



	<h2 style="margin: 0;">6th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE</h2>	
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Person-centered Health Research

Core Conference on April 29 – May 1, 2013

Pre-Conference Workmeetings on April 27 and 28, 2013

Geneva University Hospital and World Health Organization

CONFERENCE BOOKLET

❖ Conference
Program

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www.personcenteredmedicine.org

The Sixth Geneva Conference on Person-centered Medicine is organized by the International College of Person-centered Medicine (ICPCM) in collaboration with the World Medical Association (WMA), the World Health Organization (WHO), the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses ICN), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the World Organization of Family Doctors (Wonca), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the Council for International Organizations of Medical Sciences (CIOMS), the International College of Surgeon's (ICS), the International Federation of Gynecology and Obstetrics (FIGO), the Medical Women's International Association (MWIA), the International Federation of Ageing (IFA), the World Association for Sexual Health (WAS), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the Paul Tournier Association, the World Association for Dynamic Psychiatry (WADP), the European Association for Communication in Health Care (EACH), L'Observatoire de Medecine de la Personne, the WHO Collaborating Center at Imperial College London, the International Francophone Psychiatric Federation (ALFAPSY), the French Psychiatric Association, the International Federation of Medical Students' Associations (IFMSA), the Zagreb University Medical School, the University of Gothenburg Centre for Person Centred Care, the George Washington University Institute on Spirituality and Health, the Peruvian University Cayetano Heredia, the University Francisco de Vitoria, the Universite de Bretagne Occidentale, the Medical University of Plovdiv, the Belgrade University Institute of Mental Health, and the University of Buckingham, with the auspices of the Geneva University Medical School and Hospital.



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Geneva University Hospital and World Health Organization

CONFERENCE PROGRAM

Organizing Committee: Juan E. Mezzich (President, International College of Person Centered Medicine), Jon Snaedal (World Medical Association President 2007-2008), Chris van Weel (World Organization of Family Doctors President 2007-2010), Michel Botbol (World Psychiatric Association Psychoanalysis in Psychiatry Section), Ihsan Salloum (World Psychiatric Association Classification Section), Tesfamicael Ghebrehiwet (International Council of Nurses), Hernan Montenegro (WHO Unit for Health Systems Governance, Policy and Aid Effectiveness), Wim Van Lerberghe (Former Director, WHO Department for Health Systems Policies and Workforce), and Shanthi Mendis (WHO Department of Chronic Diseases and Health Promotion).

Conference Participants will be clinicians and scholars in medicine and other health fields as well as other interested individuals. ICPCM Continuing Professional Development (CME) Certificates will be e-mailed upon request to all registered participants. The registration fee is 400 Euros for persons residing in World Bank Group A (High Income Countries) and 250 Euros for persons in other countries.

Presentation Formats will include Thematic Symposia on Person-centered Health Research, other Symposia, Interactive Workshops, and Brief Oral Presentations.

Conference Secretariat: For further information as well as Registration and Abstract Forms, please visit www.personcenteredmedicine.org and write to the ICPCM 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: ICPCMsecretariat@aol.com.

April 21, 2013

**PRE-CONFERENCE WORK MEETINGS ON PERSON-CENTERED MEDICINE:
SATURDAY APRIL 27 AND SUNDAY APRIL 28, 2013**

**Venue: Geneva University Hospital Auxiliary Halls adjacent to Main Auditorium,
Rue Micheli du Crest 24, 1205 Geneva, Switzerland.**

SATURDAY APRIL 27

- 1:00 – 3:30 PM ICPCM Workgroups Plenary Session (10 minute presentations each followed by 5 minutes discussion time):
Chair: *Michel Botbol (Brest, France)*
- Role of the ICPCM Workgroups in the construction of Person-centered Medicine: *Juan E. Mezrich (New York)*
 - Update on the status of the ICPCM Project on Guiding Principles for Person-centered Clinical Care: *Neal Adams (California), Jon Snaedal (Reykjavik) et al.*
 - Update on the status of the ICPCM Person-centered Diagnostic Projects: *Ihsan Salloum (Miami)*
 - Update on the status of the ICPCM Janus Project on Person-centered Young Professionals: *Nikos Christodoulou (Nottingham)*
 - Prospective development of an ICPCM Project on Partnership and Team Approach: *Alessandro Sveltini, Tesfa Ghebrehivet, Jo Groves.*
 - Development of an ICPCM Program on Person-centered Psychiatry and Mental Health: *R. Cloninger, G. Christodoulou, Juan E. Mezrich, M. Botbol, I. Salloum, M. Abou-Saleh, H. Millar, et al.*
 - Prospective development of other ICPCM Programs related to specific specialties and disciplines (e.g. Person-centered Family Medicine, Person-centered *Pediatrics*, *Person-centered Nursing*, etc): *J. Appleyard, T. Ghebrehivet.*
 - Prospective development of ICPCM regional programs (e.g. Asian, African, Latin American): *R. Kallivayalil, W. van Staden, Elvia Velasquez.*
 - Presentation of a Draft of the Geneva Declaration on Person-centered Health Research: *Luis Salvador-Carulla et al.*
- 3:30 – 3:45 PM Coffee Break
- 3:45 – 5:45 PM Session One of parallel workmeetings of the various ICPCM Workgroups (distributed in sections of the available halls)
- 6:00 – 8:00 PM Meeting of the Board of the International College of Person Centered Medicine

SUNDAY APRIL 28

- 9:00 AM – 2:30 PM Session Two of parallel workmeetings of the various ICPCM Workgroups (distributed in sections of the available halls) (including a coffee break at 11 AM and then a lunch break that each workgroup will arrange as appropriate)
- 2:30 – 4:00 PM Plenary Reports of all the Workgroups (about 10 minutes each)
Chair: *Juan E. Mezrich (New York)*
- 4:00 – 4:15 PM Coffee Break
- 4:15 – 6:45 PM Meeting of the Editorial Board of the International Journal of Person Centered Medicine with the Board of the International College and the University of Buckingham Press.

CORE CONFERENCE FIRST DAY, MONDAY APRIL 29, 2013

Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

8:00 – 8:30 AM Registration and check-in

8:30 – 9:00 AM Conference Opening

- Welcoming words: *Panteleimon Giannakopoulos (Geneva University Medical School), Hernan Montenegro (WHO), Juan Mezzich (ICPCM) in the presence of the ICPCM Board of Directors.*
- Special Session on Constructing the 2013 Geneva Declaration on Person-centered Health Research: *L Salvador-Carulla (Sydney), CR Cloninger (St. Louis), I Ekman (Ghotenburg), K Swedberg (Ghotenburg), A Thornicroft (London), J Mezzich (New York).*

(Organizational Note for all Sessions: Unless otherwise noted, all sessions will have chairs (responsible for running it, opening with the session's objectives, introducing the speakers, zealous time-keeping, and final comments), two to four presentations [10-15 minutes each, followed by a short clarifying question], ample general discussion time, and a 5-minute summary and concluding remarks by the chair and/or co-chair. Each session will focus on what we know, what gaps we have, what we should achieve, and how to do it in different settings.)

9:00 – 10:30 AM Parallel Sessions 1:

A. Thematic Symposium on Innovative Person-centered Concepts Research (Main Auditorium)

Chairs: *Michel Botbol (Brest, France), Otmar Kloiber (WMA, Ferney-Voltaire, France)*

- Empathy: *Alain Berthoz (Paris)*
- Conceptual bridging and knowledge transfer: *Luis Salvador (Sydney)*
- Personalized medicine vs person-centered medicine: *Inger Ekman and K. Swedberg (Gothenburg)*

B. Thematic Symposium on Person-centered Diagnostic and Treatment Planning Research (Room E1-E2)

Chairs: *Tesfa Ghebrehivet (Alberta, Canada), Werdie Van Staden (Pretoria, South Africa)*

- Research on the Development of Person-centered Diagnosis: *Ihsan Salloum (Miami)*
- Integrating Illness Meaning and Experience in Person-centered Clinical Assessment: *Danielle Groleau (Montreal)*
- Strategies for Dissemination of Person-centered Treatment Planning and Care: *Neal Adams and Percy Howard (Berkeley, California)*

10:30 – 10:45 AM Coffee Break

10:45 AM – 12:15 PM Parallel Sessions 2:

A. Thematic Symposium on Person-centered Clinical Communication (Main Auditorium)

Chairs: *Robert Cloninger (St. Louis), Veljko Djordjevic (Zagreb)*

- Healthcare communication research across countries and cultures: *Myriam Deveugele (EACH, Gent)*
- The value of affective clinical communication: *Sandra van Dulmen (Nijmegen, The Netherlands)*
- Knowledge and attitudes towards palliative care: Does it affect the communication process?: *Lovorka Brajkovic (Zagreb)*
- Research on communication among professionals, patients and families: *A. Svettini (European Fed of Assoc of Families of People with Mental Illness, Bolzano, Italy)*

B. Thematic Symposium on Person-centered Treatment Research (Room E1-E2)

Chairs: *Olivier Bugnon (FIP, Lausanne), Karl Swedberg (Gothenburg)*

- Treatment Research in Family Medicine: A survey on a person-centered care model: *Waris Qidwai, Kashmira Nanji (Karachi)*
- Treatment Research in Pediatric Medicine: *James Appleyard (London)*
- Research on Team Approach to Care: *Tesfa Ghebrehivet (Alberta, Canada)*
- Translating Research into Practice: *Salman Rawaf (London)*

12:15 – 1:30 PM

Lunch (open)

1:30 – 3:00 PM

Parallel Sessions 3:

A. Thematic Symposium on Person-centered Prevention and Health Promotion Research (Main Auditorium)

Chairs: *Ted Epperly (Idaho, USA), Terry Bamford (IFSW, London)*

- General Prevention Research: *Nikos Christodoulou (Nottingham)*
- The role of physician immunization in preventing influenza outbreaks: *Tea E. Collins (WMA, Ferney-Voltaire, France)*
- Health Promotion Research: *Robert Cloninger (St. Louis)*

B. Thematic Symposium on Person-centered Research on Non-communicable Diseases and Mental Health (Room E1-E2)

Chairs: *Luis Salvador (Sydney), Inger Ekman (Gothenburg)*

- Research on General Chronic Diseases: *Shanthi Mendis (WHO)*
- Research on Mental Health: *M. Yasamy (WHO)*
- Research on Chronic Comorbidities: *Ihsan Salloum (Miami)*
- The EMPOWER program within the Jaffe Food Allergy Institute at Mount Sinai Medical Center: *Eyal Shemesb (New York)*

3:00 – 3:15 PM

Coffee Break

3:15 – 4:45 PM

Parallel Sessions 4:

A. Thematic Symposium on Person-centered Conceptualization and Metrics Research (Main Auditorium)

Chairs: *Neal Adams (Berkeley, California), Hernan Montenegro (WHO)*

- Normality, Abnormality and Mental Illness in a Person-centered Continuum: *Aleksandar Janca (Perth, Australia)*
- Research on Systematic Conceptualization of Person-centered Medicine: *JE Mezrich (New York)*
- Measurement models for Person-centered Medicine: *Levent Kirisci (Pittsburgh), JE Mezrich (New York), J Hayes (Pittsburgh)*

B. Thematic Symposium on Research on Health Narratives (Room E1-E2)

Chairs: *George Christodoulou (WFMH, Athens), Myriam Deveugele (EACH, Gent)*

- Narratives in Family Medicine: *Ted Epperly (Idaho, USA)*
- Narratives in Pediatrics: *James Appleyard (London)*
- Narratives in Mental Health: *Michel Botbol (Brest, France)*

4:45 – 5:00 PM

Coffee Break

5:00 – 6:30 PM

General Assembly of the International College of Person-centered Medicine

7:00 PM

Conference Dinner (tickets for purchase at Registration Desk)

CORE CONFERENCE SECOND DAY, TUESDAY APRIL 30, 2013

Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

9:00 AM – 10:30 AM

Parallel Sessions 5:

A. Thematic Symposium on Person- and People-centered Services and Policies Research (Main Auditorium)

Chairs: *Tesfamicael Ghebrehivet (Alberta, Canada), Ted Epperly (Idaho, USA)*

- Research Supporting Health Policy Development: *Denis Porignon, Dheepa Rajan (WHO)*
- Health Services Research: *Luis Salvador (Sydney)*
- Interactive health-promotion for older persons who are foreign-born: A person-centred approach to achieve equity in health: *Qarin Lood (Gothenburg)*
- Reflection on the concept of person-centered medicine in nursing systems: *Hana Konecna, Ludek Sidlo (Ceske Budejovice, Czech Republic)*

B. Thematic Symposium on Person-centered Health Education Research (Room E1-E2)

Chairs: *Robert Cloninger (St. Louis), Roy Kallivayalil (Kerala, India)*

- Research on Academic Training: *Salman Rawaf (London)*
- Research on Medical Curriculum Standards and Evaluation: *James Appleyard (London)*
- Research on articulating science and humanism in medical curricula: *Michael Schwartz (Round Rock, Texas)*
- Curricular journey on ethics and professionalism and its impact on students' attitudes: *F. Caballero, D. Monge, C. Garvia Leonardo, R. Abengózar, J. Perez-Miranda (Madrid)*.

10:30 – 10:45 AM Coffee Break

10:45 AM – 12:15 PM Parallel Sessions 6:

A. Special Session on Country and Region Studies in Person-centered Health Care (Main Auditorium)

Chairs: *Hernan Montenegro (WHO), Alessandro Svettini (EUFAMI, Bolzano, Italy)*

- America: *Ted Epperly (Idaho, USA)*
- Europe: *Inger Ekman (Gothenburg, Sweden)*
- Africa: *Werdie Van Staden (Pretoria, South Africa)*
- Asia: *Roy Kallivayalil (Kerala, India), Yongyuth Pongsupap (Bangkok)*

B. Workshop on Person-centered Approach to Treatment Measurement and Evaluation (Room E1-E2)

Chairs: *Ralph Tarter (Pittsburgh) and Ihsan Salloum (Miami)*

- Person-centered Multivariate Assessment: *Ralph Tarter (Pittsburgh)*
- Screening youth for current and future substance use disorders: *Levent Kirisci (Pittsburgh)*
- Person-centered Patient Progress Monitoring and Quantifying Program Effectiveness: *Steve Weatherbee (Ontario, Canada)*

12:15 – 1:30 PM Lunch (open)

1:30 – 3:00 PM Parallel Sessions 7:

A. Workshop on Developing a New Person-centered and Evidence-based Regional Medical School in the United States (Main Auditorium)

Chairs: *Michael Schwartz (Round Rock, Texas), Juan Perez-Miranda (Madrid)*

- Introduction on Intertwining Person-Centered and Evidence-Based Medicine: *Michael Schwartz (Round Rock, Texas)*
- Domains of Inquiry and Action in the Pursuit of Person Centered Medicine: *Edward Sherwood (Round Rock, Texas)*
- The Journey to the Center of Person-Centered Medicine: *Lianne Marks (Round Rock, Texas)*

- Essential Skills for Physicians in the Pursuit of Person Centered Medicine: *Jim Donovan (Round Rock, Texas)*
 - Discussants: *Inger Ekman (Gothenburg), Salman Rawaf (London)*
- B. Oral Presentations Session One (Room E1-E2)
Chairs: *Nikos Christodoulou (Nottingham), Levent Kirisci (Pittsburgh)*
- Politics, Research Agenda and Person-Centred Medicine: *Michael Loughlin (Manchester)*
 - Communicating with patients with cancer: *Veljko Djordjevic (Zagreb)*
 - Person-centered interviews in palliative medicine: *Marijana Bras (Zagreb)*
 - Interference of organizational culture on health outcome of Person Centered Care: *Tariq Saleem Alharbi (Gothenburg)*
 - Empowering through entrepreneurship leads to long lasting recovery: *Ishita Sanyal (Kolkata, India)*
 - Qualitative Research and Person Centered Medicine: *Susana McCune (Seattle, USA)*

3:00 – 3:15 PM

Coffee Break

3:15 – 4:45 PM

Parallel Sessions 8:

A. Oral Presentations Session Two (Main Auditorium)

Chairs: *Jo Groves (Int'l Alliance of Patients' Organizations, London), Marijana Bras (Zagreb)*

- Use of Patients' Narratives in research on Person-centered Medicine: *Hana Konecna, Danica Sloukova (Ceske Budejovice, Czech Republic)*
- Tools to transform standardized total hip replacements into person-centered care: *Lars-Eric Olsson (Gothenburg)*
- From standard practices to the patient as a partner: Challenges for implementing person-centered care: *Eric Carlstrom (Gothenburg)*
- Person-centered e-health in patients with coronary heart disease: *Andreas Fors, Axel Wolf, K. Dudas, J. Thorn, and E. Ekman (Gothenburg)*
- Training providers to promote person-centred maternal and newborn health care in Burkina Faso: *A. Bargo, J. Perkins, Cecilia Capello, C. Santarelli (Grand-Saconnex, Switzerland)*
- A conceptualization of the patient's perspective by doctors: *Claudia Zanini, Paolo Maino, Jens Carsten Möller, Claudio Gobbi, Monika Raimondi, Sara Rubinelli (Lucerne, Nottwil and Lugano, Switzerland)*

B. Workshop on Research on Treatment Consequences of Health-oriented Care (Room E1-E2)

Chairs: *Margit Schmolke (Munich and New York), Hans-Rudolf Pfejfer (Zurich)*

- Overview of research on positive mental health: *Margit Schmolke (Munich and New York)*
- Resource Orientation in inpatient psychotherapy: *Ilse Burbiel (Munich)*
- Outcome of person centered inpatient dynamic psychiatry: *Maria Ammon and Gisela Finke (Berlin)*
- Discussant: *Michel Botbol (Brest, France)*

CORE CONFERENCE THIRD DAY, WEDNESDAY MAY 1, 2013

Geneva University Hospital Marcel Jenny Auditorium

9:00 AM – 10:30 AM Special Session on Ethical Standards for Person-centered Health Research

Chairs: *James Appleyard (London), Eugenio Villar (WHO)*

- World Medical Association's Helsinki Declaration: *Otmar Kloiber (WMA)*
- The protection of the person is central in CIOMS International Ethical Guidelines: *Michel Vallotton (CIOMS, Geneva)*

- Person-centered perspective in WPA's Madrid Declaration: *George Christodoulou (WFMH)*
- WHO perspectives on strengthening research ethics review systems: *Marie Charlotte Bouesseau (WHO)*

10:30 -10:45 AM Coffee Break

10:45 AM – 11:30 AM Conference Closing: Geneva Declaration on Person-centered Health Research and Next Steps: *ICPCM Board, Luis Salvador, Zagreb University Academic Group.*

Post-closing Session at WHO Headquarters (Salle G, 8th Floor, Main Building)

12:15 – 2:00 PM Special Session on the Development of the WHO Strategy on High Quality People-centered and Integrated Care to Achieve Universal Health Coverage with the participation of invited representatives of major ICPCM collaborating organizations (ICPCM, World Medical Association, International Council of Nurses, International Alliance of Patients' Organizations, World Federation for Mental Health, World Psychiatric Association, International Francophone Psychiatric Federation, International Association of Medical Colleges, World Association for Dynamic Psychiatry, European Association for Communication in Health Care, American Academy of Family Physicians, International Federation of Gynecology and Obstetrics, Paul Tournier Association, German Dynamic Psychiatry Association, European Federation of Associations of Families of Persons with Mental Illness, International Federation of Medical Students' Associations, Zagreb University, Gothenburg University, Pushpagiri University, Francisco Vitoria University, Imperial College London, University of Sydney, Texas A&M University, Mount Sinai School of Medicine, University of Pretoria) as well as other key scholars and pertinent WHO officers.

Chair: *Hernan Montenegro (WHO Department for Health Systems Governance and Policy)*

- Welcome and presentation of participants
- Review of session objectives
- Short presentation on the WHO Strategy on High Quality People-centered and Integrated Care to Achieve Universal Health Coverage
- Questions and answers
- Identification of potential areas of collaboration and next steps



Invitation to Conference Dinner organized by the Paul Tournier Association

April 29, 7:00 pm
All Conference Participants

CHF 50.-
(all inclusive)
please register at
welcome desk

Restaurant des
Vieux-Grenadiers
92 rue de Carouge - 1205 Genève
Téléphone : 022 320 13 27 -
Tram 12, 13 et 14 arrêt "Augustins"



SIXTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

GALLERY OF PRESENTERS



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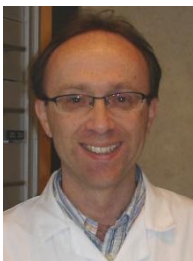




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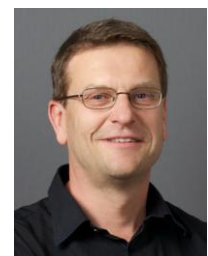
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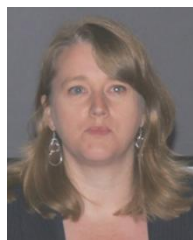


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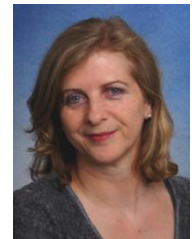
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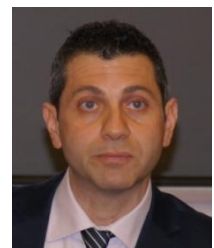
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SIXTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

ABSTRACTS

PRE-CONFERENCE WORKMEETINGS

Session on ICPCM Workgroups

ROLE OF THE ICPCM WORKGROUPS IN THE CONSTRUCTION OF PERSON CENTERED MEDICINE

Juan E. Mezzich

A review of the experience of major professional organizations and learned societies suggest that their depth and continuity are substantially enhanced when they organize scientific sections and workgroups. A case in point is the history of the World Psychiatric Association, founded in 1950 "to organize world congresses of psychiatry every six years", which became much stronger and continuously active when it started in 1961 a component of *scientific sections*. Likewise, the International Network (now College) of Person-centered Medicine (INPCM, ICPCM) emerged from a process of annual Geneva Conferences starting in 2008 [1]. In recent years, the ICPCM has initiated informal workgroups, some of them task-oriented (i.e., person-centered integrative diagnosis [2], clinical care guiding principles) and others member-oriented (e.g., young health professionals under the name of Janus Group). As the ICPCM matures, a major institutional activity should be the strengthening of existing workgroups and the development of new ones.

Scheduled for the initial Workmeetings of the 6th Geneva Conference are the following presentations:

- Update on the status of the ICPCM Project on Guiding Principles for Person-centered Clinical Care
- Update on the status of the ICPCM Person-centered Diagnostic Projects
- Update on the status of the ICPCM Janus Project on Person-centered Young Professionals
- Prospective development of an ICPCM Project on Partnership and Team Approach

- Development of an ICPCM Program on Person-centered Psychiatry and Mental Health
- Prospective development of other ICPCM Programs related to specific specialties and disciplines (e.g. Person-centered Family Medicine, Person-centered Pediatrics, Person-centered Nursing, etc)
- Prospective development of ICPCM regional programs (e.g. Asian, African, Latin American)
- Presentation of a Draft of the Geneva Declaration on Person-centered Health Research

Such presentations and the discussions they will engender shall offer valuable opportunities for the strengthening of the ICPCM in terms of group efforts on substantive ongoing activities.

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UPDATE ON THE STATUS OF THE ICPCM PROJECT ON GUIDING PRINCIPLES FOR PERSON-CENTERED CLINICAL CARE

Neal Adams, Jon Snaedal

The International College on Person Centered Medicine decided to establish guiding principles on person centered clinical care. A workgroup has been formed and met for the first time at the 4th Geneva Conference on Person Centered Medicine (PCM) in May 2011. In 1998, Jackson et al published in the *BMJ Guidelines for 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". Guidelines for Person-Centered Clinical Care should at minimum address the following six concepts: *Communication, Professional Responsibilities, Collaboration and Partnership, Ethics and the Promotion of Health and Well Being*. There is an urgent need for a broad consensus on specific strategies related to each of these categories. The Person-Centered Care Index (PCI) may be a useful tool for organizing guidelines as well as supporting and monitoring their implementation.

UPDATE ON THE STATUS OF THE ICPCM PERSON-CENTERED DIAGNOSTIC MODEL

Ihsan Salloum

The Person-centered Integrative Diagnosis (PID) is an emerging model of conceptualizing the process and formulation of clinical diagnosis. It aims at implementing into regular clinical practice the principles and vision of Person-centered Medicine, which proposes the whole person in context, as the center and goal of clinical care and public health. The Person-centered Integrative Diagnosis entails a broader and deeper notion of diagnosis, beyond the restricted

concept of nosological diagnoses. The PID multilevel schema intends to provide the informational basis for person-centered integration of health care. It involves a formulation of health status through interactive participation and engagement of clinicians, patients, and families using all relevant descriptive tools (categorization, dimensions, and narratives). This presentation will summarize recent updates on the PID model.

CONCEPT NOTE FOR ESTABLISHING AN ICPCM WORK GROUP ON PARTNERSHIPS AND TEAM APPROACH IN PERSON CENTRED MEDICINE

Tesfa Ghebrehiwet, Alessandro Svetlini, Joanna Groves

Introduction

The aim of the Concept Note is to map out the issues and way forward in establishing a Work Group on Partnership and Team Approach in Person Centred Care. The overall aim of the Work Group is to mobilise resources and expertise towards refocusing medicine and health care on the patient, clinician, family members/carers, policy makers, managers and members of the community within the overall goal of the International College of Person-Centred Medicine (ICPCM). A key component of this is the meaningful engagement of patients and families/carers in all aspects of health care. This includes considering the specific characteristics of the patient in terms of: age, developmental stage, cultural background, ethnicity, educational and health literacy level, mental status and their environment.

Definitions

For purposes of this Concept Note the following pragmatic definitions of the two key concepts of *Partnership* and *Team* are provided:

1. Partnership

Partnership is a relationship between individuals or groups that is characterized by mutual cooperation and responsibility for the achievement of a specified goal. In pursuing the agenda of person-centred care, partnership of professionals with patients and their families/carers is vital to achieving the goals.

2. Team

A team is a group of health and other professionals, patients and family cares who work towards the goals of promoting health, preventing illness, care, treatment and rehabilitation. A team has a recognisable leader but the leadership can shift depending on the issues requiring expertise of a team member. The team leader takes responsibility to coordinate the cooperation of diverse professionals, patients and family members/carers in order to pursue the goal.

The patients and their families/carers as part of the team bring a unique perspective and insight to the health problems and their solutions based on their lived experience of illness, pain and suffering. This perspective informs the decisions of health professionals and their interventions.

Objectives

The Work Group aims to achieve the following key objectives:

- To locate person-centered care in wide contexts and settings through collaborative practices and mutual responsibilities in a variety of hospital and community settings.
- Maximise interventions and outcomes of person-centered care by pooling and sharing of resources, skills, expertise and experiences.
- Enhance responsiveness to the person's needs and values, continuity of care, and team work based on common values and objectives as the core of person centered medicine.
- Transform health systems and education of health team professionals and other stakeholders to meet the needs of person-entered care by, for example, reciprocal approaches and mechanisms.
- To bring synergy to the work of health care and other professionals, lay and family care providers to person-centered care.

Mapping of Activities and Deliverables

- Develop a Concept Note as a basis for discussion and feedback
- Literature review on the subject
- Writing a paper outlining the literature review
- 10 min presentation at the 6th Geneva Pre-Conference on April 27th

Expertise of Initial Members of the Work Group

The initial members of the Work Group represent a diverse group with diverse professional and academic background that covers psychiatric/mental health services, patient advocacy, nursing and health policy. As well they can speak from first-hand experience of caring for a family member with mental and physical illness.

The Group will consider other organisations and experts that could be involved in the Work Group.

Outcome Indicators of Success

The Work Group does not intend to duplicate the work done by others within ICPCM and its activities and outcome indicators will be within its specific mandate of Partnership and Team Approach. To this end extent of achievement of the objectives will form the key outcome indicators.

PROSPECTIVE DEVELOPMENT OF AN ICPCM PEDIATRICS PROGRAM

James Appleyard

Essential components of a diagnostic model for children are listening to, looking at and learning from and gaining the trust of 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.

Suggested Action plan

To review shared current practice and to renew consultation on the clinical methodology used in paediatric practice so it will shift the emphasis from a disease and disorder of childhood paradigm to one which views the Child as a developing person whose problems may include specific disorders and diseases.

NEXT STEPS IN PERSON CENTRED MEDICINE AS SUGGESTED FROM AFRICAN EXPERIENCES

Werdie (CW) van Staden

This paper highlights important next steps in developing Person Centred Medicine (PCM) as suggested from African experiences. These steps should involve measuring tools of various kinds in PCM and the publication of conceptual work that demonstrates the scope of PCM in relation to the earlier movement called patient-centred medicine and its related fields. In particular, the conceptual work should make clear how affordances of PCM are more desirable and ethically accountable, for the interests relevant in PCM extend beyond that of the person in his or her capacity as patient and include

all relevant people in practice. They also extend to aspects of positive health and well-being, pursuing principally what is good for the person instead of what is good for his illness, and are neither merely a matter of patient satisfaction. The conceptual work should also be translated into measuring instruments that address the full scope and potential affordances of PCM, demonstrating conceptually and empirically that PCM affords a better way in practice rather than pitching it as the right way against a wrong way.

CORE CONFERENCE

OPENING

CONSTRUCTING THE GENEVA DECLARATION ON PERSON-CENTERED HEALTH RESEARCH

L. Salvador-Carulla L, CR Cloninger, I Ekman, K Swedberg, A Thornicroft, J Mezzich

Declarations are relevant tools to frame new areas in health care, to raise awareness and to facilitate knowledge-to-action together with other framing instruments such as bills, guidelines, and policy reports. Within this context, the International College of Person Centered Medicine (ICPCM) has launched a long term strategy to extend the impact of the Geneva Conferences and to generate a PCM knowledge-base that already includes the 2012 Geneva Declaration on Person-centered Care for Chronic Diseases. In December 2012 a team of six experts was constituted to prepare a draft based on iterative discussions by mail exchanges and teleconferences. The draft was sent to the ICPCM Board for feedback. An advanced draft of the Geneva Declaration on Person-centered Health Research is to be presented at the 6th Geneva Conference for discussion and refinement. This concise Declaration raises from the need for more research in Person-Centered Medicine (PCM), as well as by for making general health research more person-centered. It follows the existing definition of *person centered medicine* agreed to by the ICPCM and highlights the holistic, multidisciplinary and relational character of PCM across all levels of health care, from individual clinical interventions to general health policy. It has identified 10 priority areas as follows: 1) Conceptual, terminological, and ontological issues, 2) Studying the complexity of health, including illness and wellness, disability

and functioning, resilience and resources, plus experiences of health and contributors to health in PCM; 3) Clinical communication, 4) Exploring and validating person-centered diagnostic models, 5) Person-centered care and interventions, 6) People-centered care and related public health research, 7) Research on person-centered education and training, 8) Field analysis and dissemination through the International Journal of Person-Centered Medicine and other publications, 9) Organization, evaluation and upgrading of conferences and congresses, and 10) Further development of an internet-based information platform.

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Session 1A: Thematic Symposium on Innovative Person-centered Concepts Research

BRIDGING AND KNOWLEDGE TRANSFER IN PERSON-CENTERED HEALTH

Salvador-Carulla L, Thornicroft A, Fernandez A.

Person-centered health (PCH) is the umbrella term that encompasses models, research and activities in person-centered medicine, person and people-centered-care and planning. Being a holistic, multidisciplinary and relational field, PCH should set better links with the area of Bridging and Knowledge Transfer (KT). This is a new 'meta-science' covering an array of different sectors (health, social care, education, employment), disciplines (health and social sciences), approaches (care and support models) and stakeholders (providers, users, researchers and policy makers), that require integration in order to generate progress in relational fields such as PCH. It encompasses a wide range of concepts, tasks, technologies and practices aimed at improving knowledge sharing and collaboration across all the different components of the care and support system. In the last years B&KT has progressed considerably in different health fields, mainly in chronic illness. On-going strategies

include the development of national centres and institutes such as the... xxx in Canada, and international networks such as the IIMHL in Mental health and BADIN (Bridging Ageing and Disability International Network). These national and international strategies have generated different B&KT models, knowledge-bases, guidelines, policy reports, and specific studies. These developments are being made in knowledge-translation, knowledge-transfer, knowledge-sharing and knowledge-to-action and the differences between these components of B&KT are progressively being delineated. It is also important to define the characteristics and roles of knowledge-brokers from other experts and professionals such as champions and opinion leaders, to understand the priority areas of on-going research in B&KT and the typology of the developing evidence in this highly complex area. A better understanding of the links between B&KT and PCH are needed.

PERSONALIZED MEDICINE VS PERSON-CENTERED MEDICINE

Inger Ekman and Karl Swedberg

Person-centred care (PCC)

PCC sees patients as persons who are more than their illness. Person-centred care emanates from the patient's experience

of his/her situation and his/her individual conditions, resources and restraints.

PCC is a partnership between patients/carers and professional care givers (1). The starting point is the patient's narrative,

which is recorded in a structured manner. From this a mutual care plan is created, which incorporates goals and strategies for implementation and short and long term follow up.

Personalized Medicine (PM)

The concept of individualizing medicine based on biomarkers, proteins, genes and images has been assembled under the terminology PM.

Biological markers or images are important data, but as a basis for a care and treatment plan they are complementary to the patient's narrated experiences of his/her condition.

PCC vs. PM

PM and PCC are two concepts which are often confused and conflated. This is partly due not only to *the similarities in terminology but also to the fact that both approaches are intended to 'individualize care'*. PM explains and predicts individual exceptions based on genetic or other phenotype variations; PCC can explain and predict individual exception based on who the person is: his/her context, history, family, individual strengths and weaknesses.

Session 1B: Thematic Symposium on Person-centered Diagnostic and Treatment Planning Research

RESEARCH ON THE DEVELOPMENT OF PERSON CENTERED DIAGNOSIS

Ihsan Salloum

The Person-centered Integrative Diagnosis (PID) is an emerging model of conceptualizing the process and formulation of clinical diagnosis. It aims at implementing into regular clinical practice the principles and vision of Person-centered Medicine, which proposes the whole person in context, as the center and goal of clinical care and public health. The Person-centered Integrative Diagnosis entails a broader and deeper notion of diagnosis, beyond the restricted concept of nosological diagnoses. The PID multilevel schema intends to provide the informational basis for person-centered integration of health care. It involves a formulation of health status through interactive participation and engagement of

clinicians, patients, and families using all relevant descriptive tools (categorization, dimensions, and narratives). The PID model is intended to be used in diverse settings across the world and to serve multiple needs in clinical care, education, research, and public health. Research on the Person-centered Diagnosis involves both qualitative and quantitative analyses. The mixed model analyses is an important approach to integrate both types of analyses and to account for the narrative/qualitative as well as the quantitative data generated by domains of the PID.

DEVELOPING AND EVALUATING A PCM CLINICAL ASSESSMENT TOOL: INTEGRATING THE ILLNESS MEANING AND EXPERIENCE OF PATIENTS.

Danielle Groleau

In the PCM approach, particular attention is given to the illness meaning and experience of patient's. Although different conceptual models of PCM exist, significant challenges remain in operationalizing these models in the clinical setting. Some clinical interview tools for PCM exist in the literature, but none have been developed to access the complexity of the illness meaning and experience of patients. Our research team from various medical specialties, seeks to develop and evaluate a tool for clinical assessment that can be used in a PCM approach from a clinical version of the McGill Illness Narrative Interview schedule (Groleau et al., 2006). The MINI is an interview tool which was developed for research purposes, to

understand the complexity of illness meaning and experience of patients, their care trajectories and their health behaviors. Studies conducted with the MINI suggest that the use of an abbreviated version of the MINI in a clinical setting, could support the integration of meaning that patients attribute to their health problems in clinical communication.

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STRATEGIES FOR DISSEMINATION OF PERSON-CENTERED TREATMENT PLANNING AND CARE

Neal Adams and Percy Howard

Helping clinicians adopt person-centered practices can be complicated by both training/skill needs as well as systems challenges. A QI strategy was used to overcome systemic and structural barriers to furthering person-centered mental health care in Santa Clara County, California. The California Institute for Mental Health (CiMH) collaborated with county mental health department staff to develop an interactive curriculum on person-centered treatment planning which includes exercises integrating specific assessment instruments

in the treatment planning process, as well as integration of person-centered planning practices with documentation standards and guidelines.

Over a 2-year period 800 staff have been trained in County- and community operated programs. TA has been provided to supervisors on a monthly basis via phone, webinar and in-person. A train-the-trainer process has produced "Master Trainers" to facilitate further training and support further dissemination and implementation. There is no system of

measurement in place to gauge the effectiveness of treatment planning per se, however supervisors are using the Grieder/Tandoora Fidelity instrument to measure process adherence. Santa Clara County Contract providers also report significant improvement concerning the quality of engagement and productive interactions with clients and families, as well as increased levels of collaboration and shared decision making with the people they serve.

Session 2A: Thematic Symposium on Person-centered Clinical Communication

HEALTH CARE COMMUNICATION RESEARCH ACROSS COUNTRIES AND CULTURES

Myriam Deveugele

Communication in healthcare is of utmost importance, it has a positive relationship with satisfaction of both patient and doctor, with patient compliance, and it influences medical outcomes measures positively.

Nevertheless defining 'good communication' for every patient is not easy. During this lecture different international communication research projects will be presented. First the results of the Gulliver study, an international study looking at good communication in the eye of the general public will be shown. Second the Vr-CoDES, a system to analyze emotional communication during a medical consultation will be discussed. Both are results of inter-professional collaboration in EACH (European Association on Communication in Health Care).

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Implementation of both projects across countries and cultures will be presented and possible future actions discussed.

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KNOWLEDGE AND ATTITUDES TOWARDS PALLIATIVE CARE - DOES IT AFFECT THE COMMUNICATION PROCESS?

Lovorka Brajkovic

According to the World Health Organization, all patients and their families living with a life-threatening illness should receive consistent, high-quality palliative care to achieve optimal quality of life. Unfortunately, palliative care has not yet been incorporated into the Croatian health system, nor palliative medicine and palliative care is a mandatory subject in colleges. Therefore, we wanted to know what are the attitudes and knowledge of students of psychology, medicine, social work, theology, nursing to palliative care.

The results showed that students do not have sufficient knowledge about palliative care, most of the students stated that they do not feel competent to speak to a dying person, whereby students who have met with the dying person and / or have suffered the loss of a close person express a more positive attitude towards palliative care. Based on the obtained results, it is hard to imagine that future professionals in healthcare system are able to establish partnerships with

palliative patient. Therefore, before we even start thinking about the education of how to communicate, it is necessary to provide a good education about palliative medicine and palliative care with the goal of breaking down prejudices about palliative patient.

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RESEARCH ON COMMUNICATION AMONG PROFESSIONALS, PATIENTS AND FAMILIES

Alessandro Svettini

Clinical communication is fundamental in building a therapeutic doctor-patient relationship, facilitating bidirectional exchange of information, improving adherence to treatment and allowing a real inclusion of the patient in the decision-making process.

In order to be person-centred, clinical communication has to take into account the patient's age, mental status, intelligence and sociocultural level, ethnicity and environment.

Involving family members in the patient's treatment is central particularly for coping with chronic diseases. The family's functioning, emotional atmosphere and their involvement in the treatment process have a significant influence on compliance as well as on the patient's coping and quality of life. The role of carers becomes fundamental in case of patients with reduced levels of independence as well as cognitive and emotional capabilities (children,

elderly, people with mental retardation or severe psychiatric disorders).

Involving family members and carers through an adequate communication allows a better understanding of the clinical condition improves interaction between patient and carers, reduces the emotional burden and the expressed emotion levels in the family.

Research data show clearly the benefits of all this, especially as regards psychoeducation with families of people with psychiatric illnesses; unfortunately the

physician-family communication is not sufficiently integrated in general care.

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Session 2B: Thematic Symposium on Person-centered Treatment Research

TREATMENT RESEARCH IN FAMILY MEDICINE: A SURVEY ON A PERSON-CENTERED CARE MODEL

W Qidwai, K Nanji, TAM Khoja, S Rawaf, NY Al Kurashi, F Alnasir, M Al Shafee, M Al Shetti, M Bashir, NES Saad, S Alkaisi, W Halasa

Background: This study aimed to identify the perceptions of patients and physicians regarding person centered care in the Eastern Mediterranean Region (EMR).

Methods: A cross-sectional study was conducted in six countries of EMR during July 2012 to September 2012. 190 FPs practicing for at least six months were recruited. The recruited FPs approached 300 patients aged > 18 years with 1 or more recurring problems. Data analysis was done on SPSS version 19.

Results: Of total 360 patients, 53% were between 25-40 years of age and majority 55.7% were females. Among physicians 66.8% were females and 72.1% had done specialization in

Family Medicine. About 36% of the patients while 62.6% of the physicians preferred person centered care model.

Among physicians, field of specialization (AOR= 0.7; 95% C.I: 0.3-0.9), regularity in continuing medical education sessions (AOR= 0.3; 95% C.I: 0.1-0.5) were significant factors for preferring person care model. While, educational status (AOR= 3.0; 95% C.I: 1.1-7.9) was associated with person centered care among patients.

Conclusion: Results of the study highlights that majority of physicians prefer person centered care while patients prefer mix of both patient and physician centered care.

TREATMENT RESEARCH IN PEDIATRIC MEDICINE

James Appleyard

It really does depend on trust and how much we are prepared to risk our children. Historical experience has shown that children have been vulnerable to unethical experimentation. In reaction to this it is generally not acceptable to inflict more than minimal risk on children and there has been less research on therapeutic regimes and even though effective intervention exist medication may not even be available in appropriate dosage forms for children. This lack of availability has had a significant impact on low income countries failure to achieve some of their MDGs.

In spite of the new emphasis on research in children by the WHO, FDA and European Commission, there is an understandable parental reluctance to add any risk to their children's welfare because of a child's increased vulnerability. 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 and risks to child subjects are increased both in the short and long term. Because of the complexity, high cost and relatively low financial return, pharmaceutical companies have been reluctant to invest in medicines for children.

And, importantly, outside North America, Europe and Japan there is a lack of universal ethical and regulatory guidance for researchers and sponsors upon which parental trust depends.

In my view, such guidance should be underpinned by the seven core 'ethical' principles, namely Autonomy (respect for persons), Beneficence, Non malfesance, Fidelity, Truthfulness, Confidentiality, and Justice.

These principles need to support the statements in the medical professional ethical codes and codes of practice. They should be internalized to form the medical conscience of the physician and physician researcher upon which the trust by children and their families can be built.

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RESEARCH ON TEAM APPROACH TO CARE

Tesfamicael Ghebrehiwet

Teamwork in health care settings is widely recognized as an important factor in providing high quality patient care. Higher team functioning is associated with better patient outcomes¹ and cost savings². Research suggests that these benefits occur because well-functioning teams make quality decisions, cope effectively with complex tasks, and are able to coordinate their interventions and expertise.

Despite growing awareness of potential benefits, many health care organizations lack effective teamwork, with negative consequences on patient outcomes. The barriers to team

approach have been attributed to several factors including professional hierarchy, frequent changes in caregivers due to shift-work and patient transfers that make coordination and teamwork complicated.

The presentation will provide a highlight of research on team approach to health care using multiple dimensions of patient outcomes; cost savings, patient and provider satisfactions. As well the factors that inhibit or facilitate teamwork will be explored.

TRANSLATING RESEARCH INTO PRACTICE

Salman Rawaf

Introduction

Effective translation of the new knowledge, mechanisms, and techniques generated by advances in basic science research into new approaches for prevention, diagnosis, and treatment of disease, which is essential for improving health, is a vital process for any practitioner and indeed policy makers. The question is how the hierarchy of evidence is differ among policy and decision makers and the academic world? This paper will illustrate the knowledge generate through research may be used differently by policy makers than what the researchers are envisaging.

Methods:

Extensive review of the literature, looking at the current practices in KT and building on extensive experience in health service management in the National Health Service.

Findings:

Policy and decision makers are asking different sets of research question than academia often do. Does this work better than doing that? When an evidence is generated by a research the questions from policy side will be: How does it work? Does it matter? Will it do more good than harm? Will service users be willing to or want to take up the service offered? Is it worth buying this service? Are users, providers and other stakeholders satisfied with the services? Is it cost effective? (Less for more)? This often may create conflict between research and policy and many research papers and rendered just a long list of publication.

Conclusion:

Researchers in generating new knowledge they should take account the way the knowledge should be translated into practice. They should consider applicability and practicability as well as the costs. This paper will examine in detail how the policy and decision makers think and indeed work in practice to translate knowledge.

Session 3A: Thematic Symposium on Person-centered Prevention and Health Promotion

GENERAL PREVENTION RESEARCH

Nikos Christodoulou

In recent years, prevention research has increasingly focused more on dissemination, implementation and deployment, and less on evidence acquisition on the efficacy of proposed interventions. The reasons for this are clear: there is a large body of evidence already available on the efficacy of preventive interventions, but there is a pressing need to convert them into a tangible reality and yield benefits. In order to achieve a practical adoption of the most useful of these intervention, frameworks of evaluation and deployment have been devised. Such processes filter out those interventions that – even though theoretically efficacious – don't prove pragmatically effective, or those which cannot be deployed. As preventive interventions often need a lengthy evaluation timeframe and their evaluation rarely pertains to a single outcome, only few and relatively specific interventions are chosen. This situation becomes even more challenging with person-centred interventions due to their hard-to-assess polymorphic, humanistic and other collateral benefits. Here we

discuss the challenges posed through this evidence-based approach to person-centred prevention research, but we will also welcome the opportunity to use this as a means to develop robust ways of demonstrating the effectiveness of person-centred interventions.

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THE ROLE OF PHYSICIAN IMMUNIZATION IN PREVENTING INFLUENZA OUTBREAKS

Tea E. Collins

Influenza outbreaks in clinical settings represent a major threat to patient safety. According to the Centers for Disease Control and Prevention (2010), in the United States, an average season of influenza results in tens of thousands of deaths and up to 200,000 hospitalizations due to influenza-related causes. The risk of complications of influenza is highest among older persons, young children, patients with underlying medical conditions and pregnant women. Physicians and other healthcare professionals play an important role in both preventing and transmitting infection. The most effective way to reduce transmission from healthcare workers to patients is immunization. Yet, immunization rates among healthcare

professionals remain very low. To correct the gap, the World Medical Association launched a global campaign to promote immunization against influenza among physicians globally. The campaign intends to raise awareness among physicians about the importance of immunizations in health promotion and disease prevention. This presentation will present the results of the WMA survey of its national member associations on influenza immunization policies and practices in their respective countries and discuss campaign interventions using social behavioural change models and theories to improve immunization coverage among physicians and their patients.

THE INDISPENSABLE ROLE OF SELF-TRANSCENDENCE IN HEALTH PROMOTION

Robert Cloninger

Several lines of health care research are converging to show that spirituality as measured by Self-transcendence plays an indispensable role in health. Self-transcendence refers to a person's awareness that they are an inseparable part of something greater than their individual self. Prospective studies show empirically that the healthiest individuals are those who are self-directed, cooperative, and self-transcendent (Cloninger 2013). If any one of these is not well-developed, then individuals are less healthy in physical, mental, and social aspects of well-being.

Several lines of research support this finding. First, self-transcendent attitudes predispose people to work toward

social equity, and social inequity has been shown to diminish health consistently in studies between and within countries (Pickett & Wilkinson, 2009). Second, the empowerment of virtues like hope are essential for recovery from illness. Third, self-transcendence promotes a broadening of outlook that promotes health. Fourth, a self-transcendent outlook of unity increases heart rate variability, which strongly predicts morbidity and mortality from all causes.

Contemporary public health efforts are substantially impaired by an anti-spiritual bias. Promotion of public health cannot be optimized without appreciation of the indispensable role of self-transcendence in health and well-being.

Session 3B: Thematic Symposium on Person-centered Research on Non-communicable Diseases and Mental Health

MENTAL HEALTH RESEARCH: FROM MACRO LEVEL GOVERNANCE TO PERSON FOCUSED SERVICE DELIVERY

M. Taghi Yasamy

Keeping a balance between research at macro-level and health systems and individual level interventions is both a technical and ethical challenge. Narrowing the information gap at the global level requires governance of research on health systems and mental health subsystems and at the same time on questions regarding the person as service user in terms of her/his interactions with this system and how services are delivered to her/him. A two-pronged approach seems to be feasible. WHO launched the mental health gap Action Programme (mhGAP) in 2008 to scale up services for mental, neurological and substance abuse services. This flagship programme has a focus on scaling up services in low resource contexts where the service gap is higher. At the same time a series of tools including the evidence based mhGAP-Intervention Guide (mhGAP-IG) were developed to facilitate implementation at the facility level. The mhGAP-IG proposes a wide range of interventions which include pharmacological, psychological and social interventions and overall recommends a more holistic interaction with the person. Mental health research needs to consider the priorities identified at the country level which are usually health system

oriented. Generating evidence on how the interventions at the service outlet level need to be tailored to the needs of the person are also required. Effectiveness and real life trials are required to show how a mix of different modalities of treatment can be delivered in an integrated manner. Such models need to be also field tested in low resource settings to assure universal access to holistic person focused mental health services.

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RESEARCH ON CHRONIC COMORBIDITIES

Ihsan Salloum

Comorbidity, or the co-existence of more than one morbid condition, is the rule and not the exception in regular clinical practice. Chronic comorbidity poses significant challenges to diagnostic ascertainment and treatment choices, and has significant impact on treatment response and outcome. The prognostic significance of comorbid conditions has been recognized for general medical disorders. Comorbidity in mental disorders presents additional hurdles due to the lack of fully validated psychiatric disorders. The challenge of chronic comorbidity is yet to be adequately addressed and its etiology is not fully understood. The Person-centered Integrative Diagnosis (PID) is an emerging model of conceptualizing the process and formulation of clinical diagnosis. The Person-

centered Integrative Diagnosis entails a broader and deeper notion of diagnosis, beyond the restricted concept of nosological diagnoses. The PID multilevel schema intends to provide the informational basis for person-centered integration of health care. This model involves a formulation of health status using all relevant descriptive tools (categorization, dimensions, and narratives) and it is most suitable for accounting for the complex and intertwining course of chronic comorbidities. This presentation will review the relevance of the PID to research approaches on chronic comorbidities.

THE EMPOWER PROGRAM WITHIN THE JAFFE FOOD ALLERGY INSTITUTE AT MOUNT SINAI MEDICAL CENTER

Eyal Shemesh

Food allergy affects about 4-5% percent of children and adolescents⁽¹⁾ across the US. To ensure safety, individuals with food allergy and their immediate family members need to endure substantial restrictions to their life-style (including dietary restrictions, restrictions in travel, and others). This requires sustained changes to the affected individual's, and his / her family's, life style. Indeed, investigators ⁽²⁾ have documented that in the face of this uncertainty, families' quality of life is adversely affected.

The EMPOWER (Enhancing, Managing, and PrOmoting WEll-being and Resiliency) program within the Jaffe Food Allergy Institute was created to offer patient and family-centered care and support to affected children and their families. In this presentation, I will review:

2. Data from three initiatives, encompassing at least 750 participants in the aggregate, which illustrate the specific patient and family-centered care needs of the target population.
3. Data about current barriers to provision of such integrated care in our setting.
4. Interim data about the program's success and challenges, including data about the extent of activities provided and funding mechanisms.

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1. The scope of the program (what it includes).

Session 4A: Thematic Symposium on Person-centered Conceptualization and Metrics Research

NORMALITY, ABNORMALITY AND MENTAL ILLNESS IN A PERSON-CENTERED CONTINUUM

Aleksandar Janca

Many symptoms and signs of mental disorders are experienced by all people and thus can be seen being the points on a spectrum ranging from normal to psychopathological. Current diagnostic systems such as ICD-10 and DSM IV use personal distress, impaired functioning and cultural inappropriateness of an individual's behavior as the threshold for determining clinical significance and

diagnostic relevance of experienced psychological and/or psychopathological phenomena. This paper will discuss if the normality, abnormality and mental illness are three separate and distinct concepts with clear boundaries or a part of a person centered dimensional continuum along all human beings move across the time and lifespan.

RESEARCH ON SYSTEMATIC CONCEPTUALIZATION OF PERSON-CENTERED MEDICINE

Juan E. Mezzich

Efforts to conceptualize *person centered medicine* started from the beginning of the Geneva Conferences on Person-centered Medicine [1]. More recently, the International Network for Person-centered Medicine and the World Health Organization agreed to collaborate on an effort to better conceptualize person- and people-centered care and to the design of measures aimed at

assessing progress towards such care [2]. The specific objectives of the initial study and the methods used to approach them follow: a) Exploration through systematic literature reviews 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, b) Identification

and delineation of the key conceptual elements of person and people-centered health care through interactive collaborative

discussions with a Core Workgroup and a modified Delphi technique with a broad Consultation Group, both composed of international experts, and c) Application of the key elements towards the development of a Person-centered Care Index (PCI). The eight broad conceptual categories that emerged from this investigation are the following: 1) Ethical Commitment, 2) Cultural Sensitivity, 3) Holistic scope, 4) Relational Focus, 5) Individualized Care, 6) Common Ground for Diagnosis and Care, 7) People-centered Systems of Care, and 8) Person-centered Education and Research. Efforts to further refine the PCI in terms of wording, scaling, and correlational structure

followed as well as ongoing research to validate the PCI in terms of applicability, reliability and content validity.

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MEASUREMENT MODELS FOR PERSON-CENTERED MEDICINE

Levent Kirisci, Juan E. Mezzich, Jeanine Hayes

The overarching aim of this study is to develop a novel measurement model, in conjunction with factor analytic methods and item response theory, to assess quantification of person-centered care scale (PCS). PCS has been designed to contrast disease-centered and person-centered-care models with an objective of determining better health care alternatives by the International College of Person-centered Medicine (Mezzich, Salloum, Kirisci, 2011). Because we do not have

large enough sample for PCS at this point, we use data related to symptoms of substance use disorder diagnoses as an example for testing measurement models such as bi-factor, second order factor and first order factor. Measurement of the PCS with high precision is important in identifying health care facilities in need of improving person-centeredness portents success, especially because there is no competitor instrument.

Session 4B: Thematic Symposium on Research on Health Narratives

NARRATIVES IN FAMILY MEDICINE

Ted Epperly

Having both deep understanding and competence in the utilization of listening to patients' stories is important for the family physician. Indeed it is a skill that is critical to all physicians and one, unfortunately, most physicians do not do well. Narrative medicine and its utilization in family medicine was born out of bio-psycho-social model in an attempt to understand in a more holistic fashion the totality of the patient experience and finding a deeper meaning in it in order to help the patient. Narrative medicine is the practice of medicine with empathy, reflection, professionalism, and trustworthiness by a deep understanding of patients' stories. By seeking to understand and then being understood, a physician can help a patient by utilizing the relationship of trust to provide tenderness in the face of pain, courage in the face of danger, and comfort in the face of death (1). Authentic engagement is transformational for the person as well as the physician.

There are multiple dimensions of narratives in family medicine to include: 1. Person-Physician; 2. Physician-Self; 3. Physician-Colleagues; 4. Physician-Society. All of these examples of the dimensions of narrative medicine are

important for the critical conversations that lead to deeper meaning, a deeper understanding, and a growing need for improvement not only in self but of the larger healthcare system. Narrative skills taught in family medicine include narrative writing by our family medicine residents as well as a self-reflective piece about deeper meaning for our family physicians ongoing professional development. These are shared openly with other family physicians and behavioral health colleagues for the shared meaning feedback and bonding that can occur around these important narrative stories. This education is imperative to the future training of highly-skilled empathic and caring family physicians and will be the basis of ensuring highly skilled professional physicians for the future (2).

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NARRATIVES IN PEDIATRICS

James Appleyard

Medicine instills a sense of wonder and curiosity in all students embarking on an ethically based life course in the medical sciences.

Reflecting on ones own personal journey over the last 60 years takes me back to the experimental approach underlying the teaching of the basic sciences at school and the ever

present whys and what ifs associated even with the most controlled and standardized experiments.

While at Oxford in the 1950s our tutors challenged us to think about the evidence on which our knowledge was based and we were encouraged to challenge received wisdom. Amongst many other topics including cancer and cigarette smoking, my interest turned to the role of vitamin C, its relationship to stress and blood cholesterol.

Moving on to Guy's Hospital in London for the practical clinical training component the opportunity arose to work in a laboratory there on the level of cholesterol and Vitamin C in obese mice with fellow student Philip Harland. We started to gather data but the demands of the clinical program meant that we were unable to complete the study. The experience gave us some insight into the practical aspects of animal experimentation.

After two years of resident posts in the NHS which included 6 months in a children's hospital, the opportunity arose to join the paediatric residency at the University of Louisville Kentucky. Duties in the Emergency department of the General Hospital were not very popular and as a foreign resident I was assigned there over a five month period. The schedule involved being 24 hrs on duty followed by 24 hrs off duty. My interest had been aroused in a possible viral trigger to childhood leukaemia. The paediatric haematologist Dr Leonard Reisman gave me space in his laboratory in 1964 to conduct a clinical study on the effect on chromosomes following vaccination. Chromosome studies were relatively new then and though permission for the study was sought there was no formal 'ethical' review. During the transient viraemia following vaccination we noted a variety of changes in the chromosomes. Returning to the UK the immediate priority was to pass the MRCP examination (equivalent to the medical

boards) which then was a passport to a career in pediatrics in England.

Following a very busy 6 month residency at the Hospital for Sick Children Great Ormond Street during which I reviewed over 100 cases of Ulcerative Colitis in Children from the hospital's excellent record I progress to a research Post in Neonatology at St Thomas Hospital in London in 1968 There was an active program of research into the treatment of the effects of asphyxia but I found myself with a work bench and an underemployed technician in search of an idea. Looking at the literature I found that no one had fully documented platelet counts over the early weeks of life. We were aware of the importance of asphyxia in cerebral hemorrhage and noticed a lead article in the Lancet claiming that fresh frozen plasma could be used to correct coagulation abnormalities in vulnerable preterm neonates. We repeated their study but were unable to confirm their results. Mystified, I telephoned a colleague with whom I had worked at Great Ormond Street and arranged a visit the research unit A premature infant just happened to be delivered while I was there and I noted with surprise that the temperature of the bedside coagulation test was not properly controlled and could account for the aberrant results!

Following promotion to a senior registrar post at Guys Hospital, the emphasis changed to acute general paediatric problems and service development. We published an account the first paediatric intensive care unit outside the two main UK children's hospitals. The children's department was strongly influenced by Dr Ronald MacKeith's person centered approach to child care. This provided an important foundation for the service development in child development, neonatal intensive care and acute care that followed my appointment as Consultant Paediatrician in Kent.

NARRATIVES IN MENTAL HEALTH

Michel Botbol

May be more than other medical disciplines, Psychiatry and Mental Health are exposed to the negative effects of disorder centered approach. Because of the many competing theories about the very nature of the psychiatric disorders, mental health classifications had to neglect key aspects of the person's mental health status, such as subjectivity and psychodynamic dimensions, in order to mimic the paradigm on which are based the biomedical classifications in other medical disciplines. The first stake of a person-centered perspective is to fight against this abusive reductionism that leaves us "with half a science" (Strauss) and a nosography not well adapted to clinical practice

The Person-centered Integrative Diagnosis (PID) model has been constructed to respond with this stake. It is based on the previous *International Guidelines for Diagnostic Assessment (IGDA)* constructed on the results of a series of focus groups (involving psychiatrists, health professionals and other health stakeholders as patients, families and advocates) and of a survey realized by a global network of national classification [12]. One of the main findings of this systematic work is that the patients' perception, values and experiences of illness and health are key components of their health status and can be provided only if dimensions and narratives (idiosyncratic

formulations) are added to traditional descriptive procedures. For this reason, a PID matrix included in the diagnostic process affords a new and specific level corresponding to the patient's *Experience of Health* with the aim of taking into account the patient's health-related individual and cultural values and experiences approached through guided narrative procedure, built upon the worldwide experience of Cultural Formulation [21]. Through narratives, the physician has to access the patient's conscious and unconscious feelings and representations. He does not rely only on what he observes of the patient's behavior or physical condition. This paper will develop this idea showing how empathy (narrative empathy rather than mirror empathy) is the only tool to access the patient's subjectivity in many clinical situations.

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Session 5A: Thematic Symposium on Person- and People-centered Services and Policies Research

HEALTH SERVICES RESEARCH
L Salvador-Carulla, A Thornicroft, A Fernandez

Health and social service research on person-centered and people-centered care (PPC) is urgently needed to enhance PPC knowledge-to-action policy and priority setting. Required evidence should include context information on available legal and policy plans, local mapping of services and programmes (provision and accessibility), quality and levels of PCC implementation, relationship with integrated care and continuity of care, benchmarking and efficiency of PCC planning and programmes, and health financing including identification and appraisal of incentives and barriers. Traditional methods are not fit for the analysis of this highly complex area, and new designs, units of analysis and new analytical techniques should be explored in this area. As a matter of fact research in PCC may be considered a major sentinel case to generate knowledge in complex dynamic systems, and to overcome the two major biases in health service research: commensurability and generalisability problems. The lack of commensurability refers to the difficulty in comparing like with like as the name of a service is not related to the activity actually provided by it. The generalisability problem describes the difficulty to extrapolate results from a setting to a system due to the high influence of context factors. New units of analysis and standard coding systems have been developed to overcome the commensurability problems, mainly in the assessment of health services, health interventions, and in the assessment of the philosophy of care. Units of analysis in service assessment include different new operational categories in the organization of care at the micro-level (the service or facility) such as the minimum set of stable inputs of care (BSICs) and other arrangements such as care programmes. These units of the care organization can be described using new international coding of the 'Main Types of Care' (MTC) that allows for national and international comparison. A toolkit for assessing BSICs and TMCs has been developed in Europe (DESDE-LTC) which could effectively describe care provision at macro and meso-level (small health areas). A second area of development relevant to PCH is health interventions. A number of national systems have been implemented and WHO is currently developing the 'International Classification of Health Interventions' (ICHI) which is the third major classification at the WHO Family of Classifications (WHO-FIC). This system should incorporate and codify specific PCC interventions. Finally a number of instrument assessing the philosophy of care and its components have incorporated items or full sections on person centeredness. A significant

example is IEMAC (<http://www.iemac.org/>), that assesses the practical implementation of the 'chronic care model' at different territorial levels (micro, meso or macro). In order to improve the generalisability of the programmes of person-centered care it is important to explore new techniques that combine cross-design synthesis, modeling and use of prior expert knowledge, such as Expert-based Cooperative Analysis (EbCA) and other techniques of analysis of complexity in health system research.

Major challenges in this requires a better understanding of the different components and units of analysis in health services research a holistic, multidisciplinary and relational field, PCH should set better links with the area of Bridging and Knowledge Transfer (KT). This is a new 'meta-science' covering an array of different sectors (health, social care, education, employment), disciplines (health and social sciences), approaches (care and support models) and stakeholders (providers, users, researchers and policy makers), that require integration in order to generate progress in relational fields such as PCH. It encompasses a wide range of concepts, tasks, technologies and practices aimed at improving knowledge sharing and collaboration across all the different components of the care and support system. In the last years B&KT has progressed considerably in different health fields, mainly in chronic illness. On-going strategies include the development of national centres and institutes such as the... xxx in Canada, and international networks such as the IIMHL in Mental health and BADIN (Bridging Ageing and Disability International Network). These national and international strategies have generated different B&KT models, knowledge-bases, guidelines, policy reports, and specific studies. These developments are being made in knowledge-translation, knowledge-transfer, knowledge-sharing and knowledge-to-action and the differences between these components of B&KT are progressively being delineated. It is also important to define the characteristics and roles of knowledge-brokers from other experts and professionals such as champions and opinion leaders, to understand the priority areas of on-going research in B&KT and the typology of the developing evidence in this highly complex area. A better understanding of the links between B&KT and PCH are needed.

INTERACTIVE HEALTH-PROMOTION FOR OLDER PERSONS WHO ARE FOREIGN-BORN:
A PERSON-CENTRED APPROACH TO ACHIEVE EQUITY IN HEALTH

Qarin Lood

INTRODUCTION: Equitable healthcare implicate equal access to, and utilisation of high quality services for equal need. However, research points at inequities according to migration status, and the knowledge on how healthy ageing can be promoted in the context of migration is scant.

PURPOSE/METHODS: The aim of this research project is to challenge healthcare inequities due to migration status, to increase the possibilities for older persons who are foreign-born to promote their health. Employing a mixed methods approach, a literature review (1) and focus group discussions (2) have been conducted.

RESULTS: The results report several parameters influencing possibilities for older persons who are

foreign-born to age healthily, and also key elements of existing health-promoting interventions for this group. However, there is a research gap, and health-promotion in the context of ageing and migration is presented as complex.

CONCLUSIONS: A holistic and person-centred approach is needed in order to bridge health and healthcare inequities in a globalising and ageing society.

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REFLECTION ON THE CONCEPT OF PERSON-CENTERED MEDICINE IN NURSING SYSTEMS

Hana Konecna and Ludek Sidlo

The reference material for diagnostics and therapy consist of health care documentation, including nursing documentation. The newest nursing taxonomies NANDA, NIC and NOC are introduced in the Czech Republic. Literature states that nursing taxonomies are person-centered. Our question: Are they? Methods: Analysis of available documents on taxonomies. Results and discussion: The taxonomies include domains related to the patient's psychical and social context; they are referred to as domains with the same importance as domains related to physical changes. Nursing taxonomies should make easier the keeping of nursing documentation; easier communication, to support nursing quality, to fulfil legal

standards, to assess the nursing care quality. But we are not sure about the possibility to fulfil those goals. The communication is not easier because the taxonomy defines individual conditions and processes with concepts often more vague than the actual names of the conditions and processes. Nursing work is extremely formalized, everything must be written down. The documentation becomes chaotic and there is not sufficient time left for the patient. The nurse attending the patient cannot meet the legal standards then. Conclusion: We believe that, in spite of good will of their creators, the taxonomies do not fulfil the concept of PCM.

Session 5B: Thematic Symposium on Person-centered Health Education Research

RESEARCH ON ACADEMIC TRAINING

Salman Rawaf

Introduction

With advance in medicine technology, changing population and escalating public expectation modern medical education (undergraduate) and training (postgraduate) are changing in the face of these challenges. Research on the best methods of learning is focusing on the level of competencies needed and how to deliver to meet individual personal needs.

Methods:

Extensive review of the literature, looking at the current practices in advanced universities and in particular on the modernization of curricula, and building on personal experience in research, medical education and training in the UK and other countries.

Findings:

Most current medical education and training are developed on historical basis, tradition and faculty members strengths rather than on evidence and not in response to population's and

patients' needs. Studies show that leaning based on competencies needed for the craft is by far much more effective. The question is how to defined accurately the competencies for each specialty? how to maintain such competencies? and how to ensure that practitioners fit for purpose and able to address personal needs and centre their inputs around these needs.

Conclusion:

Medical learning and skilling through undergraduate medical education and postgraduate training provide little or no attention to the ways the service should be delivered to individual patients and their relatives. Through competencies approaches the services will be more specific and centred around the person circumstances and wishes delivered to the highest quality and in safest ways. This paper will address the research finding on undergraduate education and postgraduate training and how to ensure a continuum between the two.

RESEARCH ON MEDICAL CURRICULUM STANDARDS AND EVALUATION

James Appleyard

The diversity of medical curricula is both a strength and a weakness. The International Medical Education Directory lists

some 1,900 medical schools in 6 continents. Many of the current educational methods are based on traditions built up

over many years of experience, some have developed new methods based on current fashions in education.

Educational methods are based on improving quality, some instilling the spirit of inquiry but few considering in sufficient depth the wider public health issue of resource allocation. There is a shortage and mal distribution of physicians worldwide particularly in those countries with the highest burden of disease where the practical experience of the physicians in training would be greatest.

Educational research must be the basis for educational practice focusing not only on quality but the health and social needs of the population. One form of quality control is accreditation but many systems of accreditation are so prescriptive that they become a barrier to improvement and for **none** is there evidence of effectiveness data linking the production of highly skilled doctors with better patient care.

Accreditation processes should be transparent and based on data that is effective and efficient. That is why the IAOMC have developed a three step interactive process recognising the importance of personal factors in the local community. The scientific basis on medicine needs to embrace both the practice and education of medicine.

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RESEARCH ON ARTICULATING SCIENCE AND HUMANISM IN MEDICAL CURRICULA

Michael Schwartz

Appeal is substantial for a person-centered medicine (PCM) that promotes health and ameliorates illness. Such practice involves the intertwining of scientific and humanistic perspectives. This presentation will review the literature and critically appraise efforts in medical education that advance a PCM that is evidence-based, humane and scientifically sound.

Introduced in 1992, evidence based medicine rapidly became the gold standard for healthcare. Medical education followed suit. With clinical epidemiological tools, medical practice shifted from a preoccupation with its scientific base ("knowing what") to its present performance-oriented focus ("knowing how"). The current emphasis on medical practice that is

evidence-based and performance oriented has been called "the Flexnerian revolution of the 21st Century."

Practice and knowledge are central for medicine, as well as an appreciation of the humanness of persons ("knowledge-based practice"). Hence, the knowledge and wisdom upon which medical practice draws does not issue from a single source - a multiplicity of perspectives best serves PCM. The different ways in which medical reality discloses itself through different perspectives require different ways of grounding practice in evidence. Our curricular review will emphasize that PCM requires competency re the *different methods* needed to address the multifaceted medical aspects of persons.

CURRICULAR JOURNEY ON ETHICS AND PROFESSIONALISM AND ITS IMPACT ON STUDENTS' ATTITUDES

F. Caballero, D. Monge, C. Garcia Leonardo, R. Abengózar, J. Perez-Miranda

Currently there are no established guidelines on the most effective ways of supporting medical students to develop high standards of medical ethics and professionalism. *Francisco de Vitoria University* is developing its own curricular pathway to promote them. The curricular journey focuses on five main areas to support the development of ethics and professionalism in medical students: student selection, curriculum design, role modeling, new teaching and learning methods as well as assessment methods.

Student selection:

Our Medical School tries to avoid selecting students who have unprofessional personal characteristics likely to affect their ability to care for patients and work within a team. To achieve this purpose, candidates are assessed for non-cognitive attributes that may be indicative of future professional behaviors in addition to their prior academic achievement. We have designed a specific test to consider potentially relevant character traits (UFV-Predicting Behaviour or UFV-PB). The tool is designed to identify dysfunctional personality characteristics.

Curriculum design and role modeling:

We have tried to surpass the classic Flexner's model (clear separation between the pre-clinical and clinical years of the Degree in Medicine) with a new integrative curriculum model

that seeks to mix the theoretical knowledge and the clinical experience from the beginning.

We strive to ensure an early exposure to clinical and community settings wherein the students can identify positive and negative healthcare providers' professional models. A personal and group reflection helps each student to define their ideal professional model. The "Early Clinical Experience Program" takes place during the first two academic years.

We also have a pathway of courses related to medical humanities throughout of the 6 years of the Medical Degree: Philosophical Principles and Interpersonal Skills (1st year), Anthropology (2nd year), Ethics (3rd year), Bioethics (4th year), Clinical Issues and Ethics (5th-6th years).

New teaching and learning of professionalism methods:

We use three teaching approaches:

- a) Promotion and development of an early contact with patient centred approaches to care and ethical approaches to practice, working through real cases.
- b) Focus on encouraging the development of reflective practice in clinical settings of particular interest (psychiatry, palliative care) during the 2nd year.
- b) We develop experiential activities as *Itinerant Seminars*. Examples are:

1) A trip to historic sites of the Nazi medicine in Germany and Poland, to reflect on the value of life, about human dignity, eugenics, the physician's position before the law, limits on biomedical research and other bioethical topics of interest in medicine today.

2) Service Learning experience in Ngandanjika, Congo Democratic Republic.

Assessment methods:

We use the PIT questionnaire (*Problem Identification Test*) at entry and at the end of each year of this pathway as an instrument to assess changes in the ethical sensitivity of our students in an objective manner.

References:

Developing medical professionalism in future doctors: a systematic review. Vimmi Pansi, Manjo Doug, Ed Peile, Jill Thistlethwaite, Neil Johnson. *International Journal of Medical Education.* 2010; 1:19-29.

Session 6A: Special Session on Country and Region Studies in Person-centered Health Care

AMERICA: COLLABORATING WITH MULTIPLE PARTNERS ON PERSON CENTERED CARE IN THE UNITED STATES- LESSONS LEARNED FROM THE PATIENT-CENTERED PRIMARY CARE COLLABORATIVE (PCPCC)

Ted Epperly

This presentation will focus on the current ongoing transformation of the United States healthcare system to be more person-centered. An overview of the fractured US healthcare system will be offered to provide context to what is wrong with the world's most expensive health care system and the efforts that are currently in place to integrate and coordinate it. (1) The Patient Centered Primary Care Collaborative (PCPCC) will be highlighted as a major transformational effort occurring in the United States to move the healthcare system towards a primary-care based, person-centered system (2). The PCPCC's vision, mission, and six strategic centers will be outlined to demonstrate how collaborative partnerships have been developed in the United States between big business, the federal government, the

medical healthcare community, and major insurance companies to help drive this change. Lessons learned from this transformation will be shared. Interactive questions and answers with the audience will follow.

References

(1): Epperly T. *Fractured: America's Broken Health Care System and What We Must Do to Heal It.* Sterling & Ross Publishers, New York, New York, May 15th, 2012.

(2): Patient Centered Primary Care Collaborative – <http://www.pcpcc.net/>

EUROPE: PERSON-CENTERED HEALTH RESEARCH IN SWEDEN - EVIDENCE AND IMPLEMENTATION

Inger Ekman

Center for person-centered care research at Gothenburg University (GPCC) was established in 2010, with the support of the Swedish government's strategic funding. GPCC integrates research, education and innovation, and puts knowledge about person-centered care into practice in conjoined activities in these areas. Around 100 national and international researchers from different disciplines collaborate to create a center of excellence within person-centered care in long term illness.

The research at GPCC has gained a lot of attention since the results from implementing and evaluating person-centered care has proven to be effective care. One example is patients hospitalized for deteriorated heart failure. Hospital days were reduced by a third, and patients reported significantly reduced "Uncertainty in illness" in relation to their condition and treatment. (1)

Another focus in GPCC research is exploring the connection between symptoms and signs. One example is IBS ("Irritable Bowel Syndrome") (2).

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1. Ekman I, Wolf A, Olsson LE, Taft C, Dudas K, Schaufelberger M, Swedberg K: Effects of person-centered care in patients with chronic heart failure: the PCC-HF study. *European Heart Journal* 2011, 32:2395–2404. care pathway.

2. Tornblom H, Van Oudenhove L, Sadik R, Abrahamsson H, Tack J, Simren M: Colonic Transit Time and IBS Symptoms: What's the Link? *The American Journal of Gastroenterology* 2012;107(5):754-60.

AFRICA: DESIRABLE OBJECTS OF OBSERVATION FOR MEASURING PERSON CENTRED MEDICINE: CONCEPTUAL CONSIDERATIONS DRAWING ON AFRICAN INSIGHTS

Werdie (CW) Van Staden

Developing instruments for measuring person-centred medicine (PCM) is faced with the challenge to formulate items or criteria by which the various aspects of person-centredness may be identified and evaluated. In addition, consideration has to be given to the kinds of objects on which these items and criteria may be applied. This paper considers kinds of objects

desirable for applying criteria of person-centredness, and favours African insights in this regard.

Clinical consultations have been a popular kind of object for observation in a predecessor of PCM, patient-centred medicine. Instruments measuring patient-centredness mostly involve patient evaluations of the clinical consultation and reflect more or less patient satisfaction with a consultation.

True to the purposes of patient-centred medicine, which has a narrower scope than PCM, these instruments are at best an incomplete measure of PCM, worthy as they none the less are as a partial reflection of PCM. The point here is that these instruments are also inadequate for measuring PCM by virtue of taking the clinical consultation as object of observation, for much that is relevant to PCM also happens outside the consultation, for example, in teams, among professions, as well as at institutional, organisational, legislative and policy levels.

To include happenings outside the clinical consultation, a health system may seem to be a more suitable alternative as a kind of object for the observation of person-centredness. But using a health system as an object of observation contrasts with PCM-objectives insofar as a health system seems farther removed from the person than a consultation does. Using a health system, furthermore, incurs difficulties of reliability. The level of specification of the system that should be measured becomes critically important for a reliable measurement. At a

general level of specification, the embedded subsystems may vary considerably in the extent of their person-centredness, meaning that evaluators may easily mistake a subsystem as representative of the general case, or an "average" may become rather contradictory or of little value.

Drawing on African insights and practices, clinical consultations and health systems among other kinds of objects are compared to stories and story-making as desirable objects of observation in the measurement of PCM. The paper argues that the latter are desirable for PCM-purposes also outside Africa.

Hudon C, Fortin M, Haggerty JL, Lambert M, Poitras M. Measuring patients' perceptions of patient-centred care: a systematic review of tools for family medicine. Annals of Family Medicine, 2011; 9: 155-164.

Van Staden CW. African approaches to an enriched ethics of person-centred health practice. The International Journal of Person-Centered Medicine. 2011, 1:11-17

ASIA: NEW APPROACHES TO MEASURE QUALITY OF HUMAN DIMENSIONS OF HEALTH CARE IN THAILAND *Yongyuth Pongsupap*

To give more recognition and value to family medicine and person-centred care in the Thai health care system, new methods to measure the human dimensions of health care have been introduced, such as simulated patient surveys to analyse responsiveness, patient-centredness, therapeutic decisions and the cost of different facilities in private and public sectors (Pongsupap & Van Lerberghe 2006a) and also in family practices and non-family practices (Pongsupap & Van Lerberghe 2006b), and the measurement of responsiveness as part of person-centred care by using a set of questionnaires and vignettes to assess the experience at the intersection between the client (or patient) and the health system (Polpak et al. 2012) on the basis of agreed statistics: measurement method comparison (Bland & Altman 2012) and software for anchoring vignette data (Wand, King, & Lau 2011). The studies revealed that family practices, especially outside hospital contexts, were significantly more patient-centred and responsive as well as cheaper and less inclined to over-medicalisation. These methods are being used to facilitate the Thai health care system moving toward person-centred and people-centred care.

Key words: responsiveness, patient-centred care, person-centred care, people-centred care

References

Bland, J. M. & Altman, D. G. (2012): Agreed statistics: measurement method comparison, *Journal of Anesthesiology*, vol. 116, no. 1, pp. 182-185.

Polpak, A., Pongsupap, Y., Aekplakorn, W., Sriathamrongsawat, S., & Sansern, R.: (2012): Responsiveness under different health insurance schemes and hospital types of the Thai health care system, *Journal of Health System Research*, vol. 6, no. 2, pp. 207-218.

Pongsupap, Y. & Van Lerberghe, W. (2006a): Choosing between public and private or between hospital and primary care: responsiveness, patient-centredness and prescribing patterns in outpatient consultations in Bangkok, *Journal of Tropical Medicine International Health*, vol. 11, no. 1, pp. 81-89.

Pongsupap, Y. & Van Lerberghe, W.: (2006b): Is motivation enough? Responsiveness, patient-centredness, medicalization and cost in family practice and conventional care settings in Thailand, *Journal of Human Resource for Health*, vol. 4:19., p. 19.

Wand, J., King, G., & Lau, O. (2011): Software for Anchoring Vignette Data, *Journal of Statistical Software*, vol. 42, no. 3, pp. 1-25.

Session 6B: Workshop on Person-centered Approach to Treatment Measurement and Evaluation

OVERALL WORKSHOP ABSTRACT R Tarter, L Kirisci, S Weatherbee, I Salloum

Bearing in mind that each person in the human population is different, and these differences are important insofar as most medical and psychiatric disorders have multifactorial etiology, it is essential that valid methods are available for efficient assessment which inform intervention. Within the person-centered framework of etiology, assessment, and intervention (prevention and treatment), this presentation describes a state of the art fully automated procedure that joins multivariate assessment and outcomes measurement (at the individual and program levels). Automated reports yield an individualized

profile of treatment needs and priorities. Person-centered outcome reports inform triage decisions, resource needs, best mode/intensity of intervention, and ensures adaptations to the treatment plan aligned with changing problems and priorities. Automated follow-up assessment provides efficient quantitative monitoring over time of the individual's response to treatment as well as informs case management decision and evaluation of treatment programs taking into account both the multiple facets of intervention and manifold characteristics of the clinical program. This automated Web-based platform is

particularly well-suited to support research initiatives and guide service delivery in developing countries.

We use addiction as the example of this person-centered approach to assessment informed treatment. Ten interrelated measurement domains captured by the revised Drug Use Screening Inventory (DUSI-R) are: substance abuse, mental disorder, behavior problems, health, school, family, peers, work, social competence, and leisure/recreation. Measurement of problem severity in each domain pertinent to best practice treatment modality will be described with

scientific citations provided to the attendee for additional learning.

References:

1. Tarter, R. (1990). Evaluation and treatment of adolescent substance abuse: a decision tree method. *American Journal of Drug and Alcohol Abuse*, 16, 1-46.
2. Kirisci, L., Reynolds, M., Carver, D., & Tarter, R. (2013). Quick screen to detect current substance use disorder in adolescents and the likelihood of future disorder. *Drug and Alcohol Dependence*, 128, 116-122.

PERSON-CENTERED MULTIVARIATE ASSESSMENT

Ralph Tarter

Bearing in mind that each person in the human population is different, and these differences are important insofar as most medical and psychiatric disorders have multifactorial etiology, it is essential that valid methods are available for efficient assessment which inform intervention.

We use addiction as the example of this person-centered approach to assessment informed treatment. Ten interrelated measurement domains captured by the revised Drug Use Screening Inventory (DUSI-R) are: substance abuse, mental disorder, behavior problems, health, school, family, peers, work, social competence, and leisure/recreation. Measurement of problem severity in each domain pertinent to best practice treatment modality will be described with

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1. Tarter, R. (1990). Evaluation and treatment of adolescent substance abuse: a decision tree method. *American Journal of Drug and Alcohol Abuse*, 16, 1-46.
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SCREENING YOUTH FOR CURRENT AND FUTURE SUBSTANCE USE DISORDERS

Levent Kirisci

Screening youth for SUD is a challenging task because they have not passed through the main period of risk. Accordingly screening instruments for SUD in adolescents should not only have current and predictive validity but also should take into account the substance use behavior. This study proposes a quick screening instrument for SUD in adolescents using the items of Drug Use Screening Inventory (DUSI-R). Early, middle, and late versions the DUSI-R Quick Screen (DQS) for boys were created. Substance Use Involvement and Problems Severity Indices of the DQS were used for detecting current SUD and future SUD. Construct, concurrent and predictive validity of the DUSI-R Quick Screen (DQS) were in the good to excellent range. The results suggest that the DQS is an

efficient screen for identifying youths requiring treatment or secondary prevention.

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2. Kirisci, L., Tarter, R., Mezzich, A., Reynolds, M. (2007). Screening current and future diagnosis of psychiatric disorder using the revised Drug Use Screening Inventory. *American Journal of Drug and Alcohol Abuse*, 34, 653-665.

PERSON-CENTERED PATIENT PROGRESS MONITORING AND QUANTIFYING PROGRAM EFFECTIVENESS

Steve Weatherbee

Within the person-centered framework of etiology, assessment, and intervention (prevention and treatment), this presentation describes a state of the art fully automated procedure that joins multivariate assessment and outcomes measurement (at the individual and program levels). Automated reports yield an individualized profile of treatment needs and priorities. Person-centered outcome reports inform triage decisions, resource needs, best mode/intensity of intervention, and ensures adaptations to the treatment plan aligned with changing problems and priorities. Automated follow-up assessment provides efficient quantitative monitoring over time of the individual's response to treatment as well as informs case management decision and evaluation of treatment programs taking into account both the multiple

facets of intervention and manifold characteristics of the clinical program. This automated Web-based platform is particularly well-suited to support research initiatives and guide service delivery in developing countries.

References:

1. Tarter, R. (1990). Evaluation and treatment of adolescent substance abuse: a decision tree method. *American Journal of Drug and Alcohol Abuse*, 16, 1-46.
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Session 7A: Workshop on Developing a New Person-centered and Evidence-based Regional Medical School in the United States

OVERALL WORKSHOP ABSTRACT

Michael Schwartz, Edward Sherwood, Lianne Marks, James Donovan

Ongoing tensions in medicine between science and humanism have existed throughout the modern era. In the US, for over a hundred years, Flexner's scientific approach has been dominant. In the latter part of the last century, criticisms of Flexner-based practice as biomedical reductionism attempted to re-assert humanism by replacing such reductionism with broader biopsychosocial practice. Nonetheless, biopsychosocial medicine foundered under criticisms of excessive breadth and vagueness. More recently, "the Flexnerian Revolution of the 21st Century" has reasserted Flexner's scientific approach. Problem-based learning, evidence-based medicine and clinical guidelines have expanded the dominance of science-based practice, although shifting balance to clinical performance ("knowing how") from biomedical concepts ("knowing that"). But what does this mean for the persons/people who are the subjects at the center of

medical inquiry and practice, and for the promotion of their health and the amelioration of their illnesses? How do we learn and practice intertwined scientific and humanistic medicine in manner that is evidence-based and guideline-ready?

A new regional medical school – Texas A&M HSC College of Medicine, Round Rock, is attempting to address these questions. In this workshop, we will share our vision for comment by invited participants and the group at large.

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1. White, K. *The Task of Medicine: Dialogue at Wickenburg*. Henry J. Kaiser Family Foundation, 1988.
2. Davidoff, F. *Focus on Performance: The 21st Century Revolution in Medical Education*. *Medical Education*. 2008, 6 (1), 29-40.

INTRODUCTION ON INTERTWINING PERSON-CENTERED AND EVIDENCE-BASED MEDICINE

Michael Schwartz

Workshop presenters and their colleagues in Round Rock Texas are engaged in the development of a new Regional Campus of Texas A&M Health Science Center School of Medicine. Our efforts aim at medical education and practice that is person-centered and evidence-based. This presentation

will describe antecedents for the present effort, from Flexner's reform in US medical education through mid-20th century biomedical reductionism, the turn to biopsychosocial practice, and the reassertion of the Flexnerian Revolution of the 21st century. Such a review sets the stage for our current efforts.

DOMAINS OF INQUIRY AND ACTION IN THE PURSUIT OF PERSON CENTERED MEDICINE

Edward Sherwood

Efforts to promote the humanistic practice of medicine can, indeed must, be based upon both science and evidence. Reductionism is necessary, but not sufficient, for the dissection of humanistic practice in medicine and must be combined with a modern, holistic understanding of causation applicable to complex systems. We outline six distinct domains of inquiry and action to guide our pursuit of patient

centered medicine. These domains begin with the person and progress holistically through the dyad (person plus practitioner), the team, the enterprise and, ultimately, the healthcare system. The realization of person centered medicine will require substantial work in all six domains. We identify some of the questions which will need to be answered in each domain.

THE JOURNEY TO THE CENTER OF PERSON-CENTERED MEDICINE

Lianne Marks

Medical students aren't typically selected based on their level of compassion. Instead they are usually picked based on a numerical ranking system generally related to their grades and test scores. This system parallels traditional schooling in its duplicity. Are we trying to educate good test takers? Or,

alternatively, are we trying to engender well-rounded caring physicians? Which doctor would society rather produce and how best to procure and develop them and maintain a quality pool of health care providers?

ESSENTIAL SKILLS FOR PHYSICIANS IN THE PURSUIT OF PERSON CENTERED MEDICINE

Jim Donovan

The transition from undergraduate to graduate training and medical practice represents a time of both challenge and great potential. Indeed, this evolution may sustain or forever cripple efforts to promote the humanistic practice of medicine. New physicians face a complex and daunting system requiring a delicate balance of autonomy and compliance to negotiate structures with conflicting interests as well as a set

of skills and competencies to successfully align with a value based system. The presenter will focus upon specific capacities necessary for successful navigation of this metamorphosis and discuss how these promote a person centered model. The attainment of this model will be dependent upon the ability of systems to structure selection and mentorship in a way that values these capacities.

Session 7B: Oral Presentations Sessions One

POLITICS, RESEARCH AGENDA AND PERSON-CENTRED MEDICINE

Michael Loughlin

These are exciting times for Person-Centred Medicine (PCM). A recent editorial of the International Journal of Person-Centred medicine celebrates the new interest policy-makers are taking in PCM, but worries that: 'the nomenclature of "person-centred medicine" risks the accusation that such a term represents a further rhetorical addition to the already rhetorically overburdened nature of health services.' [1] The worries are indeed justified. With reference to the case studies of 'quality theory' in management studies [2-4] and Evidence-based medicine, [4-5] the paper argues that initially promising ideas are compromised when required to meet the agendas of policy-makers looking for a quick fix to what are in fact deep, structural problems in the delivery of health services. Attempts by some PCM-protagonists to demonstrate the potential role of PCM in reducing health expenditure suggest the radical aspects of the approach may be overlooked in favour of approaches which employ the rhetoric of 'person-centredness' to rationalise prevailing economic agendas. We must resist such moves if we are to preserve the intellectual and moral integrity of PCM as a critical perspective on medical practice.

Bibliographical references:

- [1] Miles, A & Mezzich, J (2011) The care of the patient and the soul of the clinic: person-centred medicine as an emergent model of modern clinical practice. *International Journal of Person Centred Medicine* 1 (2) 217-222
- [2] Loughlin, M (2002) *Ethics, Management and Mythology*, Radcliffe Medical Press, Oxon.
- [3] Loughlin, M (2004) Management, Science and Reality, *Philosophy of Management* 4 (2) 35-44
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- [5] Loughlin, M (2009) The search for substance: a quest for the identity-conditions of evidence-based medicine and some comments on Djulbegovic et al, *Journal of Evaluation in Clinical Practice* 15 (6) 910-14

COMMUNICATING WITH PATIENTS WITH CANCER

Veljko Djordjevic

According to the Croatian Health Statistical Annual Book (2009), oncologic diseases representing a significant part of the leading causes of death in Croatia: malignant neoplasms of trachea, bronchial and lung (8.36%), and malignant neoplasms of the colon (4.09%) in men and breast malignant neoplasms (3.4%) and malignant neoplasms of the colon (3.04%) in women. According to the data, with a tendency of increase, oncologic diseases represent one of the biggest public health problems in the Croatian medical system. Communication with patients with cancer is very important. Systematic review of research data has shown that most patients want to be informed about the diagnosis of malignant disease (96-98%), about the progress of the disease regardless of whether the prognosis is good or not (57-95%) and about all treatment options, but a smaller percentage of patients (27-61%) wanted to know about life expectancy. It has been shown that patient expectations are often not met; doctors often didn't announce prognosis of malignant disease, life expectancy, the impact of disease and treatment on quality

of life, and that information was often vague and inappropriately exposed. Although adequate communication skills increasing adherence to treatment, decreasing psychological disturbances and improving quality of life, communication is still based on paternalistic model - how to treat disease, and not the person. In this presentation the author will describe different educational activities about the communication skills with the patients with cancer and their families at the School of Medicine University of Zagreb, with the special emphasis on different teaching methods (simulated patients, role-play, "fishbowl method" etc.).

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2. Hagerty RG, Butow PN, Ellis PM, Dimitry S, Tattersall MH. Communicating prognosis in cancer care: a systematic review of the literature. *Ann Oncol*. 2005; 16: 1005-53.

PERSON-CENTERED INTERVIEWS IN PALLIATIVE MEDICINE

Marijana Bras

Effective treating in palliative medicine is impossible without effective communication and it is a central part of the therapy. Improving the techniques in communication may make it easier for the health-care professional to establish better relationship with his/her patient. Fortunately, it has been shown that communication skills can be taught and learned and that they are acquired skills like any other clinical technique. Establishing a good communication in palliative medicine provides a framework for exploring and understanding patients' concerns, fears, misconceptions, and what they bring to their illness while taking into consideration

their culture, availability of treatment options, ect. We founded Centre for Palliative Medicine, Medical Ethics and Communication Skills (CEPAMET) at the School of Medicine University of Zagreb. The conceptual framework of the CEPAMET is devoted to education, organization, and research in three domains: palliative medicine, ethics, and communication in medicine. The CEPAMET is also the first institutionalized attempt to systematically include palliative medicine into the system of medical education.. We developed Zagreb model of Person-centred medical interview, focused not only on the disease or illness but on patient's quality of life

in the context of health and disease, used until now for the patients with cancer and patients with chronic pain syndrome.

References:

1. Kurtz SM, Silverman JD, Draper J. Teaching and learning communication skills in medicine. Oxford: Radcliffe Medical Press, 1998
2. Djordjevic V, Bras M, Brajkovic L. Person-centred medical interview. *Croat Med J.* 2012;53:310-3

INTERFERENCE OF ORGANIZATIONAL CULTURE ON HEALTH OUTCOME OF PERSON CENTERED CARE

Tariq Saleem Alharbi

Background: Person Centered Care (PCC) is aimed at improving the quality of care by shifting to a staff/patient partnership to empower the patient to handle their illness after discharge. However, it is not known what role different organisational cultures dimensions, i.e. Human Relation (HR) Open System (OP), Internal Process (IP) and Rational Goal (RG), would have on the outcome of PCC.

Aim: To measure the effect of organizational cultures on health outcomes of patients three months after discharge.

Method: A quantitative study using Organisational Values Questionnaire (OVQ) and a health related quality of life instrument (EQ-5D).

Results: The regression analysis showed that; 16% of a decreased health status, 22% of pain/discomfort and 13% of mobility problems could be attributed to an organizational culture being dominated by flexibility, i.e. combination of (OS) and (HR) dimensions. **Conclusions:** The results from the present study showed an association between an organizational culture and patients' health related quality of life three months after discharge. More specifically, it showed that an organizational culture characterized by flexibility could be hindering instead of helping PCC in achieving its objectives.

EMPOWERING THROUGH ENTREPRENEURSHIP LEADS TO LONG LASTING RECOVERY

Ishita Sanyal

Introduction:

Of all persons with disabilities, those with a serious mental illness face the highest degree of stigmatization in the workplace, and the greatest barriers to employment worldwide. For people with mental illness, work can be a critical factor that helps promote health, recovery, and social inclusion. Even after treatment if the recovered person remains confined because of lack of opportunities the chances of relapses become frequent & may lead to frequent hospitalization & desertion of MI person by the family.

Aims and Objectives:

- 1) Meaningful engagement of the stakeholders
- 2) Economic Empowerment
- 3) Social Inclusion

Methodology:

We have three groups-1st group who are employed, 2nd group are not engaged & 3rd group are in entrepreneurship activities

Results:

- 32% of people who have joined jobs are often stressed leading to desire to leave the job & 15% have left the job
- People without any regular activity experience irritation, frustration & relapse
- People who are working as entrepreneurs are doing the work in their suitable time & getting paid according to the quantity & quality of their jobs.

Entrepreneurship is leading to

1. Economic freedom
2. Meaningful engagement
3. Social Inclusion

QUALITATIVE RESEARCH AND PERSON CENTERED MEDICINE

Susana McCune

Addressing Miles' and Mezzich's (2011) observation that there is an urgent need to "complement and augment" the "methodological development and evaluation of the effects of PCM" this presentation advocates using a multiplicity of qualitative research methodologies to further development of PCM theory, and to evaluate and improve clinical practice of PCM.

Although a multitude of quantitative tools for measurement of person-centered care exist, "the perspective of people" remains "absent" (Edvardsson, & Innes, 2010).

Quantitative data, such as biological makers, are vital to understanding disease and formulating treatment plans and qualitative data can complement biological data. In so doing, qualitative methodologies (e.g., narrative, phenomenological, and case study) can shift focus from disease to illness, from symptom to person. Qualitative approaches, as this

presentation advocates, can facilitate the mission of contextualizing and situating the person in person-centered medicine. This presentation also considers challenges in conducting international qualitative research, such as language considerations.

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Session 8A: Oral Presentations Sessions Two

USE OF PATIENTS' NARRATIVES IN RESEARCH ON PERSON-CENTERED MEDICINE

Hana Konecna and Danica Sloukova

The search of indicators of fulfillment of the concept of PCM is subject to permanent research. So far, no consensus on what those indicators are has been achieved. The work is aimed at trying to find the characteristics of PCM medicine in patients' narratives from a country with advanced economy and very good level of health care system. Method: Qualitative contents analysis of about 1100 patients' narratives. Results: It is extremely difficult to find common features in the narratives; our attempts to sort the narratives by any meaningful criteria have failed so far. The common features could perhaps consist in the quality of the relations between the health care worker and the patient: confidence plays an important role; it is

influence by the health care worker's professional level and good will, as perceived by the patient, to use all the health care worker's skills in favour of the patient. But we are skeptical towards the possibility to objectify that indicator. Conclusion: The concept of PCM medicine has resisted any attempts for quantification so far. We believe that it is its fundamental characteristic.

International Alliance of Patients' Organizations IAPO (2012), *Patient-centered Healthcare Indicators Review*.

O'Neill, O. (2012). Autonomy and Trust in Bioethics, CUP

TOOLS TO TRANSFORM STANDARDIZED TOTAL HIP REPLACEMENTS INTO PERSON-CENTERED CARE

Lars-Eric Olsson

Background: Primary total hip replacement is a standardized common surgery where health care tries to tailor the patients to the care and not the other way around. The surgery is usually successful, and implant survival during the first ten years is approximately 95%.¹ However, previous studies have reported a substantial variation in length of hospital stay following THA.² This variation may occur as a side-effect of the standardization.

Aim: The objective was to describe patients' self-efficacy and fear of movement two weeks before their scheduled primary total hip replacement.

Method: As a part of an interventional study a consecutive sample of 258 patients scheduled for primary total hip replacement was invited to participate.

Results: The result showed that 20 % of the patients had a low self-efficacy and 5 % had very low self-efficacy. About 10 % had a fear of motion, 30 % had high fear of motion and 10

% had very high fear of motion. The results were the same in both men and women in both instruments.

Conclusions: The results suggest that these two instruments probably could help transform the standardized care into PCC. The use of such instruments may help health care to be more personalized.

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2. Husted H, Munk Jensen C., Solgaard S, Kehlet H. Reduced length of stay following hip and knee arthroplasty in Denmark 2000–2009: from research to implementation. *Arch Orthop Trauma Surg* 2012;132 101–104

FROM STANDARD PRACTICES TO THE PATIENT AS A PARTNER: CHALLENGES FOR IMPLEMENTING PERSON-CENTERED CARE

Eric Calstrom

The health care industry in Sweden, as well as in other western countries, is facing the challenge of increasing the patient turnover and decreasing the number of hospital beds. One way to meet this challenge is to introduce new promising care models as alternatives to traditional clinical practices. However, new working models have been hindered by subcultures within the hospital organisation (Coyle and Williams, 2001). This paper sets out to detect the feasibility of

implementing person-centered care (PCC) in a psychiatric clinic in Sweden (Van Royen et al., 2010). A survey consisting of two instruments – organizational values questionnaire (OVQ) and resistance to change scale (RTC) – was distributed at the clinic. The results revealed that the dominating cultures in the outpatient centers and hospital wards were characterized by flexibility, cohesion and trust. The mean resistance to change was low, but the subscale of cognitive

rigidity was dominant, reflecting a tendency to avoid alternative ideas. An instrument like the one employed in the study could be a useful tool for diagnosing the likelihood of introducing PCC since the model is threatening the prevalent standard practices by viewing the patient as a partner (Coleman *et al.*, 2004).

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Participate in Care Delivered Across Setting: The Care Transitions Intervention", *Journal of American Geriatrics Society*, Vol. 52 No. 11 pp. 1817-1825.

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PERSON-CENTRED E-HEALTH IN PATIENTS WITH CORONARY HEART DISEASE

Andreas Fors, Axel Wolf, K. Dudas, J. Thorn, and E. Ekman

Background

Remote monitoring of patients with coronary heart disease (CHD) has yielded mixed and often disappointing results [1]. One reason could be that remote monitoring mirrors a disease focused of looking at the patient [2], hence only promoting a one-way communication between the patient and health care professionals.

Purpose

To investigate the feasibility and effect of an e-health application aimed for self-monitoring of signs and symptoms in patients with CHD.

Design

This study is part of an ongoing randomized controlled trial in Sweden for patients with CHD. Patients are trained at the hospital to use a smartphone application and a web-site for the following 12 months where they are able to 1) write a health diary 2) rate their current state of fatigue, motivation and

concentration 3) obtain daily trend graphs of physical activity, measured via a built-in accelerometer 4) establish chat-contact with other patients in the study 5) establish contact with staff at e.g. their study clinic.

Expected results

To our knowledge, this is the first study that will evaluate a combined smartphone and web-based person-centred diary for patients with CHD. Tentative findings indicate a feasibility of a smartphone application for patients. Further findings will be presented at the conference.

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TRAINING PROVIDERS TO PROMOTE PERSON-CENTRED MATERNAL AND NEWBORN HEALTH CARE IN BURKINA FASO

A. Bargo, J. Perkins, Cecilia Capello, C. Santarelli

As a component of the national strategy to improve maternal and newborn health (MNH), Burkina Faso Ministry of Health, supported by Enfants du Monde, La Fondation pour le Développement Communautaire/Burkina Faso and UNFPA, is implementing the World Health Organization's (WHO) framework for Working with Individuals, Families and Communities to improve maternal and newborn health (MNH). As a first step in district implementation, participatory community assessments (PCAs) were conducted. These PCAs consistently revealed that poor interactions with healthcare providers posed one important barrier preventing women from seeking MNH services. In order to address this barrier, healthcare providers were trained to improve their

interpersonal skills and in counselling women. During 2011-12 a total of 175 personnel were trained over a 5-day course developed using a WHO manual. The course was met with enthusiasm as providers expressed their need and desire for such training. Immediate post-test results revealed an impressive increase in knowledge and anecdotal evidence suggests that training has influenced provider's behaviours. While early findings are promising, an evaluation will be necessary to measure how the training has influenced practices, whether this translates into a shift of perceptions at community level and ultimately its contribution toward promoting person-centred care in Burkina Faso.

A CONCEPTUALIZATION OF THE PATIENT'S PERSPECTIVE BY DOCTORS

Claudia Zanini, Paolo Maino, Jens Carsten Möller, Claudio Gobbi, Monika Raimondi, Sara Rubinelli

The elicitation of the patient perspective is considered as a core activity for the implementation of a patient-centered care. Addressing the patient perspective in the medical consultations is a crucial step for better decisions resulting in improved health outcomes. Despite the emphasis on the value of the patient's perspective, the notion of patient's perspective remains vague, its definition is often left implicit and there is no clear conceptualization of what components constitute it.

The objective of this paper is to contribute to the identification of aspects of the patient perspective that is particularly important to capture in the medical encounter. The paper presents results from semi-structured interviews with doctors (N=25) active in the field of chronic pain. Interviews were analyzed using thematic analysis and principles of argumentation theory. Findings point to the identification of aspects of the patient perspective that are not routinely asked in the consultation, and refer to the beliefs that patients have in

terms of “what they think they have”, “what expectations they have” and “what they think about possible treatments”. Overall, it appears that the perspective that is particularly important to address nowadays results from patients’ exposure to health information in their social environment. This paper concludes with some remarks on the communication challenges that doctors need to face to transform the patient perspective in the basis for a partnership with their patients.

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Session 8B: Workshop 8B n Research on Treatment Consequences of Health-oriented Care

OVERALL WORKSHOP ABSTRACT

Margit Schmolke, Ilse Burbiel, Maria Ammon, Gisela Finke

Research in person-centred health care is especially needed for the benefit of patients in various treatment settings and for treatment consequences. This workshop will deal with positive mental health, resources orientation and person-centeredness in psychiatric inpatient treatment. The workshop includes following presentations:

1. Margit Schmolke (New York/Munich): Overview of research on positive mental health
2. Ilse Burbiel (Munich): Resources orientation in inpatient psychotherapy
3. Maria Ammon (Berlin), Gisela Finke (Munich): Outcome of person-centred inpatient dynamic psychiatry

OVERVIEW OF RESEARCH ON POSITIVE MENTAL HEALTH

Margit Schmolke

In recent years, we can observe an interesting shift from deficit-oriented towards positive mental health perspectives. The focus of mental health research is increasingly directed towards the patients’ strengths, resilience and a resources orientation in treatment programs as an innovative discipline compared to clinical studies mainly based on pathogenesis, symptoms and deficits of patients. In her presentation the author will give a short overview about studies and (mainly qualitative) research designs dealing with personal and social resources, resilience and individual recovery processes of psychiatric patients. The recently published service user involvement in mental health research will be summarized. These studies and developments may have an enriching and stimulating impact on a person-centred medicine since they

deal with patients’ inner subjective experiences and healthy aspects in midst of a mental illness process.

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RESOURCE ORIENTATION IN INPATIENT PSYCHOTHERAPY

Ilse Burbiel

Günter Ammon’s Dynamic Psychiatry is and has always been a resource-oriented treatment science since its introduction in the late sixties of the last century. Based on a detailed definition of the dynamic-psychiatric term ‘resources’ against a background of a positively conceived idea of man, the author’s approach is to present the implementation of resource

orientation in the psychiatric-psychotherapeutic practice of the Dynamic-psychiatric Hospital Mengerschwaige. With a questionnaire study of N=47 patients of different diagnosis groups she investigates how far this work is acknowledged and received by the hospital’s patients.

OUTCOME OF PERSON CENTERED INPATIENT DYNAMIC PSYCHIATRY

Maria Ammon and Gisela Finke

The outcome study was conducted to evaluate the person centered dynamic psychiatric treatment program of the Mengerschwaige hospital. It was conducted with N = 792 patients, mean duration of therapy was 65 days. Data used were besides others the Inventory of Interpersonal Problems (IIP), a self-report measure of maladaptive relationship behavior, the Ammon Ego Structure Test (ISTA) and questions concerning the patient’s satisfaction with their quality of life, their physical and mental health, their social relations and the quality of therapy.

At discharge and follow up patients had significantly improved in all ISTA scales measuring the constructive, healthy dimensions of personality. The changes in the IIP showed that patients after treatment had less problems in interpersonal relationship. They were more content with their mental and physical state of health, their partnership and their sexuality. Over all, in a multiple act criterium aggregated out of 7 questionnaires and measures, 71 % of the patients showed significant improvement, 22,2 % no change and 6,8 % a decline in outcome.

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Special Session on Ethical Standards for Person-centered Health Research

THE PROTECTION OF THE PERSON IS CENTRAL IN CIOMS INTERNATIONAL ETHICAL GUIDELINES

Michel Vallotton

Human medicine, in order to expand or improve the prophylactic or therapeutic arsenal, necessitates clinical trials. The results of such trials, when combined, form the basis of evidence-based medicine. Social and preventive medicine depend upon an extensive set of data derived by various statistical techniques resulting from epidemiological studies. In such entire endeavors, the data are compiled and stored electronically in vast banks, registers and registries. Stored individual samples of all kinds exist also in large numbers in university-based institutes, hospitals, and industry-based repositories. These data are then subjected to statistical analysis and can be easily combined, merged and exchanged electronically. Yet these data derive from patients, subjects, or participants -- whatever one wishes to call them -- but in the final analysis from physical persons who deserve the right to privacy. This is why CIOMS, on the basis of the general principles set forth in international declarations, has formulated

and issued two revised versions of its International Ethical Guidelines, one dealing with Biomedical Research Involving Human Subjects, in 2002, and the other with Epidemiological Studies, in 2009 (originally published in 1993 and 1991 respectively). These Guidelines set out all the details for the proper conduct of clinical trials and epidemiological studies. They stress in particular the ethical requirements with which the sponsors and investigators should comply and which the Institutional Review Board (IRB), Ethical Review Committee (ERC), or the equivalent, should ascertain are fully respected and implemented. What is at stake is to maximize the benefits, minimize the risk and potential harms, and secure the right to privacy by various modes of coding or other means to anonymize individual data so as to ensure that they remain non-identifiable, and thereby assure the protection of the persons involved in the trials.

PERSON-CENTERED PERSPECTIVE IN WPA'S MADRID DECLARATION

George Christodoulou

Principles of Ethics are more important than rules, declarations and codes for a variety of reasons but basically because it is the principles that provide the basis for the latter.

The essence of the above conclusion is reflected in the preamble of the Madrid Declaration where the psychiatrist's individual sense of responsibility is identified as the basis of ethical practice.

Ethical psychiatric practice (as described in the Madrid Declaration and in other similar texts) is personified par excellence. Yet, there are certain parts of the Declaration that are more relevant to the person-centered approach. These are the following:

Paragraph 1. Advocating therapeutic interventions that are least restrictive to the freedom of the patient.

Paragraph 3. Suggesting that the patient be accepted as a partner by right in the therapeutic process.

Empowering the patient to make informed decisions on the basis of one's personal values and preferences

Paragraph 4. Safeguarding the dignity and human rights of the patient

Paragraph 5. Informing the patient about the purpose of an assessment (especially if the psychiatrist is involved in third-party situations)

Paragraph 6. Safeguarding the privacy of information obtained in the therapeutic relationship

Paragraph 7. Safeguarding the autonomy and physical and mental integrity of the patient in research.

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