centered Care: from concept to operationalization: *Jan De Maeseneer (Ghent), Chris Van Weel (Nijmegen, Netherlands)*
- Panel Discussion and Conclusions and Future Efforts
- Conclusions of the Day: *Wim Van Lerberghe (WHO, Geneva)*

3:45 PM – 4:00 PM

Coffee Break

4:00 – 6:30 PM

**Session on Stakeholders' Roles and Contributions beyond Annual Meetings: Next Steps to Advance Person- and People-centered Care (Salle A). *By invitation only***

Chair: *Manuel Dayrit (WHO, Geneva)*

- Introductory Statements
  - Priorities and Needs: *Wim Van Lerberghe (WHO, Geneva)(10 min)*
  - INPCM Scope and Projections: *Juan E. Mezzich (New York)(10 min)*
- Perspectives from Collaborating Major Medical and Health Organizations.  
WMA (*Jon Snaedal*), Wonca (*C. van Weel*), Int. Alli. Patients' Organizations (*J. Mwangi*), Int Coun Nurses (*S. Schussele*), Int Fed Social Workers (*T. Bamford*), Int Coll Surgeons (*M. Downham*), Int Fed Pharmacists (*O. Bugnon*), CIOMS (*M. Vallotton*), World Fed Mental Health (*R. Montenegro*), Int Fed Gynecology & Obstetrics (*W.*

*Holzgreve*), Int Fed Medical Students' Assoc (*F. Balzarini*), Euro Fed Assoc Families (EUFAMI) (*S. Steffen*) (5 minutes each).

- Round Table Discussion on Patterns, Opportunities and Agreed Contributions (60 min)

Panelists listed above.

Additional Institutional Invitees: *M. Botbol (INPCM)*, *I. Salloum (INPCM)*; *O Kloiber (WMA)*; *N. Kureshi (Wonca)*; *M. Abou-Saleh (WFMH)*; *M. Aroca (IFMSA)*; *J. Appleyard (LAOMC)*, *A. Finset (EACH)*, *S. Van Dulmen (EACH)*, *P. Giannakopoulos (U Geneva)*, *G. Brera (Ambrosiana U)*, *A. Miles (Buckingham U & IJPCM)*, *S-D Kipman (French Psychiatric Association)*.

Additional WHO Invitees: *R. Bengoa*, *F. Celletti*, *S. Chatterji*, *J. De Maeseneer*, *R. Fabrega*, *R. Kaitiritimba*, *S. Kumar*, *V. Lin*, *D. Matheson*, *H. Montenegro*.

**CORE CONFERENCE THIRD DAY, WEDNESDAY MAY 4, 2011**  
**WHO Executive Board Room**

**9:00 – 11:00 AM                    Plenary Symposium on Education in Person-centered Medicine**

Chair: *Manuel Dayrit (WHO, Geneva)*

Co-Chair: *Otmar Kloiber (WMA, Ferney-Voltaire, France)*

9:00 – 10:00 AM

Perspectives on Education in Person-centered Medicine

(10 minutes per speaker and 15 minutes for questions and brief summary of key messages by the Chair/Co-Chair)

- British Perspectives: *Andrew Miles (London)*
- Italian Perspectives: *Giuseppe Brera (Milan)*
- Latin American Perspectives: *Ciro Maguina (Lima)*
- Indian Perspectives: *Roy Kallivayalil (Tiruvalla, Kerala, India)*

10:00 – 11:00 AM

WHO Initiative for the Transformative Scale up of Health Professional Education

- Presentation: *Francesca Celletti (WHO Department of Human Resources for Health)*
- Questions and Discussion
- Summary of key points by the Chair/Co-Chair

11:00 – 11:15 AM

*Coffee Break*

**11:15 – 12:00 Noon**

**Conference Closing Session: Summary and Next Steps**

*Carissa Etienne (WHO Assistant Director General) and Juan E. Mezrich (INPCM)*



# FOURTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

## *GALLERY OF PROGRAM PARTICIPANTS*



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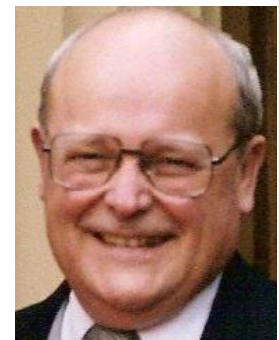


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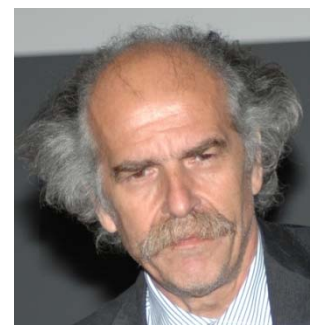
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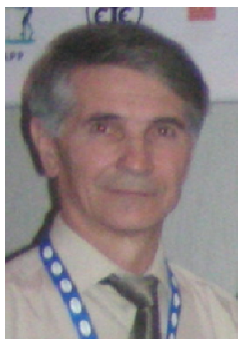
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# FOURTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

## ABSTRACTS

### PRE-CONFERENCE WORKMEETINGS

#### INPCM Workmeeting on Informational Framework

INTERNATIONAL JOURNAL OF PERSON CENTERED MEDICINE (IJPCM)

*Andrew Miles*

The *International Network for Person Centered Medicine (INPCM)* and the University of Buckingham Press are delighted to announce the publication of the first issue of their joint venture journal - *The International Journal of Person Centered Medicine (IJPCM)*. The journal will be available in print and online at [www.ijpcm.org](http://www.ijpcm.org).

*INPCM* is the leading educational, research, and advocacy organization in this field and the journal looks set to establish itself as a landmark publication of major importance to the world medical and health organizations.

The first issue of this quarterly journal will be published at the end of March 2011 and contains papers from Third Geneva Conference on Person-centered Medicine and the Conceptual Bases of Psychiatry for the Person as well as other articles.

The *IJPCM* is launched when the importance of PCM is gaining ever-greater recognition. Though science, ethics and care are the enduring traditions of the medical profession, it is PCM, in attending to the whole person and the biological, psychological, social and spiritual aspects of health which unifies these strands. Significantly, the WHO is now placing people/person at the centre of healthcare and public health, and has started discussions on adding the dimension of spirituality.

The Editorial Board of this important international Journal is drawn from all major medical specialities and health disciplines and is constituted by the world's most distinguished thinkers in the field. Regional Editors have been appointed for

North America, Latin America, Europe, Africa, Asia, and Oceania

*'The IJPCM, creating as it does an international forum for the exchange of ideas and the promotion of scholarly debate, is an extremely important contribution to the advancement and operationalisation of humanistic medicine in our times. I am honoured to be invited to be the inaugural Editor-in-Chief at this exciting time of paradigmatic change within medicine. I recommend the journal as essential reading for all clinicians and trainees and to all those academic disciplines with an interest in or responsibility for the promotion of person and people-centered medicine.'*

The ever-increasing reification of disease concepts over the past century and the associated ascendancy of numbers within the practice of medicine have tended to marginalise the very foundation of medicine which is the suffering person's immediate and subjective experience of illness and disease. Normal health is now defined in relation to a series of ideal numbers derived from every dimension of biological measurement. Yet as the great German philosopher, Hans-Georg Gadamer points out: "The limits of what can be measured and, above all, of what can be effected through human intervention reach deep into the realm of health care." There is an urgent need to relegate numbers to their proper place and to re-establish the suffering person at the very centre of the medical endeavour.

#### INPCM Workmeeting on Person-centered Clinical Care Guidelines

THE INPCM WORK-MEETING ON PERSON-CENTERED CLINICAL CARE GUIDELINES

*Jan Snaedal*

This is a workgroup meeting intended to facilitate the production of guidelines for Person-centered clinical care. Three background papers have been provided to the workgroup:

- A framework to develop guidelines on the issue for use in psychiatry, produced by Tom Sensky and Robert Montenegro
- Person-centered index, a working document of the INPCM-WHO project on Person-centered Metrics

- A list of references for evidence based knowledge.

This work is to be concluded in Clinical Guidelines in Person-centered Care to be an official document of the International Network for Person Centered Medicine (INPCM). At the end of the work-group, there should be a document that contains all the major ingredients of person-centered clinical care ready for circulation for comments before the final document is ready. The workgroup shall follow the guidelines on clinical guidelines: "Clinical guidelines should identify the key

decisions and their consequences, review the relevant, valid evidence on the benefits, risks, and costs of alternative decisions, and present the evidence required to inform key decisions in a simple, accessible format that aims to

accommodate the preferences of all those for whom the guidelines are intended (1)".

(1) Jackson R, Feder G. Guidelines for clinical guidelines. *BMJ* 1998;317(7156):427-8.

## INPCM Workmeeting on Person-centered Integrative Diagnosis

### DIAGNOSTIC ASSESSMENT PROCEDURES (CATEGORIES, DIMENSIONS, NARRATIVES)

*Michel Botbol*

In reference to person centeredness, Psychiatric Integrated Diagnostic needs to consider not only classical disorders' categories referred to ICD 10 but also other data allowing integrate positive health dimensions in each of the three relevant domains (the disorders and their consequences, the risk and protective factors, the experience of ill health and well being). This paper will discuss the assessment procedures aiming to shape and host the relevant information accordingly. Contrasting ill and positive aspects of health these procedures use categories as conflicting dimensions in a process leading to a real appraisal of the patient's health status. They do it in both their objective and subjective dimensions. While objective aspects can be approach through classical diagnostic procedures using relevant tools, subjective aspects

can be approached only through the patients', carers' and therapists' narratives.

The paper will discuss:

- ✓ The interest and reliability of these various procedures (categories, dimensions, narratives): to what extent these procedures are scientifically relevant, feasible and consistent between them,
- ✓ their adequacy to person centered purposes and to their respective objectives,
- ✓ the way they should be implemented in each of the respective domains,

the conceptual and epistemological questions raised by their integration in a common diagnostic process.

### DESORDERS AND COMORBIDITY

*Claudio Banzato*

Even though ICD-11 will be used within the PID as the reference classification of disorders, efforts have been made to simplify the classification by way of developing useful tools, which, of course, should be compatible with ICD-11. One idea, as suggested by Jablensky (2004) is to reinstate into the psychiatric realm the time-honored medical concept of 'syndrome', which has great appeal to clinicians. The adoption of this syndromic approach, with syndromes taken as grouping higher-order categories, not only could contribute to the aimed simplification, but also could lead to an increase of the validity of the diagnoses (a case has been made that the "general psychotic syndrome" is better defined in terms of boundaries than schizophrenia) (Van Os, 2011). It may be argued that the term 'disorder' is inclusive enough, but, due to its poor anchorage in medical tradition, it is also often misleading to the extent that there is a strong tendency to treat disorders as if they were diseases. On the other hand, clinicians easily tell the difference between syndromes and diseases.

Another possible advantage of giving prominence to the syndromes would be to better frame and account for the issue of comorbidity, not to mention lessening the rate of artifactual comorbidity (that is, the one that is byproduct of the classification strategy to split categorical diagnoses). It is widely known that recent diagnostic systems (DSM/ICD) have predominantly adopted a 'splitting' strategy (as opposed to a 'lumping' one), which means that from the same pool of symptoms and other clinical features, more diagnostic labels were created (First, 2005). This is certainly further complicated by the unspecific character of most psychiatric symptoms and by their lack of temporal stability. Nevertheless, as long as the presence of multiple

diagnoses is taken simply as multiple foci of clinical attention, there is no actual problem. The slicing of psychopathology could thus be seen just as part of the effort to capture the clinical complexity of the cases in the real world. But when, instead, facing multiple diagnoses, an assumption is made about the presence of multiple diseases, things get much trickier. So, perhaps, we should return to the original concept of Feinstein (who coined the term in 1970), adhering to a stricter concept of 'comorbidity', and calling comorbidity only the co-existence of diseases (or disorders) with distinct etiological and/or pathophysiological processes, be they biological or psychosocial.

Another suggestion, which could be coupled with the adoption of syndromes, is to incorporate a longitudinal framework to psychiatric diagnosis, adding, for instance, a "clinical staging" dimension. This has been suggested for the conceptualization of schizophrenia (Tandon et al, 2009; Keshavan et al, 2011). Such approach, based on a combined account of severity and progression, may prove useful for therapeutic purposes. Furthermore, as Keshavan et al (2011) pointed out, this approach – which has utility and predictive validity - has been underutilized in psychiatry compared to the rest of medicine (e.g. hypertension, cancer).

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#### TOWARDS A FORMULATION ON EXPERIENCE OF ILLNESS AND HEALTH Juan Mezzich

Person-centered Integrative Diagnosis calls for attention to experience of illness and health as one of the key levels of its structural model. Attending to the experience of illness may involve assessing suffering, idioms of ill-being, explanations and meanings of ill-being, and experience with and preferences on carers. Attending to the experience of positive health may require consideration of identity and self-awareness, self-efficacy and controlling own life, self-transcendence, resilience and positive emotions, emotional and instrumental social supports, and quality of life. Descriptive methods for assessing experience of illness and health would include categories (for example for describing idioms of ill-being), dimensions (e.g., quality of life scales), and narratives (e.g., for reporting identity and self-awareness). The evaluation process for experience of illness and health may encompass attending to the perspectives of the patient, of the family and carers, and of the clinicians, as well as the integration of such perspectives.

The above considerations would suggest the prospective value of preparing a Health Experience Formulation that would cover the following elements: Personal history, cultural identity, social stressors and supports, idioms, causes and meanings of illness, self-efficacy and controlling own life, resilience and positive emotions, coherence and self-transcendence, quality of life, clinician-patient relationship, and health restoration/promotion experiences and plans.

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#### CONTRIBUTORS TO ILLNESS AND HEALTH: AN OVERVIEW OF DISORDERS AND COMORBIDITY Wolfgang Rutz

The health definition of the United Nations and the World Health Organisation has traditionally focused on individual health as a human right, defined not only by the absence of symptoms, disorder and disease but including in the definition a state of continuous and balanced mental- and physical wellbeing.

Recently, an increasing movement on person centred treatment and public mental health promotion has started and is gaining world wide importance, not only focussing on individual persons, but even "people" - groups and populations at risk.

During the last decades the world health organisation has summarized the global research evidence on mental health and mental wellbeing and defined the following determinants of health as necessary to keep healthy and to avoid illness:

- 1) **A state of control:** Not to be helpless, to be in charge and execute mastery in your own life.
- 2) **A sense of existential cohesion and meaning:** To feel involved in an over individual context of

meaning and sense and to find individual and feasible ways to live according to this feelings.

- 3) **A feeling of social cohesion:** The need of social connectedness and relation, to experience the feeling to be needed and have others to get supported by in situations needing help, to have someone to care for and to be cared for.
- 4) **A feeling of being a person and identity by your own:** This involves feelings of integrity, identity, dignity, getting respected and the absence of alienation.

Thus, these four domains of health promotion and disease treatment will be elucidated. Self control, existential cohesion, social significance as well as personal and cultural identity have to be applied as an universal human right of all individuals and populations in a society. They will be exemplified by specific protective as well as noxious factors, adapted to the different needs of persons and peoples at risk, as e.g. age groups, genders, minorities, disabled, immigrants and others.

## STRENGTHS AND PROTECTIVE FACTORS

Janet Wallcraft

The World Health Organization defines mental health as "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community".

The key concepts for Strengths aspect of person-centred diagnosis include Mental Wellbeing; Strengths; Resilience; Protective factors for mental wellness; and Global mental health. These concepts have been developed in social work and the area of mental health promotion, but there has been a clear separation between work on positive mental health and that of doctors specialising in mental illness and psychopathology. The time has come for a greater dialogue to meet the agenda of improving global mental health with the WHO definition mental health as a goal for everyone. In this session, the concepts will be explained and a recent tool for measuring mental wellbeing will be introduced.

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## DIAGNOSIS SUMMARY, TREATMENT PLANNING AND CASE ILLUSTRATION

Neal Adams

### DIAGNOSTIC SUMMARY, TREATMENT PLANNING AND CASE ILLUSTRATION

Establishing common ground is critical to true person-centered practice. This shared understanding between the provider and the patient is central to person-centered integrative diagnosis, shared decision-making and person-centered care. Following an assessment, a diagnostic summary or formulation should be developed and shared with the patient to establish a mutual understanding that can serve as the foundation for a person-centered treatment plan. However, many clinicians are at a loss as to how to create such a formulation; forms outlines and guidelines can be helpful but cannot substitute for a genuine empathic connection and appreciation of the patient's experience and life context. There are powerful examples of how common-ground can support the creation of person-centered plans and improved outcomes.

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## INPCM Workmeeting on Person-centered Special Developments

### PEDIATRIC DIAGNOSTIC MODEL

James Appleyard

The Essential components of a diagnostic model for children are listening to, looking at and learning from the child and his or her family in a person centered way  
Listening flows from the core ethical principle of respect for a person's autonomy. It allows problems to be presented and discussed in an open way

Looking involves close observation of a person's appearance, movements, other non verbal clues and a detailed superficial inspection before a more intrusive physical examination and more invasive investigations  
Learning includes the systematic acquisition of knowledge about all the components of the child patient

Children have different physiological, psychological and pathogenic features occurring at the different ages and stages of their growth and development from the premature newborn infant through adolescence.

Information about the child's growth and development, physical, mental, emotional, social, and spiritual attributes are required so that the context within which the Child's

problems can be formulated and appropriate treatment recommended.

Sensitive information and the child or their parents 'secret fears' will not be fully shared until a professional bond of trust is established within a clear and understood ethical framework based on the seven 'core' medical ethical principles of autonomy, beneficence, non maleficence, honesty, fidelity, confidentiality, and Justice.

#### LATIN AMERICAN GUIDE OF PSYCHIATRIC DIAGNOSIS PROJECT

*Javier Saavedra*

The Latin American Guide for Psychiatric Diagnosis (GLADP) integrates the use of operational criteria and multiaxial systems and the inclusion of cultural and particular elements of each patient. The upcoming revisions of the ICD-11 and DSM-V motivated the revision of GLADP(1) and the opportunity to promote the incorporation of person centered approaches. Fifteen out of 20 national psychiatric societies have accepted to collaborate. Workgroups have been established around each main categories of ICD-10, and 3 regarding special themes. The revision is centered on updating the Latin American annotations and a special interest have been given to the inclusion of an updated person-centered diagnostic model. A survey was conducted among workgroups' members on the utility and relevance of GLADP. Forty two out of 158 psychiatrist responded: 81% were familiar with GLADP;

77.8% considered it easy to use; 88.9% adequate as an ICD-10 Latin American adaptation; 71.4% considered it useful for clinical work; 59.2%, 81.0% and 61.9% considered it adequate for community care, teaching and research respectively; 80.9% considered it to be accurate for reflecting the patient's clinical condition. Qualitative findings favored GLADP over other diagnostic systems in regard to integrative, personalized and cultural diagnostic issues. Efforts to integrate personalized comprehensive diagnosis formulations in clinical practice are crucial for an adequate clinical care.

(1)Sección de Diagnóstico y Clasificación de la Asociación Psiquiátrica de América Latina. Guía Latinoamericana de Diagnóstico Psiquiátrico. Guadalajara: Asociación Psiquiátrica de América Latina; 2004.

#### FRENCH DIAGNOSTIC PROJECT

*Michel Botbol*

French Diagnostic Project is currently at a cross road : After being focused on a widely shared opposition to DSM V principles and on advocating the counter model provided by the French Classification of Child and Adolescent Mental Disorders, the main French psychiatric associations launched various initiative around either a French participation to the ICD 11 project consultation, a new revision of the French Classification of Child and Adolescent Mental Disorder to increase its correspondence with ICD 10, and a wider dissemination of Psychodynamic Diagnostic Manual, a psychodynamic classification, an initiative of the American Psychoanalytic Association with the support of International Psychoanalytic Association. It is

only recently that all these different initiatives merged in a common reference to the Psychiatric Integrated Diagnostic seen as a common ground to each of these initiatives. Under this common umbrella everybody is now praising a permanent workshop they put in charge of Antoine Besse with the objective to adapt to the PID principles, the French proposals to WHO consultation. At the same time, the announcement and acknowledgement of the Geneva conferences has been more widely disseminated in France and in French speaking countries through the alphapsy diagnostic initiative (P Lacaze).

#### PERSON CENTERED PARTNERSHIP PROJECT

*Janet Wallcraft, Michaela Amering*

A partnership approach between health experts and users of health services and their families and friends needs to happen on different levels. User and family involvement concerns national and international strategies; policy, planning, management, evaluation and quality control of services; training and research. Also, of course, clinical encounters need to take full account of a partnership approach. During the 4<sup>th</sup> Geneva Conference the Workgroup on the person-centered partnership project aims to

- a) identify what has been achieved already in the context of the Geneva conferences
- b) define what we mean by partnership

- c) agree what this means in terms of current practice
- d) set out the vision of how we would like medicine and treatment to operate in future and what this means in practical changes to medical training, service user and family member/ carer groups and service users and carers as individuals

For this purpose we will be informed by international work on partnership such as the WHO-EC Partnership Project on Empowerment in Mental Health, the work of the WPA Task Force on Best Practice in Working with Service Users and Carers and others.

Specific regional examples such as Trialogue in Austria and Germany and New Ways of Working programmes for psychiatrists, psychologists and other health workers in the UK will be referred to for practical ways to support and implement change towards partnership.

As a result we will be clear about desirable changes as well as changes doable now and will formulate specific requests.

#### SOUTH ASIAN PROJECT *Jitendra Trivedi*

##### **Introduction:**

Person-Centred care is evolving as holistic management. Hence, considerations need to be given to all aspects of individual, involving illnesses/disorders, disabilities and all other health-related problems. The options also extend to positive aspects of health (e.g., adaptive functioning, resilience, protective factors, resources, and quality of life) (*Cloninger, 2004; Cox et al, 2007; Mezzich, 2005*). With initiative of WPA, a project has been designed to study different aspect of person centeredness in community settings.

##### **Objectives:**

To compare the outcome of person centred management versus individualised management approach in terms of client satisfaction, cost effectiveness, psychopathology and level of functioning in persons suffering with Schizophrenia at two centres in India (Lucknow & Tiruvalla); and to measure "Responsiveness" (as part of people-centeredness) in Thailand.

##### **Method:**

In India it will be Prospective follow up study over a period of three months of client suffering with Schizophrenia at two selected centres (one in North and the other is South). Each centre will have two subcentres, one for application of person centered management approach (PCMA) and other for standard approach (individualised management approach-IMA).

In Thailand, there will be a survey to measure level of responsiveness of population to different health care schemes.

**Results:** The findings are expected to be beneficial for health care planner in developing countries and will be discussed.

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#### WORLD FEDERATION FOR MENTAL HEALTH-INPCM PROJECT *Mohammed Abou-Saleh*

The World Federation for Mental Health (WFMH) has demonstrated a clear commitment over the years to a holistic approach in the care of the mentally ill as reflected in its mission statement. Since the launch of the Person-centered Medicine movement the WFMH has joined in the shared collaborative efforts across disciplines and specialities with a strong commitment to the promotion of health as a state of physical, mental and social and spiritual wellbeing and an adoption of the slogan "no health without mental health".

The WFMH has demonstrated a commitment to the INPCM to promote its longstanding principles of inclusiveness of consumers and families at the centre of the decision making process in order to reduce stigmatization, ensure fair distribution of resources, equal access to health care, and equal representation at government level. The WFMH has focused on the Great Push and the alliance we have established with the Global Movement for Mental Health. We have proposed that WFMH has an alliance/memorandum of understanding with INPCM. We see that WFMH strengths are in its global reach to NGOs

and users and carers bringing their central (person/people-centred) stake holding in the project and their paramount role in implementing the actions concerned

These key messages have been recently reiterated in the recent "Great Push" following the Call to action in the Lancet series to encourage a bottom up grass roots mobilisation of resources. The Great Push has outlined its goals in the strategic alliance with the Global Movement for Mental Health with 4 key messages :unity visibility, rights and recovery. The WFMH has already embarked on a global consensus to demonstrate the unity which exists through advocacy and shared goals and improve visibility by gathering support through campaigns such as The World Mental Health Day to effect change at an international and governmental level. The WFMH has a record of addressing issues of Human Rights and has proposed to set up a virtual centre to tackle such issues .

The WFMH has a clear recovery focus through utilization of proper assessment tools and treatment. This presentation describes the potential for an innovative global mental

health assessment tool (GMHAT) which can enable the diagnosis and proper treatment of mental health conditions using evidence based computer technology. We propose that the GMHAT in both its primary and secondary care versions be included in the armamentarium of the Person-integrated Diagnosis (PID). Through this system health care professionals can outline care pathways from assessment to treatment and address the treatment gap which exists in lower socioeconomic countries.

The WFMH has now joined with the INPCM in this international network to strengthen the global reinforcement of reaching out to other NGOs along with consumers/families to move the mental health agenda forward and promote a person centered approach to care as a key priority area in the delivery of international healthcare.

#### PERSON CENTERED CARE FOR PEOPLE ABUSING SUBSTANCE

***Ralph Tarter***

This symposium will describe the origins of individuality and how the different components contributing to individual differences in psychiatric and medical disorders need to be taken into account for prevention and treatment. The

presentations focus on the conceptual framework, method of measurement, the use of N=1 paradigms, and using addiction as the example, the importance of transgenerational integration.

#### PERSON-CENTERED YOUNG HEALTH PROFESSIONALS GROUP

***Nikos Christodoulou***

The young health professionals' workgroup on person-centred medicine (nicknamed "Janus" to allegorise diachronicity and change), was formed by an international group of people with a scope to explore aspects of the person-centred approach that pertain to young health professionals. The main platform where dialogue takes place is an online dedicated forum, which works democratically and openly for the group's

members to express their thoughts uninhibited. The group is currently working on several ideas, including conceptual issues of the person-centred approach, ethical issues related to its practical application, and its potential in specific areas such as prevention and education. Our plan is to develop these ideas into tangible projects that can be further enriched and steered during the 4<sup>th</sup> Geneva Conference.

# CORE CONFERENCE

## OPENING

### INTERNATIONAL NETWORK FOR PERSON-CENTERED MEDICINE: ACHIEVEMENTS AND HORIZONS

Juan E. Mezzich

The International Network for Person-centered Medicine (INPCM) emerged from the process of the Geneva Conferences on Person-centered Medicine, which as a paradigmatic initiative had its roots on both the wisdom of ancient civilizations and the scope of contemporary developments in clinical care and public health. The INPCM has represented since its inception the joint efforts of global medical and health institutions and of an international community of scholars both committed to the repriorizing of medicine and health care around the person as a whole and in context. It is within these broad perspectives that we can better appreciate our recent achievements. One progress sign is the increasingly growing number of international organizations that are joining forces to build person-centered medicine, from 10 in our inaugural 2008 Geneva Conference to 27 in our Fourth annual event. We must highlight among these institutions the presence of the World Medical Association which inspired and supported us from the beginning and the World Health Organization

which on the basis of the new World Health Assembly strategies on people-centered care has agreed since 2010 to co-organize the Geneva Conference and to undertake with us this year a study on the systematic conceptualization and measurement of person- and people-centered care. At the same time, our scholarly community has taken significant forward steps among which we can highlight the publication last November of the Person-centered Integrative Diagnosis model to contribute to the procedural construction of person-centered medicine and the launching this May of the International Journal of Person Centered Medicine which shall enhance immeasurably the prospects of our initiative. Finally, we can derive great encouragement from the diversity and innovativeness of our Fourth Geneva Conference displaying the vision and energy of senior and youthful contributors alike to the path-opening journey of building medicine and health that are increasingly effective and true to our vocational soul.

## Plenary Symposium on Person-centered and Contextualized Study of Disease

### EPISTEMOLOGICAL PERSPECTIVES

Ken Schaffner

Delivering both person-centered clinical medicine and people-centered public health requires a sound knowledge base involving both individuals and populations. Epistemology is that branch of philosophy that examines the nature of knowledge in general and that "investigates the origin, nature, methods, and limits of human knowledge." Application in the areas of our interest requires that we consider a broad range of levels and especially perspectives in interactions with the person. This presentation outlines a perspectives model adapted from the work of McHugh and Slavney, but now tailored to person-centered medicine and psychiatry. This adaptation prioritizes the phenomenological narrative perspective, and then situates the reductionistic biological-disease perspective, as well as the more general dimensional and behavioral perspectives, within the context of the narrative of personally delivered medical and psychiatric care. This is a

systematic scientific approach in which the various perspectives complement and inform each other. The science (in a traditional form) comes in the disease, dimension, and behavior perspectives, but now guided and interacting with the person-centered narrative perspective.

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### PRIMARY CARE PERSPECTIVES

Stephen Buetow

How can a disease be systematically studied within a person-centred framework? Put differently, how can disease, even if conceptualized as an objective, pathological deviation from a biological norm, be studied in a robust and rigorous manner that respects the subjectivity, context and uniqueness of the illness experience of the patient? As a primary care

researcher, I wish to consider these important and challenging questions by recommending a methodological menu of research options. These approaches include the use of: (1) qualitative research; (2) single subject study designs and N of 1 randomized trials; (3) pragmatic designs that include the use of case studies, mixed methods, and various approaches to

integrating quantitative and qualitative findings; and (4) measures informed by integrative theories such as Ritzer's theory of social analysis and, more recently, the multilevel,

person-centred, integrative diagnosis model suggested by Salloum and Mezzich. Such approaches to person-centred research have the potential to strengthen person-centred care.

## UNDERSTANDING DEMENTIA AND THE PERSON BEHIND

*Dawn Brooker*

It has been over 20 years since the late Professor Tom Kitwood first used the term person-centred approaches in relation to the long-term care for people living with dementia(1). In an attempt to move away from a reductionist medical model, the term was first used to bring together ideas and ways of working that emphasised communication and relationships.

The term was intended to be a direct reference to Rogerian psychotherapy with its emphasis on authentic contact and communication. Since that time, person-centred dementia care is a term that is used widely but has come to mean different things to different people. In 2004(2) I defined the VIPS model of person-centred care that *Values* people, provides *Individualised* care, looks at services from the *Perspective* of the person living with dementia and that provides the supportive *Social-psychological* support to compensate for the disability of cognitive loss. This was

followed in 2007(3) by the drawing together of 24 indicators of person-centred service provision for long term care. Within this talk I will consider these indicators and how they can be used to improve the quality of care.

<sup>1</sup>Kitwood T. (1997) *Dementia Reconsidered: the person comes first*. Buckingham: Open University Press.

<sup>2</sup> Brooker, D. (2004) What is Person Centred Care for people with dementia? *Reviews in Clinical Gerontology* 13 (3). 215-222.

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## Plenary Symposium on the Components of Care in Person-centered Medicine

### UNDERSTANDING AND SUPPORT

*Janet Wallcraft*

In the UK the concept of person-centred medicine has been accepted by Government and professional organisations as a central aspect of policy and training, but what this means in every day practice is still being worked out. The presentation will explore the considerable body of international evidence that aspects of clinician-patient interaction such as: empathy, respect, acceptance, non-judgemental attitudes, openness, information-sharing and joint decision-making lead to greater patient satisfaction and acceptance of treatment, and can also

improve health outcomes. Forms of support that have been found to be effective include peer support. Work on care pathways or journeys of recovery emphasises the need for continuity of relationships between staff and patients/service users. Some practical ways of improving clinician-patient communication, meeting support needs, ensuring care continuity and measuring outcomes will be described.

### EDUCATION AND COUNSELING

*James Appleyard*

The foundations for 'educating' and counselling lie in the establishment of Trust between physician and a person in becoming a patient.

Trust is achieved within the boundaries of medical ethics by formulating a profile of the person within a Professional Relationship of 'service' to the individual with special emphasis on the attributes of Listening Empathy and Compassion

1. Full name, age and sex
2. A list of medical and related problems including the main presenting symptoms and signs
3. Educational Achievements
4. Work
5. The family
6. Social Environment – urban/country housing
7. Culture
8. Religion/Spirituality

The **educational** Aims are

Explanation  
Understanding  
Empowerment  
Self Care  
Self Management

#### **Counselling**

Counselling is a process which includes a range of activities such as  
Consultation  
Interchange of Opinions  
Deliberation  
Judgement  
Advice  
Direction

Having mapped out the individual profile of a person the overall problems as well as specific problems can be managed by an heuristic rather than carrot and stick approach. Agreed goals identified, how they may be reached, which is the best

way and what the individual will do to achieve them. And then recognise and celebrate progress towards their achievement

#### MEDICAL TREATMENT

*Jon Snaedal*

The basis of this presentation is the work on clinical guidelines in Person Centered Medicine (PCM) that focused mainly on Psychiatry but is now being implemented in further work on PCM in other fields of medicine.

The primary components of good medical treatment in PCM are at least four: *Professional competence, ethics, communication and collaboration*. Without any of these components, the treatment will be suboptimal and the results of the treatment could be jeopardized.

*Professional competence* is the primary focus in the education and training that is provided in our Universities and Hospitals and needs not to be elaborated on further. *Medical ethics* are however more difficult to come to terms with and is subject to constant dialog even though the main outlines are fairly universal exemplified by the Declaration of Helsinki on research on human subjects. In day to day practice however, medical ethics are

subject to difference in relation to different cultures. The physician needs to take into account, not only his own ethical principles but also be aware of the expectations of his patient. This can be difficult in multi-cultural societies. The *communicational skills* of the physician are therefore of utmost importance. He needs to use all the basic skills of communication, attentive listening and displaying an empathic approach, with appropriate attention to the person's cultural, social and educational background. He must be able to negotiate a shared view of the care and to assess and understand the expectations of the patient. The physician needs furthermore to have the necessary *collaborative skills* to be able to communicate and work with other health professionals in the care of the patient as well as to enter a partnership with the patient and in relevant cases, to his/her family.

#### PREVENTION AND HEALTH PROMOTION

*George Christodoulou*

To state that prevention is better than treatment would be superfluous. Yet, in practice both prevention and promotion are difficult to implement efficiently and hence effectively. Resistance on the part of the public is one of the reasons. This can be overcome or at least be reduced by the personified approach, provided that the physician him (her) self believes in prevention.

Promotion overlaps with Prevention yet it is distinct from it in that whilst the scope of prevention is to help people avoid illness the scope of promotion is to help people keep healthy. In this context, promotion is more related to the person-centered approach as it deals with basic issues of personified care, like positive mental health, resilience, recovery, salutogenic factors (like optimism) mental capital and quality of life.

Although health promotion's targets are multiple (environmental, social and personal) it is perhaps the personal target that is of greater importance.

Interventions in prevention and promotion can be addressed to the whole population (universal) to subgroups (selected) and to individuals (indicated). It is mainly the last two interventions that are related to personified care. Under this light, attention to the needs of women, LGBT individuals and old people is clearly both selected and indicated.

Lastly, protection of civil and other personified rights is a *sine qua non* component of health promotion, especially in the mental health area.

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### First Parallel Session: Interactive Workshop on Enhancing Person-centeredness in Diagnosis and Treatment Planning

#### PERSONALIZING TREATMENT PLANNING IN MENTAL AND GENERAL HEALTH

*Neal Adams*

Treatment plans are often regarded by clinicians as a burdensome administrative paperwork requirement of little relevance to the "real" work of patient care—in both mental

health and general care settings—and too many patients are not even aware that they have such a thing as a treatment plan guiding their care. Yet, there is growing evidence that a

focus on treatment planning has the potential to be a key component to making person-centered medicine “real” and actionable beyond a commitment to the values and principles of person-centered care. At the heart of the process of treatment planning are decisions about treatment that are shared between the patient and the provider. But perhaps more important than the treatment itself is the shared understanding of the patient’s desired health and wellness

goals and the identification of the biopsychosocial barriers to those desired outcomes and the steps necessary to overcome those barriers. A treatment plan becomes an implicit and explicit social and medical ‘contract’ between the patient and clinician. This session will identify the necessary components of care and the service delivery system required to sustain person centered planning in every day care.

## **First Parallel Session: Interactive Workshop on Conducting Research on Clinical Communication**

### **HOW TO CONDUCT INTERNATIONAL RESEARCH ON CLINICAL COMMUNICATION**

**Arnstein Finset**

Communication is an important aspect of person-centered medicine. One element in the current efforts to further a more person-centered culture in medicine and health care is to promote person centered communication practices in clinical settings. In order to accomplish this aim we need research based knowledge on the associations between communication behavior and the core values and desired outcomes of person-centered medicine, such as how to develop empathic relationships between patient and provider and how person-centered encounters may promote health outcomes . We also need research to assess the effectiveness of communication skills training.

The drive for person-centered medicine is international. Therefore, research on communication should also be

international. In this paper a number of examples of international collaboration on clinical communication research will be described. Most studies are conducted in North America, Europe and Australia. However, we know that medical encounters may differ greatly in different countries and cultures. Challenges regarding intercultural research on clinical communication will be discussed.

One obstacle for international research collaboration in an area such as clinical communication research is the difficulty to obtain funding for multinational studies. The audience will be invited to share information of potential funding opportunities in different countries.

### **ADDRESSING THE PROS AND CONS OF OBSERVATIONAL RESEARCH**

**Sandra Van Dulmen**

This paper addresses the question: What are the pros and cons of participating in an observational study on communication in the consulting room between health care professionals (HCPs) and patients? After a short video-introduction on how such observational studies are (ideally) being conducted, a discussion will be held with the audience focussing on different viewpoints and concerns about participating in observational communication research. Issues that will be addressed are: the privacy of the HCP and the patient; the time investment of the HCP

and of other personnel; the ecological validity; the representativeness; and potential obtrusiveness. In addition, the prerequisites for conducting this type of research in a successful way will be reviewed as well. At the end of the presentation, the audience will be asked to vote on participating in a particular communication project or not and to explain their choice. The resulting perspectives will provide input for setting up a joint guideline on conducting person-centered research on clinical communication.

## **Second Parallel Session: Interactive Workshop on the Person with the Disease at the Center of Teaching**

### **WESTERN EUROPEAN APPROACHES**

**Salman Rawaf**

Person-centred health and health care services are at the heart of the British National Health Services (NHS). This has been achieved over the last 65 years and since the foundation of the NHS through well developed family practice where the entire population are registered with their local practices.

Various innovative approaches were developed and incorporated into the curriculum to ensure that teaching, learning and practices are sensitive to patient wishes, dignity and clinical needs. Across the whole 6 years of medical school and the two foundation years Patient Centred Education and

Communication. Examples of some of the patient centred medicine teaching include:

- Communication skills with actor patients, video with feedback from patients
- Problem based learning (case-based), often around patient experience
- Early patient contact course (called First Clinical Attachment) which allows students to engage with patients from the first days of their course, visiting them in their homes

- The use of narrative in teaching; for example we use a film called "Wit" about a cancer patient's journey
- Wide use of patient stories, eg through Healthtalk Online
- Use of patients to teach clinical skills, history taking and examination with feedback
- Patient projects in 5th and 6th year where students follow patient journey while attached to GP

- Patient journeys, increasingly integrating across disciplines (eg new attachment integrating GP and oncology, allows for focus on patient experience)
- Assessment: includes patients giving an assessment score

The presentation will address the impact of these teaching and training methods on clinicians' behaviours, patient-doctors relationship and above all the outcome(s) of the intervention.

## EASTERN EUROPEAN APPROACHES

Elena Gayvoronskaya

Shifts in medical paradigms between focusing on the disease to focusing on the whole person as well as in regard to the influence of commercialism and technologism will be examined briefly concerning the contemporary tendencies of medicine in Eastern Europe. Particular attention will be given to their impact on basic medical education, internship and residency.

Integration of knowledge will be examined through the field of psychosomatics. Teaching addressing the whole person with the disease, including clinical and organizational aspects, through pedagogy, psychology and psychiatry courses will be considered. Attention will be paid to concrete modules such as Knowledge and Meaning of a Disease, Doctor and Patient as Persons, Clinical Communication, Successful Aging, Stress and the Development of

Psychosomatic Disorders, Personal Aspects of Primary, Secondary and Tertiary Prevention, Healthy Functioning and Healthy Life Style.

Pedagogical formats, such as case studies, master classes, and teaching focused on problem solving, will be considered for the development of knowledge, skills and attitudes. The introduction of integrative perspectives to complexity and continuity of care requires guidelines in all phases of diagnostic, therapeutic and rehabilitative work. Multidisciplinary approaches, from theory to practice, can be implemented for engaging a person with a disease in the process of care.

## NORTH-AMERICAN APPROACH

Ted Epperly

Medicine in North America is transforming to being much more about the person than the disease a person has. The person's perspective is a deeply meaningful story. Their healthcare problem is a part of this story. This is not a new thought in American medicine; however, it has been one that has been relatively ignored with time pressures, incentives that reward volume over value, and advanced technology that incentivizes doing more things to people than determining if those things need to be done in the first place.

Strategies that teach these principles include how best to listen and develop the patient's story. How to reframe the visit around the patient versus around the physician. Mindfulness, joyfulness, and praise will be emphasized and how to find the balance of person centeredness without being under person centered or over person centered.

Techniques utilized in North America consist of videotaping, shadowing, organized structured clinical exams, narrative medicine, motivational interviewing, and using patients as teachers.

Additionally, there is both a gender shift and generation shift occurring in North American medicine. Much of person centered medicine aligns with these shifts. Strategies around how to deal with uncertainty, teamwork, work ethic, and life balance will also be discussed as both patients and physicians find the right relationship balance with each other to maximize the person's care and the physician's joy in their practice.

## ***Second Parallel Session: Interactive Workshop on Advancing Wellbeing and Health Promotion***

### WELL-BEING AND PERSON-CENTERED MEDICINE

Robert Cloninger

Monitoring symptoms of illness and past lifestyle behavior has failed to promote change in well-being in a strong and consistent way in either individual care or public health. A clinician's effectiveness in treatment depends substantially on his or her *attitude* toward -- and *understanding* of -- the patient as a person endowed with self-awareness and the will to direct his or her own future (Cloninger and Cloninger 2011a). Likewise, public health promotion depends on an effective

means to motivate people to desire and work for healthy lifestyle changes. Effectiveness in both individual and public health promotion requires the development of awareness of the actual causes of well-being and methods of intervention that operate at the causal level to reduce drop-out, relapse, and recurrence of illness and to promote health.

The causes of well-being operate as components of a virtuous circle of reciprocally interactive processes

(Cloninger and Cloninger 2011a). For example, emotions, cognitions, and actions have reciprocal interactions with one another. The induction of a positive mood by humor or kindness leads to a broadening of attention to be more inclusive and less defensive in thinking, which I have described as an outlook of unity (Cloninger 2004; Fredrickson 2004; Fredrickson and Losada 2005; Cohn, Fredrickson et al. 2009). In turn, an outlook of unity allows a person to cultivate greater self-acceptance, environmental mastery, creativity, which in turn lead to greater health and happiness, thereby completing the self-reinforcing cycle.

Positive emotional states can be induced by a variety of self-transcendent activities, such as acts of virtues, including cheerful humor, generosity, humility (Cloninger and Cloninger 2011a). Virtues interact with functional practices of well-being, including working in the service of others, letting go of fighting and worrying, and growing in awareness. In turn, virtues and self-regulatory functions interact with the body to promote human plasticity. Human beings are probably show greater plasticity, and hence variability, than other animal species, which has allowed us to adapt to highly variable environmental conditions successfully.

The assessment of personality in the therapeutic encounter is a crucial foundation for forming an effective working alliance with shared goals. Helping a person to reflect on their personality provides a mirror image of their strengths and weaknesses in adapting to life's many challenges. Strengths and weaknesses in TCI personality traits allow strong predictions of individual differences of all aspects of well-being (Cloninger, Zohar et al. 2010; Cloninger and Zohar 2011). Diverse therapeutic techniques, such as diet, exercise, mood self-regulation, meditation, or acts of kindness, influence health and personality development in ways that are largely indistinguishable from one another or from effective allopathic treatments (Cloninger and Cloninger 2011b). Hence the

development of well-being appears to be the result of activating a synergistic set of mechanisms of well-being, which are expressed as fuller functioning, plasticity, and virtue in adapting to life's challenges.

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## PROMOTING WELL-BEING IN DISABLED PERSONS

*Luis Salvador-Carulla*

From the wellbeing perspective, the assessment of complex conditions should not be limited to the clinical symptoms, but it should also evaluate associated functioning, impairments/disability, personal experiences (suffering, pain, spirituality and others), positive aspects, capacities, recovery and values. Even though there is a growing awareness on the application of the person centered approach to long-term care of those with severe and disabling chronic illnesses, there has not been an attempt to organise in a sound conceptual base the different key concepts involved in this new integrative/holistic approach. On the one hand, a number of international bodies, mainly WHO, have provided a global framework of Health-related Wellbeing (HrW), in areas such as health promotion, health related quality of life, and health-related functioning (ICF) (Salvador-Carulla, 2011). These concepts should be linked to the social/mental capital

approach and the person centered approach; and then incorporated both to comprehensive models of care (e.g. integrative care, social inclusion/ empowerment) and to new strategies of policy and planning such as intervention success based on the reported experiences of well-being (Shalock et al, 2011).

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## ADVANCING HEALTH PROMOTION IN LOW-RESOURCES COUNTRIES

*Yongyuth Pongsupap*

In developing countries, where resources and training were limited, health education was very often identified as a main

activity of health promotion, and was often didactic, cultural inappropriate, victim blaming, and most importantly

unsuccessful with its own terms. Education programmes were shown to have a limited impact on changing behavior. (Pongsupap, 2007) Comprehensive approach was introduced in 1986 (Ottawa Charter: providing safe or supportive environment; developing healthy public policy; develop personal skills, community action; reorienting the health service). (O'Neill et al., 2007) This approach gave a clearer emphasis on "settings" or places, where people were at work or play such as healthy cities, healthy schools, healthy hospitals, healthy workplaces, and healthy villages. (Delobelle et al., 2010) The advantages of setting approach were argued to be its emphasis on the environment rather than or not only on personal behavior, the shift away from disease focus vertical programmes, a better framework to develop community participation and a need driven approach. (Porter, 2007)

In the case of Thailand, a significant development of health promotion came in 2001 with the launching of the Universal Health Coverage Scheme as well as the establishment of the Thai Health Promotion Foundation as a health promotion funding mechanism that draw upon a 2 percent surcharge levied on alcohol and tobacco excise tax. Another significant development was the promulgation of the National Health Act in 2007. The Act embraced the principle of human right and key principles of the Ottawa Charter. These establishments have facilitated collaborations for health promotion among different sectors of the society, from the national to the grassroots level. (Buasai et al., 2007)

It was a result of dialogues not only between health personnel and people at different levels: individual; family; community; and district, and also extensive public dialogues on important health issues that enhanced public awareness on health promotion. (Li et al., 2009; Manothum and Rukijkanpanich, 2010) Smoking and alcohol consumption rates have dropped and more people have become health conscious and do more exercise. (Buasai et al., 2007) However, much remain to be done as some population groups especially the youth have become susceptible to various kinds of health risks. (Chaveepojnkamjorn and Pichainarong, 2011)

This start must be sustained and reinforced by the continuation and expansion of knowledge generation and dissemination with a strong health promotion network both inside and outside health sector as the most critical success factor.

Key words: health promotion, healthy policy, multisectoral action

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### Third Parallel Session: Oral Contributions to the Advancement of Person-centered Care

#### PERSON-CENTERED MEDICINE MUST BE CONTEXT-DEPENDENT AND METHOD-BASED

*Michael Schwartz*

How do we deal, in our pluralistic modern world, with medical practice that should be person-centered, context dependent, and at the same time population-based? In 2011, it should be abundantly clear that even a dialectic approach to this topic is insufficient, as present-day social reality requires, literally, a pluralectic. Nonetheless, in the end, what counts most of all for the doctor in day-to-day practice with the patient, now grasped holistically as a situated person in front of me? What do we seek for this patient, how do we negotiate, what is the relevant medical evidence, and how do we deal with all of it sympathetically and yet critically? A three-fold approach is herein advocated: 1) The person is the subject of medical practice. Yet, personhood is always situated and hence context-dependent. 2. Context dependency is best grasped

through a general-systems approach that is mindful of "norms" and "pathology" as described initially by Georges Canguilhem. 3. Medical practice is a discipline that must always be method-based as best described by Karl Jaspers. Canguilhem and Jaspers, respectively, can guide present-day medical practitioners to a discipline that is person-centered, context dependent, mindful of the strengths and limits of evidence, and method based.

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#### PERSON-CENTERED CARE IN CYPRUS' MEDICAL EDUCATION: THE STD EXPERIENCE

G. Lavranos, N. Papaneophytou, N. Christodoulou, S. Kyriakides, S. Michaelidou, M. Antoniadou, E. Malekou, S. Fetta.

**Introduction:** The conventional approach to the communication of medical data has long been the use of a formal announcement, either in the form of a written confidential report or orally. However, modern evidence-based medicine has stressed the need for a holistic approach, demanding more involvement in decision making and individualized procedures in terms of informed consent acquisition. The aim of this study was to examine to what extent are these principles applied in Cyprus and whether current medical education covers these needs.

**Materials and methods:** Interviews and questionnaire responses from physicians (specialized and in-training)

involved in the management of patients with STDs, especially HIV, HBV and HCV.

**Results:** Although legislation protects the confidentiality of patient records, with particular anonymity measures applied for HIV individuals, physicians of related specialties have not been given specific training or guidance on how to meet the special needs of this population and their environment. Thus, current care standards may differ according to the specific beliefs and skills of the attending carers.

**Discussion:** There is a definite need for targeted education in person-centered medicine for all physicians involved in STD care, as well as the introduction of relevant skill-building courses in undergraduate studies.

#### PROJECT PARIS: PARENTS AND RESIDENTS IN SESSION-STUDYING THE TEACHING OF PERSON AND FAMILY-CENTERED CARE IN A RESIDENCY PROGRAM.

C. Low, R. Annunziato, E. Shemesh, E. Bauml, E. Goodman, S. Church, S. Brown, D. Rode, J. Forman.

**Introduction:** Project PARIS, funded by the Picker-Gold Foundations, investigates an innovative method to teach person and family-centered care to pediatric residents at Mount Sinai Medical Center in New York City, USA.

**Methods:** Family Faculty (parents of previously hospitalized children) volunteer to present specific tenets of family-centered care to residents (physicians in training). Parents use their own experiences to discuss person-centered care, for one hour, using a manualized approach. Residents' acceptance of person-centered care is evaluated via a Likert-like scale with 6 questions, with a range of scores of 6-30. The higher the score, the higher the resident's acceptance of the role of the family in the provided care.

**Results:** The study is ongoing. For the first 5 residents, the mean pre-session attitudinal score was 22.8, whereas the mean post-session score was 27: a score increase which demonstrates that the residents' attitude has moved towards greater acceptance of person- and family-centered care.

**Discussion:** The study is ongoing; we will present more results in the meeting. At present, the results are very encouraging, as it seems that the use of parents to teach residents leads to greater acceptance of the centrality of the patient and family in providing care.

#### A PERSONAL EXPERIENCE WITH PERSON-CENTRED MEDICINE

Mohammed Abou Saleh

Recently it has been my misfortune to experience a serious physical injury-resulting in the experience of both hospital and community care in two European healthcare systems, namely Belgium and England. Moreover, and importantly, as a result of my injury I have had the experience of being physically disabled, albeit temporarily, whilst going through the process of recovery. During this period I have faced challenges and developed insights into the limitations of loss of autonomy, impaired quality of life for myself and my family.

The experience was revealing of the vagaries of care; the good, the bad and the ugly. On reflection, many lessons were learnt in relation to person-centred medicine and the totality of care: an impersonal approach, poor interpersonal and clinical communication and lack of co-ordinated and integrated care.

While specific assessment and treatment interventions were good and effective, what was less optimal was the co-ordination and integration of these elements of care. The patient is left to 'integrate' their care. The experience conjured the common quotation in Arabic "One is one's own best physician".

As a clinical teacher, I am mindful of the implications of this type of experience for enhancing the learning of health professionals, learning by experience. It is often the case that people choose a healthcare profession influenced by their personal experience of illness or illness in their families. The question arises how healthcare teachers can capitalise on this unique resource of learning by experience to facilitate the nurturing and refinement of the personal qualities of empathy,

compassion and humanism, which are the core elements and fundamental values of Person-centred Medicine.

#### COMBATING HEALTH CARE FRAGMENTATION THROUGH INTEGRATED HEALTH SERVICES DELIVERY NETWORKS Hernan Montenegro

Despite existing initiatives to integrate health services around peoples needs in the Americas, health care fragmentation remains a significant challenge. Excessive fragmentation leads to difficulties in access to services, delivery of services of poor technical quality, inefficient use of resources, increases in production costs, and low user satisfaction. To address this problem, the Pan American Health Organization (PAHO) has launched the Integrated Health Services Delivery Networks (IHSDN) Initiative to support the development of more accessible, equitable, efficient and people-centered health care models in the Region.

IHSDN are defined as a network of organizations that provides, or makes arrangements to provide, equitable,

comprehensive, integrated and people-centered health services to a defined population and is willing to be held accountable for the clinical and economic outcomes and the health status of the population served. IHSDN require 14 essential attributes for their adequate operation grouped according to four principal domains: model of care, governance and strategy, organization and management and allocation and incentives. The public policy objective is to propose a design that meets each system's specific organizational needs.

The research and evidence on health services integration remains limited; however, several studies suggest that IHSDN could improve health systems performance and people-centered care

#### PATIENT-CENTERED CARE IN PRIMARY HEALTH CARE IN THE EAST MEDITERRANEAN REGION Nabil El Kurashi

In family medicine, patient-centered health care is a continuous, comprehensive and coordinated care whose approach is centered every patient. On several studies, patient's involvement on their own medical decision-making produces great satisfaction and encourages their participation to become a more active partners of their own medical care. In this approach, the patient's input is of great importance, and this resulted in increasing the patient's confidence level for adhering with the physician to the treatment plan. It is important that the physician and the patient should agree on the problem, negotiate reasonable goals, generate options, and decide on mutually agreeable and feasible regimen. Comprehensive strategy intervention can be educational, behavioral, and affective.

This paper discusses the importance of patient-centered care and health care promotion in Primary Health Care (PHC) in the East Mediterranean Region. A study shows that patients wants their doctors to concentrate on communication, partnership and health promotion especially on ways to improve their health or prevent future illness. Fewer wanted an examination, and only a quarter of those surveyed wanted prescription. Results of a research conducted in 100 PHC patients in Al Khobar, Saudi Arabia indicate that patient-centered care is not utilized fully in PHC.

#### RELATION OF PEOPLE-CENTRED PUBLIC HEALTH AND PERSON-CENTRED HEALTH CARE MANAGEMENT: A CASE STUDY D. Stoyanov, R. Cloninger

The healthcare management is one practical tool for mediation and implementation of public health into clinical health care outcomes, and is taken in our case study as an exemplar arena to demonstrate the vital importance of the person-centered approach.

Health care personnel are threatened by the very common 'burn out' syndrome. However modern measures of burn out only establish burn out at a stage when it is fully developed. There is a lack of methods for assessment of personal vulnerability from burn out in health care systems. Therefore, our aim is to design a complex person centered model for its early detection at an initial stage of 'flame out'.

We accept the observation that decreased personal performance is one crucial expression of burn out. Low personal performance and negative emotions are strongly related to low Self-directedness, as measured by the Temperament and Character Inventory (TCI). At the same time burn-out is characterized by decreased interest and positive emotions from work. Decreased positive emotion is directly related to low self-transcendence, as measured by the TCI. Burn-out is also frequently associated with feelings of social alienation or inadequacy of support, which is in turn based on low TCI Cooperativeness.

So if performance/self-transcendence is one *severely damaged personality dimension*, then it should be damaged **on an earlier, let's say incipient stage** when it is liable to prevention. Hence we can evaluate the vulnerable populations via person centered diagnostic method like TCI and further relate well being and the psychological climate of the work place.

The proposed model can directly impact the management of human resources and related decision making. Further the introduction of such person-centered assessments can encourage and improve public health outcomes by promoting the personal well being of health care employees.

#### MOVING TOWARDS PATIENT-CENTRED CARE: HOW TO GET THERE? THE CASE OF DUTCH FERTILITY CARE Annemijn (J.W.M.) Aarts

Reproductive medicine mainly focuses on pregnancy rates and multiples as measures for quality of care. However, high-quality fertility care should not only be effective and safe, but also patient-centred. Because of the substantial emotional and physical burden of fertility treatments, patients benefit by care that is tailored to their individual needs. Patient-centredness, also known as the 'quality through patients' eyes', takes into account what in care is important to patients. However, healthcare professionals do not always acknowledge and recognize the importance of patient-centredness as a dimension of quality of care of its own right. They cannot adequately evaluate their performance regarding patient-centredness, and additionally underestimate its importance to patients.

Through a series of qualitative and quantitative research it was explored what patient-centred fertility care encompasses according to patients, how it can be measured and where improvement is needed. Analysis determined there are seven domains of patient-centredness: Accessibility; Information; Communication; Respect for patients' values; Continuity and transition of care; Patient involvement; and, Competence. Averagely, 'Communication' was the most positively experienced domain, 'Accessibility' the least. In this brief oral presentation the findings of these studies will be shortly presented and challenges for future high-quality and patient-centred care will be discussed.

#### PERSON-CENTERED PSYCHIATRY: HOW TO REACH IT? V. Krasnov

Psychiatry in era of neuropsychiatry is facing the problem to keep balance between partnership «doctor - patient» and «cool» instrumental approach in clinical practice. From one side, there is an ambitious idea to form a tailor-made, individualized treatment on the basis of pharmacogenomics and other neurobiological data. From other side, person-centered psychiatry should take into consideration very variable reactions, abilities, style of life of individuum, as well as environmental context. The question is how to combine evidence based medicine and humanistic traditions of

clinicizm. It depends not only on education and readiness of physicians, but also on changing expectations of patients. Telemedicine, internet counseling, remote control of condition are getting more and more popular, especially among technologically oriented young people. Psychiatry may be one of the last specialty saving person-to-person relationship, without neglect of new neurobiological and technological findings.

#### PERSON CENTRED PERINATAL PSYCHIATRY (PCPP): RESEARCH AND CLINICAL CHALLENGES J. Cox, P. Verhagen

In this policy paper, it is proposed that a "whole person" approach to perinatal medicine is central to an accessible, acceptable and anti-discriminatory perinatal mental health service. It is suggested that if this approach to medicine is not relevant to a perinatal service, then it is only superficial froth on the service of research and clinical work – or is "management speak", which may not motivate professionals or their consultees.

Reduction in maternal mortality in the USA and the UK, and buffering the effect of changing family structures on child development, are each contingent on a more fully integrated person centred relationship based approach.

#### References

It was argued in two recently published books that to meet the challenges of this approach required an ability to span infant and adult psychiatry, to consider the meaning and narratives of professionals and service users, to be fully aware of the dynamic of human relationships, as well as their sociocultural context – including religious rituals and spiritual practices.

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S Tyano, M Keren, H Herrman, JL Cox (2010) Parenthood and mental health: a bridge between infant and adult psychiatry. Wiley/Blackwell, Oxford

THE OCTOGONAL PERSONALITY ASSESSMENT: UPDATE OF A PUERTO RICAN PERSON-CENTERED  
MENTAL HEALTH EVALUATION SYSTEM

Efren Ramirez

Here we fully describe for the first time the **Octagonal Personality Assessment Inventory (OPA)** -the Puerto Rican Person-Centered Mental Health Evaluation System which we have utilized at the **Ocean Park Ambulatory Therapeutic Community (OPATC)** as the pre-admission requirement for all (15,000 plus) candidates for treatment since 1993. The instrument was partially validated between 1985 and 1989 while I was Assistant Secretary of Health for Mental Health of the Commonwealth of Puerto Rico. The OPA has evolved over the years to the format indicated in the power point presentation:

1. ANGLE I –**The normal personality** indicated in yellow-tinted columns marked N (no dysfunction) and L (Latent dysfunction, under control) in the mental, psychosocial, psychosomatic, indigo, temperamental, talents and character check lists. General demographic information is included in this angle.
2. ANGLE II –**Mental dysfunctions** (M-Moderate, S-Severe and C-Catastrophic) in the Attention Deficit Disorder (ADD) diagnostic indicators check list (**ADD phenotypes**). ADD phenotypes are **prodromes** of mental dysfunctions.
3. ANGLE III –**Psychosocial dysfunctions** (M, S and C) in the social behavior (**psychopathic matrix**) check list.
4. ANGLE IV –**Psychosomatic phenotypes** (M, S, and C) in the co-morbidities check list (**somatic phenotypes** are **prodromes** of degenerative diseases).
5. ANGLE V -**12 Psychic (spiritual) characteristics** and **4 Indigo sub-personalities** in the Indigo phenotypes check list (**spiritual epigenotypes**).
6. ANGLE VI –**Eight temperamental genotypes** (irrational reactivity).
7. ANGLE VII –**Eight talent genotypes** (innate skills).
8. ANGLE VIII –**Eight character endophenotypes** (executive functions).

The **Unified Theory of Personality (UTP)** that supports the OPA structure is symbolized in the **Personality Mandala** included in the power point section. Mandalic visualization meditation is useful to learn of the UTP as a therapeutic technique (**Mind Body Therapeutic Influence**).

At the OPATC we recommend a **Nutrigenomic Protocol** consisting of **Essential Nutrients (Amino Acids)** reinforced by trace minerals, especially **Chelated Lithium** (Ref. [www.club120.net](http://www.club120.net)) **instead of psychopharmacological products to achieve normality.**

The OPA serves as a guide to identify **lithium-responsive dysfunctions** (L, M, S, C) in all eight angles of the assessment and serves as an accurate monitoring resource to document treatment outcomes. The OPA system is eminently useful in promotion, primary, secondary and tertiary prevention treatment initiatives. **Linked to a drug-free nutrigenomic approach, it provides a solid empirically based comprehensive healing system available to a wide spectrum of health practitioners, who after a short training experience, can engage in preventive prodromal practice.** We envision this combination of Octagonal Assessment and Nutrigenomic Treatment as a truly world-wide primary comprehensive health system, easily available to all.

YOUNG PROFESSIONALS' PERSPECTIVES ON THE SIGNIFICANCE OF PERSON-CENTRED MEDICINE  
FOR FUTURE DIRECTIONS IN HEALTHCARE

Nikos Christodoulou

Wider conceptualisation of "the person" not only offers the opportunity for reflection and ethical adjustment of current clinical practice, but also offers the chance to shape the future directions of healthcare. This may be achieved by alerting young professionals to the leverage of this important concept, principally through training and education. To this effect, it is important to have a clear understanding of the historical and philosophical origins of the concept, in order to able to

visualise clearly its future practical applications and pitfalls. This brief presentation will offer reflection on some key issues of the person-centred approach, particularly focusing on issues that have triggered the interest of members of the young health professionals' workgroup (Janus group).

## Plenary Session on Measuring Progress towards People-centered Care

INPCM-WHO PROJECT ON DEVELOPING MEASURES TO ASSESS PROGRESS TOWARDS PEOPLE-CENTERED CARE

*Juan E Mezzich et al*

### Introduction

Building on the wisdom of ancient civilizations and contemporary clinical and public health developments, the International Network for Person-centered Medicine (INPCM) through a wide range of global medical and health institutions and a community of committed scholars collaborating on four annual Geneva Conferences and an emerging International Journal is exploring the conceptual bases and practical implications of a medicine and health care that have as center and goal the person as a whole and in context. Likewise, the World Health Organization (WHO) through the 2008 World Health Report and the 2009 World Health Assembly resolutions is seeking to upgrade public health on the basis of people-centered care. This conjunction of perspectives led WHO's Department of Health System Governance and System Delivery to collaborate formally with the INPCM in the organization of the Third and Fourth Geneva Conferences on Person-centered Medicine.

From the collaborative process outlined above arose the joint recognition of the need to conceptualize systematically person- and people-centered care and to develop measures to assess progress in these directions. This led to the formal agreement in November 2010 between the INPCM and the WHO Department of Health System Governance and System Delivery to conduct work on the conceptualization and design of measures aimed at assessing progress towards person- and people-centered care.

A key methodological approach selected for the study was that of group consultation methods, which are particularly suitable for the exploration and delineation of complex concepts. Many of these techniques are referred to under the general term of Focus Groups. Within such techniques, the Discussion Group was seen as helpful to interact with a group of experts in a flexible manner and debate general questions. Complementarily relevant appeared to be the Delphi Technique where group consensus is facilitated through iterations of individual ratings and group feedback.

### Study Design

The main components of the study are the systematic conceptualization and delineation of person- and people-centered health care and the construction and initial validation of procedures to measure progress in these directions.

The specific objectives of the study and the methods to approach them follow:

1. Exploration of the historical, clinical, public health and ethical bases of person- and people-centered health care systems in terms of distinctive procedures, services and policies. This has been approached through systematic literature reviews.
2. Identification and delineation of the key conceptual elements of person and people-centered health care. This has been conducted through interactive collaborative discussions with a Core Workgroup and a modified Delphi technique with a broad Consultation Group.
3. Development of a procedure (a Person-centered Care Index) to assess progress in person- and people-centered health systems development based on a suitable scaling of the key factors identified under objective 2. Discussion and consultation approaches similar to those listed above, plus pertinent scaling methods have been employed here.
4. Preliminary validation of the Person-centered Care Index in terms of its content or face validity and its applicability to available health systems. The Core Workgroup has been engaged for the planning of these initial validation activities and the Consultation Group for their actual execution.

The study methodology as described in a study protocol was the basis of the work agreement between the INPCM and WHO.

### Study Personnel

The Core Workgroup involved in the planning of the specific study activities has been composed of 17 experts from the Americas, Europe, Africa, Asia and Oceania, including physicians and other health professionals (nursing and social work representatives) as well as patient and family representatives. Work with them was conducted through teleconferences.

The Consultation Group included 56 international experts from across the world, including physicians and other health professionals and scholars. They responded to questions pertinent to the characterization of person- and people-centeredness, provided information on content validity of the Person-centered Care Index and conducted an exercise on its applicability.

The Project Staff included Juan E. Mezzich, M.D., Ph.D. (psychiatrist and mathematical and statistical psychologist) as study director; Luz Milagros Jara, M.D. as research associate; and Levent Kirisci, Ph.D. as statistical consultant. Secretarial support was provided by the INPCM Secretariat staff.

### Systematic Literature Review

The literature review was aimed at exploring the historical, clinical, public health and ethical bases of person- and people-centered health care systems. It involved two parts.

The first one was based on papers presented at the 2008, 2009 and 2010 Geneva Conferences on Person-centered Medicine and others in the archives of the INPCM as well as those identified by members of the Core Workgroup. The second one involved a systematic search of Pub Med using as key words "person-centered medicine, person-centered health care, person-centered clinical communication, diagnostic and treatment shared decision making, and person- and people-centered health systems". The review was conducted by the research associate under the supervision of the study director, with input and guidance from the Core Workgroup.

A tabulated summary of the literature review was prepared, containing authors and year, paper title, general content area, main results, and key ideas. Full references of the papers reviewed are presented at the end of the Report. The Core Workgroup upon reviewing through teleconferences two successive versions of this tabulated summary found it to have been quite comprehensive and useful. The Core Workgroup also found that it had been quite important to include the first source of papers given that the standard literature was just beginning to evolve concerning person-centered medicine.

#### **Elucidation, Rating, and Delineation of Literature-based Features of Person-centeredness**

Upon reviewing the tabulated summary of the literature review, the Core Workgroup identified a set of key domains relevant to person- and people centeredness in health systems. This set included first a subset of 14 domains related to "Personal Health and Care" and a second one of 7 domains related to "Public Health and services organization". In a way, the first subset seems to refer to person-centeredness and the second to people-centeredness.

The domains so elucidated from the literature were organized into a form to facilitate its presentation to and handling by the Consultation Group. The form also included space at the end for additional domains to be possibly identified by Consultation Group members. These individuals were asked to rate the importance (high, medium, low) for person-centeredness of each of the presented domains, and to identify and delineate within each domain crucial elements characterizing person- and people-centered care.

The responses received from the Consultation Group members were tabulated. It can be seen that the majority (but not all) of the domains received a predominantly high importance rating for person-centeredness. Also to be noted is that there were 20 additional domains identified by one or more Consultation Group members.

#### **Drafting of a Person-centered Care Index**

On the basis of the above mentioned responses from the Consultation Group, the Core Workgroup drafted a Person-centered Care Index (PCI). It includes 33 items nested under eight broad categories, as follows: 1. Ethical Framework, 2. Cultural Sensitivity, 3. Holistic Approach, 4. Relational Focus, 5. Individualization of Care, 6. Organization and Implementation of Person-centered care, 7. People-centered Organization of Services, and 8. Person-centered Education, Training and Research. The

rating instructions call for marking the level of presence of each indicator in a given health system using a 4-point scale: not present, moderately present, substantially present, and highly present. The PCI also calls for computing a global average score by adding the partial scores and dividing the result by the number of items actually rated. Finally, the PCI offers space at the end for narrative evaluative comments.

#### **Evaluation of the PCI Content Validity**

In addition to drafting the PCI, the Core Workgroup organized the evaluation of the content validity of the PCI through a format. This asked the members of the Consultation Group to rate six aspects of the content validity or acceptability of the PCI by using a 4-point scale that rated the degree to which content validity was fulfilled as 1) none, 2) moderate, 3) substantial and 4) high.

The results of the PCI Content Validity ratings in terms of mean, standard deviation, median, and 95% confidence interval, as well as in terms of the distribution of percentages for each of the four scale points were prepared. All six content validity aspects received quite positive ratings: the combined percentage of the top two scale points (substantial and high) ranged from 74% for the global average score to 92 % for the broad categories of person-centered care indicators being suitable and clear. The top combined percentage for the PCI as a whole seeming useful was 87%. The statistics for the quantitatively interpreted ratings (means, medians, confidence intervals) are consistent with the above mentioned frequency distributions, i.e. they were between substantial and high for every content validity aspect.

#### **PCI Application Exercise to Accessible Health Systems**

Consultation Group members were also asked to conduct an exercise to study the application of the PCI to a health system (national, city, or other) available to each of them. A wide diversity of ratings across the four levels of presence was obtained, suggesting the suitability of the PCI to cover a broad range of person-centeredness. On each of the eight broad categories of person-centeredness, the ratings of the available health systems tended to focus between moderately present and substantially present person-centeredness.

Consultation Group members were also asked to evaluate their PCI application exercise in terms of two validation aspects. Ease of completion of the PCI was rated 96% for the top two positive ratings (substantial and high levels of satisfaction), with a mean score placed between these two top ratings. Suitability of the results to describe person-centeredness of the rated health system obtained a 76% combined rating for the top two positive suitability levels, with the mean score being between these two top ratings.

An attempt was also made to analyze the ratings obtained from World Bank High Income Countries vs those in Lower Income Countries. The results of the differences between such country groups were not statistically significant possibly because of the small numbers of countries and ratings.

#### **Concluding Remarks**

The work of the International Network of Person-centered Medicine to build this paradigmatic perspective through annual Geneva Conferences and the launching of an International Journal and WHO's recent World Health Report and World Health Assembly resolutions pointing to

people-centered care as an emerging public health commitment led to the present study to advance the systematic conceptualization and measurement of person- and people-centered care.

Through a systematic literature review and the work of broad international panels using consultation and Delphi approaches a list of characterizers of people-centered care was produced, on the basis of which a Person-centered

Care Index was drafted. This was subjected to initial content validity and applicability evaluations with positive and promising results.

Next steps would include the evaluation of the reliability of the Person-centered Care Index and a fuller evaluation of its validity and applicability in a diversity of health systems across the world.

## PEOPLE-CENTERED CARE: FROM CONCEPT TO OPERATIONALIZATION

Jan De Maeseneer, Chris Van Weel

*Background and aim* The development of person centered care is based on the principle that each human is a unique autonomous entity, in illness as much as in health. In pursuing health care that is directed at the person, the determination of the human being through his social environment comes forward. This paper explores indicators for people centered public health, in order to develop an instrument to monitor the development of integration between individual, person centered, health care and people centered public health.

*Methods* This paper consists of a theoretical exploration and literature review. First the conceptual development of family medicine was explored, with its close ties to local communities. In particular the work on 'a community diagnosis' came forward as the method to address social determinants of health and secure equity of health care. This served as a template for a literature search to recruit indicators.

*Results* From the literature four sets of potentially useful indicators were identified. The first is directed at the

availability of health care for all persons in the community: available, accessible and affordable health care that is able to respond to the health problems and health threats in the population. The second is directed at the comprehensiveness of health care services, their ability to interact and co-ordinate care and provide continuity over time. Sensitivity to social and cultural variation of all groups and people must make it possible to operate in the actual context of the community. The third set is directed to the level of involvement of the population: patient participation. The last set is dealing with the professional requirements: quality management, investment in the professional human capacity, the allocation of financial resources and policy development for the local community.

*Conclusions* It was possible to identify indicators to measure, value and monitor the development of people centered public health. Further review of these indicators and field testing are needed to turn this into a robust matrix to support health policy setting.

## Session on Stakeholders' Roles and Contributions beyond Annual Meetings: Next Steps to Advance Person- and People-centered Care

WORLD MEDICAL ASSOCIATION (WMA)

Jon Snaedal.

The World Medical Association (WMA) is an association of National Medical Associations and according to the bylaws of WMA, only one Association from each country can be a constituent member. Each National Association needs to represent most doctors in the respective country. As almost 100 countries are represented, amongst those all the most populated ones, it can be argued that the WMA is representing the majority of doctors in the world.

The major issues of the WMA are medical ethics but various socio-medical issues are also discussed and policies on those are accepted after thorough dialog. WMA has been formally involved in the organization of the four Geneva Conferences on Person-centered Medicine since 2008 and is a formal member of the International Network for Person-centered Medicine.

The WMA does not have a policy on person centered medicine per se, but the various issues of the person with

medical problems is addressed in many policy documents.

The rights of all persons participating in medical research are stipulated in the Declaration of Helsinki, the rights of patients to treatment (and not to accept treatment) is found in the Declaration of Lisboa and the International Code of Medical Ethics, the duties of the doctor to his patients are clearly stipulated.

In most of the policy documents of the WMA, patients are mentioned rather than persons with a disease or symptoms. In face of the dialog that now has been ongoing for some years on person centered medicine, it could be time to change these phrases and the WMA should establish a policy on person centered medicine.

Ref.: [www.wma.net](http://www.wma.net)

INTERNATIONAL FEDERATION OF SOCIAL WORKERS (IFSW)  
Terry Bamford

The International Federation of Social Work comprises over 80 national member associations representing over half a million social workers.

Health is an issue of human rights and social justice. These two central social work values frame IFSW's understanding that all people have an equal right to enjoy the social conditions that underpin human health and to access services and other resources to promote health and deal with illness.

Social workers engage every day with people struggling to achieve these rights but blighted by poverty, social exclusion, and the physical and emotional consequences of violence and trauma. The social determinants of health have two key influences- first on health chances in terms of life expectancy and wellness, and secondly on health experience in terms of the resources available to combat illness and promoting health. Social work's core health role is engagement with the economic, social political and environmental factors which determine health chances. Its secondary role is helping to

secure and expand the resources available to improve access to health. Social workers in health settings play an important role in helping people to access health care, manage treatment decisions and secure resources to promote treatment at home.

Social work principles mean that social workers see those with whom they work as co-workers and partners seeing them as experts by experience in managing their conditions. This is particularly relevant in the mental health context.

As a consequence of this perspective social workers see themselves as allies of the public health movement building on the Alma Ata declaration and the WHO definition of health.

References: IFSW Policy statement on Health, 2008, [www.ifsw.org](http://www.ifsw.org)  
WHO Commission on Social Determinants of Health, 2008

INTERNATIONAL PHARMACEUTICAL FEDERATION (FIP)  
Olivier Bugnon

Founded in 1912, the International Pharmaceutical Federation (FIP) is the global federation of national associations of pharmacists and pharmaceutical scientists in official relations with the World Health Organisation (WHO).

Both internal and external forces are steering the course of modern healthcare and in turn how each profession can best contribute to it. Recognising this fact, FIP has developed for 2020 a new Vision, Mission and Strategic Plan. Person- and People-centered Care is part of these reflections [see [www.fip.org](http://www.fip.org)].

*Efficacy* and *Effectiveness* are terms used for describing how well a treatment achieves desired outcomes. *Efficacy* describes the performance of an intervention when delivered under optimal conditions. However, *Effectiveness* refers to the results of the individualized therapeutic relationship in routine care. The *Efficiency* represents the ability to produce some desired clinical outcomes with a minimum of effort, expense or waste. FIP assumes that the pharmacists, in collaboration with the other health care providers, can contribute to bridge the gap between the 3 E's – efficacy, effectiveness and efficiency of the medicines, which demands an urgent and fundamental evolution of health care systems.

An effective strategy for implementing any change of practice should combine 3 development axes: 1<sup>st</sup>, a research and development axe, 2<sup>nd</sup>, based on the first one, an education and coaching dimension; and 3<sup>rd</sup>, regulations for supporting the practice by quality care standards and appropriate financial incentives. Particularly for us pharmacists, there is a clear need for a new services based oriented remuneration system instead of the common system based on profit margins.

Concerning Practice and Policy,

FIP first adopted the guidelines for Good Pharmaceutical Practice in 1993. These guidelines were developed as a reference to set up nationally accepted standards of Good Pharmacy Practice. They have been subsequently adapted

and adopted in a wide number of countries. They recommend for national standards to be set:

- The promotion of health;
- The supply of medicines, medical devices, patient self-care;
- Improving prescribing and medicine use by pharmacists' activities.
- ... **and more recently developing collaborative pharmacy practices**

FIP is actively working on the publication of a Statement of Policy on Collaborative Pharmacy Practice, which is defined as the clinical practice where pharmacists collaborate with other health care professionals in order to care for patients, carers and public. FIP identified 5 levels of collaboration, from minimal contact between pharmacists and other healthcare professionals, until level 5 with Advanced Collaborative Practice when pharmacists are given authority to initiate or modify a medication therapy.

Concerning Education and Research, I would like to emphasize 2 major FIP developments:

To ensure access and appropriate use of medicines, there is a need for an appropriately-trained pharmacy workforce.

1. In November 2007, FIP, in collaboration with the WHO and United Nations Educational, Scientific and Cultural Organization (UNESCO), formed the **Pharmacy Education Taskforce**. The purpose of the Taskforce is to oversee the implementation of three domains of action: quality assurance, academic and institutional capacity, and competency and vision for pharmacy education.
2. The FIP Academic Institutional Membership, or FIP AIM, allows Faculties and Schools of Pharmacy to become inter-connected on a global platform of

discussion, leadership and shared challenges and successes. The FIP AIM, focuses on the parallel evolution of Faculties and Schools of Pharmacy alongside the ongoing changes in pharmacy practice, science, research and their respective funding.

Person- and People-centered care is considered as major topic in both projects.

#### Illustration by a successful example:

To highlight the importance for simultaneously integrating Research, Practice Standards, Education and Regulation for achieving the change implementation, I will show you one example of a successful programme in 42 nursing homes of a Swiss canton.

In March 2011, the state government edited a Policy, that approved the practice standards and the remuneration system of a specific pharmaceutical service. While general services including legal requirements, drugs stock management and drug supply remain the core activities for the pharmacists in a nursing home, they have been asked to accept even more responsibility for safer and more cost-effective use of drugs. By analyzing the data of medical prescriptions, the pharmacist identifies some effectiveness and efficiency priorities. The

pharmacist stimulates the discussion with the physicians, the nurses and members of the administrative direction until the definition and the application of more efficient therapeutic consensus.

The political recognition of this programme was obtained because its performance was clearly demonstrated by the research team(1): the annual drug costs per resident decreased by about 20% between 2002 and 2010; the mortality rate decreased also significantly without any cost transfer on the hospital budget. This is in fact the result of a long term strategy of collaborative practice implementation and interdisciplinary continuous education. Nevertheless, it should be mentioned that the main factor which enabled this political recognition was due to the fact that the population itself had become aware of the advantages of the People-centered Care effort as stated in the following wide-spread newspaper cutting: "This is the collaboration of all which allowed to contain the costs of drugs. This bright innovation was related to the networking of nursing homes, general practitioners, pharmacists, nurses and insurers."

(1)[Locca, J.-F., Ruggli, M., Buchmann, M., Huguenin, J., Bugnon, O. Pharmacy World and Science (2009); 31 (2), pp. 165-173]

### COUNCIL FOR INTERNATIONAL ORGANIZATIONS OF MEDICAL SCIENCES (CIOMS)

Michel Vallotton

A great part of the activities of the Council for International Organizations of Medical Sciences (CIOMS) are remotely related to the concept of person-centered medicine. They deal with pharmacovigilance in the broader sense including early signal detection of side-effects of drugs, harmonization of the terminology of symptoms and signs of side-effects, harmonization and survey of follow-up after vaccination particularly in low-income countries to establish pharmacovigilance in this particular field. Recently a new working-group has been formed with the task of edicting rules and criteria for inclusion of studies in the procedure of meta-analysis. The other major endeavours reside in the field of medical bioethics in research. An ad-hoc committee will examine this year the desirability of revising the CIOMS 2002 International Ethical

Guidelines for Biomedical Research Involving Human Subjects in the light of the latest version of the Helsinki Declaration of the WMA and the recently revised version of the CIOMS 2009 International Ethical Guidelines for Epidemiological Studies. In those guidelines the concept of person is central. All these informations can be retrieved on the web site : [www.cioms.ch/](http://www.cioms.ch/). At the end of last year, the Executive Committee and the General Assembly of CIOMS elected, as new president, Johannes H.H. van Delden, MD PhD, professor of Medical Ethics at the University of Utrecht, NL. and, as second vice-president, Ola Dale, MD PhD, professor of Pharmacology/Anesthesiology at the University of Science and Technology, Trondheim, N.

### INTERNATIONAL FEDERATION OF GYNECOLOGY AND OBSTETRICS (FIGO)

Wolfgang Holzgreve

The International Federation of Gynecology and Obstetrics (FIGO) which has member societies in 124 countries/territories across five regions, supports the concept of Person-Centered Medicine, because our global organization shares the value of person- and people-centeredness, ethical aspirations, communication skills and respect for cultural diversity. Therefore we were happy to participate actively and to support the Third Geneva Conference and now the Fourth Geneva Conference on Person-Centered Medicine.

FIGO was founded in 1954 in Geneva, and its ambition from the beginning was to bring together professional societies of obstetricians and gynecologists on a global basis ( S. Arulkumaran and H. Ludwig 2004). It grew from an organization representing 42 national societies who attendes the founding meeting in Geneva into a truly international organisation which is funded through subscriptions received from member societies, grants and the proceeds of its triennial World Congress. Lately FIGO is more and more recognized almost as an NGO and receives grants from major charity organisations such as the Bill and

Melinda Gates Foundation for partnership programs in Africa and Asia. FIGO's mission is to promote wellbeing of women and to raise the standards of practice in obstetrics and gynecology around the world. One of the main tasks of FIGO has become to help with promoting and achieving of the so-called Millennium Development Goals by 2015 especially in the area of safe pregnancy, motherhood and newborn health. Furthermore the commitment statement of FIGO ( FIGO website) lists as important aims:

- Improving communication with and between member associations and building the capacities of those from low-resource countries through strengthening leadership, management, good practice and the promotion of policy dialogues.
- Strengthening capacities to enable societies to play a pivotal role in the development and implementation of sustainable programmes aimed at the improvement of care available to

women and newborns, especially for poor and underserved populations.

- Recognising the importance of collaborative efforts for advancing women's health and rights, FIGO is committed to strengthening partnerships with other international professional organisations, UN agencies, and the public/private sector to achieve its objectives.

The trend for more person-oriented medicine has reached the area of obstetrics and gynecology which in itself covers a wide spectrum of subdisciplines, from fetal-maternal medicine, obstetrics, benign gynecology, cancer medicine, endocrinology, reproductive medicine, urogynecology to psychosomatic medicine, and therefore FIGO is happy to advance person- and people centered care in women's health all around the world.

## INTERNATIONAL FEDERATION OF MEDICAL STUDENTS' ASSOCIATIONS (IFMSA)

Federica Balzarini

The IFMSA is a non-political and non-profit organization established in 1951 and including now more than 100 national member organizations, representing over 1.2 million medical students. During medical training, in addition to biomedical sciences, students need social sciences, medical ethics, humanities and understanding of the influence of religion to be able to apply a person-centered medicine, defined as "promotion of health as a state of physical, mental, socio-cultural and spiritual wellbeing as well as to the reduction of disease" (1). If we truly desire for the population we serve to meet these standards of wellbeing, then we need to address the social determinants of health. IFMSA believes (2) that health-enhancing policy options and a holistic understanding of what causes disease must be addressed by the health professions together, changing the way we train future health professionals, in order to create an education which meet the challenges that cause the health inequities of the 21st century (3,4).

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## EUROPEAN FEDERATION OF ASSOCIATIONS OF FAMILIES OF PEOPLE WITH MENTAL ILLNESS (EUFAMI)

Sigrid Steffen

EUFAMI is committed to the principle that care for people with mental illness must be focused on the individual person and not on his or her symptoms. This protects both the specific and common interests and needs of those who have a psychiatric illness and their families and relatives as well. Thus Eufami spreads information and knowledge of severe mental illnesses in order to contribute to public understanding and to respect for the ill persons and their families. In this way Eufami attempts to influence politicians, public authorities and institutions to develop their care and rehabilitation programmes further, based on the special needs and life circumstances of the individuals with the illness.

Sigrid Steffen, President of EUFAMI, will highlight the important role which families and carers can play in the advancement of person-centred care. And she will show how this goal can only be achieved if families and carers are brought more into the mainstream care system and also be recognised for the important contribution which they can make to the treatment programme overall. For far too long, families and carers have been dismissed as being irrelevant to the care process and in many cases, simply ignored. But this is now changing thanks to the interventions which EUFAMI and others have undertaken over the past several years with the various medical and nursing professional bodies.

## Plenary Symposium on Education in Person-centered Medicine

### BRITISH PERSPECTIVES

Andrew Miles

Now that the philosophical basis of person-centered clinical practice (PCM) and people-centered public health (PeBPH) has been coherently described and that their relationship as entirely complementary and mutually reinforcing models of healthcare is increasingly well acknowledged, the time has come to move these clinical philosophies away from their current status as universally recognised *conceptually optimal* models of care to the status of *operationally normative* models of care. To do so has become an urgent international priority, given the reductionism and deprofessionalisation of medicine that has occurred over recent decades, so that the human costs increasingly associated with these negative developments can be properly addressed. The challenges involved in driving this change are formidable and should not be underestimated. They include not only the need to design and develop the detailed methodologies necessary to enable the operational implementation of PCM-PeBPH models of care, but also the need to design and apply systematic audit tools aimed at the quantitative measurement as well as the qualitative description of the improved health outcomes that will be generated by PCM-PeBPH interventions. The latter is important in order permanently to imbed the cultural change necessary to sustain these new models of care and also to create and maintain the political investment and funding necessary to guarantee their continued operation. If this thesis is accepted, then it is advanced that effective educational interventions at both undergraduate and postgraduate level are central to achieving these aims (not just within the UK, but internationally) and that specific university-led educational change should occur in parallel with other, internationally directed work, designed to describe operational models for PCM-PeBPH care for a wide range of epidemiologically important clinical conditions.

In the United Kingdom, it has been suggested that lectures on humanistic medicine should be introduced into undergraduate medical training with immediate effect through an essentially simple modification of existing curricula, so that humanism is learned concurrently with bioscience, indeed, quite literally, from 'Day 1' of commencement of study. It is increasingly clear, after all, that patients do not wish to be 'dealt with' by technicians in applied bioscience who seem increasingly to regard them as diagnostic codes, but that they wish to be attended by scientifically trained advocates who are competent in dealing with their problems not only at an organic, but also

at a psychological, emotional, social and and spiritual level, so that patients are treated as persons and not as statistical units. Inculcation of the fundamental principles of PCM-PeBPH approaches to care at undergraduate level via systematic education delivered in an inspirational manner is fundamental to achieving this vision. Neither can education only at the undergraduate level be anticipated, of itself, as sufficient to change the nature of medical practice away from scientific reductionism towards the embrace of the complex in clinical practice. Indeed, just as the entirely necessary undergraduate grounding in bioscience must be followed by advanced study of technological advance through postgraduate education, so must, then, this undergraduate grounding in the humanism necessary for the proper application of advances in bioscience be followed by advanced postgraduate study of the same. Here, the need to develop Master's degrees in PCM-PeBPH (to mature the student's understanding and skills) and Doctor's degrees in PCM-PeBPH (to create the transformational leaders for the future) becomes immediately clear. Such educational interventions can be operated at national level within specific countries such as the UK, or at international level, where students return to their countries with the knowledge necessary to assist the operational realisation of local change. Finally, while university-led education of this nature is of indisputable importance, such initiatives cannot reasonably or probabilistically be expected, independently, to provide all of the knowledge and skills necessary to drive transformational change in everyday clinical practice. It is here, then, that internationally designed and directed projects aimed at elucidating what PCM-PeBPH models of care *actually look like and precisely involve* for specific clinical conditions (e.g. Diabetes, HIV/AIDS, the solid and haematological malignancies, etc) will be quite vital in creating the so-called 'toolkits' to effect humanistic progress in modern healthcare. For we must be quite clear that vision is nothing without method. Thinking on these matters, originating within the United Kingdom and which is resulting in the first such initiatives becoming scheduled for operation commencing February 2012, will be presented in outline at the Fourth Geneva Conference.

### ITALIAN PERSPECTIVES

Giuseppe Brera

1 Person Centered Medicine is the foundation of the first paradigm of Medicine and Medical Science, enunciated in 1999 in the " Person Centered Medicine Epistemological

Manifesto", a change from the dominant intrinsic bio-molecular one.<sup>1</sup> i

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<sup>1</sup> Brera G.R. The manifesto of Person Centered Medicine. *Medicine, Mind Adolescence*, 1999; Vol. XIV, n. 1-2,

- 2 The paradigm key words are : Being person", Teleonomy, Objective ethics, Interactionism, Indeterminism". The paradigm change event is similar to the Physics paradigm change from mechanistic to quantum one at the beginning of the last century.
- 3 Being person- teleonomy and ethics -Epistemological and teleological roots of the PCM paradigm at philosophical level are the ancient Greece philosophy: the Socrates epistemology,ii Hippocrates ethics and epistemology,iii Aristotle's metaphysics,iv and the Aristotle's based Boethius Roman philosophy, (first Person's definition)v,the Tommaso d'Aquino's medieval philosophy ,vi the Husserl's phenomenology and Edith Stein's philosophyvii , the modern personalism of Josef Seifert,viii Kairol Woitila, Romano Guardiniix , Popper-Eccles interactionism, and Kaiology x xi.
- 4 The scientific theoretical pillars of interactionism are : at Physiological level : "Allostasis theory" xii, at genetic level "Epigenetics" xiii, at clinical level "The Relativity of Biological Reaction to coping possibilities and quality" xiv xv based on the Psycho-Neuro-Endocrine -Immunology xvi and on the "Affects science".xvii The theory introduces the concept of "Biological reaction" and into Medicine the concept of "Resilience" like action of protective factors determined by the person's possibilities and resources for health as product of coping possibilities X quality. The philosophical and existential words "possibility" and "resource" entered into laboratory and traditional clinical method and demarcated Medicine, from medical Science, with a return to the Clinics priority. The person's health is an human holistic constructive concept that can be realized only in the person-physician/nurse relationship not a fragmented biotechnological adaptation to scientific theories, built in laboratory, to which mouses can give only a limited contribution. Suffering hides the human being work to reveal to himself the "Being person" , a realized human identity , joined by it to biological reaction at molecular level. xviii
- 5 In the light of the science revolution the health concept can be reformulated like a *music* , result of a player's art who reading a score (DNA-gene expression) pushes three orders of keys belonging to three interacting fields of knowledge and existence: *Subjectivity* (symbolic level : empathy,affects,emotions,values) ,*Biology* (empirical variables at physical or molecular levels),*Environment* (interpersonal relations, physic environment). (S-B-E Person Centered Health System)xix. To date health appears to be related to more or less person-dependent indeterminate interpretation driven by a deep soul research of unity,harmony, love,truth and beauty, expression of the human being research of a fulfilled meaning xx ( Tommaso d'Aquino's "Actus humanus" ) , *a possible protective or risk factor, constituting the concepts of resilience and vulnerability ,depending on the result of the person's quality of life* ,result of its interpretation and integration of environmental, subjective, biological possibilities
6. A new scientifically and existentially based Health definition is possible: " The best possibilities for the best being"
- 7 In Italy to the aim to apply and teach PCM clinical applications and form clinical teachers' starting from the Medical Counselling structure (1991) in 1998-1999 AY at the Milan School of Medicine, the Person Centered Medicine Clinical Method (PCCM) and its teaching method was theorized and taught with standardized quality procedures xxi posed in the Ambrosiana University quality system. From 1998 national and international courses and conferences and workshop were promoted. In 2008 the Person Centered Medicine International Network has been founded to study and to spread a Person Centered Medicine Culture all over the world. xxii xxiii xxiv .
- 8 In the Milan School of Medicine the PCCM steps are taught in three phases corresponding to three years of learning procedures. Physicians learn the "Diacrisis procedure" generating, perceiving and modulating the PCM positive "Anthropic field" made by the "Acceptance-Comprehension-Help" attitude and the "Empathic assessment" applying the "Analogical thinking". They learn to "Put into commas " (Clinical Epokè) the empirical diagnosis anxiety (if there is not a biological emergency) and to learn art and method of the "Person diagnosis", to run a physical examination interacting with the person like a subject and to resume three-dimensional findings in the "Cross Model" form , studying resilience and vulnerability. They learn to make "Clinical Hypothesis", studying the interaction of environmental-subjective-biological variables and to plan "Person centered clinical objectives"(using variables belonging to Mind- Body and Soul) and a "Clinical synthesis" defined like " Clinical portrait". "Soul" is considered as the quest for an existential meaning and the religious faith is seen according scientific research as an important subjective existential resource (protective factor). Physicians learn to apply the PCM clinical sheet. The educational objectives are to put into parenthesis the anxiety diagnosis in comatose patients, the education to an analogical process in the empathic phenomena lecture and definition in 1 minute at the beginning and over the entire clinical relationship, the structured analysis of strength and protective factors before problems according the S-B-E Person Centered Health System, studying how the person interprets ,organizes the interactive dynamics between protective and risk factors and their existence possibility and creating at therapeutical level the S-B-E best possibilities for health.xxv xxvi
- 9 In 2003 the first investigation on PCCM effects in clinical resulted in a better comprehension of patients (95%) the improvement of the health and life quality of patients (75%), in avoiding useless examinations and drug prescriptions, (70%) sparing unnecessary hospitalizations ( 55%) but requesting more time to dedicate to patients (55%). PCCM effectiveness in saving useless examinations and drug prescription is significantly associated to the medical role (P=0.02). MP (100%) and Pediatricians ( 85%) declare that PCCM is effective in sparing useless examinations, drug prescription and unnecessary hospitalizations . There is general agreement about the necessity and importance of learning and spreading PCCM. With the data assessments by Lombardia Region about drugs prescription, data about a trained pediatrician's prescriptions were measured. Data confirmed the described reduction of drug prescription in an amazing way, such us to suppose that the spreading of Person Centered Medicine, could lead not only to the improvement of the patient's wellbeing but also to an important save of money for health systems. xxvii
- 10.The necessity of an international worldwide policy in Medical Education and the necessity to spread medical and health professional Education according to Person

Centered Medicine xxviii make necessary health governance programs and plans establishing a prevention and clinical shift at every level (institutional, regional, national). The general objectives ought to be the general change of the Medicine clinical applications and health assistance method toward the Person Centered Clinical Method to be realized before in primary health. The key changes are the involvement of public and private Medical Schools and health Institutions with the preparation of clinical teachers in PCCM using standardized procedures (we made available ours already experimented for many years) and the Medical Education research on their efficacy ought to be measured on the base of quality procedures to be tested and experimented into medical education of Physicians and health professionals at every health system level. A second step is to arrive to a quality certification of institutions and physicians related to the salary and funding system. The key problem common to all the medical schools and faculties, is to build an interactionist curriculum in pre-clinical courses, to be started at the third year the medical counselling teaching and to "convert" to interactionism clinical and laboratory investigators. At medical education level the objective is forming clinical teachers to apply and to teach PCM and medical Counselling. Where there are teachers certificated in Education to PCM application it is necessary to start postgraduate courses addressed to primary health physicians. This is the policy of Ambrosiana University that structured from 2001 a national MA, a Licentia Docendi, and from 2009 an International School in PCM, sharing the same quality educational procedures. To date in Italy and outside Italy our perspective is to involve medical schools and public health institution and at individual level, physicians and health workers to learn PCM application method and its teaching through a combined action of the Milan School of Medicine - Person Centered Medicine International Academy (PCMIA)xxix born in 2010, addressed to Medical Education (ME) and to research on PCCM applications and ME. This operation is addressed to create all over the world local certificated teachers and researchers and Magistri in medical Education to teach education methods in PCM. The second PCMIA important objective is to create a Quality Certification International Agency for Person Centered Medicine ©, addressed to medical education and to research on the PCCM applications quality procedures and Medical Education. In a first phase it will be addressed to directly certificate Physicians, teachers and Medical Schools, Health institutions and in a second phase National Agencies. PCMIA recently instituted Person Centered Medicine Europe a program whose funding is requested to EU in order to create a PCM European PCMIA programs in medical education and research. The financial program foresees for PCMIA and also for PCMIN a Foundation in Person Centered Medicine for funding Medical Education, Research and conference programs whose constitution is in progress with the research of private and public contributors."

In the less developed countries, where infectious disease are prominent and where health habits are nomothetical and more dependent by culture than individual choice, the PCCM could offer noteworthy possibilities to develop subjective resources with the maturation of an individual sense of responsibility, contributing in this way, to

the development of countries. Obviously this cultural operation must cope with the existence of survival possibilities. Public health measures must enhance the quality of the environment dependent protective factors and possibilities and PCCM is a good method to enhance person's individual resources at S-B-E level. Person Centered Medicine and Person Centered Health Care ought to enter into the public health programs of every country to assure "The best possibilities for the best being".

Social work is a valuable partner in the multi disciplinary team. The worker brings to the team a different perspective of the patient seeing them in their family and social context. Bringing an awareness of the social environment in which the patient operates helps the team to get a more rounded picture. Sometimes the social circumstances, for instance poor housing or poverty may inhibit the ability of the patient to follow the prescribed treatment, or carer responsibilities may make it impossible for the patient to rest and recuperate.

The commitment to service users and their empowerment is at the heart of contemporary social work. Working with the patient and encouraging the patient to direct their own care as fully as possible is both good social work and also good clinical practice.

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#### LATIN AMERICAN PERSPECTIVES Ciro Maguiña

During the Past few decades, a process of dehumanization of medicine has been taking place, making us lose sight of human beings' integrity and complexity

For this reason, we must work as an inclusive team, looking for every source of knowledge in order to improve quality of health care, including complementary and alternative medicine

In our medical school- Cayetano Heredia University- from the very first years we are teaching our students about how to deal with patients on the basis of horizontal and symmetrical relationship between patients and physicians.

We as Physicians must pay attention to professional , ethical, human, and cultural aspects when treating our patients.

For the reasons, the Peruvian College of Physicians last year 2010 instituted the patient's day, a day for deep thought about health and disease.

In Brazil, since 2003, there is a strong political commitment for rehumanization of medicine.

Also, Argentina and Uruguay have been taking steps towards humanization of healthcare .

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#### INDIAN PERSPECTIVES Roy Kallivayalil

India is one of the largest economies of the world. There has been remarkable development especially in the health sector, where budgetary allotment for health has trebled during the last decade. But with a population of 1.2 billion people, India is also facing massive challenges to the health care delivery system. With the advent of the era of globalization, commercialization is raising its head in many parts of the

country. Medicine is being seen more and more as an industry (whose motive is to make profits) rather than as a humanitarian service. With the opening up of medical education to the private sector, costs of medical education has become exorbitant to many.

Psychiatry is the one subject which is imparting education in person-centered Medicine during the under-graduate (MBBS)

course. But this branch has been largely neglected in the training of the medical graduates by the Indian Universities, Central and State Governments and the Medical Council of India. For the last three decades, Indian Psychiatric Society has been striving to make Psychiatry as a compulsory subject with examination during the MBBS course, but the efforts have not succeeded. Due to the sustained efforts of the Society, Psychiatry has now been made a compulsory subject for internship for all medical graduates. This has been a positive development.

Medical teachers in India have several times reviewed what is necessary for developing countries like India. Here Medicine is not only the most coveted but also the most expensive and needs the longest time to study. The chances of an Indian to become a medical doctor is 1:1,000. But the availability and the dependability of this one person makes life and death difference for the rest 999. In countries like India, the part that gets most attention and recognition is the relatively small tertiary segment with advanced technology and highly sophisticated procedures.

Advocates of person-centered medicine in India have argued, the health of the country can be assessed by three factors i)

whether every pregnant woman will deliver safely ii) whether every child grows to become healthy adults and iii) how long the adult lives without morbidity. Tertiary care medicine makes little difference here, but person-centered medicine will make a huge and positive impact.

Teaching Psychiatry in undergraduate medical training, supporting the branch of Family Medicine, training lay counselors and social workers, co-operation with NGOs, religious and spiritual leaders and advocacy are part of the future agenda for education in person-centered medicine in India. For this, we need the support of all and most especially WHO and the International Network for Person Centered Medicine. We look towards the future with optimism.

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#### THE WHO INITIATIVE FOR THE TRANSFORMATIVE SCALE UP OF HEALTH PROFESSIONAL EDUCATION Francesca Celletti

1. The World Health Report 2008 highlighted insufficient recognition of the human dimension in health as a major shortcoming in contemporary health care, resulting not only in inequities and poor social outcomes, but also in diminishing returns, in terms of health outcomes, on the investment in health services. Person-centered healthcare aims to tailor health systems and services to the specific situation of individuals and communities; that is to orient and organize services around the health needs of individuals and populations.
2. The implications of person-centered medicine for the education and training of healthcare providers is to strive for a more balanced focus between disease, technology and providers needs and the health needs, values and preferences of individuals and populations. As stated in the World Health Report 2008, to put people first means to give balanced consideration to health and wellbeing as well as to the values and capacities of individuals, populations and health workers.
3. Yet today, the education of health care providers too often develops skills, competencies, clinical experience and expectations that are poorly suited to the health needs, values and capacities of much of the population.
4. In addition, we are currently facing a severe global health workforce crisis with critical shortages, imbalanced skill mix and uneven geographical distribution of health professionals, leaving millions without access to health services.
5. The transformative scale-up of health professional education aims to support and advance the performance of country health systems so as to meet the needs of individuals and populations in an equitable and efficient manner. Driven by population health needs, transformative scale-up consists in a process of education and health systems reforms that address the quantity, quality and relevance of health care providers in order to contribute to universal access and improve population health outcomes
6. Reforms in education must be informed by community health needs and evaluated with respect to how well they serve these needs. Stronger collaboration between the education and health sectors, other national authorities, and the private sector will improve the match between health professional education and the realities of health service delivery. Educational institutions need to increase capacity and reform recruitment, increase student retention and transform curricula in order to improve the quality and the social accountability of graduates. The international community has an important role to play by partnering to support country-led efforts.
7. At the request of its member states and partners, WHO is developing policy guidelines to assist countries, development partners and other stakeholders in efforts to expand the health workforce and to improve alignment between education of health professionals and population health needs.
8. The WHO work is fuelling a growing movement to tackle the challenges facing the professional health workforce and is addressing the technical dimensions that can bring about a new era for health professional education.