



World Health
Organization



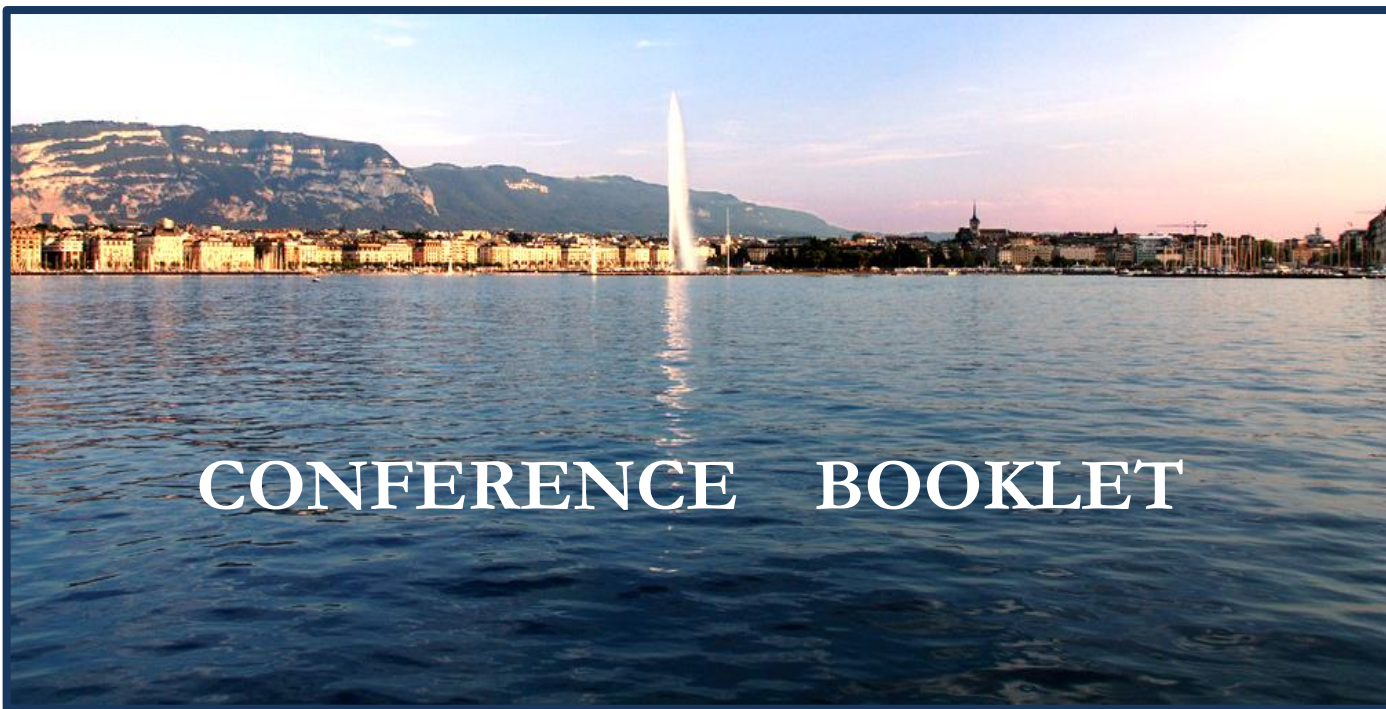
International Alliance of
Patients' Organizations
A global voice for patients

9th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

Person-Centered Integrated Care through the Life Course

Core Conference on April 11 – 13, 2016
Pre-Conference Workmeeting on April 10, 2016

Geneva University Hospital and World Health Organization



CONFERENCE BOOKLET

Organization

Program

Presenters

Abstracts

CPD Credits Form

www.personcenteredmedicine.org

icpcmsecretariat@aol.com

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), Ruth Wilson (Program Director for the 9th Geneva Conference on Person-Centered Medicine), Michel Botbol (ICPCM Director for Meetings), Tesfamicael Ghebrehiwet (ICPCM Director for Education), Jo Groves (ICPCM Director for Membership), Ihsan Salloum (ICPCM Director for Research), Sandra Van Dulmen (ICPCM Director for Publications), Jon Snaedal (Advisor to the ICPCM Board), Islene Araujo de Carvalho (WHO), Jim Campbell (WHO), and Nuria Toro Polanco (WHO).

Collaborating Organizations: The Ninth 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 Latin American Network of Person Centered Medicine (RLAMCP), the International College of Surgeon's (ICS), the International Federation of Gynecology and Obstetrics (FIGO), the International Federation of Ageing (IFA), the Medical Women's International Association (MWIA), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the Paul Tournier Association, the World Association for Dynamic Psychiatry (WADP), the European Association for Communication in Health Care (EACH), 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-Bulgaria, 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 450 Euros for persons residing in World Bank Group A (High Income Countries) and 300 Euros for persons in other countries. Full time students and official representatives of patient and family organizations pay discounted half rates.

Presentation Formats include Plenary Symposia, Parallel Symposia, Brief Oral Presentations and Poster Session.

Conference Secretariat: For further information as well as Registration and Abstract Forms, please visit www.personcenteredmedicine.org and write to the ICPCM Secretariat at Int'l Center for Mental Health, Mount Sinai School of Medicine, Fifth Ave & 100 St, Box 1093, New York NY 10029, USA. E: ICPCMsecretariat@aol.com.



CONFERENCE PROGRAM

PRE-CONFERENCE WORKMEETINGS ON PERSON-CENTERED MEDICINE: SUNDAY APRIL 10, 2016

Venue: Geneva Univ Hospital, Auxilliary Halls one floor under the Marcel Jenny Auditorium,
4 rue Gabrielle-Perret-Gentil CH-1211 Geneva 4, Switzerland.

9:00AM – 5:00 PM	Pre Conference Institutional Work Meetings Chairs: <i>Jon Snaedal (Reykjavik)</i> , <i>Tesfa Ghebrehivet (Alberta, Canada)</i> a. Person-centered Diagnosis: <i>JE Mezzich (New York)</i> , <i>I Salloum (Miami)</i> , and <i>Y Pongsupap (Bangkok)</i> et al b. Global Research Network: <i>I Salloum (Miami)</i> et al [10:45 – 11:00 AM, Coffee break] c. 2016 Geneva Declaration Draft (<i>Ruth Wilson (Kingston, Ontario, Canada)</i>) d. Membership development: <i>Joanna Groves (London)</i> et al e. Institutional Fund Raising: <i>J Appleyard (London)</i> et al [1:00 – 2:00 PM, Lunch break] f. Books Workgroup: <i>JE Mezzich (New York)</i> et al g. Person-centered Clinical Care Guiding Principles: <i>J Appleyard (London)</i> , <i>J Snaedal (Reykjavik)</i> , <i>T Epperly (Boise, USA)</i> , <i>S Van Dulmen (Nijmegen, Netherlands)</i> et al h. Other Workgroups [4:45-5:00 PM, Coffee break]
5:00 – 6:00 PM	IJPCM Editorial Board Meeting
6:00 – 7:30 PM	ICPCM Board Meeting

CORE CONFERENCE FIRST DAY, MONDAY APRIL 11, 2016 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 (<i>Jim Appleyard</i>), Geneva University (<i>Thierry Berney</i>), World Health Organization (<i>Islene Araujo</i>), World Medical Association (<i>Jon Snaedal</i>), Wonca (<i>Ruth Wilson, 9GC Program Director</i>).

(Organizational Note: For most sessions, each presentation should last 8 minutes followed by 7 min clarifying Q&As. There should be ample time at the end for general discussion and chairs' formulation of conclusions)

8:45 – 10:15 AM	Plenary Symposium 1: Symposium on the full person-centered development of family medicine Chairs: <i>Jim Appleyard (London)</i> , <i>Paul Grundy (New York)</i> <ul style="list-style-type: none">• Family medicine: universal health coverage and primary care as essential building blocks of person centered medicine: <i>Ruth Wilson (Kingston, Canada)</i>• How the person-centered medicine movement challenges family medicine: <i>Ted Epperly (Boise, USA)</i>• The development of family medicine to meet the needs of persons and communities: past, present and future: <i>Chris van Weel (Nijmegen, Netherlands)</i>• Person-centered family medicine in national health systems: Patterns and prospects: <i>Yongyuth Pongsupap (Bangkok)</i>
10:15 – 10:45 AM	Coffee Break and Poster Session: <ul style="list-style-type: none">• Patients' perspective in an evaluation study concerning professional task reallocation: <i>Monique Bessems (Maastricht, Netherlands)</i>• A change in nursing home men's everyday life: a grounded theory study: <i>Ann Karin Helgesen, Eli-Anne Skaug, Vigdis Abrahamsen Grondal (Halden, Norway)</i>• Preoperative educational program for elective patients undergoing coronary artery bypass grafting (CABG): <i>Mei Wa Lo, Kam Wai Hong, Sau Man Chan (Hong Kong)</i>

10:45 – 12:15 PM	<p>Plenary Symposium 2: Symposium on person-centered integrated care (PCIC) in families and children Chairs: <i>Ted Epperly (Boise, USA)</i>, <i>Chris Van Weel (Nijmegen, Netherlands)</i></p> <ul style="list-style-type: none"> • Ethical issues in person centered care of children, whose interests prevail? : <i>Jim Appleyard (London)</i> • Intersectoral (Health-Judicial Services) integration of person-centered care for children and adolescents: <i>Michel Botbol (Brest, France)</i>. • The role of “model husbands” in improving maternal & new born health services in Burkina Faso: <i>Janet Perkins (Geneva)</i>
12:15 – 1:15PM	Lunch (open)
1:15 – 2:45 PM	<p>Parallel Sessions 1A: Symposium on person centered medical education and health systems enhancement Chairs: <i>Ruth Wilson (Kingston)</i>, <i>David Gordon (WFME, Copenhagen)</i></p> <ul style="list-style-type: none"> • Mapping the global state of family medicine: <i>John Parks (Lilongwe, Malawi)</i> • Person Centered Undergraduate Medical Education Implementation: UFV Model: <i>Juan Perez-Miranda (Madrid)</i> • Improving quality of care through intra-professional collaboration: <i>Victor Ng (Toronto Canada)</i> • Medical doctors’ contribution to person- and people- centered care: a new medical culture for family medicine in Thailand: <i>Y. Pongsupap (Bangkok, Thailand)</i> <p>Parallel Session 1B: Symposium on PCIC for women Chairs: <i>Sandra Van Dulmen (Nijmegen, Netherlands)</i>, <i>Joanna Groves (London)</i></p> <ul style="list-style-type: none"> • Women's health and the 2030 Agenda: Leaving no woman behind: <i>Veronica Magar (WHO)</i> • The intersection of women’s health and person centered care: <i>Susan Phillips (Kingston Ontario, Canada)</i> • Changing the paradigm: Woman-centered care throughout the life course: <i>Margaret Usher Patel (Dorchester, UK)</i> • Determinants of maternal & new-born health in Haiti: <i>Cecilia Capello, Janet Perkins (Geneva)</i>
2:45 – 3:00 PM	Coffee Break
3:00 – 4:30 PM	<p>Parallel Session 2A: Symposium on PCIC for functionally challenged and special populations Chairs: <i>Michel Botbol (Brest, France)</i>, <i>Tesfa Ghebrehivet (Alberta, Canada)</i></p> <ul style="list-style-type: none"> • Best practices in communication with persons with IDD: <i>Ian Casson (Kingston Ontario, Canada)</i> • Ethical issues in care for persons with IDD: <i>Bill Sullivan (Toronto, Canada)</i> • Person-centered care for war-displaced refugees: <i>Mohammed Abou-Saleh (London)</i> • The process of resilience and post traumatic stress disorder in migrants and refugees: <i>Rachid Bennegadi (Paris)</i> • PCIC for multi-morbidity patients: <i>Ihsan Salloum (Miami)</i> <p>Parallel Session 2B: Symposium on PCIC systems and equity through the life course Chairs: <i>Alberto Perales (Latin American Net. PCM, Lima)</i>, <i>J Appleyard (London)</i></p> <ul style="list-style-type: none"> • Ethics and the social determinants of health: <i>Eugenio Villar (WHO, Geneva)</i> • Contribution of employment to health over the life course: <i>Minha Rajput-Ray (Cambridge, UK)</i> • Contribution of social workers to systems equity: <i>Terry Bamford (IFSW, London)</i>
4:45 – 6:30 PM	General Assembly of the International College of Person Centered Medicine (including presentation for discussion of the 2016 Geneva Declaration)
7:00 – 10:00PM	Conference Dinner

Invitation to Conference Dinner
organized by the Paul Tournier Association

Monday April 11, 7:00 pm
All Conference Participants
CHF 50.-

Please register at
The Conference Desk



CORE CONFERENCE SECOND DAY, TUESDAY APRIL 12, 2016
Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

- 9:00 AM – 10:30 AM Plenary Symposium 3: Symposium on person-centered integrated care (PCIC) in older age and at end of life
Chairs: *Ted Epperly (Boise, USA)*, *Glenn Brown (Kingston, Ontario, Canada)*
- Global healthy ageing: What it means to each of us? *Islene Aranjó (WHO)*
 - Non-pharmacologic strategies to enhance communication with persons living with dementia: *Susana Lauraine McCune (Seattle, USA)*
 - Global action for personhood in dementia: *Jon Snaedal (Reykjavik)*
 - PCIC at the end of life: *Otmar Kloiber (WMA, Ferney-Voltaire, France)*
- 10:30 – 10:45 AM Coffee Break
- 10:45 AM – 12:15 PM Plenary Symposium 4: Symposium on PCIC and the organization, quality and safety of health systems
Chairs: *Juan Mezzich (New York)*, *Ruth Wilson (Kingston, Ontario)*
- Implementation of the WHO Framework on Integrated People-centered Health Services: *Nuria Toro Polanco (WHO)*
 - How family medicine contributes to universal health coverage: *Shannon Barkley (WHO)*
 - The future of Patient Centered Medical Homes: *Paul Grundy (New York)*
 - Meso-level organization of primary care services to meet population needs: *Glenn Brown (Kingston, Ontario, Canada)*
 - PCIC implementation in national health systems: *Yongyuth Pongsupap (Bangkok)*
- 12:15 – 1:15 PM Lunch (open)
- 1:15 – 2:45 PM Parallel Session 3A: Symposium on inter-specialty and inter-disciplinary professional relations for PCIC
Chairs: *Jon Snaedal (Reykjavik)*, *Maria Ammon (Berlin)*
- Determining the composition of the primary care team: *Ted Epperly (Boise, USA)*
 - Upstreaming NCD prevention: An interdisciplinary approach: *Tesfa Ghebrehivet (Alberta, Canada)*
 - Contributions of social workers to person-centered team work: *Terry Bamford (IFSW, London)*
 - Inter-disciplinary work for person-centered care in epidemics: *Rosa Vallas (WHO)*
- Parallel Session 3B: Symposium on research methodology for PCIC through the life course
Chairs: *Ihsan Salloum (Miami)*, *Thomas Schulze (Munich)*
- Global “state of play” of person centered care: *Ed Harding (London)*
 - Person-centered research designs: *Sandra Van Dulmen (Nijmegen, the Netherlands)*
 - Person-centered diagnostic methodologies: *Juan Mezzich (New York)*
 - Methodologies for evaluating person centered care through the life course: *Levent Kirisci (Pittsburgh)*
 - Patient-Provider relationship for measuring primary care performance: *George Southey (Oakville, Ontario, Canada)*

- 2:45 – 3:00 PM Coffee Break
- 3:00 – 4:30 PM Parallel Session 4A: Symposium on health stakeholders' engagement and perspectives for PCIC through the life course
Chairs: *Jim Appleyard (London), Mohammed Abou-Saleh (London)*
- Enhancing patients' use of health records: *Joanna Groves (London)*
 - Person-centered research use of health records: *Levent Kirisci (Pittsburgh)*
 - Nursing contributions to PCIC through the life course: *Tesfa Ghebrehivet (Alberta, Canada)*
 - Patients' and family caregivers' goals for care during transitions out of the hospital: *Eric Coleman (Aurora, Colorado, USA)*
- Parallel Session 4B: Brief Oral Presentations 1: Person Centered Mental Health and Positive Health
Chairs: *John Cox (Cheltenham, UK), H-R Pfeifer (Zurich)*
- The Whole Heals: Humanity's one body and healing of the person: *Kondothra George (Kerala, India)*
 - European Alliance against Depression (EAAD): people-centered care for depression and prevention of suicidal behaviour.: *Ulrich Hegerl (Leipzig)*
 - Body oriented psychotherapy in the understanding of dynamic psychiatry: *Maria Ammon (Berlin)*
 - Emotional resonance and body experience in analytical-structural dance therapy: *Ilse Burbiel (Munich)*
 - Review dialogues as an opportunity to develop life course specific health goals: *Ottomar Bahrs, Susanne Heim, Karl-Heinz Henze, Franziska Löwenstein (Göttingen, Germany)*
 - Person centered recovery planning at Austin State Hospital and the integration of peer support into this: *Eulon Ross Taylor, Noah Abdenour (Austin, Texas)*
- 4:30 – 4:45 PM Break
- 4:45 – 6:45 PM Parallel Session 5A: Antoine Besse and Jitendra Trivedi Memorial Symposium on Person Centered Psychiatry and Mental Health for PCIC in the Life Course
Chairs: *Afzal Javed (Nuneaton, UK), Michel Botbol (Brest, France)*
- WPA Sections' brief perspectives
 - Biological Psychiatry: The challenges of multi-morbidity over the life course and the need for person-centered integrated care: *Helen Millar (Dundee, Scotland)*
 - Early Career Psychiatrists: Views on person centered medicine: *Florian Riese (Zurich)*
 - Genetics in Psychiatry: Person-centered approaches and psychiatric genetics *Thomas Schulze (Munich)*
 - Preventive Psychiatry: Perspectives on Person-centered integrated care: *Nikos Christodoulou (Nottingham, UK)*
 - Spirituality and Religion: the new realities for medical practice in the twenty-first century: *J Cox (Cheltenham, UK)*
 - Round of Presenters' Comments on set of presentations made
 - Chairs' conclusions and next steps for WPA Section activities on person centered psychiatry
- Parallel Session 5B: Brief Oral Presentations 2: Person Centered Health Care
Chairs: *Tesfa Ghebrehivet (Alberta, Canada), Sandra Van Dulmen (Nijmegen, Netherlands)*
- Illness, disease, understanding the person and the goals of medicine: *Joseph Burley (Kingston, Ontario, Canada)*
 - The person centered change of the health paradigm through the caregiver's person and community: *Giuseppe R. Brera (Milan)*
 - Extending simulation-based learning experiences to patients with chronic health conditions: *Eric Coleman, Sung-Joon Min (Aurora, Colorado)*

- The impact of person-centered care on residents' perceptions of care quality in nursing homes: an intervention study: *Vigdis Abrahamsen Grondahl, Liv Berit Fagerli, Ann Karin Helgesen (Halden, Norway)*
- Swiss experience translating harm reduction into addiction treatment policies: *Riaz Khan (Geneva)*
- Developing an evidence-based educational intervention protocol for improving glaucoma patients' eye drop therapy adherence and outcomes: *Suk Kwan, Victoria Ho, Mi Ling, Eliza Wong (Tuen Mun, Hong Kong)*
- Patient-centered integrated education program for surgical patients receiving trans urethral resection of prostate: *Hoi Ling Sbering Sung, Conny Chan (Hong Kong)*
- Measuring health literacy among very low literate people: a feasibility study with the HLS-EU questionnaire: *Hannelore Storms (Diepenbeek, Belgium)*
- Information and communication technology for enabled person-centered care in the "Big Five" chronic conditions: scoping review: *Sabine E. Wildevuur (Amsterdam)*

7:00 PM

Dinner (On Your Own with Suggested Networking Opportunities)

CORE CONFERENCE THIRD DAY, WEDNESDAY April 13, 2016
WHO Headquarters, Salle G

- 9:00 AM – 10:30 AM Plenary Symposium 5: Symposium on Global Health Workforce for PCIC through the life course
Chairs: *Jim Appleyard (London), Otmar Kloiber (WMA, Ferney-Voltaire, France)*
- Preparing the health workforce for PCIC: Issues through the life course: *Jim Campbell (WHO)*
 - How medical schools are recruiting and preparing health professionals for PCIC: *David Gordon (WFME, Copenhagen)*
 - The medical student and the professor/mentor as persons in a new mentorship program at a Peruvian medical school: *Alberto Perales (Latin American Network for PCM, Lima)*
 - Prospects for person-centered health professional education in Asian populations: *Roy Kallivayalil (Kerala, India)*
 - Family medicine and primary care: how do the two relate to PCIC?: *Ruth Wilson (Kingston, Canada)*
- 10:30 -10:45 AM Coffee Break
- 10:45 AM – 11:45 AM Plenary Closing Session (including presentation for adoption of the 2016 Geneva Declaration)
Chairs: *Jim Appleyard and Juan Mezzich (ICPCM)*
- 11:45 – 12:00M Break and Group Photograph
- 12:00 – 2:30PM WHO Special Session on Collaboration for the Implementation of WHO Global Strategies and Frameworks (*by invitation*)
[Light Lunch]
Chairs: *Jim Appleyard (ICPCM), Islene Araujo (WHO), and Jim Campbell (WHO)*
- Brief presentation on WHO Global Strategy and Action Plan on Ageing and Health: *Ritu Sadana (WHO)*
 - Brief presentation on WHO Framework on Integrated People Centered Health Services: *Nuria Toro Polanco (WHO)*
 - Brief presentation on WHO Global Strategy on Global Health Workforce: *Jim Campbell (WHO)*
 - Contributions from the ICPCM and Collaborating Organizations.
 - Conclusions and Next Collaborative Steps



NINTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

GALLERY OF PRESENTERS

Prof. Mohammed Abou-Saleh

Professor of Psychiatry,
St George's Medical School, University of London
London, United Kingdom.
mabousal@sgul.ac.uk



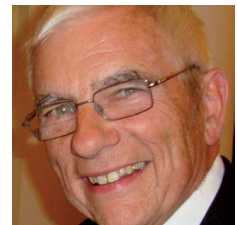
Prof. Maria Ammon

Secretary General,
World Association for Dynamic Psychiatry,
Berlin, Germany.
DAPBerlin@t-online.de



Prof. James Appleyard

President, International College of Person-centered Medicine
Vice President, International Association of Medical Colleges
Former President, World Medical Association,
London, United Kingdom.
Jimappleyard2510@aol.com



Dr. Islene Araujo de Carvalho

Gynecologist and Obstetrician,
Public Health Expert and Gerontologist
Department of Ageing and Life Course,
World Health Organization
Geneva, Switzerland.
araujodecarvalho@who.int



Dr. Ottomar Bahrs

Institute of Medical Psychology and Medical Sociology
University of Göttingen,
Göttingen, Germany
obahrs@gwdg.de



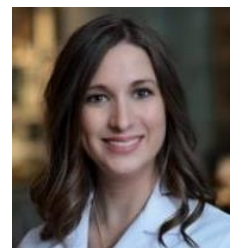
Mr. Terry Bamford

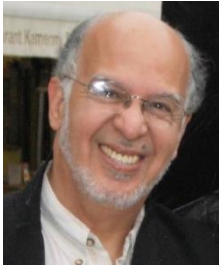
International Federation of Social Workers (IFSW)
London, United Kingdom.
terrybamford@aol.com



Dr. Shannon Barkley

Family Medicine Physician
Primary Health Care at WHO
Health Services Delivery and Safety
barkleys@who.int





Prof. Rachid Bennegadi

Secretary General, World Association for Social Psychiatry
Former Chair, WPA Transcultural Psychiatry Section
Director of Research, Minkowska Center
Sigmund Freud University, Paris, France
bennegadi@minkowska.com

Prof. Thierry Berney

Vice-Dean for Postgraduate Education,
Faculty of Medicine, University Hospitals of Geneva
Geneva, Switzerland.
Thierry.Berney@hcuge.ch

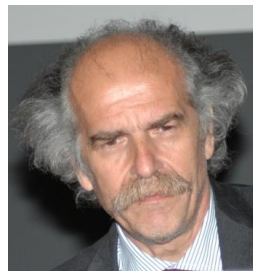


Monique Bessems, MSc

RVE Patient & Care, Research Department
Maastricht University Medical Centre
Maastricht, The Netherlands
Monique.bessems@mumc.nl

Prof. Michel Botbol

Board Director, International College of Person-centered Medicine
Chair, WPA Section on Psychoanalysis in Psychiatry
Professor of Child and Adolescent Psychiatry,
University of Western Brittany, Brest, France
botbolmichel@orange.fr



Prof. Giuseppe Brera

Rector, Ambrosiana University
Milan, Italy.
gbrera@unambro.it

Prof. Glenn Brown

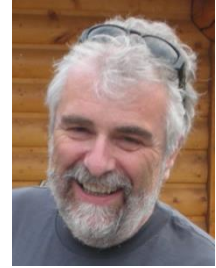
Head of the Department of Family Medicine at Queen's University,
Kingston, Ontario, Canada
glenn.brown@dfm.queensu.ca



Prof. Ilse Burbiel

German Academy of Psychoanalysis
World Association for Dynamic Psychiatry
Munich, Germany.
info.kalb@psychoanalysebayern.de

Dr. Joseph Burley
Assistant Professor
Queen's University
Kingston, Ontario, Canada.
jburley20@cogeco.ca



Mr. James Campbell
Director, Department of Health Workforce WHO
Executive Director of the Global Health Workforce Alliance (GHWA),
campbellj@who.int

Prof. Ian Casson
Family Physician
Department of Family Medicine, Queen's University
Kingston, Ontario, Canada.
ian.casson@dfm.queensu.ca



Dr. Nikos Christodoulou
Department of Psychiatry, Nottingham University
Nottingham, UK.
nikoschristodoulou@gmail.com

Prof. Eric Coleman
Internal/Geriatric Medicine
University C. Denver
Aurora, Colorado, USA
Eric.Coleman@ucdenver.edu



Prof. John Cox
World Psychiatric Association Secretary General 2002-2008
Emeritus Professor, Keele University Medical School
Cheltenham, United Kingdom.
john1.cox@virgin.net

Prof. Ted Epperly
Program Director and CEO, Family Medicine Residency of Idaho.
Professor of Family and Community Medicine,
University of Washington School of Medicine, Seattle, Washington
Boise, Idaho, USA.
Ted.Epperly@FMRIdaho.org





Kondothra George

Teologian, Priest
Kerala, India.
frkmgeorge@hotmail.com

Tesfamicael Ghebrehiwet, MPH, Ph.D.

Board Director, International College of Person-centered Medicine
Former Consultant, Nursing and Health Policy
International Council of Nurses
Alberta, Canada.
tesfa@shaw.ca



Prof. David Gordon

President, World Federation of Medical Education (WFME)
Emeritus Professor of Medicine and
Former Dean of the Medical Faculty, Manchester University
Copenhagen, Denmark.
gordoncph@gmail.com

Vigdis Grondahl, PhD

Associate Professor in Nursing Science
Ostfold University College
Halden, Norway
vigdis.a.grondahl@hiof.no



Joanna Groves B.Sc., M.Sc.

Board Director, International College of Person-centered Medicine
Former Executive Director,
International Alliance of Patients' Organizations (IAPO)
London, United Kingdom.
joanna.m.groves@gmail.com

Dr. Paul Grundy

IBM's Global Director of Healthcare Transformation
Founding President of the Patient Centered Primary Care Collaborative
New York, USA.
pgrundy@us.ibm.com



Dr. Eduard Harding

Director, Health Policy Partnership
London, UK.
ed@hpolicy.com

Ann Karin Helgensen, PhD
Associate Professor in Nursing Science
Ostfold University College
Halden, Norway.
ann.k.helgesen@hiof.no



Ms. Suk-Kwan Ho
Master of Management (Health Services)
Tuen Mun, Hong Kong.
vho99999@yahoo.com.hk

Dr. Frances Hughes
Chief Executive Officer, International Council of Nurses
Geneva, Switzerland.
icn@icn.ch



Dr. Afzal Javed
Secretary for Sections,
World Psychiatric Association
The Medical Center
Nuneaton, United Kingdom.
afzal@afzaljaved.co.uk

Prof. Roy A. Kallivayalil
Secretary General, World Psychiatric Association;
President Elect, World Association for Social Psychiatry;
Professor and Head, Dept. Psychiatry, Pushpagiri Inst of Medical Sciences,
Kerala, India.
roykalli@gmail.com



Prof. Levent Kirisci
Statistical Editor, *Int J of Person Centered Medicine*
School of Pharmacy, University of Pittsburgh
Pittsburgh, Pennsylvania, USA
levent@pitt.edu

Dr. Otmar Kloiber
Secretary General, World Medical Association
Ferney-Voltaire, France
otmar.kloiber@wma.net





Ms. Mei Wa Lo
Kiang Wu Nursing College of Macau
Macau, Republic of China
lomeiwa@hotmail.com



Dr. Veronika Magar
Team Leader, Gender, Equity and Human Rights
World Health Organization
Geneva, Switzerland
magarv@who.int



Dr. Susana McCune
Clinical Psychology
Antioch University,
Seattle, USA.
susanamccune@mac.com



Prof. Juan E. Mezzich
Secretary General, International College of Person-centered Medicine
President 2005-2008, World Psychiatric Association
Professor of Psychiatry, Icahn School of Medicine at Mount Sinai,
New York, USA.
juanmezzich@aol.com



Dr. Helen Millar
Consultant Psychiatrist,
University of Dundee,
Dundee, Scotland
h.millar@nhs.net



Victor K. Ng, MD, MSc
Division of Professional Development and Practice Support,
College of Family Physicians of Canada,
Mississauga, Ontario, Canada
vng@cfpc.ca



Dr. John Parks
Family Medicine
Global Health Corps
Lilongwe, Malawi
jparks@medcol.mw

Prof. Alberto Perales
President, Latin American Network of Person Centered Medicine
Past President, National Academy of Medicine of Peru
San Marcos National University School of Medicine,
Lima, Peru.
perales.alberto@gmail.com



Dr. Juan Pérez-Miranda
Vice-Rector for International Relations
Francisco de Vitoria University
Madrid, Spain.
j.perezmiranda@ufv.es

Dr. Janet Perkins
Association Enfants du Monde
Grand-Saconnex, Switzerland
janet.perkins@edm.ch



Dr. Hans-Rudolf Pfeifer
Board Member, Paul Tournier Association
Psychiatry & Psychotherapy FMH,
Zurich, Switzerland
H.R.pfeifer@bluewin.ch

Prof. Susan Phillips
Family Medicine and Public Health Sciences
Family Medicine Centre
Kingston, Ontario, Canada
susan.phillips@dfm.queensu.ca



Yongyuth Pongsupap, MD, MPH, PhD.
Founding Fellow, International College of Person Centered Medicine
Senior Expert, National Health Security Office,
Bangkok, Thailand.
yongyuth.p@nhso.go.th

Dr. Minha Rajput-Ray
Medical Director, Need for Nutrition Education/Innovation Programme,
University of Cambridge
Cambridge, UK.
mr539@medschl.cam.ac.uk





Dr. Florian Riese
Section on Early Career Psychiatrists,
World Psychiatric Association,
Zurich, Switzerland
florian.riese@bli.uzh.ch



Dr. Ritu Sadana
Lead Specialist, Ageing and Life Course,
World Health Organization.
Geneva, Switzerland
sadanar@who.int



Prof. Ihsan M. Salloum
Board Director, International College of Person-centered Medicine
Chair, WPA Section on Classification and Diagnostic Assessment.
Professor of Psychiatry and Behavioral Sciences,
University of Miami, Florida, USA
ihsansalloum@gmail.com



Prof. Thomas Schulze
Section on Genetics in Psychiatry,
World Psychiatric Association,
Institute for Phenomics and Genomics, University of Munich
Munich, Germany.
thomas.schulze@med.uni-muenchen.de



Prof. Jon Snaedal
Advisor to the Board, International College of Person-centered Medicine
World Medical Association President 2007-2008
Professor of Geriatric Medicine, University of Reykjavik
Reykjavik, Iceland.
jsn@mmedia.is



Dr. George Southey
Family Physician,
Dorval Medical Center,
Oakville, Canada
gsouthey.md@dorvalmedical.ca



Hannelore Storms, MSc, PhD Student
Faculty of Medicine and Life Sciences
Hasselt University
Diepenbeek, Belgium
Hannelore.storms@uhasselt.be

William F. Sullivan, MD, PhD.
Department of Family Medicine
University of Toronto
Ontario, Canada.



Shering Sung, RN, BSN, MN
Surgery, Tseung Kwan O Hospital,
Hong Kong, China.
sheringsung@ymail.com

Dr. Nuria Toro Polanco
Department of Service Delivery and Safety (SDS)
World Health Organization
Geneva, Switzerland.
toropolancon@who.int



Margaret Usher Patel, SRN, SCM, SCPHN, MCoMMH
International Scientist and Technical Adviser,
Family and Community Health
Dorchester, United Kingdom.
maggiusherpatel@gmail.com

Rosa Constanza Vallenasc, MD, MSc
World Health Organization
Geneva, Switzerland.
vallenasc@who.int



Prof. Sandra van Dulmen
Board Director, International College of Person-centered Medicine
Former Officer, European Association for Communication in Health Care
Senior Researcher, Netherlands Institute for Health Services Research and
Radboud University.
Nijmegen, Netherlands
s.vandulmen@nivel.nl

Prof. Chris van Weel
Former President, World Organization of Family Doctors (Wonca)
Emeritus Professor of Primary and Community Care,
Radboud University, Nijmegen, Netherlands.
C.vanWeel@elg.umcn.nl





Dr. Eugenio Villar

Department of Ethics, Equity, Trade and Human Rights
& Information Evidence and Research,
World Health Organization
Geneva, Switzerland
villare@who.int



Prof. C. Ruth Wilson

9th Geneva Conference Program Director
Departments of Family Medicine and Obstetrics,
Queen's University
Kingston, Ontario, Canada.
ruth.wilson@dfm.queensu.ca

NINTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

ABSTRACTS

Plenary Symposium 1: Symposium on the full person-centered development of family medicine

FAMILY MEDICINE: UNIVERSAL HEALTH COVERAGE AND PRIMARY CARE AS ESSENTIAL BUILDING BLOCKS OF PERSON CENTERED MEDICINE

Ruth Wilson (Kingston, Canada)

The philosophy of person centered medicine is one which affirms the dignity and autonomy of persons, using a holistic approach to health. The Geneva Declaration of 2014 states that "Person-centered health focuses on the needs values and perspectives of the whole person in their life context and course, rather than exclusively on their status as a patient, their medical condition, or disease."

Person centered medicine and primary care have as their central ethic the relationship between the health care provider and person seeking care. As Dr. Ian McWhinney says of family medicine, which is the medical generalist specialty supporting primary care "it is the only discipline to define itself in terms of relationships, especially the doctor-patient relationship."

Primary care by its nature is well situated to be the home for therapeutic long-standing continuous relationships. By providing first contact care for undifferentiated problems,

through offering comprehensive integrated care for chronic diseases, to giving compassionate support when no cure is possible, it seeks to provide care to the whole person in the context of their community, taking into account their own values.

As Dr. Margaret Chan has said, "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

References:

1. Geneva Declaration on Person and People-Centered Integrated Health Care for All. <http://www.personcenteredmedicine.org/>
2. McWhinney IR. William Pickles Lecture 1996. The importance of being different. Br J Gen Pract. 1996 Jul; 46(408): 433-436.

HOW THE PERSON-CENTERED MEDICINE MOVEMENT CHALLENGES FAMILY MEDICINE

Ted Epperly (Boise, USA)

At a time when the profession of medicine has lost much of its way and has become much more of a business than a service to people, family medicine, and the discipline of primary care is yelling and shouting, "don't forget about the patient and the people we serve!" Somewhere along the way, we have forgotten that the healthcare is about the people and not the physicians, hospitals, technology, nurses, and money.

The challenges family medicine faces at this time in our history of healthcare transformation to person-centeredness globally

are issues of timely access to care; truly providing team-based care; integrating and coordinating this care with other healthcare professionals; leveraging technology to assist in this endeavor; controlling costs; ushering in the concepts of population health and all of this while trying to avoid personal physician burnout. If we truly believe in person-centeredness then the person we are caring for becomes our "North Star" and the practice/system is not person-centered until the person says that it is.

THE DEVELOPMENT OF FAMILY MEDICINE TO MEET THE NEEDS OF PERSONS AND COMMUNITIES: PAST, PRESENT AND FUTURE

Chris Van Weel (Nijmegen, Netherlands)

Objectives. Primary health care with family practice is regarded the core function in the health system.

This paper analyses the historic development of family medicine's concepts of person and population centeredness and how this prepares for future challenges.

Methods. This paper is based on a historic analysis of international primary health care and case studies of Dutch and Australian family medicine.

Results. Three development phases can be identified, generated by societal urgencies.

The first was access to health care for poor people (equity). This resulted in family physicians (FP) becoming the main providers care for all health problems.

The second was in response to the increase of technology and sub-specialization (the human dimension). This triggered the founding of family medicine Colleges and Academies and identification of the scientific basis of FPs as generalists: continuity of care, integrating bio-psycho-social dimensions, building a professional relation of trust, empowerment and shared decision making [1].

The third were the increasing health care costs, and the finding that primary health care provides better health for lower costs (cost-effectiveness of health care) [2], resulting in clinical guidance for common health problems, chronic diseases and multi-morbidity in the primary health care setting.

Discussion, conclusion. From these three phases, primary health care has evolved into the key function of any health care system, centered at the person with the health problem and the population with their health needs. For the future it is essential to strengthen its evidence base of how FPs improve health of individuals and communities.

References

1. WONCA Europe. The European Definition of the General Practitioner/Family Physician. <http://www.woncaeuropa.org/sites/default/files/documents/Definition%203rd%20ed%202011%20with%20revised%20wonca%20tree.pdf> (accessed 25 January 2016)
2. Starfield B. Is primary care essential? *Lancet* 1994; 344:1129-1133

PERSON-CENTERED FAMILY MEDICINE IN NATIONAL HEALTH SYSTEMS: PATTERNS AND PROSPECTS

Yongyuth Pongsupap (Bangkok)

In the late XIXth century the nursing revolution and the innovations of scientific medicine began transforming hospitals from places to care for the dying and the poor into prominent health units able to make a diagnosis and provide an effective treatment for all kind of health problems. After World War I, hospitals became the core of modern scientific health care systems. Whereas in Europe or in the United States of America this evolution took place against the backdrop of proximity care provided by popular individual medical entrepreneurs, this was not the case in many African and Asian countries where the hospitals were the first – and often the only – places where scientific medicine had ever been practiced.

During the second half of the XXth century, practice of medicine outside the hospital, particularly at neighborhood level, assumed a new importance. Patients, and to a certain extent, the medical establishment have rediscovered the human dimension of health care and consequently, the importance of proximity care. Health care providers increasingly recognize the 'medical' value of patient-centeredness.

In many high-income countries, family practice has thus reemerged as the dominant form of proximity care provision, built on a tradition of care provided by individual or small groups of general practitioners, living and working close to

their patients' home. Its features and principles have of course evolved. Elsewhere, overcrowded "big" hospitals and low-effective proximity health care units are identified as sources of people frustration, impeding quality of care.

A wide range of studies presents evidence that, in middle- and low- income countries in particular, family medicine or its locally adapted pattern can improve population satisfaction, quality of care as well as population health outcomes, especially when embedded in wider sector reforms (1). Family medicine is recognized as a relevant strategy to provide effective, person-centered, continuous, integrated, and in complete mutual confidence proximity care (2). The challenge is to find a new balance between high technology care provided by hospitals and high patient-centered care in proximity health units at neighborhood level, each both effective and affordable, and to bridge the gap between them according to their complementarities.

References

1. WONCA (2013): The contribution of family medicine to improving health systems: a guidebook from the world organization of family doctor, Kidd M. (editor), Second Edition, Radcliffe Health.
2. World Health Organization (2008): Primary health care: now more than ever, World Health Report.

Poster Session

PATIENTS' PERSPECTIVE IN AN EVALUATION STUDY CONCERNING PROFESSIONAL TASK REALLOCATION

Monique Bessems (Maastricht, Netherlands)

Introduction

In 2012 enacted legislation gave Dutch nurse practitioners (NP) and physician assistants (PA) direct authorization to indicate and perform medical procedures which were formerly exclusively reserved to physicians. This authorization was provided for a period of 5 years. Patients' ratings and experiences with caregiving by the NP and PA in the new

situation are perceived important by the Ministry of Health to decide on the suitability of the legislation for the time after the pilot phase.

Objectives

To measure the degree of effectiveness of the care process (quality) from the patient's perspective in terms of access to treatment, the treatment success, adherence and safety.

Methods

Patient centeredness is measured as part of the evaluation study concerning task reallocation by Dutch Nurse Practitioners and Physicians Assistants. This study is a mixed method study with data triangulation. Quantitative and qualitative data were linked in order to gain a comprehensive insight into the patients' perspective related to the care received by NP and PA. Surveys were structured around patient centeredness and data have been collected before the amendment of the law (TO), 1 and 2,5 years thereafter (T1, T2). Individual interviews with patients focused how patients experience care by NP and PA, which factors are involved in positive/negative experiences and which opinion the patient has concerning the newly acquired authority. The study was supported by a grant from the Dutch Ministry of Health, Welfare and Sport.

Findings

Quantitative results are based on 276, 213 and 285 respondents during respectively TO, T1 and T2; qualitative results on 27 (most informative) interviews selected from 41 interviews. Patients are overall very satisfied with the care delivered by NP/PA. They give (very) high ratings concerning patient centeredness. Furthermore, not all items of information regarding medication use is given by NP/PA.

Conclusion

Patients are (very) satisfied with the treatment received by the NP and PA, their expertise, the waiting times for treatment (consult) and the way NP and PA treated them.

Recommendations

It is recommended that the treatment provides sufficient information, so the patient is able to decide on the treatment, resulting in greater patient satisfaction and adherence.

A CHANGE IN NURSING HOME MEN'S EVERYDAY LIFE: A GROUNDED THEORY STUDY

Ann Karin Helgesen, Eli-Anne Skaug, Vigdis Abrahamsen Grondahl (Halden, Norway)

Background: Research to date indicates that most nursing homes offer different kinds of activities for their residents, but that the activities are seldom individualized. A lack of individualized activities might have adverse physical and psychological impacts on the elderly person and also adversely affect their relatives, other residents and the staff. It is reasonable to assume that male residents are at particular risk of not having their activities individualized (1,2). They inhabit a largely 'female domain' as the majority of staff in nursing homes, and often also the residents are female. Few studies to date have focused on activities for men in nursing homes.

Objective: The aim of this study was to explore and describe elderly men's experiences of activities in nursing homes.

Methods: This study was carried out by a grounded theory approach. Data were collected by means of interviews with nine elderly men in nursing homes. All of the men were offered an activity at least once a week as part of an activity program

over the preceding year. Data collection and analysis were carried out simultaneously using constant comparison.

Findings: The core category showed that it has been 'A change in the men's everyday life' after the special activity program -for men only- was offered. The most essential issues for the men were 'Being together' and 'Getting away' which represent the categories.

Conclusion: This study shows that special activity program for men might enhance person-centered care.

References

1. Buron, B. & Killan, T.S. (2014). Promoting Personhood in Men in Nursing Homes: The Role of Activity Directors. *Annals of Long Term care*. 22(3).
2. Moss, S. Z. & Moss, M. S. (2007). Being a man in long term care. *Journal of Aging Studies*. 21:43-54.

PREOPERATIVE EDUCATIONAL PROGRAM FOR ELECTIVE PATIENTS UNDERGOING CORONARY ARTERY BYPASS GRAFTING (CABG)

Mei Wa Lo, Kam Wai Hong, Sau Man Chan (Hong Kong)

Objectives

Due to the lack of preoperative knowledge, CABG patients were reported to suffer from emotional distress, and thus were exposed to higher risk of cardiac complications and mortality. As such, the provision of preoperative educational programme to CABG patients was recommended. A literature review was conducted to evaluate the effectiveness of preoperative educational programme on elective CABG patients in terms of preoperative knowledge, postoperative anxiety and postoperative depression, as well as to identify the effective components of such programme.

Methods

Studies were retrieved from EBM Reviews, Embase, Ovid MEDLINE(R), PsycINFO and other bibliographies. The Effective Public Health Practice Project tool was adopted in literature appraisal. Only moderate and high-quality literatures were included.

Results

Four randomised controlled trials and two controlled clinical trials were included in the review. With the implementation of preoperative educational programme, positive impacts which comprised the improvement in preoperative knowledge and alleviation in postoperative anxiety and postoperative depression were illustrated. Apart from the adoption of multiple

teaching strategies such as lectures and written materials, the inclusion of psychological components in terms of counselling, psychological model or patient-centred strategies was advised. The emphasis on psychological need increased interactions with patients and made the preoperative educational programme more patient-oriented.

Conclusion

Findings demonstrated that preoperative education for CABG patients constituted to an enhancement in knowledge as well as reduction in anxiety and depression levels. The inclusion of multiple teaching strategies and psychological intervention was regarded as the effective component of the preoperative educational programme.

References

Blumenthal, J. A., Lett, H. S., Babyak, M. A., White, W., Smith, P. K., Mark, D. B., ... Newman, M. F. (2003). Depression as a risk factor for mortality after coronary artery bypass surgery. *The Lancet*, 362(9384), 604-609.

Cupples, S. A. (1991). Effects of timing and reinforcement of preoperative education on knowledge and recovery of patients having coronary artery bypass graft surgery. *Heart and Lung: The Journal of Critical Care*, 20(6), 654-660.

Dao, T. K., Youssef, N. A., Armsworth, M., Wear, E., Papatopoulos, K. N., & Gopaldas, R. (2011). Randomized controlled trial of brief cognitive behavioral intervention for depression and anxiety symptoms preoperatively in patients undergoing coronary artery bypass graft surgery. *The Journal of Thoracic and Cardiovascular Surgery*, 142(3), 109-115.

Furze, G., Dumville, J. C., Miles, J. N. V., Irvine, K., Thompson, D. R., & Lewin, R. J. P. (2009). "Prehabilitation" prior to CABG surgery improves physical functioning and depression. *International Journal of Cardiology*, 132, 51-58. doi:10.1016/j.ijcard.2008.06.001

Guo, P., East, L., & Arthur, A. (2014). Thinking outside the black box: The importance of context in understanding the impact of a preoperative education nursing intervention among Chinese cardiac patients. *Patient Education and Counseling*, 95(3), 365-370. doi: 10.1016/j.pec.2014.03.001

Perski, A., Feleke, E., Anderson, G., Samad, B. A., Westerlund, H., Ericsson, C. G., & Rehnqvist, N. (1998). Emotional distress before coronary bypass grafting limits the benefits of surgery. *American Heart Journal*, 136(3), 510-517.

Rice, V. H., Mullin, M. H., & Jarosz, P. (1992). Preadmission self-instruction effects on postadmission and postoperative indicators in CABG patients: Partial replication and extension. *Research in nursing & health*, 15(4), 253-259.

Sørli, T., Busund, R., Sexton, J., Sexton, H., & Sørli, D. (2007). Video information combined with individualized information sessions: Effects upon emotional well-being following coronary artery bypass surgery-A randomized trial. *Patient Education and Counseling*, 65, 180-188. doi:10.1016/j.pec.2006.07.006

Towell, A., & Nel, E. (2010). Pre-operative education programme for patients undergoing coronary artery bypass surgery. *Africa Journal of Nursing and Midwifery*, 12(1), 3-14.

Tully, P. J., Baker, R. A., & Knight, J. L. (2008). Anxiety and depression as risk factors for mortality after coronary artery bypass surgery. *Journal of Psychosomatic Research*, 64(3), 285-290.

Zhang, C. Y., Jiang, Y., Yin, Q. Y., Chen, F. J., Ma, L. L., & Wang, L. X. (2012). Impact of nurse-initiated preoperative education on postoperative anxiety symptoms and complications after coronary artery bypass grafting. *Journal of Cardiovascular Nursing*, 27(1), 84-88. doi: 10.1097/JCN.0b013e3182189c4d

Plenary Symposium 2: Symposium on person-centered integrated care (PCIC) in families and children

ETHICAL ISSUES IN PERSON CENTERED CARE OF CHILDREN, WHOSE INTERESTS PREVAIL?

Jim Appleyard (London)

Objectives

The best interest of a child is paramount. The question posed is who is responsible for making that decision and who is best to make it. This paper will explore the ethical foundations of person and people centered clinical decision making from the dilemmas surrounding the totally dependent neonate to the emerging independence of the adolescent

Methods

Guidance from the World Medical Association and British Medical Association were studied in association with a contemporary literature review

Findings

Though each individual child as a person within their bio medical psycho- social cultural and spiritual milieu is unique, an understanding of the medical ethical foundations of person-centered care is key to making an informed decision in the best interest of the person

Discussion

Parental responsibility is a legal concept involving authority; rights, duties and powers in respect of minors Human rights are protected from the moment of birth and all decisions about treatment or non treatment of the newborn should be made on the same basis as older 'incompetent' children who are unable to express a view

The greater the impact of any decisions, the greater the competence needed to make them. This is not solely based on

age but an environment in which children are enabled to be engaged with the decisions to the specific level of their competence without coercion. Shared decision making by a

young person with a physician depends on trust with respect, honesty and inherent confidentiality

THE ROLE OF MEN IN IMPROVING MATERNAL AND NEWBORN HEALTH SERVICES IN BURKINA FASO

Janet Perkins, Cecilia Capello, Francesca Cereghetti, Sébastien Blatt, Aminata Bargo/Maiga, Yanogo Matié, Carlo Santarelli (Geneva)

Introduction: As critical household gatekeepers, men in Burkina Faso play an important role in ensuring the care of women and newborns during the perinatal period. *Enfants du Monde*, *Fondation pour le Développement Communautaire/Burkina Faso* and *United Nations Population Fund (UNFPA)* are supporting Ministry of Health to implement the Health Promotion pillar of the MNH strategy. Working with men to help them become active participants in maternal and newborn health (MNH) is one of the axes of these efforts.

Methods: Interventions aiming to influence the role of men in MNH have been implemented since 2010. These include community meetings, household discussions with couples and implementation of a strategy entitled *Pougsidsongo*, or "Model Husbands". Within this strategy, designed by health workers and community members, men who are exhibiting positive

behaviours in supporting women are selected by local leaders and trained to educate other men in the community on care for women and newborns, on danger signs and family planning (FP) and on the need to accompany women to health services.

Results: Preliminary results suggest that men are participating more actively in MNH in particular due to the "Model Husbands" strategy. Notably, men are starting to accompany women to health facilities for antenatal care regularly and they are more aware of care practices for women during and after pregnancy and for newborns. In addition, utilization of MNH and FP services is increasing.

Conclusion: These results suggest that interventions are successfully influencing men's roles in MNH which is contributing to increased utilization of MNH services.

Parallel Sessions 1:

A: Symposium on person centered medical education and health systems enhancement

MAPPING THE GLOBAL STATE OF FAMILY MEDICINE

John Parks (Lilongwe, Malawi)

See the following text: Project Title: Mapping the global state of Family Medicine. Summary: Family doctors are key stakeholders in the effort to deliver primary care for health systems. In a globalized world family physicians can play a positive role in the advancement of health for the populations they serve. In "Mapping the Global State of Family medicine" we used a systematic approach to describe the nation-by-nation status of postgraduate family medicine training and development. The project utilized an electronic search strategy and a key stakeholder validation strategy. For phase 1, the electronic search, a pre-defined data collection tool enabled researchers to systemically construct a descriptive snapshot of

the development of Family Medicine at the country level, in 194 World Health Organization member nations, with a focus on training and its integration into the health system. Stakeholder validation, consisted of interviewing global family medicine leaders, such as *WONCA* regional presidents, in order to validate the data that was collected electronically. For the first time in 20 years an updated map of the status of Family Medicine has been created. In fitting with the times, this updated map is interactive displaying an interactive, modifiable, global landscape of family medicine training and development.

PERSON CENTERED UNDERGRADUATE MEDICAL EDUCATION IMPLEMENTATION: UFV MODEL

Juan Perez-Miranda (Madrid)

Introduction.

There are no established guidelines on the most effective ways of supporting medical students to develop a Person-Centered framework. *Francisco de Vitoria University Medical School (UFV)* has developed its own Curriculum to foster a true Person Centered Undergraduate Medical Education (UFV Model).

Objectives.

Description of the different elements of the UFV Model in its six year experience of implementation. We initiated this new medical degree with the idea of covering not only the intensive transmission of theoretical knowledge and clinical skills training, but also with the intention to offer students

opportunities for the development of an integral professional competence, including an emphasis in communication skills, clinical reasoning, the natural integration of social and ethical aspects of the medical profession as well as the recovery of a humanistic vision of medicine.

Methods.

The UFV Model focuses on five main areas: student selection, curriculum design, role modeling, new teaching and learning methods as well as assessment methods.

Findings.

The UFV Model overcomes the assumptions under the classic *Flexner's* model (clear separation between the pre-clinical and

clinical years of the Degree in Medicine) with a new integrative curriculum that seeks to mix the theoretical knowledge and the clinical experience from the beginning, together with specific focus on communicative needs and professional values. Our students who were selected with a predicting behavior assuring humanistic qualities, are exposed to a person-centered curriculum which encourages respect and empathy for the human condition of the patient.

IMPROVING QUALITY OF CARE THROUGH INTRA-PROFESSIONAL COLLABORATIONS

Victor Ng (Toronto Canada)

Person-Centered Integrated Care can be defined, in part, as the comprehensive and continuity of care provided to a person in keeping with their values, preferences and wishes in partnership with their physician and health care team. Family Medicine is a unique discipline with the responsibility for caring for persons in all stages of the lifespan in any context or community location. Recognizing that the sole doctor may not have all the necessary skills to care for an individual, the concept of team-based care has become widely accepted and practiced. While collaborations can and should exist between different disciplines and allied health professions, the importance of family doctors working together in providing person centered care should be encouraged.

Many family doctors have special interests and/or pursued enhanced training in a particular clinical area and may be able to assist a colleague with a particularly complex patient. This allows the patient to receive an added level or dimension of care in their home primary care center where the care is close to home and the caregivers are familiar. This allows a streamlined and connected care plan where different family doctors would pursue a shared care delivery model in

Conclusions.

Our experience confirms the idea of structuring a formal program for the development of Person-Centered professionalism in medical students. After six year experience of implementation, our UFV Model has a strong formative influence with great potential benefits for medical students.

partnership with the patient. The intra-professional learning that would occur during the shared care of the patient elevates the overall clinical knowledge base of the primary care center and further contributes to improving quality of person centered care.

References:

College of Family Physicians of Canada. A Vision for Canada: Family Practice—The Patient's Medical Home.

Mississauga, ON: College of Family Physicians of Canada; 2011. Available from: www.cfpc.ca/A_Vision_for_Canada_abridged_version. Accessed 2015 Feb 10.

Gerada C, Riley B. The 2022 GP: our profession, our patients, our future. *Br J Gen Pract*. 2012 Nov;62(604):566-7.

Institute of Medicine (IOM). Crossing the Quality Chasm: A New Health System for the 21st Century. Washington, D.C: National Academy Press; 2001.

MEDICAL DOCTORS' CONTRIBUTION TO PERSON- AND PEOPLE- CENTERED CARE: A NEW MEDICAL CULTURE FOR FAMILY MEDICINE IN THAILAND

Yongyuth Pongsupap (Bangkok)

Thailand modern health care system dating back to the 1880s has traditionally been anchored in hospital medicine. The family medicine concept introduced in the 1980s was therefore perceived as related to hospital-based doctors without any specific specialization.

Reforms following the move to universal health coverage in the 1990s were facilitated by the demonstration and diffusion of a new concept for proximity care: an innovative model for health centers had been developed in a few selected areas, showing that health centers have high potentials for quality and person- / people- centered care, especially when a medical doctor is part of the staff.

The universal health coverage scheme launched in the 2000s formally encouraged interaction between hospital and health centres: primary care started to be financed through

“contracting units for primary care” (CUP) made of proximity units linked with at least one physician usually active in a hospital.

Interaction between and within all four levels of care (family care givers, village volunteers, health centre staff, district hospital staff) continued to be promoted through a capacity building program - context based learning (CBL) - based on togetherness for working, learning and reinforcing the health care system. The concepts of family care- and district- matrix - teams are being introduced: four levels of care are taken into account as well as horizontal links (at each level, all concerned actors are connected, even those outside the health care system) and vertical links (actors from different levels are similarly connected). Family doctors play a crucial role in those matrix teams and contribute in this way to person- and people-centered care.

B. Symposium on PCIC for women

WOMEN'S HEALTH AND THE 2030 AGENDA: LEAVING NO WOMAN BEHIND

Veronika Magar (WHO)

Defining how we work on women's health, in the wake of the 2030 Agenda, requires that we understand how demographic-, epidemiologic-, socio-economic- and environmental-transitions affect populations and their health and wellbeing. Women's health now encompasses a range of long-established as well as emerging priority areas. By broadening its boundaries, we take into account equity, gender and rights to reduce burden of diseases disproportionately affecting women. Specifically, we continue to focus on reproductive and maternal health, but with greater attention to inequalities. We also consider incipient risk behaviours that produce disproportionate global burden of disease affecting marginalized women. Diet, lack of exercise, air pollution on the one hand and intersecting inequalities such as gender, ethnicity, poverty, age, migrant status on the other, represent both risk behaviours and social determinants needing immediate consideration. Attention to

health system strengthening and universal health coverage to reduce catastrophic health expenditures which disproportionately affect women is critical. Moreover, in many countries over three-quarters of the health workforce is female. Yet, discrimination and opportunities for meaningful engagement and advancement for women are greatly constrained. Solutions include Intersectoral approaches to ensure behavioural and social change while applying an intersectionality and relational theoretical lens. WHO encourages strengthening of health systems through: social protection and universal health coverage, health inequality monitoring across a range of determinants of health, addressing barriers and facilitating factors and institutionalizing women's labour in the formal system. Establishing and strengthening women's agency through empowerment groups cannot be underestimated.

DOUBLY BLIND: DOES EVIDENCE-BASED MEDICINE PRECLUDE PERSON-CENTRED CARE FOR WOMEN? FOR EVERYONE?

Susan Phillips (Kingston Ontario, Canada)

Objective:

With the ascendance of evidence-based medicine (EBM) comes the strength of practice based on more than experience, belief and bias. However, evidence is, at best, blind to different expectations, presentations and treatment effects for women and men. At worst, EBM models people as machines, made of parts that malfunction for specific, universal and replicable reasons. Can this standardized approach to illness account for individuality or social circumstances of, for example, women? Can a physician steeped in EBM see patients as persons whose contexts, experiences, hopes and constraints are central to their health and function?

Method:

Starting with a review of how women are included in recruitment and analyses of RCTs in leading journals I will then qualitatively analyze whether the research base of medicine precludes person-centred care, particularly for women.

Findings

Clinical trials include women only to randomize them into invisibility. Biologic sex differences are rarely examined and social experiences of gender are never considered.

Discussion

EBM informs clinical practice based on population risks. With objectivity about etiology, diagnosis and treatment comes blindness to the patient as a person whose wellbeing is shaped by subjective circumstances and interactions with the world.

Conclusion

Embracing evidence from current RCTs has meant abandoning human contexts. In the process, physicians walk away from caring and comforting and favour a standardized approach to risks, diagnoses and treatments. The scientific basis of medicine is essential but not sufficient to ensure person-centred care. Perhaps the invisible woman is the harbinger of where EBM will take us. The challenge is to avoid going there.

CHANGING THE PARADIGM: WOMAN-CENTERED CARE THROUGHOUT THE LIFE COURSE

Margaret Usher Patel (Dorchester, UK)

This paper is designed to catalyse discussion on changing the paradigm of health care to one of women-centered care focused on optimizing health and wellbeing across the life course based upon a review of published evidence-based information. The paper will examine the concept of a life course approach to women's health and well-being as a conceptual framework in order to examine how the social determinants of health affect health and well-being across the life course which, when combined with issues associated with the vertical provision of health care, act as barriers to providing holistic patient-centered care¹

An analysis of the evidence will examine factors within the

microcosm of our own practice and within health systems that are feasible to change and contribute to enhancing both interprofessional collaboration and support a more equitable holistic approach to health promotion, management and prevention across the life course.² The paper will conclude by analyzing current evidence to determine if effective multidisciplinary collaboration linked to specific interventions fostering person-centered health care across the life course can strengthen health systems, reduce fragmentation, meet health needs and address missed opportunities to enhance the health and well-being of women.³

References:

1. De Maeseeneer, J. Willems, S. De Sutter, A. Van de Geuchte, I. & Billings, M. (2007) Primary health care as a strategy for achieving equitable care: a literature review commissioned by the Health Systems Knowledge Network. [Online] WHO Commission on the Social Determinants of Health. World Health Organization, Switzerland. Available from: http://www.who.int/social_determinants/resources/csdh_media/primary_health_care_2007_en.pdf [Accessed 30.01.06].
2. Usher-Patel, M. (2013). Improving the health and well-being of women: Life course approach: Evidence, Trends and Action. International Council of Nurses (ICN), Switzerland. Available from: http://www.icn.ch/images/stories/documents/publications/free_publications/Improving_Womens_Health.pdf
3. Gounder C.R. & Chaisson R.E. (2012) A diagonal approach to building primary healthcare systems in resource-limited settings: women-centred integration of HIV/AIDS, tuberculosis, malaria, MCH and NCD initiatives. *Journal of Tropical Medicine and International Health*. 17, 1426 – 1431.

DETERMINANTS OF MATERNAL & NEW-BORN HEALTH IN HAITI
Cecilia Capello, Janet Perkins, Carlo Santarelli (Geneva)

Background: Haiti suffers from among the world's poorest maternal and newborn health (MNH) indicators and in particular utilization of skilled MNH care remains alarmingly low. In 2013, Enfants du Monde (EdM) and Médecins du Monde Switzerland initiated a project aiming to empower women and communities to improve MNH and increase demand for skilled care. During 2013 and 2014 a participatory community assessment (PCA) and a baseline study were conducted to better understand the situation and lay the groundwork for intervention planning.

Methods: For the PCA, six roundtable discussions were conducted with 118 community members. A mixed-methods approach was used for the baseline. The quantitative component consisted of a randomized survey of 320 women who had given birth during the previous year. Qualitative methods included focus groups discussions with women (n=8)

and male partners (n=2) and semi-structured interviews (n=10) with health workers.

Results: Community members expressed that health services are not generally person-centered. Women tend to prefer care provided by traditional and spiritual healers and giving birth at home where they can be surrounded by family, have personalized care and give birth in the position of their choice. Moreover, women express low satisfaction regarding formal health services and interactions with providers.

Conclusions: These studies revealed a number of factors which contribute to preventing women and newborns from accessing MNH services. Effectively improving MNH in Haiti requires action to make health services more person-centered, improve community participation in evaluating the services as well as action at community level to tackle these determinants.

Parallel Sessions 2:

A. Symposium on PCIC for functionally challenged and special populations

BEST PRACTICES IN COMMUNICATION WITH PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
Ian Casson (Kingston, Ontario, Canada)

Communication is essential for health care professionals to understand and interpret the lived experience of persons with disabilities. We commonly assume communication to be verbal interaction between two people. In reality, it is more complex than this and the complexity is increased in our interactions with a person with an intellectual and developmental disability (IDD). Person-centered integrated care requires that we develop an understanding of our patient's experience of self and the world and how it is affected by disability and illness.

How do we achieve the kind of communication so that we can attend to both the bio-medical and experiential aspects of the ill person with IDD? This paper will examine aspects of communication among health care professionals and patients and their caregivers through case examples and will review recommendations for best practices.

References:

1. Wullink M, Veldhuijzen W, van Schrojenstein Lantman-de Valk HMJ, Metsemakers JFM, Dinant G. Doctor-patient communication with people with intellectual disability - a qualitative study. *BMC Family Practice* 2009, 10:82 doi:10.1186/1471-2296-10-82 (Accessed Feb 7, 2016)
2. Sullivan, W & Developmental Disabilities Primary Care Initiative Co-editors (2011). *Communicating Effectively with People with Developmental Disabilities*. In: *Tools for the primary care of people with developmental disabilities*. Available at the link, "Communicating Effectively with People with Developmental Disabilities", on the webpage <http://www.surreyplace.on.ca/primary-care?id=135> (Accessed Feb 7, 2016)

ETHICAL ISSUES IN CARE FOR PERSONS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

Bill Sullivan (Toronto, Canada)

In its mission statement, the International College of Person-Centered Medicine affirms the ethical imperatives of promoting autonomy, responsibility and dignity of every person. Three case scenarios involving care of people with IDD will be used to comment on how these principles guide an appropriate PCIC approach to vulnerable members of this special and diverse population, in whose care additional ethical considerations might arise than in care of those without IDD.

Conclusions:

- (1) Autonomy in health care involves the capacity to deliberate, make and express decisions regarding alternative interventions according to one's goals and commitments. But autonomy understood in this sense might be where a person with IDD's vulnerability lies. A PCIC approach would recognize and support appropriately such vulnerability.
- (2) Responsibility for one's own or another's life, health-related decisions and behaviours might sometimes

entail going beyond an informer/consumer model of the Dr-Pt relationship, which distinguishes sharply between the physician's role in addressing questions of fact and the patient's or substitute-decision maker's role

in addressing questions of value and making decisions. (i)

(3) Promoting the intrinsic dignity of people with IDD includes affirming and incorporating in health care the importance to them of family and support systems, of stage in their life course, and of their own and their community's stances on ultimate meaning and spirituality.

I report how ethical considerations, like the ones above, are being incorporated into a framework for updating guidelines regarding the primary care of adults with DD. (ii)

References: (i) Emanuel EJ; Emanuel LL. Four models of the physician-patient relationship. JAMA. 1992 Apr 22-29;267(16):2221-6. (ii) Sullivan WF; Berg JM; Bradley E; et al. Primary care of adults with developmental disabilities: Canadian consensus guidelines, Canadian Family Physician (2011; 57:541-53)

PERSON-CENTERED CARE FOR WAR-DISPLACED REFUGEES

Mohammed Abou-Saleh (London)

Introduction: The UNHCR reported that 60 million people are currently impacted by humanitarian emergencies arising from armed conflicts and an unprecedented 19.6 million individuals in 2015-half of them children-and the number is steadily increasing with Syria as the leading country of origin of refugees. In Syria there are 7.6 million internally displaced persons and 4.7million refugees half of them are children, the Lost Generation. The WHO estimates 5% to 10% of these people suffer from a mental health condition such as depression as a result of the emergency.

Aims: To develop a framework for person-centred care for war refugees

Methods: To review the evidence base for mental health and psychosocial support (MHPSS) for what works and current guidelines, actions and interventions.

Results: There is a growing evidence base for effective interventions for MHPSS and international action by the WHO, UNHCR, national and international professional organisations and NGOs.

Conclusion: There is need to issue the ICPCM Declaration on the Health of Refugees, Internally Displaced Persons and Other Populations Affected by Conflict: A Call for Action and to develop a framework for Person-centered care guided by the conceptual framework of person-centered medicine.

References

Abou-Saleh, M.T. and Mobayed, M (2013) Mental Health in Post-conflict Syria International Psychiatry 10:58-60.
Abou-Saleh, M.T., Hughes,P;(2015) Mental Health of Syrian Refugees: Looking Backwards and Forwards, Lancet Psychiatry 10:870-871.

THE PROCESS OF RESILIENCE AND POST TRAUMATIC STRESS DISORDER IN MIGRANTS AND REFUGEES

Rachid Bennegadi (Paris)

The idea of resilience has become an essential reference in the practice of clinical transcultural psychiatry to better understand the impact of trauma on the psyche.

Thanks to his many years of clinical experience working with migrants and refugees situated in France, the author will demonstrate, using clinical cases as examples, the reality of the process of resilience and the links it has with the personality.

The concepts of secure, insecure and intermediate attachment, are fundamental in understanding the response of

the psyche towards what one calls 'the mental agony' caused by trauma.

The article "Resilience in the face of adversity: Protective factors and resistance to psychiatric disorder" by Sir Michael Rutter, as well as the book "De chair et d'ame" by Boris Cyrulnik will level of complexity and in not only a dialectical dynamic, but a dialogical one as well.

Key Words: resilience, PTSD, social determinants, personality structure, complexity

PERSON CENTERED INTEGRATED CARE FOR MULTI-MORBIDITY PATIENTS

Ihsan Salloum (Miami)

While comorbidity and multimorbidity, with worldwide increased rate of noncommunicable chronic diseases, have become the rule rather than the exception in regular clinical care. Current predominant model of care with heightened emphasis on disease specialization is inadequate to address the multiple, interrelated needs of persons with multimorbidity. This model has led to a shift in the practice of medicine away from a view of health as an interdependent whole resulting in fragmentation, incoordination, and in some instances decreased access to care. The exceptional burden of chronic diseases with comorbid mental health conditions, along with the key role of behavioral determinant of health call for alternative models of care and strongly emphasize the need for integrated care.

This presentation will review the rationale for an integrated care model along with reported positive experiences in the field. It will discuss the emerging Person-centered Integrative

Diagnosis (PID) model. The PID is a person- and patient-centered approach to care anchored in person-centered medicine. The PID considers the person-in-context as the center and goal of interventions and care models of care that address the totality of health with emphasis on disease prevention and health restoration, which is may be particularly applicable for persons with multimorbidity.

References:

Salloum IM & Khazai L. The integration of mental health and primary care: A person-centered approach. *World Medical Journal* 2015; 61(3): 109-113

Mezzich JE, Salloum IM, Cloninger R et al. Person-centered integrative diagnosis: conceptual bases and structural model. *Canadian Journal of Psychiatry* 2010; 55: 701-708

B. Symposium on PCIC systems and equity through the life course

CONTRIBUTION OF EMPLOYMENT TO HEALTH OVER THE LIFE COURSE

Minha Rajput-Ray (Cambridge, UK)

During an individual's lifecourse there are multiple opportunities to engage in employment; for example, transitioning from school to the world of work, job insecurity, job loss, re-employment and post retirement opportunities. Indeed meaningful employment provides an individual with a sense of vocation, financial stability and may also be used as a marker of health and social status.¹

However in practice, life events may pose challenges that a worker may encounter in an effort to be able to continue engage in meaningful, safe and sustainable employment. In 2014 the International Commission on Occupational Health (ICOH) and World Organization of Family Doctors (WONCA) pledged to work with their partner organizations (including WHO and ILO) to address the gaps in services, research, and policies for the health and safety of workers and to better integrate occupational health in the primary care setting, to the benefit of all workers and their families.

In addition although on average, people are living longer, there is a growing burden of global long-term health conditions and disability.² It is therefore imperative that employing a person centered approach is the keystone to fully support workers at a primary care level. In order to explore this concept further, on behalf of ICOH's scientific committee on unemployment, job insecurity and health; this presentation will focus on the current available evidence and to propose the creation of a person centered best employment practice model in order to prevent the premature loss of skills from the workforce.

1. Vuori J, Blonk R, Price RH. *Sustainable Working Lives: Managing Work Transitions and Health throughout the Life Course*. Springer Publishing: New York ISBN: 978-94-017-9797-9

2. Murray CJ et al. Global, regional, and national disability-adjusted life years (DALYs) for 306 diseases and injuries and healthy life expectancy (HALE) for 188 countries, 1990-2013: quantifying the epidemiological transition. *Lancet*. 2015 Nov 28;386(10009):2145-91

CONTRIBUTION OF SOCIAL WORKERS TO SYSTEMS EQUITY

Terry Bamford (IFSW, London)

Health inequalities are seen globally, nationally and locally. In the London Borough in which I used to work- one with the highest life expectancy in the UK- there was a gap of 12 years in life expectancy between the most deprived ward and the most affluent ward. The geographical gap was 3 miles.

Thanks to the Marmot report we know a lot about the social determinants of health. We know that differential income levels, differential access to employment, differential housing impact on health and wellbeing. The incidence of long term

conditions is greater in deprived communities. Access to health care is more limited with fewer primary care professionals, and the cost of medical care acting as a deterrent for poor families in many countries.

Social work is concerned with health inequalities. It has a value base rooted in social justice which requires it to challenge social systems and social policies which increase inequalities. Social workers have been active throughout Europe in opposition to the policies of governments committed to a neoliberal doctrine of austerity. But at the same time

social work by virtue of its direct engagement with many of the causative factors driving inequalities can have an impact on the lives of individuals and families to improve their social situation .

References: State of inequality: Reproductive, maternal, newborn and child health WHO 2015
Marmot M, Fair Society, Healthier Lives, Department of Health UK, 2010

Plenary Symposium 3: Symposium on person-centered integrated care (PCIC) in older age and at end of life

GLOBAL HEALTHY AGEING: WHAT IT MEANS TO EACH OF US?

Islene Araujo (WHO, Geneva)

The WHO World report on ageing and health highlights that while there is strong evidence that we are living longer, older people are not necessarily experiencing these extra years in better health than previous generations.

Comprehensive public health action on population ageing is urgently needed. This will require fundamental shifts, not just in the things we do, but in how we think about ageing itself. The World report on ageing and health outlines a framework for action to foster Healthy Ageing built around the new concept of functional ability. This will require a transformation of health systems away from disease based curative models and towards the provision of older-person-centred and

integrated care. It will require the development, sometimes from nothing, of comprehensive systems of long-term care. It will require a coordinated response from many other sectors and multiple levels of government. And it will need to draw on better ways of measuring and monitoring the health and functioning of older populations.

These investments will have valuable social and economic returns, both in terms of health and wellbeing of older people and in enabling their on-going participation in society. But the benefits will be lost to us unless we are all prepared to act. The presentation provides concrete examples of how countries around the world are making this happen.

CREATING A PICTORIAL LIFEBOOK TO EVOKE GEROTRASCENDENCE IN PERSONS LIVING WITH DEMENTIA

Susana Lauraine McCune (Seattle, USA)

Objectives: The World Health Organization (2012) has focused attention on dementia as a significant public health challenge. We aimed to discover if the care paradigm could be enhanced and well being enriched for people living with dementia by incorporating understandings revealed through art therapy using reminiscence and preserving memories to create a pictorial lifebook.

Methods: This was a mixed-methods, quasi-experimental, pretest and posttest, control group, field study. Treatment and control groups were pre-tested and post-tested for both cognition and mood.

Findings: Qualitative findings demonstrated that using reminiscence to document the participant's life narrative through the art therapy process of creating a pictorial lifebook revealed the presence of gerotranscendence and ability for meaning making. The intervention enhanced wellbeing, and improved mood and cognition. Quantitative data demonstrated creating pictorial lifebook improved cognition, yet did not provide significant evidence that the intervention improved mood.

Discussion: Subjective experiences of individuals living with dementia have remained largely unexplored. More research that reveals the lived experience of persons living with dementia is needed to improve care.

Conclusions: Creating a pictorial lifebook strengthened relationships between persons living with dementia and their loved ones and caregivers. Creating a pictorial lifebook proved to be a practical, person-centered approach to dementia that focused on the whole person by illuminating and preserving each person's life narrative, thereby enhancing well being, facilitating a continued sense of self, and evoking Gerotranscendence. The researchers recommend education and training for personal and professional caregivers to facilitate creating pictorial lifebooks with people living with dementia.

References

World Health Organization. (2012). Dementia: a public health priority. World Health Organization. Retrieved from http://www.who.int/mental_health/publications/dementia_report_2012/en/
Prince, M., Acosta, D., Albanese, E., Arizaga, R., Ferri, C. P., Guerra, M., . . . Rodriguez, J. L. (2008). Ageing and dementia in low and middle income countries—Using research to engage with public and policy makers. *International Review of Psychiatry*, 20(4), 332-343.
Beard, J. R., & Bloom, D. E. Towards a comprehensive public health response to population ageing. *The Lancet*, 385(9968), 658-661. doi: 10.1016/s0140-6736(14)61461-6

GLOBAL ACTION FOR PERSONHOOD IN DEMENTIA

Jon Snaedal (Reykjavik)

Dementia is a debilitating illness that in many cases affects the central core of each individual, the cognitive abilities that create a person. Classically, dementia is described in terms of symptoms, not only in cognitive domains but also in terms of psychiatric symptoms. The most frequently used constellation is the term “Behavioral and Psychiatric Symptoms in Dementia (BPSD), widely used in the health service for individuals with dementia not least in describing results of interventions such as pharmacological treatment. The focus on symptoms results in degrading views on the individual as he or she is seen in the light of the symptoms rather in the light of personality. To counter this tradition, an initiative called **Global Action for Personhood in Dementia (GAP)** was presented officially at The Alzheimer’s Disease International Conference in Perth, Australia last year¹). The initiative is based on the work of the late professor in psychology, Tom Kitwood, published twenty

years ago²). He paved the way for more personalized focus in dementia service and he pointed at the risk of belittling individuals with dementia. He coined the term “Malignant Social Psychology” for processes that make a negative contribution towards peoples experience of dementia. The use (and misuse) of language is one of the first aspects the GAP initiative has been focusing on. One very simple example is the difference in saying “demented individual” or “an individual with dementia”. The GAP initiative is a very fine example of how Person Centered Medicine can make a difference.

1) Brooker, D: (April, 2015) Global Action on Personhood in Dementia, The Alzheimer’s Disease International Conference. Perth, Australia, oral presentation.

2) Kitwood, T. (1997). Dementia reconsidered: the person comes first. Buckingham: Oxford University Press.

Plenary Symposium 4: Symposium on PCIC and the organization, quality and safety of health systems

IMPLEMENTATION OF THE WHO FRAMEWORK ON INTEGRATED PEOPLE-CENTERED HEALTH SERVICES

Nuria Toro Polanco (WHO, Geneva)

Making progress on universal health coverage requires countries moving towards all people and communities having access to health services that are high quality, safe and accessible. An integrated, people-centred approach is critical to the development of health systems to respond to emerging and varied health challenges, including urbanization and the globalization of unhealthy lifestyles, ageing populations, dual disease burden of communicable and non-communicable diseases, multi-morbidities, as well as outbreaks and other health-care crises.

In response, WHO has drafted a “Framework on integrated people-centred health services” that sets forth a vision where “all people have equal access to quality health services that are co-produced in a way that meets their life-course needs, are coordinated across the continuum of care, and are comprehensive, safe, effective, timely, efficient and

acceptable; and all carers are motivated, skilled and operate in a supportive environment”. The Framework is based on experience and evidence gained recently in different countries and wide ranging consultation with experts at the global, regional and national levels.

The Secretariat is developing several initiatives to support the implementation of the Framework. The Service Delivery and Safety department will launch the “integratedcare4people” web platform at the 69th session of the WHA in May. Further efforts include fostering partnerships; promoting demonstration sites; developing self-assessment and improvement tools; and performing research and development on indicators to trace global progress on integrated people-centred health services, among others.

This presentation will provide an overview on these implementation efforts.

HOW FAMILY MEDICINE CONTRIBUTES TO UNIVERSAL HEALTH COVERAGE

Shannon Barkley (WHO, Geneva)

Universal health coverage ensures that all people are able to receive needed health services without fear of financial hardship and, critically, requires that care be of sufficient quality to be effective. Achieving universal health coverage requires a strong, efficient, well-run health system. International reviews repeatedly demonstrate that health systems based on high-performing primary health care are able to achieve better health outcomes, more equitably, with

higher satisfaction at lower relative cost than health systems that over emphasize selective disease-specific and/or hospital-based care. A family practice approach, including Family Medicine, incorporates essential elements of integrated, people-centred care in pursuit of universal health coverage: family and community orientation, continuity, coordination and comprehensiveness and is, therefore, a critical part of necessary service delivery reforms.

THE FUTURE OF PATIENT CENTERED MEDICAL HOMES

Paul Grundy (New York)

Objectives

Participant will understand/be able to discuss the important trend of PCMH in delivering patient centered medicine

Participant will understand/be able explore the rationale and supporting evidence for PCMH

Participant will understand/be able understand the impact on patients, providers and payers

In the next 10 years, we will be living in 1) mobile world 2) in the middle of an aging and chronic disease epidemic and 3) data. But, we will also have the ability to analyze data in a cognitive way this will do for doctors' minds what X-ray and medical imaging have done for their vision. How? By turning data into actionable information. We need the basic foundation to support this transformation a system integrator where data at the level of a patients flows and is held accountable and that model is the Patient Centered Medical Home. (PCMH) starts to happen when clinicians/ healers step up to comprehensive relationship based care empowered by tools to manage the data and communicate effectively. This move to PCMH level care requires the discipline of leading a team that delivers population health management, patient centered prevention,

care that is coordination, comprehensive accessible 24/7 and integrated across a deliver system and all of that is power by data made into meaningful information. But at its core it is a move toward integration of a healing relationship in primary care and population management all at the point of care with the tools to do just that.

A Patient Centered Medical Home (PCMH) happens when primary care healers keeping that core healing relationship with their patients step up to become specialists in Family and Community Medicine. The move is to the discipline of leading a team that delivers population health management, patient centered prevention, care that is coordination, comprehensive accessible 24/7 and integrated across a deliver system. PCMH happens when the specialists in Family and Community Medicine wake up every morning and ask the question WITH DATA how will my team improve the health of my community today?

PHYSICIAN ADVOCACY FOR PERSON CENTERED CARE *Glenn Brown (Kingston, Ontario, Canada)*

Objectives

As primary care structures evolve the advocacy role for physicians has become increasingly important. The objective of this talk is to highlight the role of physician advocacy in achieving person centered care.

Methods

Milestones in the development of person-centered care in Canada will be outlined. This will begin with the introduction of Medicare in 1962 and then discuss the role of Dr. Ian McWinney in articulating the principles of patient-centered care and the enshrining of these principles in our postgraduate education programs in Family Medicine. The more recent development of the CanMeds roles facilitates physician engagement in the role of advocacy in person-centered care.

Physicians have a great tradition of advocating on behalf of their patients and recognize their duty to contribute to efforts to improve the health and well-being of their patients. Increasingly, we are accepting responsibility for improving health by promoting health equity. Being "person-centered" involves more than taking account of our individual patient's life context. By broadening our perspective to include the insights from a population health perspective, relevant to our patients, we can accomplish much more in our person-centered approach. Our successes in this approach can be appreciated by exploring examples in the Canadian experience of facilitating the decline in cigarette smoking, the increased understanding and respect for women's self-determination in reproductive health, and in addressing public safety issues.

Discussion

Canada, along with many other countries, has recognized the foundational role that primary care plays in its health care system. Like others, we have reformed our system but still haven't achieved a system where our citizens, practitioners, and funders feel confident about our effectiveness, accountability, or sustainability. Our primary care system remains a "work in progress".

Conclusion

Canadian physicians have adopted patient-centered approaches to care and are embracing person-centered care concepts. Advocacy for our patients and the population of patients for whom we provide care is important. Advancing the advocacy role of physicians in our evolving primary care systems will be critical to the advancement of person-centered care in Canada.

References

1. Royal College of Physicians and Surgeons of Canada. CanMeds Framework, Health Advocate
2. Health Care Transformation in Canada. Physicians and Health Equity: Opportunities in Practice. Canadian Medical Association
3. 2015 Geneva Declaration on Person-Centered Primary Health Care. International College of Person Centered Medicine
4. A Vision for Canada: Family Practice: The Patient's Medical Home. College of Family Physicians of Canada

PCIC IMPLEMENTATION IN NATIONAL HEALTH SYSTEMS *Yongyuth Pongsupap (Bangkok)*

Moving from hospital- toward people-centred district health systems (DHS) has benefited in Thailand from dramatic reinforcement of infrastructure and staffing in the periphery

(community hospitals, health centres), and simultaneously from progressive physicians' concern for primary care. The universal health coverage scheme launched in the 2000s

encouraged interaction between levels of care: primary care started to be financed through “contracting units for primary care” made of proximity units linked with at least one physician usually active in a hospital. Reinforcement of DHS workforce capabilities has been boosted from 2007 onwards through a “Context-based learning (CBL)” approach the main features of which have been starting from the context and activities in the field, and interaction within and between levels of care (district hospital and health centre staff, village volunteers and family caregivers). CBL has evolved from “Primary Care Practice Learning” (2007) for reinforcing health centre staff clinical skills, to “Family Practice Learning” (2012) for enhancing cooperation between levels of care and “District Health System Management Learning” (2014) for strengthening decision makers’ partnership. CBL constitutes a learning system with synergies. It relies on different learning processes (on-the-job inter-service holistic practice, follow up of special families, implementation of projects ...), each starting from identification of gaps between expected performance and existing capabilities of individuals, teams, and systems. The process has trespassed the district boundaries, stimulating exchanges at provincial, regional and national forums and

during demonstration visits for among others, policy makers. CBL has progressively been introduced nationwide. It has become a concept defined as the development of functional and sustainable relationships between district hospital, first line health services staff and other partners (from even beyond the district limits), as well as within hospital, health centre teams and communities, with reference to shared concepts (primary health care, family and community medicine, integrated health system), for better working together (*functional relationship*), for continuously learning together (*learning relationship*), for strengthening the organisation together (*managerial relationship*), in order to make the health system responsive to people’s current and emerging demands and needs (including quality care provision). CBL fuels DHS main organisation components, i.e. the family care matrix team (care providers connected within and between levels of care), the extended district matrix team (which involves also non-health professional actors for inter-sectoral health interventions) and the district health board. CBL is expected to be supported by a district techno-structure, communities of practice and academic partners for research and scientific accompaniment.

Parallel Sessions 3:

A: Symposium on inter-specialty and inter-disciplinary professional relations for PCIC

DETERMINING THE COMPOSITION OF THE PRIMARY CARE TEAM

Ted Epperly (Boise, USA)

Family medicine and primary care is a team-based sport! The ability to take care of a person, a family, and a community is dependent on an interdependent team working with one clear purpose: the health of the person.

The size and makeup of the primary care team can vary based on practice size/location, scope of practice, and patient population’s served. At a minimum, the team must have a family physician or other primary care provider, nurse (RN, LPN, or MA), reception and scheduling person, and a business manager for billing and/or administrative paperwork.

As a practice grows in size and complexity then additional personnel can be added. These consist of behavioral and mental health (social work, psychologist), clinical pharmacist, nutritionist, nurse care coordinator, case managers, community health workers, and IT personnel. Each professional should work to the top of their healthcare license.

The person-centered medical home allows the perfect example of how this integrated and coordinated care team can work interdependently for the best care of the person.

UPSTREAMING NCD PREVENTION: AN INTERDISCIPLINARY APPROACH

Tesfa Ghebrehwet (Alberta, Canada)

The growing rise of non-communicable diseases (NCDs) is a significant global public health threat. The determinants of NCDs are embedded in lifestyle, behavioural, political, social, cultural and structural factors that are causing much preventable premature death and disability in the form of diabetes, heart disease, cancer and chronic respiratory diseases. These four NCDs have shared risk factors namely: unhealthy diet, physical inactivity and tobacco use [1].

In the battle plan against the NCD epidemic, all health professionals must be mobilised. It is estimated that there are about 26 million nurses, physicians, pharmacists, dentists and physical therapists globally and they have a historic opportunity to roll back NCDs [2].

In order to tackle the global epidemic of NCDs, the focus of healthcare must shift from downstream, illness-focussed care

to upstream approaches including health promotion and disease prevention, and the millions of nurses, physicians and other health professionals are best positioned to lead in the shift towards this new paradigm.

The aim of the presentation is to focus on strategies for mobilising health professionals in leading the shift from acute care to a continuum of care encompassing health promotion, disease prevention and cure of NCD. I will argue that health professionals - now more than ever - can lead the shift to chronic disease prevention and management.

References

1. World Health Organization(2005). Preventing Chronic Diseases: A vital investment. www.who.int/chp/en/.

CONTRIBUTIONS OF SOCIAL WORKERS TO PERSON-CENTERED TEAM WORK

Terry Bamford (IFSW, London)

From cradle to grave social work plays a role in person-centred care. It recognises the impact of the social environment- housing, income, domestic stability, employment, social relationships-on wellbeing. By intervening in these areas social work can equip individuals to cope better with the stresses of life and to modify those factors impacting on wellbeing.

Healthcare professionals address the whole person but are not necessarily well placed to deal with the wider social determinants of health. Working collaboratively with social

workers increases the prospect of better outcomes for patients. Health care does not end with hospital discharge and social workers can help to stitch together the community supports needed to promote recovery.

Successful person-centred integrated care requires professions to be clear about their respective roles and to demonstrate mutual respect.

References: Bamford, T, A Contemporary History of Social Work, (2015), Policy Press

INTER-DISCIPLINARY WORK FOR PERSON-CENTERED CARE IN EPIDEMICS

Rosa Vallenás (WHO)

The objectives of this presentation are:

To explain the paradigm shift, in the approach to clinical management of epidemic diseases, from isolating and quarantining patients to improving the quality of care while searching for specific curative therapies.

To describe some key challenges for patient-centred clinical care faced during epidemics of high-threat pathogens and how inter-disciplinary work is not only desirable but crucial.

B: Symposium on research methodology for PCIC through the life course

GLOBAL “STATE OF PLAY” OF PERSON CENTERED CARE

Ed Harding (London)

Objectives

This presentation will offer an overarching ‘state of play’ narrative in the research, implementation of measurement of person-centred care, illustrated through key examples of recent and ongoing work and materials.

Methods

This presentation is based on a research synthesis drawn together from a pragmatic search of recent literature, including interviews with leading commentators in the field, and written responses to an international call for information.

The final report and catalogue were published in December 2015 in partnership with the Health Foundation UK, with a further 12 page lay summary published in January 2016.

Brief overview of findings, discussion

Some interim findings are offered below, to be expanded upon in the session:

- The ‘use of person-centred care’ as a term is rooted in culture and context.
- Commentators give different emphasis and priority to different qualities of person-centred care. These are not necessarily exclusive, but include:

- An overarching grouping of concepts
- Personhood and anti-reductionism
- Diology, co-production

- Research ‘hotspots’ in different settings and diseases are encouraging but siloed activity may slow diffusion of good practice, and risk divergent concepts.

- Patient involvement in helping to shape research priorities is rare.
- There is a significant presence of ‘person-centred care’ in health care policy in English speaking and Northern European countries, however implementation lags behind.
- Measurement is widely considered to be vitally important in embedding person-centred models and approaches in the mainstream.
- However, a number of practical and ethical concerns arise, including a lack of validated models for measurement

Conclusion

The report and catalogue have paved the way for a new dialogue across the diverse field of person-centred care around the world. But it is imperative that organisations go much further in understanding synergies and promoting best practice exchange across and within different geographies, areas and approaches of care, and settings.

Referees

Darshan Patel Research Manager The Health Foundation
90 Long Acre, London WC2E 9RA
darshan.patel@health.org.uk

Professor Alan Cribb King's College London
Centre for Public Policy Research
Waterloo Bridge Wing, Waterloo Road London SE1 9NH
United Kingdom
alan.cribb@kcl.ac.uk

PERSON-CENTERED RESEARCH DESIGNS

Sandra Van Dulmen (Nijmegen, the Netherlands)

Objectives

Prevailing paradigms in healthcare policy and practice demand increased patient participation. This is reflected in more self-management, informed decision-making and empowered healthcare interactions. The patient voice counts and so do his preferences, needs and values, i.e. the building blocks to person-centered medicine. Interestingly, such a democratic approach does not count for study designs; an RCT is still considered the gold standard for testing treatment effectiveness. However, RCTs make an assumption of clinical equipoise and provide research evidence of group efficacy not of individual efficacy. The aim of my presentation is to describe different, more person-centered research designs and methodology.

Methods

Examples of studies that make use of more person-centered research designs (e.g. n-of-1 studies and patient preference

trials) will be presented and discussed on their pros and cons in view of the level of evidence they provide.

Findings

The hierarchy of study designs which is traditionally based on the level of evidence at the expense of the contribution and input of individual study participants may need to be twisted around in order to have a patient's voice heard. More person-centered research designs can be used to make this possible.

Conclusions

By considering, before the start of an intervention study, alternative ways to account for individual preferences and needs, it may, to a certain extent, still be possible to reach an acceptable level of evidence.

PERSON-CENTERED DIAGNOSTIC METHODOLOGIES

Juan E. Mezzich (New York)

The methodologies for person centered diagnosis are those pertinent to the development, evaluation and implementation of person centered diagnosis models and guides aimed at fulfilling the role of diagnosis in person centered medicine. Such methods have to help responding to the following key questions in person centered diagnosis, starting with the most conventional ones.

First, one must deal with the description, terminology and codification of diseases or clinical problems. This is the main or only question in conventional diagnostic systems such as the WHO International Classification of Diseases (ICD) or, for a psychiatric example, the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (DSM). Special challenges here are how to deal with symptoms, non-well defined diseases, and non-disease clinical problems as well as the very common case of multi-morbidity.

Second, one must deal with the need to describe positive health, contributory risk and protective health factors, and the person's health experience and values, which are required to fulfill not only curative but also preventive and health promotion tasks. All this is not relevant to conventional diagnostic systems which are typically disease-centered, but it is very germane for the diagnosis of health and the provision of the informational base necessary to practice person centered medicine.

Third, one must address the procedures needed for obtaining, formulating and using the information required by a given diagnostic model and guide. For person centered diagnosis, issues of empathetic communication and establishing a common ground among clinicians, patient and family for collaboration towards joint diagnostic understanding and shared decision making are crucial.

While much work is in progress and needs to be done, an encouraging development is the recent official diagnostic guide for psychiatric diagnosis in Latin America [1], which follows the principles of the Person Centered Integrative Diagnosis (PID) model [2].

References

1. Asociación Psiquiátrica de América Latina, Sección de Diagnóstico y Clasificación. (2012). Guía Latinoamericana de Diagnóstico Psiquiátrico, Versión revisada (GLADP-VR). Lima: Asociación Psiquiátrica de América Latina.
2. Mezzich, J. E., Salloum, I. M., Cloninger, C. R., Salvador-Carulla, L., Kirmayer, L., Banzato, C. E., Wallcraft, J., & Botbol, M. (2010). Person-centered Integrative Diagnosis: Conceptual Bases and Structural Model. *Canadian Journal of Psychiatry*, 55, 701-708.

APPLICATION OF PROPENSITY SCORE TO ANALYZE OBSERVATIONAL DATA

Levent Kirisci, Jeanine Hayes (Pittsburgh), Juan E. Mezzich (New York)

Objective. The randomized clinical trials (RCT) has been the most reliable way to draw causal inferences about the effects of treatment, and interventions. However, in recent years, researchers are tempted to analyze observational data to address important clinical questions with the assumption that

results are reliable and trustworthy. It should be noted that observational databases involve confounding effects such as selection bias. To overcome selection bias effects in observational database research one method is to use propensity score methodology. In this study, we will

demonstrate how to use the propensity score-matching, stratification, propensity score weighting to address selection bias in analyzing the effects of being in the high risk group for substance use disorder (SUD) during childhood in developing cannabis use disorder (CUD) at young adulthood.

Method. A cohort consisted of 10-12 year old boys (N= 500) and girls (N= 200) recruited by the Center for Education and Drug Abuse Research (CEDAR) and tracked until 22 years of age. This is the first study to examine the neurocognitive, health and social adjustment sequelae of adolescent marijuana use. The participants were accrued through their biological fathers who either qualified for lifetime diagnosis of SUD consequent to consumption of illegal drugs (high average risk (HAR) group, N= 350), had no adult psychiatric disorder, or a non-SUD psychiatric disorder (low average risk (LAR) group, N= 350).

Results. The propensity score adjustment in prediction of SUD at age 22 will be presented. **Discussion.** The benefits of using propensity score in obtaining more accurate results for observational data will be discussed. The use of propensity score will help clinicians, families, and care takers to make optimum decisions in prevention of substance use in children.

References.

Guo, S., and Fraser, MW. (2010). *Propensity Score Analysis: Statistical Methods and Applications*. Thousand Oaks, CA: Sage Publications.

Kirisci, L., Tarter, R., Ridenour, T., Reynolds, M., & Vanyukov, M. (2013). Longitudinal modeling of transmissible risk in boys who subsequently develop cannabis use disorder. *American Journal of Drug and Alcohol Abuse*, 39, 180-185.

PATIENT-PROVIDER RELATIONSHIP FOR MEASURING PRIMARY CARE PERFORMANCE

George Southey (Oakville, Ontario, Canada)

Starfield observed that the quality of the patient/doctor relationship is associated with lower cost and better equity. Assuring relationships could lead to performance benefits in three perspectives; the patients, the profession and the system. Measuring and assuring the relationship is essential to patient satisfaction. Relationships enable the pursuit of profession and system performance. Unlike system level initiatives, measuring performance at the level of the Province's 1,000 group practices provides fertile opportunity (and considerably lower risk) to find ways in which

relationships can benefit the system's performance. Dorval Medical created a patient centric measurement of the patient doctor relationship and observed the measurement over 5 years along with measurements of system cost and practice efficiency. Assurance of the relationship quality and the reduction of system cost were observed as the group used existing, assured relationships to help patients navigate hazardous health transitions. Cost per patient was about \$300 to \$600 less than the provincial average despite caring for a sicker population.

Parallel Sessions 4:

A. Symposium on health stakeholders' engagement and perspectives for PCIC through the life course

ENHANCING PATIENTS' USE OF HEALTH RECORDS

Joanna Groves (London)

Health records contain a wealth of information about our health status and our treatment and care over the course of our lives. Historically, these records have not been routinely accessible to patients. However, this is changing as it has been recognised that patient's engagement in their own care contributes to improvement of people's knowledge, better experience of services, better outcomes and better use of resources. The use of health records to support patient engagement and empowerment is being explored in various contexts.

This presentation will consider the potential of enhancing patients' use of health records to foster greater integration and continuity of care, improve efficiency and patient safety, and

promote patient engagement in healthcare by breaking down information barriers and facilitating shared decision-making. It will also consider important factors which need to be considered such as balancing increased access to data with ensuring appropriate levels of privacy, confidentiality and security are maintained. Examples of initiatives to enable and enhance patients' use of health records from around the world will be shared.

References

1. National Voices, 2014. Prioritising person centred care: the evidence www.nationalvoices.org.uk/evidence
2. World Health Organization, 2015. People-centred and integrated health services: an overview of the evidence

NURSING CONTRIBUTIONS TO PCIC THROUGH THE LIFE COURSE

Tesfa Ghebrehiwet (Alberta, Canada)

Person-centred care gives a human face to the continuum of care encompassing disease prevention, treatment, care and support services through the life course, based on the needs

and voices of people, not on the needs of a system or health professionals. From the nursing perspective, a focus on the patient in a holistic way- as a whole person, not simply a

health problem - has always been at the centre of nursing care. Nursing leaders and theorists have always promoted self-care, focusing on enabling people to do as much as possible for themselves. In this model, the nurse strives to “get inside the skin” of the person by listening and establishing a dialogue with a view to creating a therapeutic relationship in which the person is a key partner [1].

McCormack and colleagues [2], for example, identified several values related to person-centred health care based on the assumption that human autonomy can be retained in the presence of debilitating illness and disability through partnership with nurses obtained by getting “close to the

person”, providing care that is consistent with the person’s values, taking a biographical approach to assessment and ensuring a focus on ability, rather than on dependency.

The presentation will highlight nursing contribution to PCIC through the life course.

References

- [1] Virginia Henderson (2004). *ICN’s Basic Principles of Nursing Care*. Geneva: ICN.
- [2] McCormack, B. (2001). Autonomy and the relationship between nurses and older people. *Ageing and Society*, 21, 417-446

PERSON-CENTERED RESEARCH USE OF HEALTH RECORDS

Levent Kirisci (Pittsburgh)

Objective.

In recent years, researchers are tempted to analyze electronic medical records (EMR) to address important clinical questions with the assumption that results are reliable and trustworthy. It should be noted that observational databases including EMR involve confounding effects such as selection bias. To overcome selection bias effects in EMR research one method is to use propensity score methodology (Guo and Fraser, 2010). In this study, we will demonstrate how to use the propensity scores to address selection bias in reanalyzing the effectiveness of phenobarbital, propofol, dexmedetomidine, and ketamine added benzodiazepine treatment (BNZ+) over benzodiazepine treatment only (BNZonly) in patients with resistant alcohol withdrawal (RAW) syndromes (Wong et al., 2015).

Method. Studies showed that patients with RAW do not respond to benzodiazepine treatment and are more likely to have incidences of mechanical ventilation and nosocomial pneumonia and longer intensive care unit stay. A retrospective cohort of 184 adult patients were identified via International Classification of Diseases, Ninth Revision codes for severe alcohol withdrawal in the University of Pittsburgh Medical Center the Medical Archival Retrieval Systems database, an

electronic repository used for the health system that contains clinical and financial data.

Results. The sample was mostly middle-aged white males. The analysis will involve demographic, clinical risk factors and outcome variables such as Acute Physiology and Chronic Health Evaluation II (APACHE II) score; Riker Sedation Analgesia Scale scores; presence or absence of withdrawal seizures, hallucinations, arrhythmias, and delirium tremens on that admission, etc.

Conclusion. The propensity score approach will provide a more accurate treatment effect estimates which in turn helps patients, caretakers and clinicians in better shared decision making.

References

- Guo, S., and Fraser, MW. (2010). *Propensity Score Analysis: Statistical Methods and Applications*. Thousand Oaks, CA: Sage Publications.
- Wong, A., Benedict, N., Kane-Gill, S. (2015). Multicenter evaluation of pharmacologic management and outcomes associated with severe resistant alcohol withdrawal. *Journal of Critical Care*, 30, 415-409.

PATIENTS’ AND FAMILY CAREGIVERS’ GOALS FOR CARE DURING TRANSITIONS OUT OF THE HOSPITAL

Eric Coleman (Aurora, Colorado, USA)

Objective

A critical step towards operationalizing patient and family caregiver engagement is to encourage identification and pursuit of personal goals. Our aims were to (1) describe the nature of the goals elicited from patients, family caregivers’ goals for their loved ones, and family caregivers’ goals for themselves; (2) determine the degree of concordance with respect to the three elicited goals; (3) ascertain goal achievement; and (4) examine factors predictive of goal achievement.

Methods

Patients and their family caregivers were recruited upon hospital discharge. Patients identified a goal for themselves

while family caregivers identified a goal for their loved ones as well as a goal for themselves.

Findings

Goals were grouped into four categories: function, employment, socialization, and symptom management. Concordance between patient’s goal type and family caregiver’s goal type for her/his loved one was 41%. 51% of patients achieved their goals; 61% of family caregiver achieved their goals for their loved ones; and 64% of family caregivers achieved their own goals. Patient’s goal attainment was correlated (0.49) with family caregiver’s goal attainment. Patient’s goal attainment was predicted (R-square=0.22) by patient’s goal type and residing with a spouse.

Discussion

Patients discharged from the hospital more often identified goals related to functional status or returning to social activities or hobbies while family caregivers more often identified goals related to symptom management. The majority of patient goals were achieved.

Conclusions

Eliciting patient and family caregiver goals and fostering goal achievement may represent an important step toward promoting greater patient and family caregiver engagement.

References

Robben SHM, Heinen MM, Perry M, van Achterberg T, Olde Rikkert MGM, Schers HJ, et al. (2013) First experiences with a two-step method for discussing goals with community-dwelling frail older people. *Expect* doi:10.1111/hex.12145.

Health Bradley EH, Bogardus ST, Tinetti ME, Inouye SK. (1999) Goal-setting in clinical medicine. *Soc Sci Med* 49:267-278.

B. Brief Oral Presentations 1: Person Centered Mental Health and Positive Health

THE WHOLE HEALS: HUMANITY'S ONE BODY AND HEALING OF THE PERSON *Kondothra George (Kerala, India)*

Each human person with his/her body, mind and soul is unique. While the identity is distinct each human person shares in the corporate identity of humanity. There is a physical-biological dimension in which we can speak, even literally, of the one body of humanity.

A profound awareness of this "one-body-ness" of the human species can alter our approach to the issues of illness and

health in a human person. The sense of the one body can be extended to the cosmic body of the created world with implications for our understanding of wellness and the integrity of creations.

EUROPEAN ALLIANCE AGAINST DEPRESSION (EAAD): PEOPLE-CENTERED CARE FOR DEPRESSION AND PREVENTION OF SUICIDAL BEHAVIOUR *Ulrich Hegerl (Leipzig)*

The community based 4-level-intervention concept developed within the "European Alliance against Depression" (www.EAAD.net) aims at improving the care and treatment of persons suffering from depression and suicidal tendencies. It has been shown to be effective concerning the prevention of suicidal behavior (1, 2) and is world-wide the most broadly implemented multifaceted intervention targeting depression and suicidal behavior. The 4-level intervention concept comprises training and support of primary care providers (level 1), a professional public relation campaign (level 2), training of community facilitators (teacher, priests, geriatric care givers, pharmacists, journalists) (level 3), and support for selfhelp of persons suffering from depression and for their relatives (level 4). In order to deepen the understanding of factors influencing the effectiveness of the intervention, the EU-funded study "Optimizing Suicide Prevention Programs and Their Implementation in Europe" (www.OSPI-europe.com; 7th

Framework Programme) has been run from 2008 – 2013. This study provides data from four intervention and four control regions from four European countries concerning intervention effects on suicidal behaviour as well as concerning intermediate outcomes (e.g. changes in attitude or knowledge in different populations) and process evaluation. Synergistic and catalytic effects of simultaneously being active at four different levels as well as predictable and unpredictable obstacles to a successful implementation of such community based programs will be discussed. Via the EAAD and partners from 22 countries, the intervention concept and materials (available in many different languages) are offered to interested regions in and outside of Europe.

- 1) Székely et al 2013; PLOS One (in press)
- 2) Hegerl et al 2013; *Neurosci Biobehav Rev*; doi:pii: S0149-7634(13)00045-

SWISS EXPERIENCE TRANSLATING HARM REDUCTION INTO ADDICTION TREATMENT POLICIES *Riaz Khan (Geneva)*

Aims: The aim of this presentation is to illustrate how Switzerland was able to play such a pioneering role in the field of addiction treatment, by creating a drug policy integrating the medical prescription of diacetylmorphine (heroin) in the therapeutic arsenal of addiction treatments.

Discussion: The medical prescription of diacetylmorphine, introduced initially as a harm reduction measure has become an approach based on public health and integrated care goals. The prescription of HAT has been the exotic element of the Swiss drug policy of 1991. It is still is one of the most

controversial practices in clinical medicine despite its documented effectiveness (1).

Efforts by a coalition of change actors across stakeholder groups from various professional groups and politicians involved in the process of policy making, succeeded in laying down the innovative steps of a policy based on public health and integrated healthcare. The Swiss HAT experience is 20 years old (2) and the paradigm has now shifted from a harm reduction measure to a viable public health and integrated

healthcare for a specific target group of patients who otherwise would be marginalised by the system.

Conclusion: In the case of Switzerland, the Swiss Confederation took a leading role by facilitating communication, encouraging scientific knowledge and bringing the various stakeholders on a platform to deliver a consensual policy based on the rationale of public health and integrated healthcare through the life course of the patient. This was largely facilitated by the Swiss direct democracy system and a sustained dialogue between researchers and its users is more likely for research to impact policy and decision making.

References:

- 1) Khan R, Khazaal Y, Thorens G, Zullino D, Uchtenhagen A: Understanding Swiss drug policy change and the introduction of heroin maintenance treatment. *European Addiction Research* 2014; 20-20:200-207
- 2) R. Khan, Y. Khazaal, G. Thorens, S. Achab, R. Annoni-Manghi, D. Zullino, A. Uchtenhagen: Two decades of the Swiss program based on the prescription of Diacetylmorphine, from a public health intervention to a treatment option. *Canadian Journal of Addiction* vol. 6 no.1 April 2015

BODY ORIENTED PSYCHOTHERAPY IN THE UNDERSTANDING OF DYNAMIC PSYCHIATRY

Maria Ammon (Berlin)

The author describes the development and history of the different approaches and treatment methods of body oriented psychotherapy.

The spectrum of body oriented psychotherapy started with Wilhelm Reich and ranges from functional, conflict oriented to integrative treatment methods. The body represents an essential part of a holistic understanding of the human personality and has therefore to be integrated into psychotherapeutic treatment. In the Dynamic Psychiatric treatment conception the body language has to be considered from the beginning in diagnostic as well as treatment.

Dynamic Psychiatry's treatment concept will be demonstrated by verbal and non-verbal approaches. In this context the author emphasizes the importance of the human structural

dance therapy developed by Gunter Ammon as a body oriented psychotherapy within the holistic concept which is helpful especially for patients with personality disorders.

References

- Maria Ammon: Dynamic Psychiatry- an Integrative Psychiatric-Psychotherapeutic Concept *Dynamische Psychiatrie/Dynamic Psychiatry* Pages 162-166, Vol 30, 1. -4. Issue 1997
Maria Ammon: Theory and Practice of Dynamic Psychiatry, *Dynamische Psychiatrie/Dynamic Psychiatry* 1966. Volume 29
Luborsky L (1984): Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment. Basic Books, New York.

EMOTIONAL RESONANCE AND BODY EXPERIENCE IN ANALYTICAL-STRUCTURAL DANCE THERAPY

Ilse Burbiel (Munich)

Analytical-structural dance therapy (AST) – previously known as human-structural dance therapy- was conceived in 1982 by Gunter Ammon. Its aim was to help structurally disturbed patients with early attachment disorders, who are rarely reached by verbal communication alone. Dance provides these patients with a space for development in which they could gain access to their early biographical and unconsciously stored affective body experiences of relationships. The patient's spontaneous expression in their

dance motions is viewed as an unconscious enactment on the level of their body-Ego. AST is carried out in a group setting in which the dancer is dancing alone in the middle of the group; after the dance the members of the group will reflect back to the dancer the kinds of feelings, ideas, associations and phantasies certain aspects of the dance had evoked in them. The authors will discuss the significance of this emotional resonance space for personality development in dance therapy.

REVIEW DIALOGUES AS AN OPPORTUNITY TO DEVELOP LIFE COURSE SPECIFIC HEALTH GOALS

Ottomar Bahrs, Susanne Heim, Karl-Heinz Henze, Franziska Löwenstein (Göttingen, Germany)

Background: Family physicians accompany people at all ages, whose health situation is closely connected to missions and tasks in the context of their family. These tasks are modified in the life course and form the background for health goals, which, however, rarely are discussed in GP encounters. A specific instrument, the Review Dialogue (RD), has been developed in order to gain a person-related overall diagnoses and agree on shared health goals.

Research question: Do regularly conducted RDs help to identify the specific development challenges, to agree on

corresponding health objectives and to assist in achieving them?

Method: Our presentation is based on the in-depth analysis of 20 case histories (each 3-4 Video-based RDs). We illustrate with respect to 2 cases, in which way the specific development tasks have been focused in the RDs and correspond to the shared health goals.

Results: RD help to become aware of the meaning of the patient's biographical based current tasks and thus better to

reflect how they are connected to the respective health objectives.

Conclusions: RD make it easier to build a bridge between medical world and life of the patient and to agree on shared health objectives.

Key words: GP-patient-interaction, family medicine, salutogenic orientation, overall diagnosis

References:

Bahrs O: The Argument on Pills – a Medical Sociological Examination of the Usage and Effectiveness of Drugs; in: Mayer CH, Krause C: Mental health: theoretical and empirical discourses on salutogenesis. A text collection.; Pabst, Publishers, Lengerich 2012, p. 118-141

Bahrs O et al.: Review Dialogues as an Opportunity to Develop a Person-related Overall Diagnosis; International Journal on Person-centered Medicine, 2015, 5 (3), 112-119

PERSON CENTERED RECOVERY PLANNING AT AUSTIN STATE HOSPITAL
AND THE INTEGRATION OF PEER SUPPORT INTO THIS
Eulon Ross Taylor, Noah Abdenour (Austin, Texas)

The presentation will further elaborate on the person centered care initiative at Austin State Hospital. The program was originally presented at the Person-Centered Care Conference in Zagreb, Croatia. Data will be presented to show the impact of the program across several parameters of care at the hospital. The presentation will also discuss the evolution of our peer support program as it relates to person centered care. The peer support program utilizes the services of people who have lived experience with psychiatric treatment and have received training and certification to support people receiving services at the Austin State Hospital. The peer support program has evolved to become an integral part of the person centered initiative and is now recognized as a national model in how to use peers in support of the overall hospital mission.

References:

Lodge, A.C., Kaufman, L., and Stevens-Manser, S. 2015. Findings from a Review of Person-centered Recovery Plans at Austin State Hospital: Fiscal Year 2011 to 2014. Texas Institute for Excellence in Mental Health, School of Social Work, University of Texas at Austin

Adams, Neal and Grieder, D. Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery. Burlington, MA: Elsevier Academic Press

Parallel Sessions 5:

A. Antoine Besse and Jitendra Trivedi Memorial Symposium on Person Centered Psychiatry and Mental Health for PCIC in the Life Course

□ WPA Sections' brief perspectives

BIOLOGICAL PSYCHIATRY: THE CHALLENGES OF MULTI-MORBIDITY OVER THE LIFE COURSE
AND THE NEED FOR PERSON-CENTERED INTEGRATED CARE
Helen Millar (Dundee, Scotland)

Background

The concept of multimorbidity has been increasingly recognized as the norm and occurring in an increasingly younger population particularly in areas of socioeconomic deprivation and in low income countries. Multimorbidity challenges current approaches to diagnosis, understanding of its aetiology with reference to its life course and the current single disease model of care.

Aim and Methods

To review the epidemiology of multimorbidity, its aetiology using the life course approach for the development of a person centered integrated model of care.

Findings

There is extensive evidence for the global burden of multimorbidity with common risk and causative factors. There is limited evidence for effective and cost-effective preventative and treatment interventions. The literature demonstrates

promising global initiatives for the development of more integrated models of care.

Conclusions

The burden of multimorbidity is the major challenge for medicine in the 21st century. Providing person centered integrated care is essential to address the challenge of multimorbidity, achieve better clinical and social outcomes and improve mental and physical wellbeing.

References

1. Mezzich J. E. and Salloum I. M. (2009). Comorbidity, positive health, and integration of services. Psychiatric Diagnosis: Challenges and Prospects. J. M. IM Salloum. Oxford, UK, Wiley-Blackwell.
2. Millar H.L. and Abou-Saleh M. T. Multimorbidity in Mentally Ill People: The Need for a Person-centered Integrated Approach. The International Journal of Person Centered Medicine 2015 Vol5 Issue 1 pp28-33

EARLY CAREER PSYCHIATRISTS: VIEWS ON PERSON CENTERED MEDICINE

Florian Riese (Zurich)

While person-centeredness is arguably at the heart of psychiatry, it is rarely discussed as such and training opportunities explicitly focussing on person-centeredness are scarce. In order to better understand the currently prevailing concepts of person-centeredness among early career psychiatrists worldwide, an online survey was performed on

behalf of the World Psychiatric Association's Section of Early Career Psychiatrists. Among other items, the survey contained the Patient-Practitioner Orientation Scale (PPOS) which is considered a standard instrument to determine doctor's and patient's beliefs about their role in the relationship. In the presentation, the results of the survey will be presented.

GENETICS IN PSYCHIATRY: PERSON-CENTERED APPROACHES AND PSYCHIATRIC GENETICS

Thomas Schulze (Munich)

Psychiatric genetic has made tremendous progress over the last two decades. Large-scale genome-wide association studies (GWAS) have helped identify well over a hundred vulnerability genes for schizophrenia at genome-wide and thus robust levels of significance. With an ever increasing sample size for GWAS in bipolar disorder or major depression totaling several tens of thousands of patients and control individuals, the number of identified risk genes for these disorders is expected to rise as well. The polygenic background susceptibility identified by GWAS is complemented by studies interrogating rare genetic variation such as copy number variants (CNVs) or by whole genome sequencing approaches. Large consortia on pharmacogenetics or imaging genetics are adding to our knowledge of the genetic architecture of psychiatric illness.

Notwithstanding these scientific successes, the challenges facing the psychiatric genetic community are manifold: Can findings readily be translated from bench to bedside? How to communicate them to physicians, patients, their relatives, and

the general public? What are the ethical, legal, and societal implications of genomic research?

Following an update on the state-of-the art of psychiatric genetics, I will discuss the aforementioned challenges. A critical appraisal of approaches like the use of polygenic scores or rare genetic variation for predictive purposes will be given. The usefulness of widely marketed direct-to-consumer tests including pharmacogenetic tests will be discussed.

References

Gould TD, Hashimoto R, Schulze TG. Going longitudinal in biological psychiatric research: All things considered. *Neurosci Res.* 2016 Jan; 102:1-3

Schulze TG. Genetic research into bipolar disorder: the need for a research framework that integrates sophisticated molecular biology and clinically informed phenotype characterization. *Psychiatr Clin North Am.* 2010 Mar;33(1):67-82

PREVENTIVE PSYCHIATRY: PERSPECTIVES ON PERSON-CENTERED INTEGRATED CARE

Nikos Christodoulou (Nottingham, UK)

Objectives: Explore the confluence of Person-Centred Care and Preventive Psychiatry

Methods: Conceptual review and discussion of practical examples. Specifically, the theoretical background of the interface between Person-Centred Care and Preventive Psychiatry is tested against the pragmatic reality of psychiatric disorders and clinical services. The critical appraisal of this pragmatism is conducted by experts in the respective fields of the examples given.

Discussion: The conceptual review and the critical appraisal of the examples have both reached the conclusion that the

synergy between preventive psychiatry and person-centred care has both substance in current practice and prospects for research, service development and education for the future.

Conclusions: Preventive Psychiatry and Person centred care share a significant common ground, both conceptually and in practice. For instance, they both represent a paradigm shift away from nosocentrism and closer to holistic care. The need to tackle disease has yielded remarkable scientific advances for Medicine, but has left a lot to be desired for the development of broader considerations, such as illness prevention and person-centredness. This field of development currently represent an important target towards advancing meaningful care.

SPIRITUALITY AND RELIGION: THE NEW REALITIES FOR MEDICAL PRACTICE IN THE TWENTY-FIRST CENTURY

John Cox (Cheltenham, UK)

Abstract: Implicit in person-centred holistic medicine is an awareness that body, mind and spirit are interwoven strands of the Self - and of the Self in relation to others (Buber, Frankl,

Tournier, Paulos Mar Gregorios). They cannot in vivo be pulled apart. In this presentation I suggest that current core issues of forced migration, globalisation, spiritually derived therapies

(Yoga, Mindfulness, Meditation), political abuse of religion, the 'compassion gap', and faith-based health care provision (Olivier et al 2015) have each heightened awareness that neglecting religious belief and spirituality in health care provision is disadvantageous for patients and practitioners (Koenig).

The Religion, Spirituality and Psychiatry Section of the WPA has recently completed its work on a Position Statement, Spirituality, Religion and Psychiatry, which was recently endorsed by the WPA Executive Committee. Its seven recommendations will be described, and the history of this remarkable institutional achievement outlined.

Finally the implementation of these recommendations is considered for modern medical practice across the life span,

for public health, the engagement of faith communities and the education of clinicians and managers.

References

Olivier J, Tsimpo C, Gemignani R, et al. Understanding the roles of faith-based health-care providers in Africa. *Lancet* 2015; 386: 1765-75.

Cox J L, Gray A, Abou-Saleh M, Kallivayalil R, Pfeifer S, and Almeida A ((2015) Spirituality and Person Centered Care: holding it together in a multi-faith world. In: Person Centered Psychiatry. Eds Mezzich J, Botbol M, Christodoulou G, Cloninger R, Salloum I. Springer Verlag. in press.

B. Brief Oral Presentations 2: Person Centered Health Care

ILLNESS, DISEASE, UNDERSTANDING THE PERSON AND THE GOALS OF MEDICINE

Joseph Burley (Kingston, Ontario)

Objectives: 1) explore the phenomenology of lived experience of the ill person including embodiment, intentionality, temporality, intersubjectivity, empathy, altered sense of self, altered sense of the world and others. 2) identify and discuss ways in which we can explore these aspects of personhood and lived experience with our patients in clinical settings 3) explore the complementary aspects of the biomedical and person centered models of care 4) examine and discuss these concepts within the context of the overarching goals of medicine

Method: review of the literature and presentation of ideas using case presentations.

Findings: When we are healthy, how do we experience ourselves as a person and the world in which we live. What are the phenomenological dimensions of lived experience, embodiment, our interactions with other, our perception of ourselves. These aspects of "being in the world" are most often pre-reflective, that is, we find ourselves at home in the world and in ourselves and have little need to reflect on our day to day existence as we are pre-occupied with the goals and business of living.

When we become ill this changes. The mind/body and the world which we have taken for granted become less

accessible. The sick mind/body gets in the way of the normal experience of living and our world is now less accessible and often seems hostile, out of sync. Our experience of relationships and ourselves feels foreign and altered and our confidence in how we see ourselves through the eyes of others is lost.

How do we explore these experiences in the clinical setting and how does such exploration help the person move toward healing and recovery?

Conclusions: the biomedical and the person centered models of care are, by themselves, inadequate methods of providing care for our patients and achieving the overarching goals of the medical meeting. Together they provide a more complete empirical and disease oriented and humane and experientially oriented form of care which achieves the basic goals of medicine.

References: 1) Gergel, T. Medicine and the Individual: Is Phenomenology the Answer *Journal of Evaluation in Clinical Practice* Vol 18, 2012 pp 1102-1109

2) Svenaeus F. The Hermeneutics of Medicine and the Phenomenology of Health: Steps Toward a Philosophy of Medical Practice (International Library of Ethics, Law and The New Medicine) Kluwer Academic Pub 2001

THE PERSON CENTERED CHANGE OF THE HEALTH PARADIGM THROUGH THE CAREGIVER'S PERSON AND COMMUNITY

Giuseppe R. Brera (Milan)

The revolution of medical science during last 40 years (Allostasis, Epigenetics, Affect Science, Psycho-neuro-endocrine-immunology) synthesized by the Relativity theory of biological Reactions, (1996) constituted the epistemological basis of the Person Centered Medicine Paradigm (1998) and then the Person Centered Health Paradigm (2005). It gives to the previous WHO definition of health as "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." (1946) a new epistemological and scientific structure. The new paradigm is founded on two main concepts: interactionism among three

dimensions of the person being: subjectivity (spirit ,values,affects,emotions), biology (biological constants and variables), Environment (coping , relation with human and physical environment, adaptational changes to environment) and teleonomy of the person being, as discovered by human sciences (Freud ,Adler ,Jung's Psychoanalysis, Piaget's cognitive psychology , Existential analysis, Kairology). The person is naturally called for building a meaning unity for perceiving, feeling, loving interpreting himself and other people, through the interpretation of possibilities received in the experience of reality. In such a way the Person Centered

Health Paradigm determined a shift from a mechanic-deterministic paradigm to an indeterminate one, because the person's interpretation of possibilities and the meaning given to these entrusted to the person quality, that is to existential choices, appears of undeterminable nature. Possibilities, perception of one real possibility for realizing a true reality at a propitious moment (Kairos) are undeterminable a "priori", a true mystery (kaiology) but gives reality to the essence of being person (Personalistic realism). Health is an undeterminable concept whose essence –substance-meaning is the person's life quality. Starting from this theory and the epistemological revolution in medical science, one of us in 2011 presented in WHO a new definition of health: "The best possibilities for being the best human person". Health could be considered the result of the interpretation of a score (natural laws-DNA) played by the person through a choice (Existence) among keys (cell receptors, symbolic possibilities, knowledge, affects, values) resulting in a music (epigenetic synthesis of proteins, cognitive and affective creativity, genitality). "Music" is the quality of being persons that decides the life style quality, inducing health and pathogenesis.

The unforeseeable meeting time for both the caregivers and the patient, necessarily is constituted and made real or unreal only by both the persons involved face to face in the suffering scenario. Consequently the person quality of the caregivers for being "the best person" quests for a particular vocational education to a the "Person centered clinical method and counselling", starting from medical colleges and schools

curricula. However any person centered educational method can be methodologically learnt only after a specific personal training, through a particular program addressed to improve the being, feeling, loving her/him self as human person through empathy, arousal of positive affects and catharsis of guilty senses, development of abilities for looking for and building a true meaning in experience, and develop the awareness of Medicine like ethical mission independent from any power, individual ambitions and concupiscence, first from the health stock market. This necessary work centered on the caregiver person is the simplest way to realize a person centered unity among theories, institutions and health organizations, "conditio sine qua non" for the Person centered health revolution. Only this could transform "groups" in Communities with a social transformation that could contribute to build new horizons of peace and cooperation between caregivers belonging to different cultures and religions, that could induce policies where health and respect for all the persons at any stage of life up to natural death is seen as the first human right, in such a way warranting a future for the humankind.

References

1. Brera G.R. La medicina centrata sulla persona e la formazione dei medici nel terzo millennio. Roma, Pisa; IEPI, 2001 (Italian)
2. Brera G.R. Person Centered Medicine theory, teaching research. Int. J. Pers. Cent. Med. ; 1, 1: 69-79

EXTENDING SIMULATION-BASED LEARNING EXPERIENCES TO PATIENTS WITH CHRONIC HEALTH CONDITIONS *Eric Coleman, Sung-Joon Min (Aurora, Colorado)*

A key element of population-based health is the support of individuals and their family caregivers in the self-management of chronic health conditions. Inadequate support for self-care in turn leads to poor health outcomes, recidivism, and subsequent higher health care expenditures. In the absence of any type of feedback loop, health care professionals are simply unaware of where the breakdown occurs.

When it comes to how we prepare health care professionals to manage acute and chronic health conditions, simulation experiences are recognized as the single most prominent innovation in medical education. If there is such consensus on the effectiveness of simulation, why don't we offer this learning approach to our patients? Offering patients a simulation experience would help us to identify obstacles and adjust the care plan accordingly.

Proof of concept for the feasibility and value of offering patients and their family caregivers simulation experiences is found in a growing number of illustrative examples that will be

described.

Simulation has become the gold standard for how we train health care professionals to manage health conditions. Perhaps now is the ideal time for us to ask: shouldn't our patients learn about managing chronic health conditions the way we do?

References

- Greer L, Fagan AT, Coleman EA. Reducing Hospital Re-admissions for CHF Patients with Pre-Discharge Simulation Learning. JCOM 2014 21(11):513-517.
- Coleman EA. Extending Simulation Learning Experiences to Patients with Chronic Health Conditions. JAMA 2014;311(3):243-244.

THE IMPACT OF PERSON-CENTERED CARE ON RESIDENTS' PERCEPTIONS OF CARE QUALITY IN NURSING HOMES: AN INTERVENTION STUDY *Vigdis Abrahamsen Grondahl, Liv Berit Fagerli, Ann Karin Helgesen (Halden, Norway)*

Objectives: The quality of care offered to older people is still poor (1). Nursing home administrators often claim that they provide person-centered care, but research indicates that

institutional goals take precedence (2). In our study, person-centered care was operationalized into one intervention: one-to-one contact (resident – carer). The aim was to explore the

impact of person-centered care on residents' perceptions of care quality.

Methods: The intervention was systematically conducted for 12 months in one nursing home (41 residents). One of the carers should spend 30 minutes twice a week alone with one resident. This form of companionship comprised activities such as talking, watching TV and going for a walk. Face-to-face interviews using the Quality from Patient's Perspective (QPP) questionnaire were conducted both prior to intervention and immediately after the 12-month period. Descriptive and comparative statistics were used to test for differences between care quality perceptions before and after intervention ($p < .05$).

Findings: The residents rated all four quality dimensions (caregivers' medical-technical competence and identity-oriented approach, and care organisation's socio-cultural approach and physical-technical conditions) significantly more

highly after the 12-month period. At item level significantly higher scores were given to 'The healthcare personnel showed commitment', 'The healthcare personnel were respectful towards me', 'I received the best possible medical care' and 'There was a pleasant atmosphere at the ward'.

Conclusions: Residents' perceptions of care quality increase when person-centered care is operationalized and takes precedence over ward routines. The results indicate that it is possible to design a care system where the residents are at the center of the health care offered.

1. Askari M., Wierenga, P.C., Eslami, S., Medlock, S., Rooij, S.E. and Abu-Hanna, A. (2011), "Assessing quality of care of elderly patients using the ACOVE quality indicator set: a systematic review", PLoS ONE, Vol. 6 No. 12, e28631.

2. Hughes, K. and Moore, S. (2012), "Quality of life versus quality of care: elderly people and their experience of care in South Australian residential facilities", Practice: Social Work in Action, Vol. 24 No. 5, pp. 275-285.

DEVELOPING AN EVIDENCE-BASED EDUCATIONAL INTERVENTION PROTOCOL FOR IMPROVING GLAUCOMA PATIENTS' EYE DROP THERAPY ADHERENCE AND OUTCOMES

Suk Kwan Victoria Ho, Mi Ling, Eliza Wong (Tuen Mun, Hong Kong)

Objective

To develop an effective educational interventional (EI) protocol to improve eye drop therapy (EDT) adherence and outcomes for patients with primary open angle glaucoma (POAG).

Background

Glaucoma is the leading cause of irreversible blindness worldwide and it can cause a psychological burden to patients. POAG is a lifelong asymptomatic disease that patients may face side-effects of EDT without vision improvement. Clinical trials have shown that EDT can prevent vision loss but its non-adherence rate is very high (Muir, 2011).

Intervention development

A literature search was undertaken. A total of 89 articles were identified and eventually two SRs, four RCTs and two quasi-experimental designs were eligible for analysis. The SR found that based on the health belief model and self-efficacy theory, effective EI was proven useful to improve adherence. Based

on the evidence, structured education program, written information, a hotline, and reminder calls may be useful to enhance self efficacy in the medication adherence and self management at home. Therefore, the intervention protocol for the patients with glaucoma comprises of (1) watching a self-developed video on self-instillation eye drop skills (SIEDS), explain the nature of glaucoma, its management, effect and side-effects of EDT, and risk of non-adherence of therapy, (2) return demonstration on SIEDS, and question and answer will be followed in the educational session, then (3) a booklet and (4) telephone follow up and (5) hotline will be given to meet the needs of patients. Its effectiveness will be evaluated by a randomized control trial in Hong Kong.

Conclusion

The proposed intervention may improve patients' eye drop therapy (EDT) adherence and outcomes. In clinical practice, protocols can promote effective clinical management and reduce variability in care. The detailed protocol allows replication of EI in other centers to improve patient-centered quality of care.

PATIENT-CENTERED INTEGRATED EDUCATION PROGRAM FOR SURGICAL PATIENTS RECEIVING TRANS URETHRAL RESECTION OF PROSTATE

Hoi Ling Shering Sung, Conny Chan (Hong Kong)

Benign prostatic hyperplasia (BPH) is a worldwide males-specific urological problem in recent decades. It is an age-related degenerative disease due to hormonal changes leading to enlargement of prostate causing lower urinary tract symptoms such as dribbling and retention. Transurethral resection of prostate (TURP) is the gold standard intervention for BPH with excellent outcomes and minimal invasion. Retrieving the database from Demographic Statistic Section (2012) in Hong Kong, male population aged from 60 to 85 or above will be rose from 9.2% in 2011 to 15.1% in 2041. To

respond to such aging trend, an increase in prevalence rate of BPH and surge in case load of TURP are expected.

Despite satisfactory outcomes from TURP, postoperative complications including infection, urinary retention and haematuria are commonly seen. In Hong Kong, the education program for TURP is currently led by ward nurses with providing written pamphlet preoperatively while quality and content of pamphlets varies among hospitals. Lack of standard nursing intervention plan and absence of evaluation review the

outcomes of the current education program. Also, Incomprehensive postoperative education and lack of post-discharge support also leads to almost 10% of unplanned readmission.

In this presentation, a patient-centered integrated evidence-based education program will be introduced. Objective of this program is to develop and evaluate the effectiveness of a patient-centered integrated education program in improving knowledge, reducing anxiety and enhancing satisfaction, of elective Chinese patients receiving TURP. It is believed that it could be a good exemplification to facilitate in setting up patient-centered education program in Asia.

**MEASURING HEALTH LITERACY AMONG VERY LOW LITERATE PEOPLE:
A FEASIBILITY STUDY WITH THE HLS-EU QUESTIONNAIRE
Hannelore Storms (Diepenbeek, Belgium)**

Introduction

As health care is becoming more patient-centered, patients are increasingly expected to make health care decisions. Therefore, detecting people with limited health literacy (HL) is crucial. Limited HL is associated with lower levels of education [1]. A relatively new instrument, HLS-EU-Q47, underwent a comprehensibility test, allowing inclusion of low literate people. However, its shorter form 'HLS-EU-Q16' did not [2]. In this study suitability of HLS-EU-Q16 for use in a population of people with low literacy was examined.

Methods

Purposive sampling of adults with low (yearly) income (< €16,965.47, for one person) and limited education (maximum high school), with Dutch language proficiency. Excluding criteria were: psychiatric and/or neurodegenerative diseases or impairments. To determine suitability (length, comprehension and layout) participants were randomly distributed either HLS-EU-Q16 or a simplified version and were interviewed directly afterwards by one researcher. Qualitative and quantitative analyses were performed on respectively interviews and questionnaires.

Findings

Thirteen participants completed the HLS-EU-Q16 (7) or the simplified version (6). Questions about 'disease prevention' (domain

Reference

Callaghan, P., Cheung, Y. L., Yao, K. Y. I., & Chan, S. L. (1998). Evidence-based care of Chinese men having transurethral resection of prostate. *Journal of Advanced Nursing*, 28(3), 576-583.

Valiee, S., Kalhor, M. M., & Dehghan Nayeri, N. (2013). Experience of transurethral resection of the prostate: a qualitative study. *International Journal of Urological Nursing*, 7(2), 68-75.

or 'appraisal' of information (competency) are frequently reported to be incomprehensible. Difficulties are attributed to comprehension (vocabulary, sentence structure) and decision process (abstraction, distinguishing "appraising" from "applying" information, indecisive on the appropriate response). Non-responses were highest and HL was predominantly scored 'inadequate' for HLS-EU-Q16 questionnaire.

Conclusions

HLS-EU-Q16 is a suitable instrument to determine HL in people with limited literacy. However, to facilitate the use and interpretation, some questions would benefit from minor adjustments and from the provision of explanatory, contextual information.

References

- [1] Kickbush I (2013) Health literacy: the solid facts. Kickbusch, I. (ed) et al. (2013). Health literacy: the solid facts. Copenhagen: World Health Organization (WHO), Regional Office for Europe.
- [2] Röthlin F, Pelikan J, Ganahl K (2013) Die Gesundheitskompetenz Jugendlichen in Österreich.

**INFORMATION AND COMMUNICATION TECHNOLOGY FOR ENABLED PERSON-CENTERED CARE IN THE "BIG FIVE"
CHRONIC CONDITIONS: SCOPING REVIEW
Sabine E. Wildevuur (Amsterdam)**

Objective: Person-centered information and communication technology (ICT) could encourage patients to take an active part in their health care and decision-making process, and make it possible for patients to interact directly with health care providers and services about their personal health concerns. Yet, little is known about which ICT interventions dedicated to person-centered care (PCC) have been studied. The aim of this research is to investigate the extent, range, and nature of these research activities and identify research gaps in the evidence base of health studies regarding the "big 5" chronic diseases: diabetes mellitus, cardiovascular disease, chronic

respiratory disease, cancer, and stroke, with respect to 2 questions: (1) which ICT interventions have been used to support patients and health care professionals in PCC management of the big 5 chronic diseases? and (2) what is the impact of these interventions, such as on health-related quality of life and cost efficiency?

Methods: This research adopted a scoping review method. Three electronic medical databases were accessed: PubMed, EMBASE, and Cochrane Library. In 5 stages of systematic

scanning and reviewing, relevant studies were identified, selected, and charted.

Findings: From the initial 9380 search results, we identified 350 studies that qualified for inclusion: diabetes mellitus (n=103), cardiovascular disease (n=89), chronic respiratory disease (n=73), cancer (n=67), and stroke (n=18). Persons with one of these chronic conditions used ICT primarily for self-measurement of the body, when interacting with health care providers, with the highest rates of use seen in chronic respiratory (63%, 46/73) and cardiovascular (53%, 47/89) diseases. We found 60 relevant studies (17.1%, 60/350) on person-centered shared management ICT, primarily using telemedicine systems as personalized ICT. The highest impact connected to health professionals was an increase in clinical outcome (11.7%, 41/350). The impacts on organization outcomes were decrease in hospitalization (12.3%, 43/350) and increase of cost efficiency (10.9%, 38/350).

Conclusions: This scoping review outlined ICT-enabled PCC in chronic disease management. Persons with a chronic disease could benefit from an ICT-enabled PCC approach, but ICTPCC also yields organizational paybacks. It could lead to an increase in health care usage, as reported in some studies. Few interventions could be regarded as “fully” addressing PCC.

References

Ekman, Inger, Swedberg, Karl, Taft, Charles, Lindseth, Anders, Norberg, Astrid, Brink, Eva, . . . Kjellgren, Karin. (2011). Person-centered care—Ready for prime time. *European journal of cardiovascular nursing*, 10(4), 248-251.

Wildevuur, Sabine E, & Simonse, Lianne WL. (2015). Information and Communication Technology–Enabled Person-Centered Care for the “Big Five” Chronic Conditions: Scoping Review. *Journal of medical Internet research*, 17(3).

Plenary Symposium 5: Symposium on Global Health Workforce for PCIC through the life course

HOW MEDICAL SCHOOLS ARE RECRUITING AND PREPARING HEALTH PROFESSIONALS FOR PCIC

David Gordon (WFME, Copenhagen)

Standards for medical education, such as the widely-used World Federation for Medical Education (WFME) global standards, will normally include standards for student recruitment. The WFME standards state that student selection must be objective and should “state the relationship between selection and the mission of the school, the educational programme and desired qualities of graduates”. Elsewhere, the standards explain how the mission of the school must include the health needs of the community and the needs of the health care system. These statements are necessarily broad, but there is no connection between the needs of the community at large and any person-centred commitment to the individual patient.

Other standards for medical education may be more explicit. For example, “Tomorrow’s Doctors” from the General Medical Council of the UK repeatedly mentions the responsibility of

the student and the doctor to the individual patient, both in student selection and in course content, for example the “legal, moral and ethical responsibilities involved in protecting and promoting the health of individual patients”.

Reasons for this divergence between different sets of standards, and subsequent divergence in the degree to which doctors are oriented to the individual patients, will be discussed. Cultural differences are likely to be the most important factor: the WFME standards must be potentially applicable to any culture, world-wide: standards such as those of the GMC can be suited to a society where the individual patient is paramount.

References

1. <http://wfme.org/standards/bme>
2. [www.gmc-uk.org/Tomorrow_s_Doctors_1214.pdf_48905759.pdf](http://www.gmc-uk.org/Tomorrow_s_Doctors_1214.pdf)

THE MEDICAL STUDENT AND THE PROFESSOR/MENTOR AS PERSONS IN A NEW MENTORSHIP PROGRAM AT A PERUVIAN MEDICAL SCHOOL

Alberto Perales (Latin American Network for PCM, Lima)

Background: Traditionally medical schools have trained undergraduate students as if they were learning machines aimed at processing scientific information. References to their personal development and social maturity have been seldom considered. Studies at a Peruvian public medical school rendered worrying results as to the students’ mental health and moral development (1). To respond to this challenge, the medical school of San Marcos National University (the oldest of the Americas) decided to re-organize its mentorship program.

Objectives: To inform about San Marcos University School of Medicine Mentorship Program based on the consideration of the medical student and the professor/mentor as persons.

Methods: Several mental health surveys with a validated questionnaire were carried out. The first study sample was composed of 601 undergraduate students (1st to 6th grades) and the second and third of 159 and 156 (both 1st grades of 2013 and 2014) respectively. The Mentorship Program was re-organized accordingly including special training and supervision of medical professors as mentors and sensitization of medical students to their mental health and moral development for their professional and personal lives.

Findings: Life prevalence rates of antisocial behavior indicators reached 19 %; suicidal attempts, 4%; homicidal ideation, 13%; and problems with alcohol: 7 %. A mentorship training course was developed for medical professors. A new

course was included in the 1st year students' curriculum to provide them with basic learning abilities as well as to sensitize them regarding the importance of their own moral development.

Discussion: The worrying levels of mental health and personal development of undergraduate medical students demanded not only a scientific but also a moral and responsible answer of the medical school. Such problems prompted the generation of new educational and research strategies within a new framework consistent with Person Centered Medicine [3]. This involved the consideration of the medical student and the medical professor as persons as well as the medical school as a center to form good persons as well as good professionals.

References:

1. Perales A, Alarcón J, Sánchez E, et al. Suicidal conduct in medical students of a Peruvian public university. In: Bustamante I, Rivera M, Matos L (Eds): Violence and trauma in Peru: Challenges and responses. Trauma and Global Health Program, Peruvian University Cayetano Heredia and McGill University, Lima, 2013. Pp: 105-113.
2. Wagner P, Perales A, Armas R, et al: Latin American Bases and Perspectives on Person Centered Medicine and Health. International Journal of Person Centered Medicine, 4: 220-227, 2014.
3. Saavedra C, Perales A, Oliveros M, Zavala S, Izaguirre M (Eds). Manual de Tutoría Universitaria. Facultad de Medicina, Universidad Nacional Mayor de San Marcos, Lima, 2015.

PROSPECTS FOR PERSON-CENTERED HEALTH PROFESSIONAL EDUCATION IN SOUTH ASIAN POPULATIONS

Roy Kallivayalil (Kerala, India)

South Asia has a population of 1.7 billion, about 25% of the world population. India is the largest country with a population of 1.3 billion. Health care is universally available in India and is largely financed by the Union and State Governments. Primary care covers almost the entire population. Health care in India is one of the cheapest and most cost-effective in the world. Strong families help in the care and treatment of its members. Some States like Kerala have emerged as models for the rest of India. Some of the weaknesses are: Quality of care in some government run hospitals is not upto the mark which has forced 75% in urban areas and 65% of people in rural areas to seek private care, Private hospitals are often unaffordable to common man, Out of pocket payments is the rule rather than exception, as more than 80% people are not covered by health insurance, Bureaucratic control over health matters makes progress difficult in many places, Mental health is of low priority, Number of mental health professionals is

woefully inadequate with the number of psychiatrists just 6,000 for 1.3 billion population. But National Health Policy adopted in 1983, updated in 2005 and a National Mental Health Policy document released in 2014 offers India new hope. There is a similar situation prevailing in other South Asian countries. Mental health through Primary Care offers the best prospects for Person-centred health profesional education in South Asia.

References

1. International Institute for Population Sciences and Macro International (September 2007). "National Family Health Survey (NFHS-3), 2005–06" (PDF). Ministry of Health and Family Welfare, Government of India. pp. 436–440.
2. Umesh Kapil and Panna Choudhury National Rural Health Mission (NRHM): Will it Make a Difference? Indian Pediatrics Vol. 42 (2005): 783

FAMILY MEDICINE AND PRIMARY CARE: HOW DO THE TWO RELATE TO PCIC?

Ruth Wilson (Kingston, Canada)

Primary care is 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-centered, providing co-ordination, continuity, community-based, holistic services. Some argue that family physicians are too expensive to be the main providers of primary care. Others call for more well-trained generalists to increase patient safety. 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/Bar>



**International College of Person Centered Medicine (ICPCM)
Continuing Professional Development Program**

Attendance Report Form

Title of event: **9th Geneva Conference on Person-Centered Integrated Care through the Life Course**

Organised by: **ICPCM**

Dates: 10-13 April, 2016

Please use this form to mark your attendance at ICPCM-CPDP approved sessions and add up at the end the number of credits earned. One credit is equivalent to 60 minutes of approved learning experience. After the event, complete and sign this form, scan it and e-mail it to ICPCMsecretariat@aol.com On the basis of this information, the Secretariat will e-mail you a CPDP Certificate.

Dates	Session Periods	Session Titles	Session times and credits earned	Check-off attendance
11.04.2016	8:45 - 10:15	Plenary Symposium 1	90 minutes, 1.50	
	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	
12.04.2016	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 - 6:45	Parallel session 5 (A)	120 minutes 2.00	
		Parallel session 5 (B)	120 minutes 2.00	
13.04.2016	9:00 - 10:30	Plenary session 5	90 minutes 1.50	
	12:00 - 2:30	WHO Special Session	150 minutes 2.50	
Total Credits Earned () :				

Name:

Email:

Signature: