



World Health  
Organization



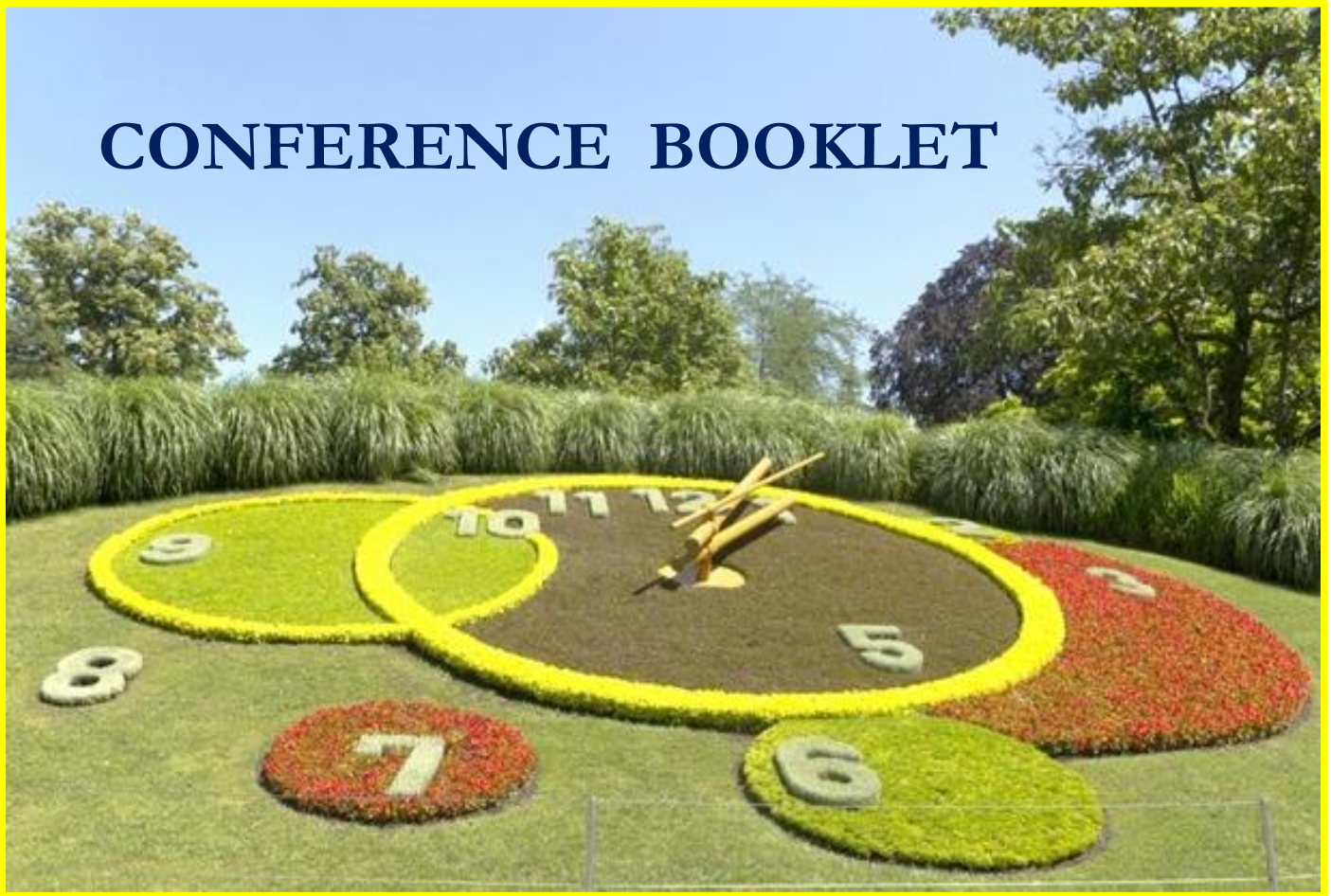
## 8th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

### *Person-Centered Primary Health Care*

Core Conference on April 27 – 29, 2015  
Pre-Conference Workmeeting on April 26, 2015

Geneva University Hospital and World Health Organization

## CONFERENCE BOOKLET



☐ Organization

☐ Program

☐ Presenters

☐ Abstracts

☐ CPD Credits Form

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

[icpcmsecretariat@aol.com](mailto:icpcmsecretariat@aol.com)

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



## CONFERENCE ORGANIZATION

**Organizing Committee:** James Appleyard (President, International College of Person Centered Medicine), Juan E. Mezzich (Secretary General, International College of Person Centered Medicine), Ted Epperly (Program Director for the 8<sup>th</sup> Geneva Conference on Person-Centered Medicine), Michel Botbol (World Psychiatric Association Psychoanalysis in Psychiatry Section), Tesfamicael Ghebrehiwet (Former Officer, International Council of Nurses), Jo Groves (Former Executive Director, International Alliance of Patients' Organizations), Ihsan Salloum (World Psychiatric Association Classification Section), Sandra Van Dulmen (Former Officer, European Association for Communication in Healthcare), Nuria Toro Polanco (WHO), E. Kelley (WHO), and Hernan Montenegro (WHO).

**Collaborating Organizations:** The Eighth 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 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 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 Francophone de Medecine de la Personne, the WHO Collaborating Center at Imperial College London, the International Francophone Psychiatric Federation (ALFAPSY), the French Psychiatric Association, the German Association for Dynamic Psychiatry, the International Federation of Medical Students' Associations (IFMSA), the Zagreb University Medical School, San Fernando Medical School of San Marcos National University of Peru, the Peruvian University Cayetano Heredia, Francisco de Vitoria University, the Universite de Bretagne Occidentale, the Medical University of Plovdiv, the Belgrade University Institute of Mental Health, and University of Buckingham Press, with the auspices of the Geneva University Medical School and Hospital.

**Conference Participants** are clinicians and scholars in medicine and other health fields as well as other interested individuals. ICPCM Continuing Professional Development (CME) Certificates will be e-mailed upon request to all registered participants. The registration fee is 400 Euros for persons residing in World Bank Group A (High Income Countries) and 250 Euros for persons in other countries. Full time students and official representatives of patient and family organizations will pay discounted half rates.

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

**Conference Secretariat:** 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](mailto:ICPCMsecretariat@aol.com)  
[www.personcenteredmedicine.org](http://www.personcenteredmedicine.org)



## 8th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

### *Person-Centered Primary Health Care*

Core Conference on April 27 – 29, 2015

Pre-Conference Work Meetings on April 26, 2015

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## CONFERENCE PROGRAM

### PRE-CONFERENCE WORKMEETINGS ON PERSON-CENTERED MEDICINE: SUNDAY APRIL 26, 2015

Venue: Auxilliary Halls one floor below the Main Auditorium,  
4 rue Gabrielle-Perret-Gentil CH-1211 Geneva 4, Switzerland.

1:00 – 5:00 PM	Pre Conference Institutional Work Meetings: Chairs: <i>Michel Botbol (Brest, France), Sandra Van Dulmen (Nijmegen, Netherlands)</i> a. Person-Centered Diagnosis: <i>JE Mezzich (New York) and I Salloum (Miami) et al</i> b. Person-Centered Clinical Care Guiding Principles: <i>J Appleyard (London), Ted Epperly (Boise, USA), S Van Dulmen (Nijmegen, Netherlands) et al</i>
3:00 – 3:15	Coffee Break
	c. 2015 Geneva Declaration Draft Presentation: <i>Ted Epperly (Boise, USA) et al</i> d. Books Workgroup: <i>JE Mezzich (New York) et al</i> e. Global Research Network: <i>I Salloum (Miami) et al</i> f. Other Workgroups
5:00 – 6:00 PM	IJPCM Editorial Board Meeting
6:00 – 7:00 PM	ICPCM Board Meeting

### CORE CONFERENCE FIRST DAY, MONDAY APRIL 27, 2015 Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

8:00 – 8:30 AM	Registration and check-in
8:30 – 8:45 AM	Conference Opening Welcoming words from officers of the ICPCM, Geneva University, World Medical Association, and World Health Organization
8:45 – 9:15 AM	Keynote Presentation: "Person-Centered Primary Health Care (PCPHC): Now More Than Ever" <i>Ted Epperly (Boise, USA)</i>

**(Organizational Note for all Sessions: *Each of the regular sessions would have 3-5 scholarly presentations (all typically involving systematic literature reviews or data-based studies) made by 1-2 core invitees, 1-2 WHO or WMA reps, 0-1 specially supported invitees, and 1-2 non-supported contributors selected from those submitting abstracts on their own.*)(Each presentation 8 minutes followed by discussion 7 minutes, and general discussion and conclusions at the end)**

- |                  |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           |
|------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 9:15 – 10:15 AM  | <p>Plenary Symposium 1: WHO and International Experience and Perspectives on Person- and People-Centered Primary Health Care</p> <p>Chair: <i>J. Appleyard (London)</i></p> <ul style="list-style-type: none"> <li>• The WHO Perspective on Primary Care – <i>Nuria Toro Polanco (WHO, Geneva)</i></li> <li>• Interpersonal universal care : All Together in Dignity – <i>David Jousset (Brest, France)</i></li> <li>• How Does Person Centeredness Work? – <i>Chris Van Weel (Nijmegen, Netherlands)</i></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |
| 10:15 – 10:45 AM | Coffee Break                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 10:45 – 12:15 PM | <p>Plenary Symposium 2: PCPHC Throughout the Life Cycle</p> <p>Chair: <i>Ted Epperly (Boise, USA)</i></p> <ul style="list-style-type: none"> <li>• WHO Perspectives on person centered care for ageing populations – <i>Islene Aranjó de Carvalho (WHO, Geneva)</i></li> <li>• Family Centered Maternity Care – <i>Kim Stutzman (Boise, USA)</i></li> <li>• Person and people centered primary health care in pediatrics – <i>J. Appleyard (London)</i></li> <li>• Personalized care planning for long-term conditions – <i>Angela Coulter (Oxford, UK)</i></li> <li>• More Good Days: Person Centered Care at the End of Life – <i>Molly Mettler (Boise, USA)</i></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                             |
| 12:15 – 1:15PM   | Lunch (open)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 1:15 – 2:45 PM   | <p>Parallel Sessions 1:</p> <p>A: Health Care Integration</p> <p>Chair: <i>Tesfa Ghebrehivet (Calgary, Canada)</i></p> <ul style="list-style-type: none"> <li>• What is a Patient Centered Medical Home PCMH? – <i>Dave Schmitz (Eagle, USA)</i></li> <li>• What is the Patient-Centered Medical Home Neighborhood? – <i>T. Epperly (Boise, USA)</i></li> <li>• Introducing individual and family continuous records for person-centered care – <i>Yongyuth Pongsupap (Bangkok)</i></li> <li>• Novel Measurement Models for Person Centered Care – <i>Levent Kirisci (Pittsburgh)</i></li> </ul> <p>B. Clinical Communication</p> <p>Chairs: <i>Herve Granier (Montpellier, France), Afzal Javed (UK)</i></p> <ul style="list-style-type: none"> <li>• Basic Communication – <i>Sandra Van Dulmen (Nijmegen, Netherlands)</i></li> <li>• How do people as patients want to be spoken to? – <i>Joanna Groves (London)</i></li> <li>• Shared Decision Making and Primary Care – <i>Jaques Cornuz (Lausanne, Switzerland)</i></li> <li>• Clinical communication across cultures – <i>Rachid Bennegadi (Paris)</i></li> </ul> |
| 2:45 – 3:00 PM   | Coffee Break                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                              |
| 3:00 – 4:30 PM   | <p>Parallel Sessions 2:</p> <p>A. The Linking of Medical Specialties and Health Care Disciplines in PCPHC</p> <p>Chair: <i>Ihsan Salloum (Miami)</i></p> <ul style="list-style-type: none"> <li>• How Should Specialties and Disciplines Link in PCPHC? – <i>C. Van Weel (Nijmegen, Netherlands)</i></li> <li>• The role of behavioral health psychiatry in PCPHC – <i>Michel Botbol (Brest, France)</i></li> <li>• Organization and Training of Pediatrics in PCPHC – <i>Jim Appleyard (London)</i></li> <li>• Team Approach in PCPHC – <i>Tesfa Ghebrehivet (Alberta, Canada)</i></li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |

B. Brief Oral Presentations 1

Chair: *Hans-Rudolf Pfeifer (Zurich)*

- Patient Centred-care and Reforms in the Latvian Primary Healthcare – *Peteris Apinis (Riga, Latvia)*
- Health Care Reform in Austria: Changes in Primary Care – *Gottfried Endel (Vienna)*
- An Evidence-Based Patient-Centered Interview Makes the Biopsychosocial Model Scientific – *Robert Smith (Michigan, USA)*
- Review Dialogues as an Opportunity to Develop a Person-related Overall Diagnosis – *Ottomar Babrs (Gottingen, Germany)*

C. Work Group Meeting 2: Refining the 2015 Geneva Declaration (*Ted Epperly and Declaration Workgroup*)

4:30 – 4:45 PM	Coffee Break
4:45 – 6:45 PM	General Assembly of the International College of Person-centered Medicine
7:00 – 10:00PM	Conference Dinner

## Invitation to Conference Dinner organized by the Paul Tournier Association

**Monday April 27, 7:00 pm**  
**All Conference Participants**

**CHF 50.-**

(Dinner, music, dancing and taxes  
included)

**Please register at**  
**The Conference Desk**

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



### CORE CONFERENCE SECOND DAY, TUESDAY APRIL 28, 2015 Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

9:00 AM – 10:30 AM	Plenary Symposium 3: Health Services Organization to Achieve Person- and People-Centered Primary Health Care Chair: <i>Otmar Kloiber (Ferney-Voltaire, France)</i> <ul style="list-style-type: none"><li>• The Role of the WHO in Achieving Person- and People-Centered Primary Health Care – <i>H. Montenegro or E. Kelley (WHO, Geneva)</i></li><li>• The Ethical Framework for Person-Centered Care – <i>M. Bouesseau (WHO, Geneva)</i></li><li>• What Do People Want and Expect of PCPHC? – <i>Joanna Groves (London)</i></li><li>• What is the Nursing Profession Contribution to PCPHC? – <i>Yukiko Kusano (ICN, Geneva)</i></li><li>• What Should a Nation's Commitment be to PCPHC? – <i>Salman Rawaf (London)</i></li></ul>
10:30 – 10:45 AM	Coffee Break
10:45 AM – 12:15 PM	Plenary Symposium 4: Collaborative Interdisciplinary Professional Training for PCPHC Chair: <i>Yongyuth Pongsupap (Bangkok), Olivier Bugnon (Lausanne, Switzerland)</i> <ul style="list-style-type: none"><li>• Inter-Professional Training in PCPHC – <i>Tesfa Ghebrehivet (Calgary, Canada)</i></li></ul>

- The Integration of Primary Care and Public Health: The Journey of Asclepius and Hygieia - *Ted Epperly (Boise, USA)*
- How Family Medicine Uses a Collaborative Interdisciplinary Training Model – *Ruth Wilson (Kingston, Canada)*
- The Integration of Behavioral Health/Psychiatry and Primary Care – *I. Salloum (Miami)*
- New Models of Collaborative Training for Resource Challenged Areas – *Dave Schmitz (Eagle, USA)*

12:15 – 1:15 PM

Lunch (open)

1:15 – 2:45 PM

Parallel Sessions 3:

A. Jitendra Trivedi WPA Sections Symposium on Person-Centered Mental Health Contributions to Primary Care

Chair: *Roy Kallivayalil (WPA, Kerala, India)*

- Classification Section - *Ihsan Salloum (Miami)*
- Multimorbidity and polypharmacy in the severely mentally ill : the need for guidelines and a person-centered integrated approach – *Helen Millar (Dundee, Scotland)*
- WPA Psychoanalysis in Psychiatry Section perspectives and contributions to primary health care – *Michel Botbol (Brest, France)*
- Spirituality Section: The adventure of living and the primacy of the person – *John Cox (Cheltenham, UK)*
- Person Centered Approach in Oncology & Palliative Care - *Luigi Grassi (Ferrara, Italy)*

B. Shared Decision Making (SDM)

Chair: *Ruth Wilson (Kingston, Canada)*

- The Framework and Science of SDM – *Molly Mettler (Boise, USA)*
- European Experience with SDM – *Angela Coulter (Oxford, UK)*
- North American Experience with SDM – *Don Kemper (Boise, USA)*
- Shared Decision-making in Maternal and Newborn Health in Burkina Faso – *Janet Perkins (Burkina Faso and Geneva)*

2:45 – 3:00 PM

Coffee Break

3:00 – 4:30 PM

Parallel Sessions 4:

A. Antoine Besse Interinstitutional Symposium on Person Centered Mental Health and Primary Care

Chair: *Michel Botbol (Brest, France)*

- Person Centered Mental Health and Primary Care: World Psychiatry Perspectives – *Roy Kallivayalil (Kerala, India)*
- World Federation for Mental Health Perspectives – *Mohammed Abu-Saleh (London)*
- Francophone Observatory for Person Centered Medicine: A short history - *Brigitte Greis (Poitiers, France)*
- World Association for Dynamic Psychiatry (WADP) Perspectives - *Maria Ammon (Berlin)*
- The french concept of psychiatric primary care (ALFAPSY) - *Herve Granier (Montpellier, France)*

B. Well-Being Promotion

Chair: *Joanna Groves (London)*

- Wellness in Medical Education – *Kim Stutzman (Boise, USA)*
- Physicians Well Being and Resilience – *Dave Schmitz (Eagle, USA)*
- Person Centered Prevention – *Don Kemper (Boise, USA)*
- A New Patient Centred Approach to Unlock the Individual's Potential to Adopt Healthy Lifestyles: Health Coaching - *AB Cinar (Copenhagen)*

C. Workgroup Meeting: Person Centered Clinical Care Guiding Principles: *J Appleyard, T. Epperly, S. Van Dulmen et al*

4:30 – 4:45 PM

Coffee Break

4:45 – 6:15 PM

Parallel Sessions 5:

A. Advocacy and Leadership Policy in Primary Care

Chair: *Dave Schmitz (Eagle, USA)*

- Africa & Middle East – *Salman Rawaf (Iraq/UK)*
- Europe: Challenges and Chances in Changing Environment – *Aleksandra Weber (Munich)*
- North America: The Achievement of the Triple Aim – *Robert Phillips (Washington, DC)*
- Asia: Advocacy/leadership for policy making in primary care– *Yongyuth Pongsupap (Bangkok)*
- Latin America: Social audit for assuring accountability in maternal and newborn health care in El Salvador – *Janet Perkins (El Salvador and Geneva)*

B. Brief Oral Presentations 2:

Chair: *Kim Stutzman (Boise, USA)*

- Intensive Mental Health Training For Medical Residents - *Robert Smith (Michigan, USA)*
- Resource Oriented Group Psychotherapy– *Ilse Burbiel (Munich, Germany)*
- The Roots of Compassion and its Flourishing in Primary Care – *Alison Gray (Hereford, UK)*

C. Work Group Meeting: Person Centered Diagnosis: *J Mezzich, I Salloum, M. Botbol, J. Appleyard, T. Epperly, J. Groves, S. Van Dulmen et al.*

7:00 PM

Dinner (On Your Own with suggested networking opportunities)

<p><b>CORE CONFERENCE THIRD DAY, WEDNESDAY April 29, 2015</b> <b>WHO Headquarters Salle A</b></p>
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8:30 AM – 9:00 AM

Key Note Lecture:

Chairs: *Jim Appleyard (London), T. Epperly (Boise, USA)*

Person-centered Medicine: Professional Requirement and Ethical Commitment – *Xavier Deau (WMA President, Epinal, France)*

9:00 AM – 10:30 AM

Plenary Symposium 5: Research Priorities for PCPHC

Chairs: *Yongyuth Pongsupap (Bangkok), Eugenio Villar (WHO, Geneva)*

- Research Priorities on the Conceptualization of Person Centered Medicine – *Juan Mezzich (New York)*
- Research Priorities for Social Determinants of Care – *Robert Phillips (Washington, DC)*
- Research Priorities for Person Centered Primary Care – *C. van Weel (Nijmegen, Netherlands)*
- The Future of Shared Decision Making – *Don Kemper (Boise, USA)*

10:30 -10:45 AM

Coffee Break

10:45 AM – 11:45 AM

Plenary Closing Session:

Chair: *Juan Mezzich (New York, USA)*

- The Winds of Change: The Essential Role of Primary Care and Family Medicine in Meeting the Changing Healthcare Needs of Society – *Ruth Wilson (Kingston, Canada)*
- 2015 Geneva Declaration – *Ted Epperly (Boise, USA)*
- Closing Remarks – *J. Appleyard and J. Mezzich*

11:45 – 12:00M

Light Lunch

12:00 – 2:00PM

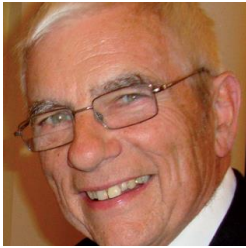
WHO Special Session: Collaborating towards the implementation of WHO's Global Strategy on People-centered and Integrated Services  
Chairs: *E Kelly (Geneva), H Montenegro (Geneva), J Appleyard (London)*

- Report on the WHO Global Strategy – *Nuria Toro-Polanco (Geneva)*
- Contributions from the 2015 Geneva Declaration on Person Centered Primary Health Care - *Ted Epperly (Boise, USA)*
- Contributions from International College of Person Centered Medicine (ICPCM) Collaborating Organizations  
ICPCM, World Medical Association, International Council of Nurses, International Alliance of Patients' Organizations, International Pharmaceutical Federation, World Organization of Family Doctors (Wonca), World Federation for Mental Health, World Psychiatric Association, Francophone Observatory for Person Centered Medicine, International Francophone Psychiatric Federation, International Association of Medical Colleges, World Association for Dynamic Psychiatry, French Psychiatric Association, German Association for Dynamic Psychiatry, American Academy of Family Physicians, Paul Tournier Association, International Federation of Medical Students' Associations, Imperial College London, University of Western Brittany, University of Geneva as well as key scholars.
- Next steps towards Implementation of and Collaboration on the WHO Global Strategy: *E. Kelley (Geneva), H. Montenegro (Geneva), J Appleyard (London) and JE Mezzich (New York)*



# EIGHTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

## *GALLERY OF PRESENTERS*



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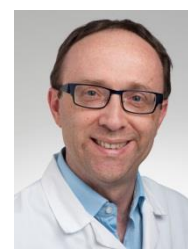
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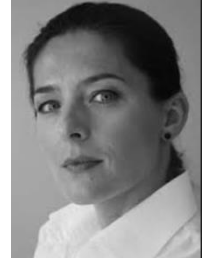




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# EIGHTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

## ABSTRACTS

### Opening Keynote Lecture

PERSON-CENTERED PRIMARY HEALTH CARE (PCPHC): NOW MORE THAN EVER  
Ted Epperly (Boise, USA)

Person-Centered Primary Health Care is defined as the person being the focal point and central to their health care and wellness efforts. Primary care serves as the entry point into the health care system for people. Primary care provides first contact care that is comprehensive, continuous, accessible, compassionate, caring, team-based, and above all else person-centered. Primary care by its very nature is integrative. It connects and coordinates care for the person and uses shared decision making to help value and respect the person's choices as they navigate through a complex and fragmented health care system. Evidence has clearly shown that primary care is a systems integrator and improves both the quality of care and the lowering of cost to both people and populations<sup>1</sup>. The use of the relationship of trust established through primary care providers is an effective and efficient

means to achieve the triple aim of better health, improved healthcare, and lower costs<sup>2</sup>. We must build a robust and vibrant person-centered primary health care system now more than ever to rebalance a health care system for the people that we serve.

1 Starfield B., Leiyu S., Mackinko J., Contribution of Primary Care to Health Systems and Health, (Milbank Quarterly, Vol. 83., No. 3, 2005) 457-501

2 Donald M. Berwick, Thomas W. Nolan and John Whittington. The Triple Aim: Care, Health, And Cost. Health Affairs, 27, no.3 (2008):759-769

### Plenary Symposium 1: WHO and International Experience and Perspectives on Person- and People-Centered Primary Health Care

THE WHO PERSPECTIVE ON PRIMARY CARE  
Nuria Toro Polanco (WHO, Geneva)

Back in 2008, WHO published the "World health report 2008: primary health care; now more than ever" on the thirtieth anniversary of the international conference of Alma-Ata. This report identifies four broad policy directions for reducing health inequalities and improving health for all: tackling health inequalities through universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health; and also welcoming the final report of the Commission on Social

Determinants of Health. One year after, the 62<sup>nd</sup> World Health Assembly adopted a resolution in which Member States were urged to put people at the centre of health care.

This presentation will provide an overview on these policy directions and will also introduce country examples in which health systems' efforts around the strengthening of the primary care have proven successful.

INTERPERSONAL UNIVERSAL CARE : ALL TOGETHER IN DIGNITY  
David Jousset (Brest, France)

First of all, I will summarize the historical debate between holistic Primary Health Care and Specific PHC. My hypothesis is that the evolution of PHC, especially in Selective PHC choosing the most effective treatment plan in terms of cost and effectiveness, is overwhelmed by a goal of rationalization, based on an economical model of cost-effectiveness. This evolution is a blurred vision of the Alma Ata's core principle which is a new model of collaboration between care givers and communities : health as a component of self-development, of

people's empowerment. In a radical way, community PHC is really "an adjunct of social revolution" (Cueto, 1871).

Then, I should present the contribution of the international movement ATD (All Together in Dignity) Fourth World, especially the 'Merging of Knowledge' methodology which enable to take into account the poorest's ideas and strategies to fight poverty. Their testimonies underline especially that a barrier to primary health care access is the humiliating attitude

from the medical staff toward the families living in extreme poverty.

From the experience and knowledge of the poorest people, a conceptual reframing of the Person's notion can be deduced, using the notions of connected self (e.g. Kittay's conception of personhood in her dependency's theory ) and social self, interpersonal trust and recognition as "vital human need" (C. Taylor, 1992), self-esteem and dignity as crucial health components, the ethical value created by relationship itself (Frankfurt 2004) and the political responsibilities derived from the human relationship throughout the social and cultural differences (S. Reader 2003; J. Tronto 2012).

Finally, Person-Centered Medicine may perform a mediating role between vertical and bottom-up approaches thanks to its integrative method and to its focus on the very core of health care, that is to say the interaction between healers and patients and relatives.

This implies a new approach of an ethics and politics of care centered on interpersonal relationship: interpersonal universal care.

#### HOW DOES PERSON CENTEREDNESS WORK?

*Chris Van Weel (Nijmegen, Netherlands)*

Individuals experience a large variety of health problems over time. Most health problems individuals experience will never be presented to professionals. When presented, patients will have implicit or explicit reasons for it [1], and the likely point of contact is primary health care. The mission of primary health care is to provide care for all health problems in all individuals and this integrated orientation makes it possible to relate interventions to individual needs and preferences.

The person centered approach is built from the 'first contact' very start of an episode of care:

- The patient's reason for the encounter [1] establishes the 'patient's agenda; with additional data of:
  - The patient's health care history and individual and community related needs and preferences;
- To this, the professional agenda will be built on:
- The health problem identified in terms of its prognosis and benefits of treatment; complimented by:

#### References

- Marcos Cueto. The Origins of Primary Health Care and Selective Primary Health Care. *American Journal of Public Health*: November 2004, Vol. 94, No. 11, pp. 1864-1874.
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- Frankfurt, H., 2004, *The Reasons of Love*, Princeton: Princeton University Press.
- Soran Reader « Distance, Relationship, and Moral Obligation », *Monist*, 86 (3), 2003, p.367-381
- Charles Taylor, 1992, "The Politics of Recognition," in *Multiculturalism: Examining the Politics of Recognition*, A. Gutmann (ed.), Princeton: Princeton University Press, pp. 25-73.
- Joan Tronto, *Partiality Based on Relational Responsibilities: Another Approach to Global Ethics*. *Ethics and Social Welfare* 6 (3):303-316. *Ethics and Social Welfare* 6 (3):303-316.

- The patient's medical history and individual and community related risks.

This places the episode in the framework of continuity of care, in which a process of shared decision making is possible to review the benefits and risks of preventive and treatment interventions, with the objective to secure the lasting capability for the patient to function [2].

#### References:

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2. Huber M Kottnerus AJ, Green L, van der Horst H, Jadad AR, Kromhout D, Leonard B, Lorig K, Loureiro MI, van der Meer JWM, Schnabel P, Smith R, van Weel C, Smid H. How should we define health? *BMJ* 2011;343:d4163

## Plenary Symposium 2: PCPHC Throughout the Life Cycle

#### WHO PERSPECTIVES ON PERSON CENTERED CARE FOR AGEING POPULATIONS

*Islene Araujo de Carvalho (WHO, Geneva)*

The world is getting older and as people age their health-care needs tend to become more complex. Older people frequently experience more than one disease at the same time, or do live with a long-term condition, such as dementia.

The health system has a key part to play in a multisectoral response to population ageing, this role, however remains unfulfilled in many settings. The current ways health systems are organized are not conducive to meet the health needs of older people. First because health services are delivered through vertical programmes, secondly because fragmented services are unaffordable for an older person who has multimorbidities, and need to make multiple consultations and payments to different providers.

Current evidence has shown that such disintegrated and uncoordinated services are associated to negative health outcomes for older people such as hospitalization, institutionalization, disability and death. [1]. A system that favours coordination and integration across the continuum of care is critical for maintaining functional capacity and autonomy in older age. [2]

This presentation will discuss the concept of older person centred and integrated care, and its implications for health systems

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1. Low, L.F., M. Yap, and H. Brodaty, A systematic review of different models of home and community care services for older persons. [Review]. BMC Health Services Research, 2011. 11: p. 93.
2. Ham, C., The ten characteristics of the high-performing chronic care system. Health Econ Policy Law, 2010. 5(Pt 1): p. 71-90.

#### FAMILY CENTERED MATERNITY CARE

**Kim Stutzman (Boise, USA)**

One of the most rewarding areas in healthcare transformation is the re-emergence of family centered maternity care. The care of a woman and her child ideally should begin in pre-conception and continue through the creation of her new family unit. To be successful, women and their partners need to develop a relationship with a provider that they can trust. The provider, in turn, relies on a team of skilled caregivers, nutritionist, lactation specialists, social workers, and nurses. The provider also has relationships with consultants to assure smooth transitions of care when necessary. The quality of care is assessed and evidence based guidelines are explained to patients and followed. Shared decision-making means that a woman participates in her care. This care should be timely

and labor management directed by maternal and fetal physiology. The physical space in the clinic and delivery area needs to be welcoming to the support team the women deems important, yet provide for safe delivery. Many women have access to parts of this model but a concerted effort is required to transform all our practices to family centered care systems.

1. Saleeby E., Brindis C. D. Women, reproductive health, and health reform. JAMA. 2011. 306(11): 1256-1257.
2. Larimore W. L., Reynolds J.L. Family practice maternity care in America: Ruminations on reproducing and endangered species – family physicians who deliver babies. JABFP. 1994;7(6): 478-488.

#### PERSON AND PEOPLE CENTERED PRIMARY HEALTH CARE IN PEDIATRICS

**J. Appleyard (London)**

Children bear a disproportionate burden of preventable diseases: with around 6 million children under the age of five dying each year. The good news is that with a people and person centered approach including improved perinatal support and practical, low-cost interventions around two-thirds of child deaths are preventable. Indeed 20% of these deaths worldwide could be avoided if WHO feeding guidelines including exclusive breastfeeding for at least six months were followed.

An integrated management of childhood illness focuses on the well being of the whole child. It aims to reduce death, illness and disability, and includes both preventive and curative elements that are implemented by families, local communities and health facilities. Evaluation of such programs in five countries found that such an integrated approach can reduce under-five mortality and improve nutritional status, if implemented well. It is a worthwhile investment as it costs up

to six times less per child when correctly managed than current care!

Physician led primary care has important attributes to make such integrated care possible in all health systems. Family practice provides access by unselected health problems. It is comprehensive, coordinated, collaborative and local community orientated with key personal longitudinal support for children and their families.

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- 1) A systematic analysis for the Global Burden of Disease Study 2012. Lozano, R, et al. *Lancet*. 380: 2095–2128
- 2) Analytic review of the Integrated Management of Childhood Illness Strategy Final Report 2003. World Health Organisation
- 3) Improving Health Systems: The contribution of Family Medicine. World Organisation of Family Doctors 2002

#### PERSONALIZED CARE PLANNING FOR LONG-TERM CONDITIONS

**Angela Coulter (Oxford, UK)**

People with long-term health conditions play an important part in managing their own health, but they need appropriate support from health professionals to do this effectively. Personalised care planning aims to provide support that is tailored to the needs of individual patients by discussing and jointly agreeing goals and actions for managing the patient's health problems. This type of collaborative approach is encouraged by policymakers, but not routinely implemented by clinicians.

We carried out a systematic review to compare the effects of personalized care planning to usual care (i.e. forms of care in

which active involvement of patients in treatment and management decisions is not explicitly attempted or achieved. We found evidence of improvements in patients' physical health, psychological health and confidence and skills to manage their health. The process appears to work best when it includes preparation, record-sharing, care coordination and review, when it involves more intensive support from health professionals, and when it is integrated into routine care.

Personalised care planning is a promising approach that offers the potential to provide effective help to patients, leading to better health outcomes.

## MORE GOOD DAYS: PERSON CENTERED CARE AT THE END OF LIFE

*Molly Mettler (Boise, USA)*

Gaps exist in what kind of care patients want at end of life and what kind they get. In a large scale study in the USA, most patients with serious illness said they would prefer to die at home. Yet most patients died in hospitals and care was rarely aligned with the patients' preferences. (1)

Evidence suggests that patients often prefer a more conservative pattern of end of life care than they actually receive. People living with advanced illness and their family caregivers are often not asked about the care they want, and receive little help in making decisions that reflect their values and preferences. (2)

What can be done to close these gaps and make end of life care more person-centered?

"More Good Days" is a patient-centered approach designed to provide patients with the framework and information to help them clarify their values and express their treatment preferences for care at the end of life. In this approach, rather than asking a patient to choose between more care or less care, patients are encouraged to identify and define what a "good day" means for them. Goals of care are refocused on maximizing the number of "good days" that the patient can enjoy, ensuring care that is truly patient centered. (3)

1. End-of-Life care. The Dartmouth Atlas of Health Care. <http://www.dartmouthatlas.org/keyissues/issue.aspx?con=2944>. Accessed February 25, 2015.
2. Transforming Advanced Illness Care. Coalition to Transform Advanced Care. 2014
3. Kemper, D. et al. More Good Days. Healthwise. 2013

### Parallel Sessions 1:

#### A: Health Care Integration

## WHAT IS A PATIENT CENTERED MEDICAL HOME PCMH?

*Dave Schmitz (Eagle, USA)*

The Agency for Healthcare Research and Quality defines the Patient Centered Medical Home PCMH as having key domains delivering patient-centered care which is comprehensive, coordinated, accessible, and focused on quality and safety<sup>1</sup>. PCMH is a model for achieving excellence in the delivery of primary care which best meets a patient's needs. Recognized strategies that place patients at the center of primary care include: partnership with patients engaging them in their own care, quality improvement in the primary care practice, and the development and implementation of both policy and research<sup>2</sup>. The Patient Centered Medical Home model has evolved since its inception while it has remained foundational in the transformation to increasingly person-centered medicine.

1. Agency for Healthcare Research and Quality. Patient Centered Medical Home Resource Center: <http://pcmh.ahrq.gov/page/tools-resources> , Accessed March 12, 2015.
2. Peikes D., Genevro J., Scholle S., Torda, P. (February 2011). The Patient-Centered Medical Home: Strategies to Put Patients at the Center of Primary Care, <http://pcmh.ahrq.gov/page/patient-centered-medical-home-strategies-put-patients-center-primary-care>. Accessed March 12, 2015.

## WHAT IS THE PATIENT-CENTERED MEDICAL HOME NEIGHBORHOOD?

*T. Epperly (Boise, USA)*

The Patient-Centered Medical Home Neighborhood is a description of the other health care services that support, connect, and integrate care for the person in conjunction with the person's Patient-Centered Medical Home.<sup>1</sup> This "neighborhood" is comprised of medical specialists, subspecialists, hospitals, pharmacies, social workers, psychologists, dietitians, physical therapists, dentist, home health nurses, hospice, and others that help provide high-quality health care to and for the person. Both the Patient-Centered Medical Home Neighborhood and the Patient-Centered Medical Home help integrate and coordinate a

person's care with them at the center of all care efforts in a seamless manner.<sup>2</sup> This "neighborhood" is predicated on clear communication, timely sharing of data and patient information, and coordinated transition of care all while keeping the person in the center of the health care system.

1. Patient-Centered Primary Care Collaborative, Patient-Centered Medical Home Neighborhood, [www.pccpc.org](http://www.pccpc.org).
2. National Committee for Quality Assurance, Patient-Centered Medical Home Neighborhood, [www.ncqa.org](http://www.ncqa.org).

## INTRODUCING INDIVIDUAL AND FAMILY CONTINUOUS RECORDS FOR PERSON-CENTERED CARE

*Yongyuth Pongsupap (Bangkok)*

To promote an empathic approach of care, develop trustful relationships between patients and primary care providers,

and person-centered care, individual and family continuous records are used in the Thai health care system since 1990s.

These records include family folders, synthesis cards, operational cards, tickler files, personal tickets and personal books. This system of recording is being progressively transformed from hard copies to more and more electronic records.

The family folder basically contains information on the location of the house and names, date of birth, and relationships of the family members.

When a person consults the primary care unit for the first time, an individual synthesis card is open. All details are not written down at each contact, but only what should be remembered, after an important episode (illness, period of risk), to ensure further continuity of care: occurrence of an illness or a disease, reason of an admission at the hospital and results etc.

When needed, an operational card is opened to facilitate a specific process of care: for chronics (tuberculosis, diabetes, hypertension, AIDS etc.) and preventive care to persons at risks (pregnancies, children under five years old, etc.). The

operational cards are either kept in the family file or sorted in a tickler file according to the expected appointment for follow up. The tickler file is useful not only for organizing the consultation (indicating who will attend the session) but also for being proactive with defaulters.

The personal ticket or personal book is handed over to the client to recall instructions and information about his/her case.

There is now a move to computerize the information system. High skill IT (information technology) staff is mobilized to that effect. The challenge is to ensure that the information produced will still support case management, not only facilitate reporting. An added value of the computerized system should be the accessibility of the information to all those among the care provider's team who need it.

Keywords: family file, synthesis card, operational care, personal ticket, global medical record

## NOVEL MEASUREMENT MODELS FOR PERSON CENTERED CARE

*Levent Kirisci (Pittsburgh)*

The main purpose of this presentation is to introduce novel measurement models for the Person-Centered Care Index (PCI). More specifically, variance-covariance structure of the PCI is explored. Alternative models are tested: unidimensional, bi-factor, second-order factor, eight-first order factor, etc. The PCI includes 33 items under 8 broad categories. These categories are: (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, Training, and Research. A four-point scale (never, occasionally, frequently, always) was used to mark the level of presence of each indicator in a given health system. The PCI also provided a global average score. In a second study, the same measurement approach is applied to DSM-IV substance use disorder diagnoses symptoms. The

measurement model of SUD symptoms are explored in a sample of 550 adults. In the final section, statistical recommendations are provided in selecting the best possible model.

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Mezzich, J., Adams, N., Wallcraft, J., Trivedi, J., Salloum, I., Kirisci, L. (2012). Conceptual refinement and further development of the Person-centered Care Index. Paper presented at the annual meeting of the International College of the Person-centered Medicine in Geneva.

Kirisci, L. (2014). Statistical approaches to scale development and refinement and validation. Paper presented at the annual meeting of the International College of the Person-Centered Medicine in Geneva.

## B. Clinical Communication

### HOW DO PEOPLE AS PATIENTS WANT TO BE SPOKEN TO?

*Joanna Groves (London)*

The health professional-patient relationship influences a patient's experience of health care. In the past communication often comprised of a straightforward exchange of information where a patient gave information about the problem they were experiencing and the doctor provided a diagnosis and informed the patient what the treatment would be. The doctor was seen as the medical expert and this led to sayings such as "The Doctor knows best" and "Trust me, I'm a doctor". However, as is increasingly recognised, the patient is also an expert; an expert in how their condition affects their life and in what their goals are for their health and well being.

Person-centered health care requires communication which enables respect for people's needs, preferences, dignity, values, autonomy and independence. There is not a 'one size fits all approach' as people respond to different levels and types of communication but there are some fundamental principles. This presentation will consider how patients want to be spoken to in order to feel respected and so that their experiences can inform shared decision-making in mutually trusting and equal partnerships with health professionals about their health and well being.

### SHARED DECISION MAKING AND PRIMARY CARE

*Jaques Cornuz (Lausanne, Switzerland)*

Shared decision making, a process whereby health professionals and patients work together to make healthcare

choices, is fundamental to informed consent and patient-centered care. In recent years, the number of shared decision

making publications in scientific journals has surged. Furthermore, more and more primary health care professionals agree that applying shared decision-making in clinical practice might be effective in enabling patients to more collaboratively take part in decisions about their care. SDM interventions, i.e., using appropriate decision aids, has been recently adopted by several primary healthcare professionals societies.

During the workshop, we will describe activities, opportunities and barriers of SDM for primary care professionals, as well as several decision aids for preference sensitive care interventions, such as screening tests and chronic conditions treatments. We will also demonstrate that, in spite of the many myths surrounding shared decision making, it is a feasible, suitable and adequate means to approach the clinical encounter in the 21st century.

## CLINICAL COMMUNICATION ACROSS CULTURES

*Rachid Bennegadi (Paris)*

In this presentation, I wish to outline the three key conditions that make an interview or a consultation between a healthcare professional and a patient ethical in a transcultural context:

1. There is no possibility for clinical care if there is no possible communication between both actors. Either the professional and his/her patient have a language in common which is sufficiently mastered on both sides to allow for the metaphorisation of affects, or the professional resorts to an interpreter whose role is closer to mediation than to sheer translation.
2. No diagnosis or treatment can be elaborated adequately if there is no room for the confrontation of social and cultural representations of physical or psychological suffering.

Even though the process may be more complex in the context of a psychiatric interview than for a physical exam, the underlying dynamics and objectives are the same.

3. It is mandatory to take into account the societal context and its conditions for healthcare access in a transcultural setting, be it in relation to immigration or asylum trajectories. Lacking the proper training to work in such settings necessarily leads to ill-adapted care, obstacles in healthcare access, low quality in the clinical response, and the risk to sustain existing feelings of exclusion or stigmatization for patients, as well as to create burn-out situations for professionals.

## Parallel Sessions 2:

### A. The Linking of Medical Specialties and Health Care Disciplines in PCPHC

#### HOW SHOULD SPECIALTIES AND DISCIPLINES LINK IN PCPHC?

*C. Van Weel (Nijmegen, Netherlands)*

Most health care is taking place in the community where people live and to a large extent based on a long-term personal working relation between a family physician and patient, and built on trust and established expectations. A person-centered approach is part of this [1].

Involvement of other providers poses a risk to lose this person-centeredness, in particular the case in out-of-hours care and referrals within the primary health care or to secondary care professionals.

In order to preserve patient-centeredness it is important to re-define a framework in which professionals in health care collaborate, to replace the (implicit) agreement that each professional and discipline should focus on its specific expertise. The following conditions provide building blocks of person-centered linking of specialties and disciplines:

- Professional collaboration serves first and foremost the interests of the person of the patient, and requires from all professionals involved a focus on personalized goals of care;

- Integration of various interventions into a coherent approach serving individual needs and preferences;
- Shared decision making, with patients as partners of all professionals involved;
- Primary health care function to co-ordinate and navigate patients in case of controversial or ambiguous care proposals.

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1. WONCA Europe. The European Definition of General Practice/Family Medicine. <http://www.woncaeurope.org/sites/default/files/documents/Definition%203rd%20ed%202011%20with%20revised%20wonca%20tree.pdf> (accessed February 27, 2015).
2. Elwyn G, Lloyd A, May C, van der Weijden T, Stiggelbout A, Edwards A, Frosch DL, Rapley T, Barr P, Walsh T, Grande SW, Montori V, Epstein R. Collaborative deliberation: a model for patient care. *Patient Educ Couns* 2014 97:158-64. doi: 10.1016/j.pec.2014.07.027.

#### THE ROLE OF BEHAVIORAL HEALTH PSYCHIATRY IN PERSON CENTERED PRIMARY HEALTH CARE

*Michel Botbol (Brest, France)*

Behavioral Health Psychiatry has recently emerged in the US as a new way to address mental health issues focusing on behavioral effects of mental and emotional illnesses that disrupt one's life affecting relationships, jobs, family and life goals. In a global stream where psychiatry is mainly focused on biological and neurodevelopmental processes underlying

mental disorders, it is a way to give more space to psychological aspects of these disorders and to develop approaches dealing with these dimensions in patients with the common goal of assisting them to regain control of their lives and to reconnect with their families and community. In that sense, this is very close in aims to the recovery movement and

to person centered psychiatry because it shows a central concern for the person of the patient in both his psychological subjective aspects and the relevant context.

As these two other approaches, behavioral health psychiatry attempts to connect modern advances in psychiatry to a

humanistic approach putting respect for patient's rights and values at the top of its agenda, with the objective of empowering people rather than having a restricted focus on disease alone. This paper will pointedly discuss how these new psychiatric approaches may contribute to primary care.

## ORGANIZATION AND TRAINING OF PEDIATRICS IN PCPHC

*Jim Appleyard (London)*

The care of the newborn infants children and adolescents is part of the core content of family practice. Knowledge of normal human bio psychosocial development, growth and wellbeing is an essential background to understanding and recognizing the acute and chronic disorders and diseases of childhood within the context of the family. This should form the foundation of the educational content for child health within family practice. Practical clinical skills notably listening to and observing the child with his or her parents and carers own narrative, an empathic attitude and a supportive ethical framework need to be taught in both hospital and community child friendly settings. Hospitals provide a helpful learning environment for the more severe acute illnesses of childhood, the common problems of the newborn infant and the less

common but important complex disorders seen in the pediatric specialties. But the hospital 'episodes' of children are increasingly brief with little continuity of care. It is therefore very important that children's disease and disorders are learned and understood within the primary healthcare setting supported by experienced clinical pediatric educators.

### References

1. The contribution of Family Medicine to improving Health Systems. World Organisation of Family Doctors 2013
2. A personal approach to person-centred paediatric care Appleyard W J 2011 Journal of Evaluation in Clinical Practice 17 2 376-378

## TEAM APPROACH IN PCPHC

*Tesfa Ghebrehiwet (Alberta, Canada)*

In an era of growing interest in person-centred care, increased consumer demand from health care, shifting disease patterns and increasing co-morbid conditions, providing quality, cost-effective care, requires a team-based primary health care approach [1]. Team approach can be effectively introduced in the delivery of comprehensive primary health care services for episodic and continuous care for patients with chronic conditions.

It is well accepted that, within each profession, there are varying levels of competence and overlapping areas of expertise that can be integrated to avoid fragmentation, improve cost-effectiveness and outcome of care. It is also clear that no single health profession can claim ownership of knowledge that could contribute to health and wellbeing. Working together, the healthcare providers in the PCPHC team can integrate their knowledge for the benefit of their

patients. However, in order to do this there is need to go upstream and provide opportunities for interprofessional education. In fact some argue that team approach in PCPHC is unlikely to succeed without interprofessional education [2].

The presentation will highlight the implications and benefits of team approach in the delivery of person-centred primary health care.

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## B. Brief Oral Presentations 1

### PATIENT CENTRED-CARE AND REFORMS IN THE LATVIAN PRIMARY HEALTHCARE

*Peteris Apinis (Riga, Latvia)*

During the last twenty years an impressive number of different initiatives has changed the health organization, funding mechanism, medical staff training and the very structure of the health care system in Latvia. Reforms strengthening the primary healthcare and introducing the family doctor speciality have been implemented. Although due to the political force and fast reforms, the institution of family physician has not gained the authority and support from community as it was envisaged before. Patient-centred care is impossible without established and strong primary health care and patients having knowledge and willingness to take

responsibility about their own health and treatment. Given the heritage of soviet system and approach to health where the part of ideology was to make people dependent on system, health care served as a tool to increase this dependence from the system. There was little knowledge about health and disease prevention among lay persons. Unfortunately many patients still now have got this attitude that their health is responsibility of healthcare professionals.

To change the situation and let patient-centred approach become a part of primary health care several strategies and activities have to be implemented in Latvia:

1. Re-assessment of existing primary healthcare with adequate financing for it.
2. Introducing of health education in schools and programs for adults on health maintenance and disease prevention as a part of life-long education.
3. Elaboration of existing curricula for undergraduate medical education emphasising family medicine and patient-centred health care

## HEALTH CARE REFORM IN AUSTRIA: CHANGES IN PRIMARY CARE

*Gottfried Endel (Vienna)*

**Objective:** Austria's health care system provides free access to basically all levels of care. According to the health care reform primary care should become the single point of contact to comprehensive care. Future primary care should be provided by a multiprofessional team and not only by a GP in a traditional single-handed practice. The intention is to implement a continuous and comprehensive outpatient care system as a replacement for the popular as well as costly hospital outpatient departments.

**Methods:** Using existing reimbursement data to analyze usual care should provide the basic information to model different possible scenarios for the design of the future primary care system.

**Results:** The demographic changes in the field of the health care providers and a service utilization skewed towards hospitals needs a new distribution and arrangement of responsibilities and work load. The calculation of different scenarios shall support political decisionmaking in the context of the ongoing health care reform.

## AN EVIDENCE-BASED PATIENT-CENTERED INTERVIEW MAKES THE BIOPSYCHOSOCIAL MODEL SCIENTIFIC

*Robert Smith (Michigan, USA)*

Medicine's isolated disease focus precludes adopting the systems-based approach embraced by other sciences long ago. Advocated to replace the disease-only biomedical model, Engel's systems-based biopsychosocial (BPS) model integrates the psychosocial aspects with disease information.

I review that the BPS model has gained little traction because there was no reliable, valid patient-centered interviewing method to define it. Ill-defined, general methods led to inconsistent, often contradictory teaching and precluded interventional research, leaving a field dominated by descriptive work viewed as soft science or non-scientific.

Our new behaviorally-defined patient-centered method (see workshop) defines, for the first time, the BPS model by efficiently eliciting relevant psychosocial data in a repeatable way. A RCT showed the method was learned well, 2 two later

RCTs demonstrating its association with improved health outcomes.

I propose that, by defining the BPS model, this reliable, valid patient-centered method merits widespread adoption if we want a more scientific, systems-based medicine.

### References

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## REVIEW DIALOGUES AS AN OPPORTUNITY TO DEVELOP A PERSON-RELATED OVERALL DIAGNOSIS

*Ottomar Bahrs, Susanne Heim, Karl-Heinz Henze, Heinz-Harald Abholz, Katharina Ilse, Sabine Weißbach, Stefan Wilm (Göttingen, Germany)*

**Background:** In long-term care of chronically ill patients, the treatment process is rarely in the focus of GP-patient interactions. A specific interaction tool, the Review Dialogue (RD), has been developed to integrate patients' health-related problems/risks as well as coping strategies/resources and to agree upon shared treatment objectives.

**Research question:** Do periodical RDs contribute to a better achievement of treatment objectives and to arrive at an overall diagnosis (Balint)?

**Method:** GPs were randomized into either an intervention group (extra training and regular RD with 20 chronically ill patients) or control group (usual care). Videos of a sub-sample of patients (n=5 per practice) were taken at four time points.

This presentation focuses on a sub-sample of 110 video-recorded GP-patient interactions of the intervention group, analysed using a semi-standardised procedure (RLI). An in-depth analysis of a maximum variation sample of 7 GPs'

videotapes across four time points was made to identify professional interaction strategies.

**Results:** Implementing the RD and creating an overall diagnosis is case-specific with respect to both, the GPs and the patients.

**Conclusions:** Review Dialogues facilitate the GP-patient communication process about diagnostics and therapy helping to make the implied overall diagnosis explicit.

**Key words:** GP-patient-interaction, chronic illness, salutogenic orientation, overall diagnosis

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## Plenary Symposium 3: Health Services Organization to Achieve Person- and People-Centered Primary Health Care

### THE ETHICAL FRAMEWORK FOR PERSON-CENTERED CARE

*M. Bouesseau (WHO, Geneva)*

In March 2015 the World Health Organization launched a global strategy on people-centred integrated health services. The main challenge of this initiative is to adopt the perspectives and expectations of the individuals, their families and communities and actively include them in decision making processes for all health interventions. This approach reflects the need to ensure that people make informed autonomous decisions, one of the pillars of clinical and public health ethics, as well as research ethics. The strategy also insists on the need to integrate health services in the continuum of care, from prevention to palliation; and to strengthen good governance mechanisms in order to provide equitable access to efficient health services. Each of the five strategic directions of the strategy is embedded in fundamental components of

what should be the ethical framework for health services, it is thus important to make this linkage explicit.

The example of palliative care programs will be used to show how the WHO global strategy on people-centred integrated health services applies to specific health programs, answering the diversity of needs and expectations of the people.

#### References:

1. WHO global strategy on people-centered and integrated health services, Interim report, 2015
2. Public health: ethical issues, Nuffield council, 2007, available in <http://nuffieldbioethics.org/wp-content/uploads/2014/07/Public-health-ethical-issues.pdf>

### WHAT DO PEOPLE WANT AND EXPECT OF PCPHC?

*Joanna Groves (London)*

The World Health Organization's World Health Report of 2008 titled, "Primary Health Care – Now More Than Ever" put renewed emphasis on the values of achieving health for all and putting people at the centre of health care. These values are being taken forward by numerous national and global initiatives to further patient-, person- and/or people-centered care in order to support the achievement of universal health

coverage. At the core is the need to understand what people expect and want from health care in order to design health systems for the future that can respond to patients' needs, wishes and preferences. This presentation will consider what people want and expect from Person Centered Primary Health Care and how patient views and experiences can inform the development and delivery of primary health care.

### WHAT IS THE NURSING PROFESSION CONTRIBUTION TO PCPHC?

*Yukiko Kusano (ICN, Geneva)*

The International Council of Nurses believes that equity and access to primary health care (PHC) services, particularly nursing services, are key to improving the health and well-being of all people [1]. Nurses, as the largest group of health professionals, and the closest, and often only available, health workers in many communities, have contributions to make in achieving equitable access to person- and people-centred PHC services. This presentation will discuss nurses' contributions in each of the four sets of the PHC reforms set by the World Health Organization [2] – through nurses' person- and people-centredness, through their knowledge and experience and through their participation both at the decision

making tables and at the point of care where they touch and impact lives.

[1] ICN. (2007). ICN Position Statement: Nurses and primary health care. Available at:

[www.icn.ch/images/stories/documents/publications/position\\_statements/D02\\_Nurses\\_Primary\\_Health\\_Care.pdf](http://www.icn.ch/images/stories/documents/publications/position_statements/D02_Nurses_Primary_Health_Care.pdf).

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## Plenary Symposium 4: Collaborative Interdisciplinary Professional Training for PCPHC

### INTER-PROFESSIONAL TRAINING IN PCPHC

*Tesfa Ghebrehiwet (Alberta, Canada)*

Governments around the world are looking for innovative solutions that will ensure the appropriate supply, mix and distribution of the health workforce. One of the most promising solutions can be found in interprofessional collaboration and education. Effective interprofessional education (IPE) fosters

respect among the health professions, eliminates harmful stereotypes, and fosters a patient-centred ethic in practice. IPE occurs when students from different professions learn together at some point during their training in order to prepare them to work together in health teams [1].

This means, the approach and content of medical, nursing and midwifery and other curricula must adapt to adequately prepare health professionals to practice within the health team model. This will require the implementation of well-planned educational strategies, IPE so that health professionals learn together in order to work together in delivering person-centred primary health care [2].

The presentation will highlight key issues in IPE and its benefits in the delivery of person-centred primary health care.

#### THE INTEGRATION OF PRIMARY CARE AND PUBLIC HEALTH: THE JOURNEY OF ASCLEPIUS AND HYGIEIA *Ted Epperly (Boise, USA)*

Asclepius was the Greek God of Medicine. Hygieia was one of his five daughters and the Goddess of hygiene, cleanliness, and sanitation.<sup>1</sup> Primary care is a person-centered care model that focuses on individualized care of the person. Public health on the other hand focuses on the health of an entire population of people. These two disciplines are typically separated in their own silos of medicine and public health without too much thought about overlap and synergy. That was the past. In the present and into the future, the paths of primary care (Asclepius) and population health (Hygieia) are not only brought together but bonded together. The transformation of health care will see more primary care physicians managing populations of patients with common conditions such as diabetes, hypertension, heart failure, asthma, and emphysema

#### References

[1]. Framework for Action on Interprofessional Education & Collaborative Practice: WHO 2010. [http://www.who.int/hrh/nursing\\_midwifery/en/](http://www.who.int/hrh/nursing_midwifery/en/).

[2]. Reeves S et al. Interprofessional education: effects on professional practice and health care outcomes. Cochrane Database of Systematic Reviews, 2008, Issue 1

as groups through electronic medical record registries using population health techniques.<sup>2</sup> Person-centered and people-centered care using software tracking tools will help care for groups of similar people while not losing the focus of the individual within the population.

1 Asclepius. (2015, March 5). In Wikipedia, The Free Encyclopedia. Retrieved 16:31, March 12, 2015, from <http://en.wikipedia.org/w/index.php?title=Asclepius&oldid=649920367>

2 Epperly, MD, T. (2014). *Fractured: America's Broken Health Care System and What We Must Do to Heal It* (Paperback ed.). Boise, Idaho: Ted Epperly, MD.

#### HOW FAMILY MEDICINE USES A COLLABORATIVE INTERDISCIPLINARY TRAINING MODEL *Ruth Wilson (Kingston, Canada)*

Family physicians are skilled providers of generalist person-centred medical care. The relationship between physician and patient is therapeutic in itself. Family physicians are trained to encourage patients to present any and all undifferentiated problems to them.

This model of an individual physician-patient relationship may be at odds with a model of collaborative interdisciplinary care. Certainly other health care providers have a range of skills which may supplement, extend, or replace those of family physicians. And no one physician can provide 24/7 care for all the health needs of his or her patient. Team-based primary care is practical, cost-effective, and holds the potential to be of higher quality.

Family medicine residency programs balance the training needs of their learner, which include developing strong attachments to individual patients, with the requirement that family physicians function well in a team environment. These two educational needs are in tension, but can be resolved with careful attention.

#### References:

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College of Family Physicians of Canada. *CANMEDS-Family Medicine* 2009

#### THE INTEGRATION OF BEHAVIORAL HEALTH/PSYCHIATRY AND PRIMARY CARE *I. Salloum (Miami)*

Ancient medical tradition, such as the Indian, Chinese or Greek had a holistic view of health with integrated concept of healing and care. On the other hand, modern medicine emphasized a focused and specialized approach to health. The call for integrated care has become increasingly pressing with the negative consequences of fragmentation of care, especially when dealing with chronic diseases. Mental health is one of the key domains of primary care. Despite of the fact that most people seek help for mental health from primary care than specialized psychiatric providers, the fragmentation in

mental health care and its separation from primary care has been significant. Even within mental health there has been a major fragmentation of care for those with substance use disorders from other psychiatric conditions.

In this presentation we will review experiences of care integration and their expected outcome of enhancing health restoration as well as health prevention. Further, we will discuss the rationale for a person-centered integrative diagnostic model as the optimal approach for the integration of mental health and primary care.

## NEW MODELS OF COLLABORATIVE TRAINING FOR RESOURCE CHALLENGED AREAS

*Dave Schmitz (Eagle, USA)*

Person-centered medicine will require new models of care which place the primary care physician within the context of a highly functioning health care team that is both collaborative and interprofessional<sup>1</sup>. While resource challenged areas by definition do not have everything common to other environments, they may in fact be ideal communities for training in preparation for care in rural areas or when delivering care to underserved populations. Given limited resources, rural education is by nature more interprofessional allowing physicians, mental health workers and others to learn side by side in team-based care delivery<sup>2</sup>. Several new models of medical education similarly provide training in environments strained for resources to meet patient needs while strengthened by the opportunity for collaboration in prioritizing person-centered care delivery.

1. Saba G. W., Villela T. J., Chen E., Hammer H., Bodenheimer T. (2012). The Myth of the Lone Physician: Toward a Collaborative Alternative. *Ann Fam Med*, Mar, 10(20): 169-173.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3315136/>.

Accessed March 12, 2015.

2. National Rural Health Association (policy). "The Role of Distributed Rural Medical Education in Access to Quality Healthcare" (2014).

<http://www.ruralhealthweb.org/go/left/policy-and-advocacy/policy-documents-and-statements/official-nrha-policy-positions> . Accessed March 12, 2015.

### Parallel Sessions 3:

#### A: Jitendra Trivedi WPA Sections Symposium on Person-Centered Mental Health Contributions to Primary Care

##### CLASSIFICATION SECTION

*I. Salloum (Miami)*

The Classification Section is one of the scientific section of the World Psychiatric Association that addresses issues related to classification, diagnostic assessment and nomenclature in psychiatry and mental health. An ongoing effort and a key project of this Section has been the contribution to the development of the Person-Centered Integrative Diagnostic (PID) Model as well as to collaborate with other classification

sections of other international psychiatric associations, such as the Latin American Psychiatric Associations on development of guidelines to psychiatric diagnosis. This presentation will review the development of the PID as well as the adoption of this model into the Latin American Guidelines for Psychiatric Diagnosis (GLADP).

##### MULTIMORBIDITY AND POLYPHARMACY IN THE SEVERELY MENTALLY ILL : THE NEED FOR GUIDELINES AND A PERSON-CENTERED INTEGRATED APPROACH

*Helen Millar (Dundee, Scotland)*

The concept of multimorbidity in the severely mentally ill population continues to attract increasing attention with the recognition of multiple burdens of disease, reduced life expectancy and the complexity of providing treatment in the current single disease model of care. Patients with severe mental illness, multimorbidity and polypharmacy under the care of several specialities is therefore the norm and not the exception.

The combination of a chronic medical condition and a mental health problem presents specific challenges for the current single disease framework model of health care, by increasing the risks of drug-drug interactions and prescribing errors which can compromise the therapeutic safety for the individual patient.

This presentation will demonstrate the growing evidence and experience for adopting an integrated person- centered model of care for this population and the need for further evaluation

of technology to coordinate and assist communication across primary and secondary health care systems and specialities. The presentation will highlight the gaps in the literature in this area with the need for further research to provide comprehensive guidelines to improve medication management and optimize clinical outcomes for patients with severe mental illness and multimorbidity co-prescribed multiple medications.

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2. Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B. Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. *Lancet* 2012; 380:37-43

## WPA PSYCHOANALYSIS IN PSYCHIATRY SECTION PERSPECTIVES AND CONTRIBUTIONS TO PRIMARY HEALTH CARE

*Michel Botbol (Brest, France)*

If it is considered only a psychotherapeutic technique, psychoanalysis has a limited role to play in primary health care. But if one considers, as Freud himself stated it, that psychoanalysis is also a method to investigate the mental processes and a set of theories produced by this method, it can inform professional practice in the primary care setting. In this presentation we will try to show how, in a person centered perspective, it can inform professionals and teams to work

through many of the practical issues that are crucial in this type of clinical approach, particularly when dealing with the need to take into account subjective aspects involved in the patient-professional relationship and to integrate a dynamic approximation to everyday primary health care. We will particularly consider the role of empathy to understand the patient's inner world in general medical situations.

## SPIRITUALITY SECTION: THE ADVENTURE OF LIVING AND THE PRIMACY OF THE PERSON

*John Cox (Cheltenham, UK)*

This talk will explain my advocacy of the WPA Section of Religion, Spirituality and Psychiatry, and of the more vestigial Perinatal and Infant Mental Health Section, when I was Secretary General of the WPA (2002-8). It is based on recent publications in these fields, new models of health care delivery (which respect the person in relationships), and on the story which has shaped me.

I will point to sign posts along the way. These explain my interest in primary care and the role of Health Visitors as beacons of hope in a turbulent health service. The NHS is unmoored from its source of values and being diminished by rampant managerialism. A new culture of care is required as recommended by Robert Francis.

The sign posts include: genetics and epigenetics (my grandparents were protestant practitioners, my father a Methodist minister), the wholeness of the brain (if I was not a doctor I might have been a singer), seminal thinkers (especially the Genevan physician Paul Tournier), my wife and other family members.

The talk concludes with a summary of the draft statement of the Religion and Psychiatry Section about the roles and responsibilities of psychiatrists when considering their own faiths and values- and the need to understand their patients' priorities, religious beliefs and spiritual practices.

In conclusion it is suggested that the bio- psychosocial model may no longer provide an adequate framework for health care delivery, and that the body-mind-spirit paradigm (or world view) is more fit for purpose - as it contains the primacy of relationships and the centrality of the Person.

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## PERSON CENTERED APPROACH IN ONCOLOGY & PALLIATIVE CARE

*Luigi Grassi (Ferrara, Italy)*

Oncology and palliative care should have the person (and the family) at the center of the intervention (patient/family-centered care) in all the phases of the disease and treatment. It is important that oncology and palliative care integrate the scientific method with psychological, interpersonal and spiritual insights, since psychosocial needs and conditions (e.g. demoralization, distress and existential pain) as well as psychiatric disorders (e.g. depression, stress-related disorders) have to be addressed through a person-centered approach by multidisciplinary cancer and palliative care teams. Screening for psychosocial needs and proper psychosocial assessment are mandatory parts of the encounter with cancer patients and their families along the illness trajectory.

A series of psychosocial interventions have been developed as helpful approaches to be applied in oncology and palliative

care (e.g. supportive-expressive, meaning-centered, dignity psychotherapy). These interventions, integrated with proper psychopharmacology treatment, have the aims to heighten the patients' sense of dignity, to increase their sense of purpose and meaning, to lessen their sense of suffering and to decrease demoralization, anxiety and depression in all the phases of illness, including end of life.

References:

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## B: Shared Decision Making (SDM)

### THE FRAMEWORK AND SCIENCE OF SDM

*Molly Mettler (Boise, USA)*

Shared Decision Making (SDM) is a process through which clinicians and patients work together to select tests, treatments

and other care plan strategies based on both the clinical evidence shared by the clinician and the informed goals,

values and preferences shared by the person. SDM provides patients with the support they need to make the best individualized care decisions while allowing providers to feel confident in the care they prescribe.

To help providers to introduce SDM to their patients, the Informed Medical Decisions Foundation and Healthwise, a merged not-for-profit organization in the USA, have formulated a six step framework: (1)

1. Invite the patient to participate.
2. Present the patient with treatment options.
3. Provide the patient with information on risks and benefits.
4. Help the patient evaluate the options based on his or her goals and concerns.
5. Facilitate deliberation and decision making.
6. Assist with next steps.

Clinicians and patients can use specialized tools to achieve SDM. Patient decision aids (pDAs) are “tools designed to help people participate in decision making about health care options . . . they prepare patients to make informed, value-based decisions with their practitioner.” (2) More than 100 randomized trials of SDM supported by pDAs have shown that people who have used these tools are more informed, more accurately perceive their risks, and more often get treatments consistent with their values. (3)

1. Wexler MD, R. Six steps of shared decision making. Informed Medical Decisions Foundation. 2012
2. The International Patient Decision Aid Standards Collaboration. 2015
3. Stacey et al. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews. 2014

### EUROPEAN EXPERIENCE WITH SDM

*Angela Coulter (Oxford, UK)*

Shared decision making has been enthusiastically embraced by policy makers and professional societies in several European countries, but it has been slow to filter into mainstream clinical practice. Experience in various demonstration projects leads us to believe that the following ten factors need to be in place to promote more widespread adoption:

1. Research evidence that it can work in a particular local context
2. Effective medical leadership willing to encourage it
3. Demand for it from patient leaders
4. Incentives for clinicians to change their practice

5. Training for clinical staff, plus support and supervision
6. Availability of good quality patient decision aids
7. Integration of these into electronic medical record systems
8. Institutional support for developing and updating patient decision aids
9. Certification schemes to ensure the quality of patient decision aids
10. Measurement and feedback to ensure it's happening.

The extent to which these factors are in place in five European countries – France, Germany, Netherlands, Spain and UK – will be presented and discussed.

### NORTH AMERICAN EXPERIENCE WITH SDM

*Don Kemper (Boise, USA)*

While patient decision aids are widely available for free on hundreds of US and Canadian health Websites the use of PDAs or SDM in general has been slow to develop within clinical practices. In spite of well-run and positively-evaluated SDM demonstrations at leading health systems, economic, infrastructure and mindset factors have, until now, slowed its

broader integration into care. However, current shifts toward pay-for-quality reimbursements, electronic medical record requirements and on-line clinician training are significantly increasing the likelihood of the routine use of SDM in the near future.

### SHARED DECISION-MAKING IN MATERNAL AND NEWBORN HEALTH IN BURKINA FASO

*Janet Perkins (Burkina Faso and Geneva)*

Primary health care requires that health services be organized around people's needs, expectations and sociocultural context. Community participation in decision-making within the health sector is an essential component in accomplishing this. Since 2006, Enfants du Monde, a Swiss non-governmental organization (NGO), in collaboration with the local NGO Fondation pour le Développement Communautaire/Burkina Faso (FDC/BF), has been supporting Ministry of Health of Burkina Faso to include communities in decision-making related to maternal and newborn health (MNH) in the context of implementing the World Health Organization's framework for Working with Individuals, Families and Communities to improve MNH.[1] Participatory community assessments (PCAs) are conducted to provide a platform for communities to be involved in the decision-making within the health sector.[2]

During PCAs, participants (pregnant women, husbands, health workers, community leaders) identify and prioritize MNH needs and problems, and propose solutions which are then integrated in the district health action plan. Integrated interventions include: promotion of birth preparedness; training health care providers in counselling skills; building awareness of men on MNH issues and their capacity to support women; strengthening community bodies to manage obstetrical and neonatal complications. These actions contribute to ensuring that health services are organized around people's needs and realities, thus moving primary health care forward.

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[2] Perkins, J; Fyon, C; Capello, C; Sankara, T; Bargo, A; Santarelli, C. Barriers to assuring women's rights to safe

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## **Parallel Sessions 4:**

### **A. Antoine Besse Interinstitutional Symposium on Person Centered Mental Health and Primary Care**

#### **PERSON CENTERED MENTAL HEALTH AND PRIMARY CARE: WORLD PSYCHIATRY PERSPECTIVES**

**Roy Kallivayalil (Kerala, India)**

There are severe constraints for mental health resources in many parts of the world. Paucity of mental health personnel and poor infrastructure are important among them. In this context, mental health through primary care appears to be the only viable alternative. The WHO has developed a report on 'Integrating Mental Health in Primary Care: a Global Perspective' (2008) which documents the justification and advantages of such an initiative and how some health systems have successfully implemented it. The WPA Institutional Programme on Psychiatry for the Person approved by its General Assembly in 2005, where the whole person was conceived as the centre and goal of clinical care is an important landmark (Mezzich 2007). The WPA has a Section on 'Psychiatry, Medicine and Primary Care' which can implement many of these goals and foster person centered mental health through primary care. The WPA had also

organized Health Systems Performance Round Tables for four regions- Africa, Asia Pacific, Americas and Europe in 2013. The theme for the upcoming WPA International Congress at Bucharest in June 2015 is "Primary Care Mental Health: Innovations and Transdisciplinarity". We have also conducted an International Study on Depression Screening in Primary Care in China, India, Iran and Romania (WCP Madrid 2014). Other organisations like World Association of Social Psychiatry has also made significant contributions.

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2. World Health Organisation. Integrating Mental Health Into Primary Care: A Global Perspective (2008)

#### **WORLD FEDERATION FOR MENTAL HEALTH PERSPECTIVES**

**Mohammed Abu-Saleh (London)**

The World Federation for Mental Health (WFMH) had launched on the World Mental Health Day 2009, Mental Health in Primary Care, the campaign that focussed on the critical role that mental health advocacy organizations, along with patient/service user groups, need to play in shaping the major general health and mental health reform movement for achieving parity in the delivery of mental health services and the effective integration of mental health into primary care.

The WFMH has maintained this campaign in developing and delivering key work programmes and initiatives including the establishment of the WFMH-ICPCM Alliance in 2011 to promote its longstanding principles of inclusiveness of

consumers and families at the centre of the decision making process in order to reduce stigmatization, ensure fair distribution of resources, equal access to health care, and equal representation at government level.

The WFMH has demonstrated global leadership in the development and the launch of the WHO Global Mental Health Action Plan (2013-2020), the Great Push for Mental Health, People's Charter for Mental Health in 2014, actions that strongly endorse the Person-Centered approach and the primacy of integrating mental health into primary care in all countries.

#### **FRANCOPHONE OBSERVATORY FOR PERSON CENTERED MEDICINE: A SHORT HISTORY**

**Simon Daniel KIPMAN, OFMP President (Paris) and Brigitte Greis, OFMP Vice President (Poitiers, France)**

OFMP is a new french speaking organization whose purpose is to link associations, institutions, and persons around the complexity of the question : what is medicine, by the way of local experiences, researches, and reflexions.

It seems too early to explain the OFMP history, because it is still too small compared to the whole history of medicine. And as creators, it is difficult for us to explain and comment something that is still evolving.

But, at the same time, the medical world is complex, in difficulties, and it is a necessity to know it from inside for our purpose: let everybody be able to know initiatives when they occur, help them, in the very moment when they are growing.

OFMP was born from a collective book: « manifeste pour une médecine de la personne » (Doin, 2010)

That book has been written by caregivers, patients, nurses, doctors gathered together with a common objective: humanize a sometimes too technical medicine, without losing its technical and/or scientific qualities.

But nothing could have happened without the person centered psychiatry program story, launched in 2005 by Juan Mezzich, who was, at that time, president of the WPA.

In France, that initiative has been transmitted by a book « Manifeste pour une psychiatrie de la personne » (Doin 2008), an important work in the psychiatric field that was spread through the Geneva conferences, and the creation of the International College.

Rebellion and revolution.

OFMP was born from two rebellions and one revolution

The first rebellion is well known by the caregivers all over the world. It is against the submissiveness of many of parts of

health systems to the lobbies organized by the health industry. It is also a rebellion against the strong economical thought which conducts to a mind's exhaustion; and, therefore, an exhaustion of medical clinics.

That thinning out is not only accounted as loss of jobs, it also goes against the needs and interests of sick people, and all those who are involved in the caring industry. That means everybody.

The despair of caregivers in front of the mechanization of their works, their loss of autonomy, in front of more and more rigid behavioral rules, to the point of becoming absurd; pushing them to be less and less involved –so less effective.

Practitioners, in their own fields, can't deal with this anymore – so do the patients - ; and they feel themselves abandoned. However, they try to gather together their acts, their initiatives, their ideas. OFMP has been created for that.

We add also an ancient rebellion against the universal use of our language. After all, we always have to speak to exchange using the patient's own language.

Let it be in the same way, between us. It's an effort, but it is one of the ways to struggle against standardization between persons, groups, people; standardization of thoughts and methods.

We cannot keep denying patients and health workers; denying their own originality.

At last a revolution: that means that we have to reverse the tendency to confine contemporary medicine into technical, automatic, and material fields. We have to restore, to remove theory and methods of the current medicine, considering the important technical progresses of the last century. That is in restoring ancient concepts for instance the therapeutic values of personal implication of health workers, in their observations and methods.

The general idea is: taking away biological and technical knowledge is like cutting one's arm off. Taking away psychological knowledge, particularly unconscious; is like cutting off the other arm. One of OFMP goals is to participate into the actual scientific movement, that one of the sciences of complexity, and coordinated approaches.

#### FROM PERSON CENTERED PSYCHIATRY TO PERSON CENTERED MEDICINE.

As you know, a person centered program in psychiatry has been launched by Juan Mezzich at the WPA. We all realized that the search of invariants in each way was one of the source of contemporary knowledge. So, what we all wrote on psychiatry for a person may be applied to medicine as a whole. That means also that psychology is a medical specialty as part of the others, closer to some; further from others.

That was conduct to the Geneva Conferences, well known in that journal.

OFMP is currently a member of the International College, and tries to help and to support those conferences.

#### OFMP GOALS

OFMP goals are to detect links around the sick person : links with caregivers, links between caregivers, links between care, culture and society where they are given.

In one word, it's to notice the complexity of one person, characterized by his own story, his own group of reference, his actual comportment, his choices.

OFMP tries to disrupt the patient's isolation, alone in front of a shattered and diversified medicine, according to its competences and specialties.

OFMP pushes to respect the patient's choices, in his own treatments, as for in his own life.

Simultaneously, OFMP tries to disrupt the caregivers and family isolation.

OFMP sustains and discuss every initiative in the field of person centered medicine.

OFMP offers 3 approaches

-a medicine for one person, in extension of the field of the personalized medicine.

-a medicine BY people, showing the importance of personal involvement in our works, and the training involved

-and a medicine WITH people, linking the collective dimension of team, ring, network, service.. ; and also, widely, care and medical realization, in all dimensions, i.e ; economical too.

#### MODES OF OFMP

If OFMP is a mode of linking, of liaison between the health industry actors, it has a few possibilities.

It is constituted by individual members and associations or institutions as partners. Those partnerships are various : scientific associations for experiences and research ; professional trade unions for the management and working conditions, insurances, research groups, public institutions.. ;

#### OFMP METHODS

One of the first OFMP 's action is the first francophone congress of person centered medicine in Poitiers ( march 2013)

But a congress is not enough. We have an alert duty and an information duty, a function for research and reflection (or, precisely, we can HELP researchers, but we do not want to take the place of any research institution ?)

Furthermore, we favorize a research's type generally forgotten by the fund donors : the « meditative research », alone or not. That's a form of research which may be efficient, without needing many funds.

Books, reviews, participating in congresses etc...

Some committees : Atelier

-one on teaching/training, of which work is splitted

-teaching health for everybody

-professional training including therapeutic relationship, professional implication, teaching by experience.

-another on announcement of illness

-another on death management

-another on theory and practice in medicine.

But of course we have many other projects ;

So, as huge is the project, so frightening are perspectives. But everything is on his own way.

Hereford nothing, neither the conservative reluctances, neither difficulties in terms of time, availability, or resources, can stand in the way of that movement which arouses enthusiastic reactions by all those who continue to believe in care in medicine. They were in search of a reason of hope for themselves, for patients, for colleagues, for all of us.

## THE FRENCH CONCEPT OF PSYCHIATRIC PRIMARY CARE

*Herve Granier (Montpellier, France)*

France has progressively implemented , since the 60s, an original and advanced primary care organization, as part of French psychiatric tradition which attaches great value to a humanistic approach to mental health care, still inspired by classic French psychodynamic references and the place of psychoanalysis in " French cultural exception ". Actually, this approach is no longer an exception but shared more and more by all Frenchspeaking countries all over the world.

In France, psychiatry has always been influenced by an epistemological reflection coming from outside of psychiatry, from sociology and especially philosophy.

The organization is based on the complementary between a public mental health sector and a psychiatric sector of private practice, financially covered entirely by the national health insurance system, therefore accessible and affordable for all patients whatever their mental health or social conditions and whatever their income.

The public offer of care comprises of around 6000 psychiatrists and 55 000 beds in psychiatric hospitals . ( including the university services) and alternative structures. The private offer of care is very developed and comprises of 6000 psychiatrists and 12000 beds in private clinics and alternatives structures.

I stress the fact that, currently, equivalent numbers of patients with serious disorders are being treated in both sectors. The single splitting line is only the violence.

Public or private psychiatrists are not confined to the hospitals , they assure the initial care and follow up ( the essential continuity of care ), in the community with the help of general practitioners, in private offices , public medico-psychological centers and different alternative structures.

Complementary of the sectors, liberty of the professionals ( installation , consultation, treatment and prescription ) , " Psydiversity" of practices, absolute medical confidentiality, free choice of the psychiatrist by the patient, easy access to care are the key words of this so-called

"non hierarchical professional model, left to the physician's initiative".

The integration of psychiatry in primary care has needed a gravitational shift towards different modalities of ambulatory care ( care in the community ) and the research of a new balance with hospitalization also considered as a primary care . The refusal to dissociate hospitalization and ambulatory consultations are very significant, notably, in response to the increase in request for care, the new pathologies such addictions and the intricacy of social problems. The care in the community always has a limit when the patient , in the first instance, must be removed from his family or social environment . In these situations the patient is like an "asylum seeker".

Besides , an imbalance in the system,( for instance, a system which leans too much towards ambulatory and neglects hospitalization) sparks a failure of primary care and the patients end up in the inappropriate overstretched emergency services or, at worst , on the streets or in prisons.

Beyond this organization, a psychiatric primary care is, first of all, an initial meeting, and first and foremost a relationship-centered care which requires several "essential subjective conditions " to cross the internal path of a patient with mental suffering and distress .

As you know, psychiatric treatment always depends on the concept of mental illness that you have. Mental illness is not a disease like any other but inherent to the human condition . Mentally ill patients are also sick of their history, their lives , their family ties , and cannot be reduced to a biological or genetic disorder. They insist on wanting to stay human, they need primary transference, that is to say , to believe that what they are saying, their symptoms, means something. They want to talk and to be listened to at liberty , and in a respectful, confidential manner.

Not to impede the patient's speech, but to analyze , bear and support this primary transference is the first step to a trustworthy relationship . The confidence allows the emergence of clinical manifestations to reach a diagnosis in the transfer and , in the meantime , a real engagement in a relationship centered mental health care.

## B. Well-Being Promotion

### WELLNESS IN MEDICAL EDUCATION

*Kim Stutzman (Boise, USA)*

Much work has been done to address the stress and burnout of medical education and the impact it has on learner's ability to provide safe and effective patient care. Work hour limitations have been in place for close to a decade in many countries but this has not had the attended consequences of improved resident or student well-being or safer patient care. In order to achieve these goals we need to change the definition of wellness from just a lack of burnout and distress to encompass the global well-being of the learner. The focus can be seen by some as a desire to work less but it truly is a desire to strengthen oneself to maintain resilience along the challenging path of medical education. To accomplish this goal of well-being many training sites are developing wellness programs. We will discuss measures to assess the current

state of wellness and review potential models of programs to improve student, resident well-being. Although these programs often target individual health, their overwhelming utility is in changing the medical culture to accept the responsibility of caring for ourselves and each other with the same voracity that we care for our patients.

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2. Keim S. M., Mays M. Z., Williams J. M., Serido J., Harris R. B. Measuring wellness among resident physicians. *Medical*

*Teacher.* 2006; 28(4): 370-374.

## PHYSICIANS WELL BEING AND RESILIENCE

*Dave Schmitz (Eagle, USA)*

Resilience can be defined as the capacity to respond to stress in a healthy way and is a key to enhancing quality of care, quality of caring, and sustainability of the health care workforce.<sup>1</sup> Studies have identified substantial rates of physician burnout with differences observed by specialty, with the highest rates occurring among physicians at the front line of care access, including primary care.<sup>2</sup> Concepts associated with the Patient Centered Medical Home model of care such as collaboration, quality and safety may reduce factors associated with provider burnout. Delivery of person-centered medicine must be reflective of self-care, resilience and a work environment which promotes healthcare provider well being.

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## PERSON CENTERED PREVENTION

*Don Kemper (Boise, USA)*

Prevention needs a new brand. The current consumer brand is challenged by three problems:

- The pain is immediate
- The benefit is delayed
- Rarely can you tell if it helped at all

What's needed is a more direct way to link preventive services to the well-being or happiness of the individual. One simple question, asked of every patient, can help to align prevention opportunities with outcomes that really matter to the person.

Personal care plans built around the goals of the individual may help to advance a greater sense of value for the preventive services that protect chances for greater well-being and happiness.

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Siahpush Am J Health Promo 2008;23:18-26

## A NEW PATIENT CENTRED APPROACH TO UNLOCK THE INDIVIDUAL'S POTENTIAL TO ADOPT HEALTHY LIFESTYLES: HEALTH COACHING

*Ayse Basak Cinar (Copenhagen)*

Health Coaching (HC), a patient-empowerment focused approach, is guided and supported by the medical professional, to facilitate patient to explore, unlock and activate his/her self-potential to adopt healthy lifestyles. HC, a whole person and also a population-based approach, can be defined as a system-wide innovation aiming positive social change. A NHS review showed that there is promising evidence about HC, particularly for supporting behaviour change<sup>1</sup>. HC in our international intervention project, to our knowledge, is used for the first time as a holistic health promotion approach for oral health and diabetes management; in line with IDF-FDI(2007)<sup>2</sup> declaration stating that oral health promotion should be part of diabetes management. Our study's preliminary results show that at post-intervention there was a significant reduction at HbA1C (Turkey:0.7%, Denmark:0.4%, p=0.001) in HC groups.

The figures for HE groups were non-significant. Daily toothbrushing was correlated with change at HbA1c and regular physical activity in HC groups. Person-centered approach focusing on multidisciplinary collaboration is essential to improve the whole well-being of individual in daily life, and thereby the society, in line with WHO 2014 Geneva Declaration. HC, a promising new approach, can speak as one of the key implementations/approaches at health care-settings to meet this essentiality.

References:

1. Does health coaching work? A rapid review of empirical evidence. NHS, 2014. <https://www.eoeleadership.nhs.uk/>

2. IDF. Diabetes and oral health. <http://www.idf.org/oral-health-vital-component-wellbeing>.

## Parallel Sessions 5:

### A. Advocacy and Leadership Policy in Primary Care

## EUROPE: CHALLENGES AND CHANCES IN CHANGING ENVIRONMENTS

*Aleksandra Weber (Munich)*

Health is the main asset of life. Primary care is the backbone of the health care system and a central integrating point of individual regular care with the broad spectrum of preventive and curative services. Central to the concept is the patient with

individual needs and interests regardless of age, socioeconomic or geographic origins, ethnicity or education with all manner of acute and chronic physical, mental and

social health issues, including multiple chronic diseases. Integrated collaboration among all providers is essential for the quality and efficiency of care applying principles of evidence-based medicine in a person centered orientation through mutual decision-making process. The WHO with the target 'health for all' attributes the integral and inclusive primary health care strategy. The aim of the European Forum for Primary Care is to improve the health of the population by promoting strong primary care. European societies are facing

significant challenge of rapidly ageing citizens and also of increased number of patients with cognitive impairment and multimorbidity. Health care systems are operating in permanently changing environments.

Goroll, AH; Mulley, AG: Primary Care Medicine. Lippincott Williams&Wilki, 2014  
<http://www.euprimarycare.org>

#### NORTH AMERICA: THE ACHIEVEMENT OF THE TRIPLE AIM

**Robert Phillips (Washington, DC)**

The United States spends more on healthcare than any other developed nation yet ranks near the bottom in health outcomes. The Patient Protection and Affordable Care Act ushered in a multi-billion dollar effort to rectify this imbalance. The Triple Aim for Healthcare has become the organizing focus. The Triple Aim proposes to achieve better health, better healthcare, at lower cost.<sup>1</sup> This focus has spawned a number of experiments including: 1) Medicare waivers like the Vermont Blueprint for Health; 2) the multipayer Comprehensive Primary Care Initiative; 3) facilitated change through the Transforming Clinical Practice Initiative; and, 4) expansion of health insurance. There is also an increasing focus on patient-centered outcomes, including an entirely new research agency, and an increased focus on social determinants of health. The latest strategy is a move to value-based payments

and pledge to abandon fee-for-service payments.<sup>2</sup> The Triple Aim is on an aggressive track which has many US health systems in a state of schizophrenia as they try to figure out how to move to a value-based system from a volume-based system. This presentation will review some of the mentioned experiments and will also review examples where experiments are beginning to demonstrate the Triple Aim.

1. Berwick DM, Nolan TW, Whittington J. The Triple Aim: Care, Health, And Cost. *Health Affairs*. May 1, 2008 2008;27(3):759-769.
2. Burwell SM. Setting Value-Based Payment Goals — HHS Efforts to Improve U.S. Health Care. *New England Journal of Medicine*. 0(0):null.

#### ASIA: ADVOCACY/LEADERSHIP FOR POLICY MAKING IN PRIMARY CARE

**Yongyuth Pongsupap (Bangkok)**

This presentation reports on two aspects of primary care development in Thailand. There is on the one hand, a change of paradigm in terms of policy making: from disease oriented- and hospital-centered care toward person- and people-centered care. On the other hand, there is an evolution related to capacity building: the introduction in 2007 of "Context Based Learning" (CBL) in order to improve on performance of existing human resources. CBL has been a stimulating factor for policy making through different processes like demonstration visits, exchange of experiences at different levels (district, provincial, regional and national), synthesis of lessons learnt from experiences in different contexts etc. Conversely, the new policy supports CBL.

Two examples of CBL influencing/supporting policy making may be underscored: i) capacity building of health care providers in the family and in the community (Family Practice Learning - FPL) and the Family Care Team policy (FCT); ii) capacity building of district/local health management teams (District Health Management Learning - DHML) and the setting-up of a new managerial structure for the health care system, the District Health Board (DHB).

Each person should be able to refer to a family care team made of a doctor from the hospital, a nurse from the health centre, a community volunteer and a care giver from the family. Despite their difference, or thanks to their differences (specificities), they should be able to contribute to quality care provision to the related patients. Competencies of each member can be broader developed through interactions, working together in the team in a manner of "polyvalent team"

sharing the same goal. Each category of staff has its added values, which cannot be replaced by others'. FPL is new strategy for training family doctors which was launched in 2012. The concept at stake is that family doctors, working in local health care systems, should be able to provide direct health care to individuals and families, but also support health care provision by "family health care teams". They are trained along with nurses working at health centre level. This training should facilitate the implementation of family care team.

DHML concerns all staff involved in reinforcing health system organisation. In particular, it intends to train the district health system management actors through their support to a district health project. It is a move to reinforce the partnership between the district key stakeholders and their capabilities to work together: the community hospital, the district health office responsible for health centres, local governments, and members of the community. There is a process to set up district health boards which may be responsible for planning and supporting district health activities, and answerable for health district responsiveness to needs and demands of the district population. In the board, there should be a balanced mix of representatives of people and representatives of health professions from the health care system.

Primary care strengthening within the district local health system is a move towards a Thai responsive health care system. This requires both operational and administrative integration: family care teams and district health boards. Capacity building and policy making can reinforce each other to this effect.

## LATIN AMERICA: SOCIAL AUDIT FOR ASSURING ACCOUNTABILITY IN MATERNAL AND NEWBORN HEALTH CARE IN EL SALVADOR

*Janet Perkins (El Salvador and Geneva)*

Accountability of health services to the people they serve is essential to primary health care and to quality improvement. Increasingly, community participation in assuring accountability is being explored as a strategy.[1] In El Salvador, social audit in which communities participate in assuring accountability is included in the national health policy, the reproductive health policy and other strategic documents; however, implementation has been limited. Enfants du Monde (EdM) has been supporting Ministry of Health (MoH) to implement this within the context of a programme based on the World Health Organization's framework for Working with Individuals, Families and Communities to improve maternal and newborn health (MNH). [2] In this effort, four Social Audit Commissions were formed, composed of male and female leaders, members of community health committees and intersectoral municipal committees. These Commissions were supported to conduct a survey to understand people's (n=161)

experiences utilizing health services and identify issues that need to be addressed. This survey brought to light a number of areas for improvement which have been taken to the intersectoral municipal committees and to health authorities at regional level, in charge of following up the implementation of appropriate solutions. This process allows communities to actively contribute to increased accountability and quality of health services.

[1] Hoffmann, K.D. The Role of Social Accountability in Improving Health Outcomes: Overview and Analysis of Selected International NGO Experiences to Advance the Field. Washington, DC: CORE Group; 2014.

[2] The World Health Organization. Working with Individuals, Families and Communities to improve maternal and newborn health. Geneva: The World Health Organization; 2010.

### B. Brief Oral Presentations 2:

#### INTENSIVE MENTAL HEALTH TRAINING FOR MEDICAL RESIDENTS

*Robert Smith (Michigan, USA)*

With >85% of mental health patients under the sole care of untrained physicians, we must better prepare the latter.

Based on RCTs with positive patient outcomes,<sup>1</sup> I present a HRSA-supported mental health curriculum for medical residents.<sup>2</sup>

Two fellowship-trained (by us) primary care faculty train 39 medical residents in mental health care (<http://bpsmedicine.msu.edu>).

Residents master objectives for: 1) patient-centered interviewing model; 2) model of shared decision-making; 3) mental health treatment model; 4) personal awareness; 5) working in a multi-disciplinary team.

At ~70 hours each year in the same settings where residents other training occurs., in PGY-1, objectives 1-3 are the focus

via a full-time one-month rotation. In PGY-2/3, objectives 3-5 are the focus in a mental health clinic. Lectures and Balint groups are in all years.

A pre/post, quasi-experimental design evaluates: a) simulated patient interviews for Objectives 1-3; b) knowledge and self-efficacy with all objectives.

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2. Smith R, Laird-Fick H, D'Mello D, et al. Addressing Mental Health Issues in Primary Care: An Initial Curriculum for Medical Residents. *Patient Educ Couns* 2014;94:33-42.

#### RESOURCE ORIENTED GROUP PSYCHOTHERAPY

*Ilse Burbiel (Munich, Germany)*

In the literature and in clinical practice we often find only descriptions of individual psychotherapy when we look for "resources oriented psychotherapy". But often clinicians cannot do clinical work without group psychotherapy for the healing process of patients with early attachment disorders, development arrestment, family induced extremely and/or complex trauma disorders, or "archaic identity disorders" according to Günter Ammon and others authors. The group indeed provides a suitable "container" for the necessary psychic-mental and social demands for repair with the variety of mirror, reflection, resonance and mentalization processes

and the multiple transference and counter-transference phenomena in order to enable emotionally (re)construction and development facilitating processes for the patients. It is the aim of the authors to describe the variety of these processes and the therapeutic methods and to explain why the group with its specific resources represents an essential therapeutic developmental space for those patients. Traumatic reality is far in the past but is always present and the group - good enough environment- helps to (re)construct the self. The specific resources oriented method in group psychotherapy will be illustrated with short clinical examples.

## THE ROOTS OF COMPASSION AND ITS FLOURISHING IN PRIMARY CARE

*Alison Gray (Hereford, UK)*

All round the world doctors experience high rates of burnout, leading to unhappiness, many leaving the profession and even suicide. UK healthcare is in crisis, the National Health Service is failing in many places. Individual practitioners are struggling to deal with unrealistic workloads and many are retiring early. It is hard to maintain person centred care against such pressures. The Francis report into a recent UK hospital scandal speaks of the importance of compassionate care, but does not define compassion or state how this virtue is developed and maintained. In my presentation I will outline the history and significance of empathy and compassion, the underpinning science, and how compassion is cultivated and sustained. Calls to avoid depersonalisation and treat patients as whole people have been heard since at least 1927; we also need to ensure that healthcare staff are treated as whole people, not just cogs in a machine to be discarded when worn out. For staff to flourish and continue to give person centred

care there need to be appropriate, healthy structures and systems. Individuals and teams need realistic staffing levels, access to supportive supervision (e.g. Schwartz rounds), and time for reflection and self-compassion.

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*European Journal for Person Centered Healthcare* 3(1) In press.

## Key Note Lecture

### PERSON-CENTERED MEDICINE: PROFESSIONAL REQUIREMENT AND ETHICAL COMMITMENT

*Xavier Deau (WMA President, Epinal, France)*

Person-centered medicine should not only be a professional requirement, but it should also be considered an ethical mandate.

Reasons to return to a person-centered medicine were often enumerated, but let us consider how to take concrete steps towards its implementation

1. RECONSIDER THE LOGICS OF ADMISSION TO MEDICAL SCHOOL on the basis of scientific disciplines exclusively, and shift the admission focus on the basis of students' humane values and aptitude :
  - to the peculiarity of the doctor-patient relationship
  - to respect the human being's entity : a combination of « flesh and spirit », its relation to an affective family and professional environment
  - to listen : « I listen to you and I welcome you »
  - to be empathetic at the same time as be able to respect « the independence and freedom of choice » of patients
2. A CORE TRAINING IN THE HUMANITIES during the first five years of medical education on ethics-related themes such as the patient-doctor relationship. Include exams in such disciplines as philosophy and sociology, with the same coefficients as in scientific disciplines.
3. PRACTICING PERSON-CENTERED GENERAL MEDICINE: mandatory internships in general medicine during the first five years of medical school, before any specialization. The practice of person-centered general medicine must be mandatory for all students, and it cannot be merely taught through course attendance, but through the experience direct contact with patients.
4. THE DYNAMICS OF PERSON-CENTERED MEDICINE

Continuing professional education, reference documents, protocols, and theory courses must all integrate person-centered medicine's items throughout a doctor's professional career, and starting in medical school. The doctor-patient relationship is not only about applying expert skills, but also about interpersonal skills.

5. KEY ITEMS of person-centered medicine: medical practice and consultation remain the basics
  - habitus
  - interview, dialogue
  - clinical exam
  - diagnosis
  - differential diagnosis
  - information
  - consent
  - therapeutic conduct
  - accompanying the patient

### Required qualities of the practitioner:

- empathy
- respect
- dignity
- quality of the gaze, listening ability, ability to personalize each physical exam
- does not dissociate body and spirit
- takes into account the social determinants specific to each patient
- engages in a true partnership between doctor and patient
- provides intelligible and quality information
- understands the singularity of each patient and not his/her disease
- is conscious of the vulnerability proper to each patient

Without forgetting about fundamental ethical principles in the practice of medicine:

- the doctor's independence

- confidentiality
- the protection of privacy
- the absence of conflict of interest
- the sustaining of professional skills through continued training

It is paramount for our university faculty to integrate all these ethical items in their teaching on medical practice

Person-centered medicine could thus become not merely a « professional necessity » but also « an ethical duty for every medical practitioner »

## Plenary Symposium 5: Research Priorities for PCPHC

### RESEARCH PRIORITIES ON THE CONCEPTUALIZATION OF PERSON CENTERED MEDICINE

*Juan Mezzich (New York)*

What is Person Centered Medicine (PCM)? An ethical commitment? A scientific theory or method? An experiential journey? It may be argued that there are reasons to believe that PCM is all of them. Each proposition, however, needs to be examined carefully.

The process of advancing the conceptualization of PCM, of understanding its principles and components may be illuminated by the consideration of multiple angles or perspectives. Among these are philosophical, historiographic, cultural, clinical, epidemiological, organizational, and statistical viewpoints.

Philosophical analyses may include particularly axiological and epistemological approaches. Historical considerations may look at both ancient civilizations and their broad understanding of health and personalized approaches to restore and improve health as well as at contemporary developments in medicine from narrow focus on organs and disease and ensuing compartmentalization of the field to recent encompassing and contextualized approaches to the whole person.

Our collaborative institutional journey to build person centered medicine is based on early contributions from related organizations, and includes eight yearly Geneva Conferences and their main themes and associated Geneva Declarations, the six-year old International Network (now College) of Person-centered Medicine and its scholarly Journal and workgroups. And we are being enlightened by the ongoing

results of a research project on systematic conceptualization and measurement of person- and people-centered care. It was based on critical literature reviews and broad international consultations. The key concepts emerging from this project as underlying person-centered medicine are ethical commitment, holistic scope, cultural sensitivity, relationship focus, individualized care, common ground for joint diagnostic understanding and shared clinical decision-making, people-centered systems of care, and person-centered education and research. From these concepts and their components a prototype Person Centered Care Index is being developed and validated.

Our Geneva Conferences and our Journal offer special opportunities for addressing progressively the conceptualization of Person Centered Medicine.

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1. Mezzich JE, Appleyard J, Botbol M, Ghebrehwet T, Groves J, Salloum IM, Van Dulmen S: The Sixth Geneva Conference and person centered health research. *International Journal of Person Centered Medicine* 3: 99-105, 2013.
2. Mezzich JE, Kirisci L, Salloum IM: Towards Developing Measures to Assess Progress towards Person- and People-centered Care. Technical Report, International College of Person Centered Medicine, New York, 2014.
3. Snaedal J: World Medical Association Perspectives on Ethics and Person Centered Medicine. *International Journal of Person Centered Medicine* 4: 159-162, 2014.

### RESEARCH PRIORITIES FOR SOCIAL DETERMINANTS OF CARE

*Robert Phillips (Washington, DC)*

It is estimated that 40 percent of deaths are caused by behavior patterns that could be modified by preventive interventions.<sup>1</sup> Many of these behavioral patterns are related to social determinants of health, both personal and ecological. Several developed countries now use indices of social determinants to allocate more resources to specific neighborhoods.<sup>2</sup> It would be helpful to test how such measures correlate with health outcomes, what the right blend of ecologic and individual elements are to improve that correlation, how to use them clinically, and which call for community partnership. Community Oriented Primary Care has held promise for more than 50 years, and we finally have the geospatial tools to define and characterize the populations of our practice. Now we need to understand what to do to change the impact that social determinants have on our patients and our communities. We need to study how

community-centered interventions translate in to patient-centered outcomes. In the U.S., our largest federal health insurance programs have declared population health a priority focus, and are shifting from volume-based payments to value-based payments to support this new focus. We need new health services research on how payment policy best serves addressing social determinants to improve health.

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## RESEARCH PRIORITIES FOR PERSON CENTERED PRIMARY CARE

*C. van Weel (Nijmegen, Netherlands)*

Primary health care is directed at individuals, in their societal context. This is the conceptual basis of community-oriented primary health care, with person centeredness and people centeredness as core elements [1].

There is strong evidence that community-oriented primary health care is a major determinant of effective, efficient, safe health care, with concomitant cost-effectiveness. This makes primary health care essential in every health system and insight of the mechanisms through which it operates, important for further improvement. A major issue is that, although it is clear that person- and people-centeredness, continuity of care, a comprehensive holistic approach and the long-standing relation of trust are essential determinants of these outcomes [2], insight in how this works is scant. And this limits further improvement of primary health care.

From this priorities for research are:

- Understand the mechanisms through which continuity of care, the relation of trust and other primary health care values influence

- The acuity of diagnosis and prognostication;
- The safety of interventions;
- Improvement of the sensitivity of a 'community diagnosis' and risk stratification of individuals in that population for prevailing social determinants of health;
- Sustainable financing incentives that reward the creation of health rather than the provision of interventions.

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## THE FUTURE OF SHARED DECISION MAKING

*Don Kemper (Boise, USA)*

Even after three decades of evidence that SDM improves the quality of treatment decisions, enhances patient satisfaction and generally reduces the use of unneeded clinical services, three factors have held back SDM from achieving mainstream use. Economic, infrastructure, and mindset barriers have combined to block mainstream use in all but a few leading health systems in the US and elsewhere.

Now, there is good reason to expect a much more rapid advance of SDM due to significant changes in all three barrier areas. The advances in electronic medical records are making it easier both to send a patient decision aid to a patient and to

get the patient's response and preferences back into the clinical record. Health economic changes shifting from pure fee-for-service towards pay-for-quality reimbursement methods are starting to remove the disincentives that previously penalized clinicians from encouraging the patient's voice in treatment decisions. And, new on-line and in-person skill building opportunities for clinicians are available to re-set beliefs about the importance of SDM within clinical practice. These changes plus the expected certification of patient decision aids and incentives for their use should cause a rapid expansion in the use of SDM over the next five years.

## Plenary Closing Session

### THE WINDS OF CHANGE: THE ESSENTIAL ROLE OF PRIMARY CARE AND FAMILY MEDICINE IN MEETING THE CHANGING HEALTHCARE NEEDS OF SOCIETY

*Ruth Wilson (Kingston, Canada)*

Primary care and family medicine are the backbone of an effective health care system. Health care systems which have strong primary care, including the contributions of family medicine, have better outcomes at less cost. They are also able to mitigate the adverse effects of social inequity and consequent adverse effects on health. Characteristics of family medicine which contribute to these outcomes include being person-centred, providing co-ordination, continuity, community-based, wholistic services. Countries around the world are expanding their primary care and family medicine workforces. Director General Dr. Margaret Chan of the WHO has stated that "A health system where primary care is the backbone and family doctors are the bedrock delivers the best health outcomes, at the lowest cost, and with the greatest user satisfaction". The rationale for structuring health systems to be

more responsive to the needs of people, challenges to achieving this vision, and family medicine's response to these challenges will be addressed.

### References:

The Contribution of Family Medicine to Improving Health Systems: A guidebook from the World Organization of Family Doctors, Second Edition ISBN: 9781846195549  
Published: June 2013 Radcliffe  
Editor: Michael Kidd

The Barbara Starfield Collection. WONCA  
<http://www.globalfamilydoctor.com/InternationalIssues/BarbaraStarfield.aspx>



**International College of Person Centered Medicine (ICPCM)  
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Dates	Session Periods	Session Titles	Session times and credits earned	Check-off attendance
27.04.2015	8:45 -9:15	Keynote presentation 1	30 minutes, 0.50	
	9:15-10:15	Plenary Symposium 1	60 minutes, 1.00	
	10:45-12:15	Plenary Symposium 2	90 minutes, 1.50	
	1:15-2:45	Parallel session 1 (A)	90 minutes 1.50	
		Parallel session 1 (B)	90 minutes 1.50	
	3:00-4:30	Parallel session 2 (A)	90 minutes 1.50	
		Parallel session 2 (B)	90 minutes 1.50	
28.04.2015	9:00-10:30	Plenary symposium 3	90 minutes 1.50	
	10:45-12:15	Plenary symposium 4	90 minutes 1.50	
	1:15-2:45	Parallel session 3 (A)	90 minutes 1.50	
		Parallel session 3 (B)	90 minutes 1.50	
	3:00-4:30	Parallel session 4 (A)	90 minutes 1.50	
		Parallel session 4 (B)	90 minutes 1.50	
	4:45-6:15	Parallel session 5 (A)	90 minutes 1.50	
		Parallel session 5 (B)	90 minutes 1.50	
29.04.2015	8:30 -9:00	Keynote presentation 2	30 minutes 0.50	
	9:00 -10:30	Plenary session 5	90 minutes 1.50	
	10:45 -11:45	Plenary Closing Session	60 minutes 1.00	
	12:00 -2:00	WHO Special Session	120 minutes 2.00	
Total Credits Earned (Maximum: 18.50) :				

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