



5th GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

Chronic Diseases: Person- and People-centered Perspectives

Core Conference on April 30 – May 2, 2012

Pre-Conference Workmeetings on April 28 and April 29, 2012

L' Auditoire Marcel Jenny, Geneva University Hospital

CONFERENCE BOOKLET

✱ Conference Program

✱ Gallery of Presenters

✱ Conference Abstracts

www.personcenteredmedicine.org

The Fifth Geneva Conference on Person-centered Medicine is organized by the International College of Person-centered Medicine (ICPCM) in collaboration with the World Medical Association (WMA), the World Health Organization (WHO), the International Alliance of Patients' Organizations (IAPO), the International Council of Nurses ICN), the International Federation of Social Workers (IFSW), the International Pharmaceutical Federation (FIP), the World Organization of Family Doctors (Wonca), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the Council for International Organizations of Medical Sciences (CIOMS), the International College of Surgeons (ICS), the International Federation of Gynecology and Obstetrics (FIGO), the Medical Women's International Association (MWIA), the International Federation of Ageing (IFA), the World Association for Sexual Health (WAS), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the World Federation for Medical Education (WFME), the International Association of Medical Colleges (IAOMC), the Paul Tournier Association, the World Association for Dynamic Psychiatry (WADP), the European Association for Communication in Health Care (EACH), the WHO Collaborating Center for Public Health Education and Training at Imperial College London, the International Federation of Medical Students' Associations (IFMSA), the Zagreb University Medical School, the University of Gothenburg Centre for Person Centred Care, the George Washington University Institute on Spirituality and Health, the Peruvian University Cayetano Heredia, the Università degli studi di Milano, the Medical University of Plovdiv, the Buckingham University Press, and with the auspices of the Geneva University Medical School and Hospitals.



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CONFERENCE PROGRAM

Organizing Committee Juan E. Mezzich (President, International College of Person Centered Medicine), Jon Snaedal (World Medical Association President 2007-2008), Chris van Weel (World Organization of Family Doctors President 2007-2010), Michel Botbol (World Psychiatric Association Psychoanalysis in Psychiatry Section), Ihsan Salloum (World Psychiatric Association Classification Section), Tesfamicael Ghebrehiwet (International Council of Nurses), Shanthi Mendis (WHO Chronic Diseases Department), and Ruben Torres (PAHO/WHO Health Systems Area).

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

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

April 22, 2012

**PRE-CONFERENCE WORK MEETING ON PERSON-CENTERED MEDICINE:
SATURDAY APRIL 28 AND SUNDAY APRIL 29, 2012**

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

SATURDAY APRIL 28

- 1:00 – 2:30 PM ICPCM Organizational and Informational Projects:
Chair: *Ihsan Salloum (Miami)*
- International Journal of Person Centered Medicine (IJPCM): *Andrew Miles and Christopher Woodhead (London)*
 - Upgrading Journal and College Websites: *Christopher Woodhead (London), Juan E. Mezzich (New York)*
 - Use of Social Media in the Promotion of Person-centered Medicine: *Andrew Williamson (London)*
 - International Conference and Publication Series: *Andrew Miles (London), Juan E. Mezzich (New York)*
 - PCM Book Project: *Andrew Miles (London), Juan E. Mezzich (New York).*
- 2:45 – 6:15 PM ICPCM Workmeeting on Person-centered Integrative Diagnosis (PID) and Related Diagnostic Projects [Including a 4:00 PM coffee break]
Chair: *Michel Botbol (Brest, France)*
- A. Person-centered Integrative Diagnosis (PID): From Theoretical Model to Practical Guide
- Strategies and timeline for preparing a PID Guide: *Juan Mezzich (Lead) and Ihsan Salloum*
 - Developmental use of ontological analysis: *Luis Salvador (Lead) and Ihsan Salloum*
 - Disorders and comorbidity: *Ihsan Salloum (Lead), Claudio Banzato, M Abu-Saleb, V Krasnov*
 - Disabilities and functioning: *Luis Salvador (Lead) and J Saavedra*
 - Positive health and well-being: *Robert Cloninger (Lead), J Mezzich, I Salloum*
 - Health Experience and Values: *Juan Mezzich (Lead), Lawrence Kirmayer*
 - Contributing (Risk and protective) factors: *I Salloum(Lead), J Saavedra, M Botbol, L Salvador, J Wallcraft, E Gayvoronskaya*
 - Categories, dimensions and narratives as descriptive procedures: *Michel Botbol (Lead), C Banzato, L Salvador, I Salloum*
 - Evaluators and evaluation process: *Janet Wallcraft (Lead), Sigrid Steffen, Ihsan Salloum*
 - Diagnostic summary, treatment planning and case illustration: *Neal Adams (Lead), Ihsan Salloum and Juan Mezzich*
 - Consideration of a fundamental, minimalist version: *E Gayvoronskaya, I Salloum, J Mezzich*
 - Validation Studies: *Ihsan Salloum (Lead), Levent Kirisci, K Schaffner*
- B. Related Person-centered Diagnostic Projects
- Revising the Latin American Guide for Psychiatric Diagnosis: *Juan Mezzich (Lead), Ihsan Salloum, Luis Salvador, Angel Otero, Javier Saavedra.*
 - French Diagnostic Project: *Michel Botbol (Lead), Antoine Besse, Paul Laca ze*
 - World Federation for Mental Health Assessment Project: *M Abou-Saleb (Lead), H Millar, G Christodoulou*
 - Pediatric Project: *James Appleyard, Michel Botbol*
 - Internal and Family Medicine Project: *Ihsan Salloum, Marc Jamouille, Chris van Weel*
- 6:30 – 7:30 PM Editorial Board Meeting of the International Journal of Person Centered Medicine

SUNDAY APRIL 29

- 9:00 – 12:00 AM ICPCM Work Meeting on Person-centered Clinical Care Guiding Principles.
[Including a 10:30 AM coffee break]
Chair: *Jon Snaedal (Reykjavik)*
Michel Botbol (Paris), Neal Adams (Berkeley, USA), James Appleyard (London), Chris Van Weel (Nijmegen, Netherlands), Elena Gayvoronskaya (Voronezh, Russia), Nikos Christodoulou (London), Janet Wallcraft (London), Sigrid Steffen (Salzburg), Luis Salvador (Jerez, Spain), Jitendra Trivedi (Lucknow, India)
- 12:00 – 3:00 PM Extended Lunch Break (separate working lunches of the various ICPCM Workgroups [1)Person-centered Clinical Care Guiding Principles (*J Snaedal et al*), 2) PID and Related Diagnostic Projects (*J Mezzich, I Salloum et al*), 3)Person-centered Partnership (*J Wallcraft, S Steffen*), 4) Person-centered Young Health Professionals (*N Christodoulou, Sophia Michaelidou*), and other Workgroups] to meet among themselves and advance their activities and reports.)
- 3:00 – 4:00 PM Plenary Reports of all the Workgroups (about 10 minutes each)
Chair: *Tesfamicael Ghebrehivet (Geneva)*
- 4:00 – 4:15 PM Coffee Break
- 4:15 – 6:45 PM Board Meeting of the International College of Person-centered Medicine

CORE CONFERENCE FIRST DAY, MONDAY APRIL 30, 2012

Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

- 8:00 – 8:30 AM Registration and check-in
- 8:30 – 9:00 AM Conference Opening (*Master of Ceremony: Nikos Christodoulou, London*)
- Welcoming words:
 - *Panteleimon Giannakopoulos, Vice-Dean Geneva University Medical School*
 - *Manuel Dayrit, Director, World Health Organization*
 - International College of Person-centered Medicine: Developments and Opportunities: *Juan E. Mezzich (New York)*

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

- 9:00 – 10:30 AM Plenary Symposium on the Effectiveness of Person-centered Care for Chronic Diseases (Main Auditorium)
Chair: *Chris van Weel (Nijmegen, Netherlands)*
- Contextualized approach to enduring clinical complexity: *Ted Epperly (Boise, Idaho)*
 - Psychological approaches and emphasis on well-being: *Robert Cloninger (St. Louis)*
 - Patients' perspectives on person-centered care for chronic diseases: *Jo Groves (LAPO, London)*
 - WHO Perspectives on Chronic Disease: *Shanthi Mendis (WHO, Geneva)*
- 10:30 – 10:45 AM Coffee Break

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

1. Workshop on Person-centered Care for Chronic Psychiatric & Neurological Diseases (Main auditorium)

Chair: *George Christodoulou (Athens)*

- Affective and Substance Use Disorders: *Ihsan Salloum (Miami)*
- Dementia: *Jon Snaedal (Reykjavik)*
- Chronic Child Mental Health Disorders: *Michel Botbol (Paris)*
- Recovery and Person-centered Care: *Margit Schmolke (Munich)*

2. Workshop on Person-centered Care for Oncological Diseases (Room E1-E2)

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

- Informational Procedures to support patients' decision-making roles in cancer care: *Gabriella Pravettoni, Marianna Masiero, Ketti Mazzocco (Milan)*
- Psychological Issues on Person-centered Care for Cancer Pain: *Marijana Bras (Zagreb)*
- Promoting Communication on Sexual Health with the Cancer Patient: *Lovorka Brajkovic (Zagreb)*
- Person-centered Care at the End of Life: *Ted Epperly (Boise, Idaho)*

12:15 – 1:30 PM

Lunch (open) and Poster Session

- The contribution of Eastern Orthodox Psychotherapy to person-centered mental health care: *Sebastian Moldovan (Sibiu, Romania)*
- Person-centered care reduces self-report uncertainty in illness among patients with chronic heart failure: *K. Dudas, L-E Olsson, K Swedberg, M Shaufelberger, C. Taft, A. Wolf, I. Ekman (Gothenburg, Sweden)*
- Care experience in Sweden amongst 34,000 hospitalized patients: *A. Wolf, L-E Olsson, C Taft, K Swedberg, I. Ekman (Gothenburg, Sweden)*
- Experiences of patients affected by the “broken heart” syndrome – Takotsubo cardiomyopathy: *S. Walstroem, K. Dudas, E. Omerovic, I. Ekman (Gothenburg, Sweden)*
- Person-centered culture-specific patient education in Bulgaria: *B. Levterova, D. Dimitrova, D. Stoyanov, M. Orbetzoba (Plovdiv, Bulgaria)*
- Aspects of hypertension – A multiperspective approach on the way towards adherence and self-management: *U. Bengtsson, K. Kjellgren, I. Hallberg (Gothenburg, Sweden)*
- Contextualization of functional symptoms in primary health care: *D. Kokkinakis, E. Liden, S. Svensson, E. Bjoerk Braemberg, S. Maatta (Gothenburg, Sweden)*

1:30 – 3:00 PM

Parallel Sessions:

1. Workshop on Person-centered Care for Chronic Circulatory and Respiratory Diseases (Main auditorium)

Chair: *Jon Snaedal (Reykjavik)*

- Patients' experiences in acute coronary syndromes: *Andreas Fors (Gothenburg, Sweden)*
- Outcome Studies on Person-centered Cardiovascular Care: *Inger Ekman (Gothenburg, Sweden)*
- Person-centeredness for Intensive Care Medicine: *Mark Tonelli (Seattle, USA)*

2. Workshop on Self-Care and Integrative Approaches to Non-communicable Diseases (Room E1-E2)

Chair: *Shanthi Mendis (WHO, Geneva)*

- WHO review of the evidence on self-care for non-communicable diseases: *Shanthi Mendis (WHO Department on Chronic Diseases and Health Promotion, Geneva)*
- Education for person-centered care of chronic non-communicable diseases: *Salman Rawaf (WHO Collaborating Center, Imperial College London)*

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|----------------|--|
| 3:00 – 3:15 PM | Coffee Break |
| 3:15 – 4:45 PM | Plenary Symposium on Person-centered Care and Modern Clinical Practice(Main Auditorium) Chair: <i>Andrew Miles (London)</i> Co-Chair: <i>Juan Mezzich (New York)</i> <ul style="list-style-type: none"> • Ethics and Social Determinants of Health Perspectives on Person-centered Care: <i>Eugenio Villar (WHO)</i> • Case-based models of person-centered medicine in action: <i>Mark Tonelli (Seattle, USA)</i> • Evidence-based and Person-centered Models: Taking local factors into account: <i>Amit Saad (Tel Aviv, Israel)</i> • Towards an integrated clinical care model: <i>Andrew Miles (London) & Juan Mezzich (New York)</i> |
| 4:45 – 5:00 PM | Coffee Break |
| 5:00 – 6:30 PM | General Assembly of the International College of Person-centered Medicine |
| 7:00 PM | Conference Dinner (tickets for purchase at Registration Desk) |

CORE CONFERENCE SECOND DAY, TUESDAY MAY 1, 2012

Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

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| 9:00 AM – 10:30 AM | Plenary Symposium on Transformative Education for Person- and People- centered Care (Main Auditorium) Chair: <i>Manuel Dayrit (WHO, Geneva)</i> <ul style="list-style-type: none"> • The WHO Transformative Education Initiative: <i>Erica Wheeler (Geneva)</i> • World Health Professional Alliance Personalized Card on Preventing Chronic Diseases: <i>Julia Seyer (WMA, Ferney-Voltaire, France)</i> • Professional training and the cruciality of team work: <i>Tesfamicael Ghebrehiwet (ICN, Geneva)</i> • Building up person-centered medical education and training: <i>Salman Rawaf (London)</i> |
| 10:30 – 10:45 AM | Coffee Break |
| 10:45 AM – 12:15 PM | Plenary Symposium on Spirituality and Health (Main Auditorium) Chair: <i>Manuel Dayrit (WHO, Geneva)</i> <ul style="list-style-type: none"> • Integrating spirituality into health care: Clinical applications: <i>Christina Puchalski (Washington D.C.)</i> • Healing the body and spirit: Integral to the mission of faith traditions: <i>Robert Vitillo (Geneva)</i> • Religious and secular counseling: the relevance of faith, the need for science and the variety of values: <i>John Cox (Cheltenham, UK)</i> • Summary comments: <i>Ehvira S.N. Dayrit (Geneva), Andrew Miles (London)</i> |
| 12:15 – 1:30 PM | Lunch (open) |
| 1:30 – 3:00 PM | Parallel Sessions: <ol style="list-style-type: none"> 1. Workshop on Conceptualization and Measurement of Person- and People-centered Care (Main auditorium) Chairs: <i>Ruben Torres (PAHO/WHO) and Juan Mezzich (ICPCM, New York)</i> |

- Conceptualizing person- and people centeredness in primary health care: a literature review: *Christine Leyns, Jan De Maeseneer, Sara Willems, Pauline Boeckxstaens, Peter Decat, Lieve Daeren, Veerle Vyncke (Ghent, Belgium)*
- Conceptual refinement and further development of the Person-centered Care Index (PCI): *Juan Mezzich (New York), Neal Adams (Berkeley, California), Janet Wallcraft (London), Jitendra Trivedi (Lucknow, India), Ihsan Salloum (Miami), Levent Kirisci (Pittsburgh).*
- Developmental studies on the PCI: *Levent Kirisci (Pittsburgh), Ihsan Salloum (Miami) & Juan Mezzich (New York)*
- A Pilot Reliability study of the PCI in India: *Jitendra Trivedi, Sujit Kar (Lucknow, India), Levent Kirisci (Pittsburgh);*
- Inter-rater Reliability of the Person-centered Care Index: A Pilot Evaluation of 5 Community Mental Health Programs in Santa Cruz California: *Neal Adams (Berkeley, California), J Mezzich (New York), L Kirisci (Pittsburgh, Y Jacobs (California), B Clark (California);*
- A Pilot content-validity study of the PCI among UK service users: *Jane Wallcraft (London), Levent Kirisci (Pittsburgh)*

2. Workshop on Swedish Clinical Research on Person Centered Care (Room E1-E2):

Chairs: *Inger Ekman (Gothenburg), Andrew Miles (London)*

- Fundamentals in person-centred care: *Inger Ekman (Gothenburg)*
- Effects of Person Centered Care in hip fracture: *Lars-Eric Olsson (Gothenburg)*
- Effects of Person Centered Care in heart failure: *Karl Swedberg (Gothenburg)*
- Patient Reported Outcomes – Applications in Person Centered Care: *Charles Taft (Gothenburg)*
- Implementation of Person Centered Care: *Henrik Rosen (Gothenburg)*
- Organization of Person Centered Care: *Erik Carlström (Gothenburg)*

3:00 – 3:15 PM

Coffee Break

3:15 – 4:45 PM

Parallel Sessions:

1. Oral Presentations Session on Conceptual Studies on Person-centered Care (Main auditorium)(8 minutes each)

Chair: *Michel Botbol (Paris)*

Co-Chair: *Rory Truell (IFSW, Berna)*

- Towards person-centered care: Neuroscience perspective: *Lukasz Konopka & Elizabeth Zimmerman (Chicago)*
- Personalizing Education and Mental Health through Neuroscience and Neuroesthetics: *Patricia Scherer (Chicago)*
- Islamic heritage and traditions and person-centered medicine: *M. Abou-Saleh (Doha, Qatar)*
- Person Centered Gynecological and Obstetrical Care: *W. Holzgreve (Basel)*
- Personality in Russian psychology and psychiatry: *Valery Krasnov (Moscow)*
- Bringing child-centered hospital care to Serbian children: A rights based approach to change provider practices : *D. Nikolic, B. Schwethelm, P. Brylske (Belgrade)*
- Building a person-centered culture in a psychiatric prevention and recovery care service (PARCS): *Wendy Cross (Victoria, Australia)*
- A role for traditional birth attendants in promoting person-centered care in Netrokona District, Bangladesh: *J. Perkins, C. Capello, A. Muzahid, C. Santarelli (Geneva)*
- A paradigm in pediatrics to deliver family and child-centered care: *Paul Rosen (Delaware, USA)*

2. Workshop on Person-centered Pain Management (Room E1-E2):
Chair: *Marijana Bras (Zagreb)*
Co-Chair: *Bernard Rüedi (Neuchatel, Switzerland)*
 - Multidisciplinary approach in pain management: *Marijana Braš (Zagreb)*
 - Person-centered invasive pain management in patients with cancer: *Rudolf Likar (Klagenfurt, Austria)*
 - The role of culture and spirit in pain management: *Alexey Danilov (Moscow)*
 - Person-centered pain rehabilitation: *Roberto Casale (Montescano, Italy)*
 - Person-centered pain management in palliative medicine: *Fabrizio La Mura (Barletta-Andria-Triani, Italy)*
3. Workshop on Shared Care Plan and Person-centered Integrative Diagnosis (Room E3): *Neal Adams (chair)(Berkeley, California), Diane Grieder (Sacramento, California)*

4:45 – 5:00 PM

Coffee Break

5:00 – 6:30 PM

Parallel Sessions:

1. Oral Presentations Session on Experimental Studies on Person-centered Care (Main auditorium) (8 minutes each)
Chair: *Robert Cloninger (St. Louis)*
Co-Chair: *Hans-Rudolf Pfeifer (Zurich)*
 - Project PARIS: Parents and Residents in Session: Studying the teaching of person- and family-centered care in a residency program: *Christine Low, M Rubes, R Annunziato, E Shemesh, D Rode, J Mezzich, J Forman (New York)*,
 - Effects of an early clinical experience program in medical school: *Fernando Caballero, C Garcia de Leonardo, D. Monge, R. Ruiz, J. Perez, I. Salinas, JM Blanco, J. Gutierrez, F. Leon (Madrid)*
 - Risk assessment for type 2 diabetes in UK general practices: Implications for practitioners and patients: *Maxine Johnson (Sheffield, UK)*
 - A systematic review of barriers and facilitators in life style modifications for the prevention of type 2 diabetes in at risk populations: *Josie Messina, M. Johnson, H.B. Woods, N. Payne, E. Goyder (Sheffield, UK)*
 - A comparison of pain scores with and without anesthesia for neonatal circumcision using plastibell technique: *Aminu Fikin (Nguru, Nigeria)*
 - Organizational culture and the implementation of person-centered care: Results from a change process in Swedish hospital care: *Tarik Saleem Alharbi (Gothenburg, Sweden)*
 - The Potential of Person Centred Medicine in Dementia: *Sophia Michaelidou (Nicosia) and Nikos Christodoulou (London)*
 - The patient with multiple chronic conditions: altering medication prescriptions: *Allison Williams (Victoria, Australia)*
 - Reliability and validity of Ambrosiana's Person Centered Medicine Clinical Method: *Giuseppe Brera (Milan)*
2. Workshop on Person-centered Health Systems (Room E1-E2):
Chair: *Andrew Miles (London)*
Co-Chair: *D. Stoyanov (Sofia)*
 - Integrated health services: *Hernan Montenegro (WHO Dpt. Health Systems Governance and Service Delivery)*
 - Person-centered Reproductive Health: *Alfredo Fort (WHO Dpt. Reproductive Health)*
 - Person-centered approach to human resources management in health care: A contribution to early assessment and prevention of burnout: *D. Stoyanov, D. Dimitrova, R. Raycheva (Plovdiv, Bulgaria)*
 - Educational factors in health systems: *James Appleyard (London)*

3. Workshop on Internet and Person-centered Medicine (Room E3): *Francesco Bollorino (Genoa) (Chair), Andrew Williamson (London)*

6:45 – 7:45 PM

Scientific Panel for the Launch of the International Conference and Publication Series on Person-centered Healthcare (ICPSPH) (Main Auditorium):

- Welcome from the Chair: *Juan Mezzich (New York)*
- Aims and Scope of the Series: *Andrew Miles (London)*
- Implications for the Personalization of population Health and WHO policy: *Manuel Dayrit (WHO, Geneva)*
- Implications for Primary and Secondary Healthcare Services: *Chris van Weel (Nijmegen) and Jon Snaedal (Reykjavik)*
- Implications for the person at the centre of care: *Jo Groves (LAPO, London)*
- Implications for undergraduate and postgraduate medical education: *Gianluca Vago (Milan)*
- Presentation of the Series Website: *Simon Pateman (London)*
- Discussion and Chair's closing remarks

7:45 PM

Drinks Reception

8:10 PM

Dinner (by invitation)

CORE CONFERENCE THIRD DAY, WEDNESDAY MAY 2, 2012

Geneva University Hospital Marcel Jenny Auditorium and Auxiliary Halls

9:00 AM – 10:30 AM

Parallel Sessions:

1. Session on Region and Country Experiences on Person- and People- centered Care (Main Auditorium)

Chair: *Salman Rawaf (London)*

Co-Chair: *James Appleyard (London)*

- Measurement of responsiveness as part of person-centered care of the Thai health care system: *Yongyuth Pongsupap (Bangkok)*
- North American and Latin American developments: *Ruben Torres (Pan American Health Organization, Washington DC)*
- Person context in the ICF model: Recent advances in Europe: *Luis Salvador, A. Cieza (Jerez, Spain)*
- Promoting person-centered care for diabetes and depression in Africa: *Helen Millar (Dundee, Scotland), S. Babendeka, T. Ghebrehiwet, R. Holt, A. Jalang'o, A. Joubert, B Majikela-Diagamandla, H. McGuire, A. van derMerwe, S. Rataemane, N. Sartorius, I. Westmore.*
- African Contributions to Decision Making in Person-Centred Health Practice: *Werdie Van Staden (Pretoria)*

2. Workshop on Dance Therapy in Person Centered Medicine (Room E1-E2):

Chairs: *Sigrid Steffen (Salzburg), Janet Wallcraft (London)*

- Integrative Dance/Movement Psychotherapy and Person-centered Health: *Elena Gayvoronskaya (Voronezh, Russia)*
- Expressive-psychoanalytic Dance Therapy: *Maria Ammon (Berlin), Margit Schmolke (Munich)*

10:30 – 10:45 AM

Coffee Break

10:45 AM – 12:15 PM Special Session on Stakeholders' Policies and Contributions for Person- and People-centered Care (Main Auditorium)

Chair: *Manuel Dayrit (WHO, Geneva)*

- Introductory Statements
 - World Health Organization: *Wim Van Lerberghe (WHO Department for Health Systems Policies and Workforce, Geneva), Ivan Ivanov (WHO Department of Public Health and Environment, Geneva)*
 - International College of Person-centered Medicine: *Juan E. Mezzich (ICPCM, New York)*
- Policy Statements from Collaborating Major Medical and Health Organizations: World Medical Association (*O. Kloiber*), Wonca (*C. Van Weel*), International Alliance for Patients' Organizations (*J. Groves*), International Council of Nurses (*T. Ghebrehiwet*), International Federation of Social Workers (*R. Truell*), International College of Surgeons (*M. Downham*), International Pharmaceutical Federation (*O. Bugnon*), World Federation for Mental Health (*G. Christodoulou*), International Federation of Gynecology & Obstetrics (*W. Holzgreve*), International Federation of Medical Students' Associations (*P. Vega*), European Federation of Associations of Family of People with Mental Illness (*A. Sveltini, S. Steffen*).

12:15 – 1:00 PM Conference Closing Session: Geneva Declaration on Person-centered Care for Chronic Diseases and Next Steps: *ICPCM Board*



Invitation to Conference Dinner organized by the Paul Tournier Association

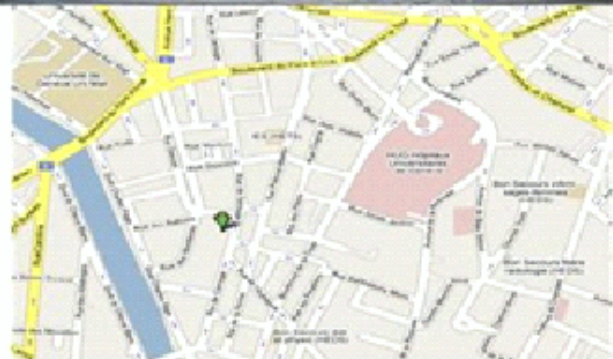
April 30, 7.00 pm
**For all speakers and
participants**

**CHF 50.-
(all inclusive)**

**please register at
welcome desk**

**Restaurant des
Vieux-Grenadiers**

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



FIFTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

GALLERY OF PRESENTERS



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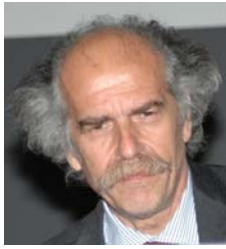
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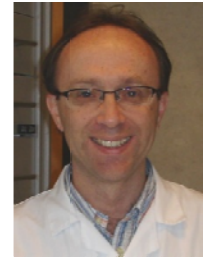
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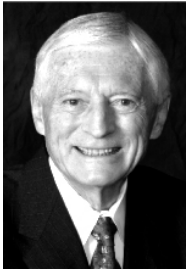
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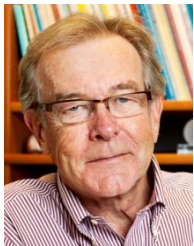


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FIFTH GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE

ABSTRACTS

PRE-CONFERENCE WORKMEETINGS

ICPCM Workmeeting on Organizational and Informational Projects

INTERNATIONAL JOURNAL OF PERSON CENTERED MEDICINE (IJPCM)
Andrew Miles & Christopher Woodhead

The International Journal of Person Centered Medicine (*Int J Pers Cent Med*/IJPCM) was launched at the Fourth Geneva Conference on Person Centered Medicine (4GC) in 2011. The journal was created in order to advance the global communication of scholarship and research for personalized healthcare and to supplement, rather than replace, the publication of person-centered medicine articles by the then International Network of Person Centered Medicine in the wider international medical press. The journal boasts a large and distinguished editorial board membership drawn from a wide variety of countries across the globe. The formal academic proceedings of 3GC were published in issues one and two of volume one of IJPCM alongside other special and regular articles. The IJPCM has now completed its first full volume over some 843 pages and at the time of writing is being actively considered for full PubMed listing, the IJPCM having fulfilled all of the relevant criteria in this context. Volume 2, Issue 1 has now been published, documenting approximately one half of the proceedings of 4GC, with the remaining papers from that conference scheduled for publication in Issue 2 in late June 2012. In addition to the remaining 4GC papers awaiting publication, IJPCM currently has more than 120 other papers of relevance to the development of person-centered medicine awaiting publication across Issues 3 & 4 of Volume 2. These works have been

submitted from an extensive number of countries worldwide, addressing the imperative for re-personalization of health services across a gamut of high, medium and low income countries. Of importance at this stage of the journal's infancy is the submission to its pages of a range of papers from Harvard Medical School, Yale University, Stanford University, The Mayo Clinic, Oxford University, the Veterans Administration of the USA and the World Health Organisation among other such prestigious and globally important educational and policy institutions. The IJPCM is being actively marketed using a range of techniques and a substantial increase in readership and subscriptions is anticipated following the confirmation of PubMed listing. Volume 3, which commences publication in 2013, will see, in addition to the regular quarterly issues, the publication of a range of special Supplements of the Journal arising from the work of the International Conference and Publication Series on Personalized Healthcare. As the official journal of the International College of Person Centered Medicine (ICPCM) and given the very great strengths and prestige the journal has achieved in such a short period of time, the IJPCM is advanced as an additional major vehicle through which the ICPCM will continue to move forward in promoting and operationalising the principles of person-centered care within international medicine.

USE OF SOCIAL MEDIA IN THE PROMOTION OF PERSON-CENTERED MEDICINE *Andrew Williamson*

A basic human need is to connect with others. Each day we connect with each other through a smile or a verbal greeting. Today, most connections seem to happen online. We chat with friends or we communicate via email as this is instant. In recent years, the Internet and more so the World Wide Web (WWW) enables us to send and retrieve information that it has changed the way we live and work. A recent trend to this is the introduction of Social Networking Sites (SNS). These allow us to view and to share information whether it be about ourselves and family or in our business activities. In the International Conference Series (ICS) we aim to use 2 to 3 SNS sites to share our information.

Facebook: Facebook is an SNS and website that was launched in February 2004. It is operated and privately owned

by Facebook Inc. Users must register after which they can create personal profiles, add other users and exchange messages and include automatic modifications. It is a two-way process. It is estimated that there are 845 million users.

Twitter: Twitter is an online SNS and microblogging service that enables users to send and read text-based posts of up to 140 characters. It was created in March 2006 and it is estimated that there are 300 million users and that over 300 million texts and 1.6 billion search queries are made each day. Twitter is a useful tool for the ICS as it can post updates that are immediate and picked up by those who follow the ICS tweets. It should be pointed out that Twitter is a one-way process.

Google+: Google+ is an SNS and identity service operated by Google Inc. It was originally opened as an invitation only "field

test". In September 2011, it was opened up to anyone if age 18+. In order to use the service you must have a Google account. The *New York Times* declared it to be Google's biggest attempt to rival Facebook. It is estimated that there are 130 million users. Considering the power of Google as a search engine and its popularity and ease of use, it seems very probable that this SNS will grow rapidly as more people use Google as their preferred search engine, web browser and email provider.

Conclusion: The ICS website, to promote and publicize the ICS of conferences to further promote person-centered care in disease specific areas, will employ the use of Facebook and Twitter in the early stages. This will enable a two-way interaction between prospective and signed up delegates and disseminate updates immediately. It is more likely that users will check their Facebook or Twitter accounts on a daily basis rather than check the ICS website.

INTERNATIONAL CONFERENCE AND PUBLICATION SERIES *Andrew Miles, Juan E. Mezzich*

The International Conference and Publications Series on Person-centered Healthcare (the 'Series') is a major new initiative of the International College of Person Centered Medicine (ICPCM). The initiative derives from discussions held at the Fourth Geneva Conference which examined how the values and clinical care practices of person-centeredness could be organised in diverse settings, from the bedside to the community and also in direct response to the exhortation of the World Health Organisation at the conclusion of 4GC for scholars to commence work on methodological development in the field, particularly with reference to the importance of the person and people-centered approach to care in the context of the global epidemic in chronic illnesses/NCDs. The Series is scheduled to be launched in Geneva on the evening of 1 May 2012 as part of a scientific symposium on methodological development in person-centered medicine. The Series will stimulate the debate and development of person-centered models of care for a range of common illness, beginning with Dementia, Parkinson's Disease and HIV/AIDS and progressing to Prostate Cancer and Breast Cancer, Diabetes, Chronic Respiratory Disease and Chronic Cardiovascular Disease and Rare Diseases over the course of 2012 and 2013. In addition to the illness-specific projects, the Series will additionally consider topic-specific areas of study. Here, projects are being planned which will look at spiritual and religious care in clinical practice, at values and preferences in clinical practice, at narrative in clinical practice and at other areas such as person-centered care of the elderly and at child and family-centered care. As with the Geneva Conferences on Person Centered Medicine, the Series will work in partnership with a wide range of international clinical associations and societies in order to draw upon their academic and clinical expertise and to collaborate together in the international advertising of planned events. Conferences will typically adopt an intensive 2-day design where recent advances in biomedicine and

technology will be reviewed and the methods through which such science can be applied to patients within a humanistic framework of care intensively studied. If required and subject to funding, a Day 3 may be added so that current policymaking and operationalisation of policies can be studied in detail when and where necessary. Presentations at the conferences, given mainly in plenary, but also in parallel presentations, will be typically 20mins in length, providing a rapid overview of the specific subject area. Presenters will then write up their overview into a formal academic paper, so that knowledge delivered in overview can be recorded in detail. The 50 or so academic papers will then be guest edited together into a special Supplement of the International Journal of Person Centered Medicine and made available open-access, on-line as part of the international dissemination strategy. In addition to the plenary and parallel presentation of the conference, a Case Symposium will also be integrated into the academic programme so that delegates are able to study the application of person-centered medicine principles and techniques to individual patients, the case examples in this context being drawn from the clinical practice of the case-presenting Expert Panel. These, too, will achieve written description within the special Supplement. The Series will be funded from a range of sources, including patient and disease-specific charities, Industry (in the form of unrestricted educational grants) and philanthropists with a special interest in health. The overall Director and Coordinator of the Series is Professor Andrew Miles with Series planning and operation conducted in close consultation and with the approval of the ICPCM Board as the model of governance. The Series will therefore have a strong emphasis on method development and method implementation within health services and its proceedings will also be available in the form of an Executive Summary with Recommendations for the use of individual country governments and policymakers.

PCM BOOK PROJECT *Andrew Miles, Juan E. Mezzich*

At the conclusion of the Fourth Geneva Conference on Person Centered Medicine, a special session at the World Health Organisation Headquarters considered in detail the need for reform and up-scaling of educational interventions as part of the global shift towards person and people-centered healthcare. In response to these discussions and in parallel with the construction of an International Conference and Publications Series on Personalized Healthcare, the idea of a major 'Oxford Textbook of Medicine' type volume explaining in detail the fundamental principles of person-centered medicine emerged. The first draft of the proposal suggested that the

volume would look in intensive detail at each of the fundamental components of person-centered medicine available for employment in 'hands on' clinical practice (e.g. narrative, values, preferences, cultural sensitivity, spirituality, psychosocial and psychosexual medicine, shared decision-making - etc), but also at a range of other necessary areas of study including economic evaluation of PCM approaches, the re-organisation or building *de novo* of more person-centered healthcare facilities, PCM-orientated IT and Informatics systems, ethical and regulatory facilitators and barriers to PCM and indices for process and outcome

measurement for PCM and undergraduate and postgraduate education themselves. A 33 chapter volume was advanced, constructed with reference to these study areas, with the draft proposal being subsequently examined by a body of distinguished scholars working within the person-centered medicine field. The advice received was extensive and valuable and is being fully assimilated as part of the preparation of a second draft of the plan. The volume will be aimed at a range of colleagues in clinical training and in clinical practice and also to health academics and

policymakers. The University of Buckingham Press, the publishers of the International Journal of Person Centered Medicine, would also publish the new book with Professors Andrew Miles and Juan Mezzich as lead editors. It is anticipated that this general text on person-centered medicine will be followed by the publication of illness- or specialty-specific toolkits/clinical manuals which will educationally review PCM principles in the context of given clinical conditions or fields.

ICPCM Workmeeting on Person-centered Integrative Diagnosis (PID): From Theoretical Model to Practical Guide

STRATEGIES AND TIMELINE FOR PREPARING A PID GUIDE

Juan Mezzich, Ihsan Salloum

The ongoing global initiative to construct a person-centered medicine requires as a critical component the development of pertinent methodology that would allow and promote the implementation of such initiative in regular clinical work. One of the key aspects of clinical care is diagnosis as fundamental basis of treatment planning. These considerations led in recent years to the planning and design of a Person-centered Integrative Diagnosis (PID) model. The initial work on this model has been centered on psychiatry and mental health (Mezzich & Salloum, 2007; Salloum & Mezzich, 2009). The conceptual bases and structure of this model were published in the Canadian Journal of Psychiatry (Mezzich, Salloum, Cloninger, et al, 2010) and more recently a conceptual appraisal it was conducted and published (Salloum & Mezzich, 2011).

The next major task is the development of a PID practical guide. This effort is due to start around the Fifth Geneva Conference (5GC) on Person-centered Medicine through the presentation and ample discussion of a set of papers aimed at moving forward this developmental process. The topics planned for the workmeetings on the PID preceding the Core Conference include the heuristic value of ontological analysis, the instrumentation of the various domains and levels of the PID, the integration of descriptive categories, dimensions and narratives and of the interactions among clinicians, patients and families to achieve common ground leading to diagnosis

as joint understanding and treatment planning as joint decision-making for care. Flexible modular arrangements will be also considered. Validation studies will be planned to follow the completion of the first version of the PID Guide and into 2013.

Diagnostic projects related to the PID that will be also discussed at the 5GC workmeetings include Latin American and Franco-phone regional approaches and person-centered diagnosis for pediatrics, internal medicine and primary care.

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DISORDERS AND COMORBIDITY

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The lack of objective validators for psychiatric disorders makes them subject of significant scientific debate. Categorical diagnosis has been the predominant form of classifying psychiatric disorders. The merit of non-categorical (or hybrid) schemes as well as dimensional models, and a spectrum approach are being considered. Psychiatry clinical comorbidity has increasingly become a defining reality of presenting health needs, the frequency of which is expected to increase in an aging world population affecting developing and developed countries alike. Clinical comorbidities are the rule and not the

exception in regular clinical care settings, and are associated with increased morbidity, mortality, and overall economic and humanitarian burden. Comorbidity within psychiatry presents additional challenges related to the limited nosological validity of psychiatric diagnoses. Patient-centered, holistic, community-oriented, and comprehensive approach, as opposed to a narrow, single-disease, acute care model, is critical to addressing the challenges and complexities of clinical comorbidities.

PRACTICAL GUIDE FOR POSITIVE HEALTH AND WELL-BEING IN PID

CR Cloninger, JE Mezzich, IM Salloum

Physical, mental, social, and spiritual measures are useful in the assessment of each of the domains of Person-centered Integrative Diagnosis (PID) [1, 2]. The three major domains of PID are health status (functioning/wellness versus Disability/disorder), the experience of health (self-awareness/fulfillment versus unawareness/suffering), and contributors to health (protective versus risk factors)[3]. Indicators of vitality in physical health status include a person's bodily fitness, number of days out of the past 30 days that a person felt very healthy and full of energy, and overall satisfaction with one's level of energy [4]. Flourishing in mental health is measured in terms of satisfaction with life, presence of positive emotions (cheerful) and absence of negative emotions (hopeless), as well as feeling that life is purposeful and meaningful [4-6]. Virtue in social and spiritual health can be measured by satisfaction with family life, friends and social life, and spiritual life, contributing to one's community as a considerate citizen and contributing to the happiness and well-being of others, and feeling one is a good person who is living a good life [4, 7-10]. Brief subjective measures of well-being are helpful as a brief initial assessment, but they provide no way to detect deliberate or unconscious bias in subjective reports [4]. Brief personality measures are also now available and more useful because their validity can be more objectively assessed and their administration promotes awareness and understanding of the person's strengths, weaknesses, and goals, thereby contributing to the formation of a therapeutic alliance [11, 12]. Fortunately, the maturity and integration of personality is strongly related to all of the physical, mental, social, and spiritual aspects of well-being [13]. Measures of personality and well-being are powerful predictors of both physical and mental disorders [12, 14].

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PID FORMULATION OF HEALTH EXPERIENCE AND VALUES

Juan Mezzich, Laurence Kirmayer

The conceptual bases and structural model of Person-centered Integrative Diagnosis (Mezzich, Salloum, Cloninger, Salvador, Kirmayer et al, 2010) calls for an evaluation of the experience of illness and health as one of the three key domain levels of the diagnostic model. A major aspect of such domain level involves a broad concept of culture with an emphasis on its experiential base. In line with this, a significant operational precedent would be the Cultural Formulation (Mezzich, Kleinman, Fabrega & Parron, 1996) proposed for and then included in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders (DSM-IV). This Formulation was considered one of the few significant innovations in DSM-IV, but was published there in a very schematic fashion. Few years ago a more elaborate guide was

published to assist in the preparation of Cultural Formulations (Mezzich, Caracci, Kirmayer, & Fabrega, 2009).

Another key element of person-centered medicine is attention to the values and needs of the patient who presents for evaluation and care. This is crucial to medicine's ethics commitment and the importance of individualization of care. In pointed reference to these aspirations, values-based medicine has been promoted (Fulford, 1999) and has been found conceptually consistent with person-centered care (Fulford, Christodoulou & Stein, 2011).

Procedurally, an efficient option to fulfill the objectives outlined above may be to combine the elements of the Cultural Formulation (expanded to address the experience of positive

health in addition to that of illness) and a query on the person's needs and values.

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CONTRIBUTING (RISK AND PROTECTIVE) FACTORS

I Salloum, J Saavedra, M Botbol, L Salvador, J Wallcraft, E Gayvoronskaya

Contributing (risk and protective) factors are key domains in the assessment and appraisal of the health status. The PID includes a focused emphasis on the bio-psycho-social contributors to ill health as well as to positive aspect of health. Etiopathogenic and risk factors are defined as causative and contributing factors to ill health while protective factors are

those bio-psycho-social factors that enhance positive health and the likelihood of recovery and restoration of health. The various domains of the PIDs contributing factors and their measurements as they apply to complex cases will be discussed.

EVALUATORS AND EVALUATION PROCESS

Janet Wallcraft, Sigrid Steffen, Ihsan Salloum

Patients, service users and family members have an important contribution to make to evaluation and assessment of mental/emotional health problems based on their lived experience and frequently also based on their work of self-education, and their work in educating healthcare providers and wider communities. It is known that shared decision-making about health problems at the level of identification, diagnosis and treatment prescribing can lead to better health outcomes. However, barriers to the integration of patients, service users and family members still exist.

Work led by service users and family members indicates that key factors for wellness include self-esteem, sense of purpose and personal fulfilment through appropriate social interaction, occupation and employment and support services. Continuous

personal support for patients and their families, and written plans in relation to the patient's life as a whole and his or her future are essential. Examples of help that patients need include information and support to exercise informed choices about medication, and about how to access additional complementary treatments and psychosocial therapies, physical exercise, nutritional supplementation, acupuncture.

Wider social factors include help with developing social networks, reduction of discrimination and better public understanding of mental ill-health.

This workshop will address the continued barriers to implementation of this work, and what actions need to be taken to move forward with this agenda.

DIAGNOSTIC SUMMARY, TREATMENT PLANNING AND CASE ILLUSTRATION

Neal Adams, Ihsan Salloum, Juan Mezzich

In an effort to support person-centered approaches to care, clinical data gathered during a diagnostic assessment should be used to create a formulation or integrative narrative summary consistent with categorical, dimensional and narrative elements of the Person-Centered Integrative Diagnosis (PID). This formulation must be shared with the patient so that points of shared understanding and perspective can be acknowledged and differences can be identified and hopefully resolved. The shared understanding is also referred to as common-ground and should serve as the basis for the creation of a treatment plan in the context of a therapeutic

partnership involving both the clinical team and the patient. The insights that are part of that formulation can support plan development by clarifying the individual's unique health and wellness goals, barriers to attaining those goals, short-term objectives designed to resolve barriers, and lastly services, interventions and/or treatments designed to help the patient move forward. This presentation will utilize clinical data from the assessment of an 18 year old female Latina to develop a formulation and treatment plan that is consistent with the values and principles of person-centered medical practice

CONSIDERATION OF A MINIMALIST, FUNDAMENTAL PID VERSION: FOCUS ON LIFE PROJECT AND COMPREHENSIVE DIAGNOSIS

Elena Gayvoronskaya, Ihsan Salloum, and Juan Mezzich

Nowadays, as a new paradigm on person-centered medicine is emerging, all key clinical activities, including diagnosis, need to be examined. In effect, it appears clear that person-centered diagnosis should cover all spheres of health and life as fully as possible. One intriguing aspect of this, is the consideration of the fulfillment of the person's life project as germane to the conceptualization of person-centered medicine (Mezzich, Snaedal, van Weel & Heath, 2010) and to the full scope of person-centered diagnosis (Mezzich, Salloum et al, 2010). Further work on the conceptualization and assessment of the person's life project may provide an opportunity to touch on a central element of person-centered health. Likewise, it may advance the promotion of the person-centered approach in medicine and the development of modern medical education

and training. Some practical options for the assessment of the person's life project within the framework of person-centered integrative diagnosis will be discussed.

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VALIDATION STUDIES

Ihsan Salloum, Levent Kirisci, K Schaffner

PID validation studies of a diagnostic model may involve a complex and sequential assessment of the models' various domains and axis. However, beyond reliability and content or construct validity, the major evaluative criterion is the models'

clinical utility in terms of facilitating care and optimizing outcome. The PID's potential impact on key areas of optimizing care will be reviewed.

ICPCM Workmeeting on Related Person-centered Diagnostic Projects

REVISING THE LATIN AMERICAN GUIDE FOR PSYCHIATRIC DIAGNOSIS

Juan Mezzich, Ihsan Salloum, Luis Salvador, Angel Otero, Javier Saavedra

The Latin American Guide for Psychiatric Diagnosis (Guía Latinoamericana de Diagnóstico Psiquiátrico) (GLADP) was originally prepared and published in 2004 by the Latin American Psychiatric Association (APAL) as an adaptation of the ICD-10 for the use of psychiatrists and mental health professionals in Latin America. Its major motivations were, first, to make the Classification of Mental Disorders in ICD-10 more relevant to the realities and needs of mental health care and life in Latin America, principally through Latin American Annotations attached to the diagnostic criteria of pertinent mental disorders. And second, to personalize the diagnostic approach and include the assessment of positive health (quality of life). It was received warmly by mental health professionals in the region because of the features mentioned above as motivating its development. Additionally, as it can be downloaded freely from the websites of the APAL and other official bodies, it has become the main way of accessing the ICD-10 classification of mental disorders, the original version of which appears to be out of print.

In 2009, in view of the emerging revision of the ICD and DSM disease classification systems, the APAL and its Diagnosis and Classification Section decided to update the GLADP to enhance further its cultural sensitivity and person-centeredness (Otero et al, 2011). This effort was undertaken in association with the ongoing development of the Person-centered Integrative Diagnosis model (Mezzich, Salloum, Cloninger, Salvador et al, 2010) by the World Psychiatric Association Classification Section and the International

Network of Person-centered Medicine. Workgroups have been established with experts from 15 Latin American countries dealing respectively with ten broad disorder categories as well as integrative diagnosis, cultural framework, and public health epidemiology. An initial survey of Latin American psychiatrists showed the GLADP preferred over the ICD and DSM systems because of its integrative, personalized and culturally sensitive features (Saavedra et al, in press). Work is advancing towards completing in a year's time a GLADP Revision (maintaining the still official ICD-10 categories and codes) to be followed by a full new edition of the GLADP by 2015 when it is expected that ICD-11 be finalized.

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WFMH-ICPCM PROJECT: CONTRIBUTION TO ADVANCE PERSON-CENTRED AND PEOPLE-CENTRED CARE

Mohammed T Abou-Saleh

The WFMH has demonstrated a commitment to the International Network of Person-centred Medicine (INPCM) to promote its longstanding principles of inclusiveness of consumers and families at the centre of the decision making process in order to reduce stigmatization, ensure fair distribution of resources, equal access to health care, and equal representation at government level. The WFMH in its last Meeting of the Board of Directors in Cape Town in October 2012 approved the establishment of an alliance with the INPCM. A landmark development was the WHO Executive Board Directive on Global burden of mental disorders and the need for a comprehensive, coordinated response from health and social sectors at the country level in January 2012 (http://www.aen.es/docs/12%201_WHO_EBoard-Global_Burden_Resolut.pdf).

The present focus of the WFMH work is People-centred care expressed in the Great Push global campaign for Mental

Health and its alliance with the Movement for Global Mental Health (MGMH). The prime objective is to identify civil society world mental health priorities to inform the WHO action plan on Mental Health. A major step is to develop the Peoples Charter for Mental Health to incorporate Civil Society's priorities and to be ready to present to WHO and the UN, before their High Level Session. We will continue to push for a UN General Assembly High Level Session for Mental Health. The WFMH-MGMH Alliance has declared that "A United Nations General Assembly Special Session (UNGASS) is needed to focus global attention on MNS disorders as a core development issue requiring commitments to improve access to care, promote human rights, and strengthen the evidence on effective prevention and treatment" (<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1001159>) In this presentation we aim to update the INPCM on the current and future activities of the WFMH and explore the opportunities for joint work to advance People-centred care.

Other ICPCM Related Person-centered Projects

PERSON-CENTRED PARTNERSHIP

Janet Wallcraft and Sigrid Steffen

Partnership is known to be an essential aspect of person-centred medicine. The skills and knowledge now exist to develop partnership working internationally. Trialogue is one tried and tested technique recommended as a low-cost and transferable technique to raise awareness of shared issues. However, partnership has not become universal, due to a number of identifiable barriers. Doctors argue they do not have enough time to spend talking to patients and their families, or may not accept the concept of partnership with patients and family members, who do not have scientific training. The WPA User and Carer task force found that all groups including doctors state that they want to see greater partnership but change is slow to happen. Person centred partnership is essential to improving the physical and mental health of patients through holistic treatment, and to educate and train patients as peers and give them opportunities to be more

actively involved in the psychiatric clinic or in community health centres.

One good practice example is PROSPECT, which provides a unique peer to peer training method that EUFAMI has developed which would be delivered by family members. It includes modules for professionals and people with self-experience, in addition to the modules for family members. It has now been successfully used in over 14 European countries.

This workshop explores ways to drive forward the partnership process through identification of good practice (such as involving patients and families in curriculum development, education and training of doctors), and how these good practice examples can become the normal way of working.

CORE CONFERENCE

OPENING

INTERNATIONAL COLLEGE OF PERSON-CENTERED MEDICINE: DEVELOPMENTS AND OPPORTUNITIES

Juan E. Mezzich (ICPCM President, New York)

Having as its roots the wisdom of ancient civilizations, enlightened medicine's traditions, and contemporary developments in clinical care and public health, a global initiative toward person-centered medicine was launched at an inaugural Geneva Conference in 2008 [1], and continued through annual editions of this Conference. From this process emerged in 2009 an International Network for Person-centered Medicine [2], which assumed the responsibility of core organizer of the Geneva Conferences in collaboration with a continuously growing number of top international medical and health institutions including the World Medical Association, the World Health Organization, the International Council of Nurses, and the International Alliance of Patients' Organizations to mention a few. These initial efforts are finding consolidation in the International College of Person-centered Medicine [3] which emerged in 2011 from the International Network. Among the signal activities of the International College are, first, the establishment of an International Journal of Person-centered Medicine as a joint venture with the University of Buckingham Press [4]. The Journal has already started its second annual volume of quarterly issues with papers of growing quality coming from prestigious institutions from across the world. Other recognized College activities are workgroups aimed at developing methods to facilitate the implementation of person-centered medicine in the clinical arena, such as the Person-centered Clinical Care Guiding Principles and the Person-centered Integrative Diagnosis model [5], as well as a project in collaboration with the World Health Organization to develop metrics to assess progress towards person- and people-centered care. To be launched

soon is an International Conference and Publication Series on Person-centered Healthcare focused on specific challenging clinical conditions.

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Plenary Symposium on the Effectiveness of Person-centered care for Chronic Diseases

CONTEXTUALIZED APPROACH TO ENDURING CLINICAL COMPLEXITY

Ted Epperly

Medicine and health care in general is a fascinating career. It is important to recognize that health care and its provision is around the people we are caring for and should not be centered around the system and the providers who provide that care. It's about our patients and not about us. In order to provide the best person-centered health care to people we

must understand who they are as people and the context of their illness in the context of their lives. This lecture will explore the six context areas that provide insight and meaning to caring for people and underscore the importance of the physician-person relationship as being the central axis of trust in which health care not only occurs but succeeds.

PSYCHOLOGICAL METHODS FOR PROMOTION OF WELL-BEING IN CHRONIC DISEASE

C. Robert Cloninger

Chronic medical disorders, such as heart disease, chronic obstructive pulmonary disease, asthma, and arthritis, are strongly associated with immature personality, emotional instability, and social dysfunction [1, 2]. All indicators of physical, mental, and social well-being are strongly related to the level of maturity and integration of personality [3, 4], so personality is a particularly useful focus for the promotion of

well-being because it can be quantified and analyzed to detect intentional or unconscious biases in self-report [5]. Assessment of personality also facilitates the awareness of the clinician and the patient about the patient's strengths, weaknesses, and goals, thereby contributing to the formation of an effective therapeutic alliance [6]. Health, well-being, and recovery of functioning all involve increasing levels of the

character traits of Self-directedness, Cooperativeness, and Self-transcendence [6]. Person-centered programs that enhance self-regulation of functioning to achieve personally valued goals improve compliance with medical treatment and personal quality of life in people with chronic diseases like heart and lung diseases [7-9]. Effective therapeutic approaches for promotion of well-being all work by activating a complex adaptive system of feedback interactions among functioning, plasticity, and virtuous ways of thinking and acting that promote health, happiness, and resilience [6, 7]. The probability of increasing personal growth can be predicted by high levels of Self-transcendence which give rise to an outlook of unity and connectedness, particularly when combined with the temperament traits of high Novelty Seeking and high Persistence [10, 11]. In summary, person-centered psychological treatments that facilitate the development of well-being and personality development are crucial in the effective treatment of chronic medical diseases.

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Workshop on Person-centered Care for Chronic Psychiatric & Neurological Diseases

AFFECTIVE AND SUBSTANCE USE DISORDERS

Ihsan Salloum

Affective disorder and substance use disorders are among the most frequent psychiatric conditions worldwide. These conditions are associated with increased disease burden and represent a major challenge for clinicians and treatment services. Traditional care systems, emphasizing specialized care with primary focus on pathologies, often lead to fragmentation of care and less than optimal outcome. The Person-centered Care model, with its emphasis on addressing the totality of health status and on integrating care is poised to address the treatment needs for these patients. Furthermore, it also integrates other fundamental aspects key to individualized care including a biopsychosocial approach to contributors to the totality of health status, the person's seeking care subjective experience and the partnership in care such as family and significant others along with health care professionals. This presentation will compare/contrast traditional model of care with person-centered care approach to patients with complex neuropsychiatric comorbidity.

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CHRONIC CHILD MENTAL HEALTH DISORDERS

Michel Botbol

In children, as in adults, person centered care for chronic mental health disorders have to be personalized, taking into account ill and positive aspects of health, objective and subjective aspects of the child's health status, in a

biopsychosocial approach of his situation. In this global perspective person centered care have to be particularly attentive to the dimensions that are of specific importance in

children. Among them are of major importance for the assessment and the treatment of the child:

The developmental dimensions of the disorder, their involvement in the determinant of the disorder or in its consequences. Particularly important is the way in which care can remain person centered in spite of the child's limitation in the development of his communication, cognitive or moral capacities related to his care or to the many other aspects that can be involved in his follow up

The child's dependence to his psychic environment, that is to say to his parents' and carers' materialistic, affective, educative, and legal functions.

These specificities raise controversial issues to the professionals in their relations to the child's carer, to his family and to the professional guidelines related to his disease, with frequent legal consequences that have to be carefully considered in the interest of the child

RECOVERY AND PERSON-CENTERED CARE

Margit Schmolke

The comparison between Person-centered and Recovery Orientation perspectives displays unique features for each approach as well as considerable points of convergence. One of the main differences between these perspectives is that Recovery Orientation is primarily centered within the mental health and psychosocial fields while the Person-centered approach covers general and specialty medicine and general health care. Among the points of convergence is a holistic theoretical perspective covering both ill health and positive health, an emphasis on contextualization for understanding and action, development of person-centered procedures for communication, assessment, treatment, prevention, and

health promotion, and respect for the autonomy, responsibility and dignity of every person involved.

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Workshop on Person-centered Care for Oncological Diseases

INFORMATIONAL PROCEDURES TO SUPPORT PATIENT'S DECISION-MAKING ROLES IN CANCER CARE

Gabriella Pravettoni, Marianna Masiero, Ketti Mazzocco

Since the end of the Human Genome Project in 2003 when the high quality reference sequence has been completed, genomic medicine has become an important predictive tool for cancer syndrome. Genomic approach has represented the starting point of personalized medicine, and it permitted to develop tailored clinical trial related to patient's genotypic and phenotypic features. Although of crucial importance, the current approach is not complete, relying exclusively on biological and clinical information, and neglecting all psychological, social, cognitive and behavioral characteristics that typify every single patient and her approach to the medicine.

Our assumption is that knowing the patient's psycho-cognitive profile would help enhancing her empowerment. Accordingly, in the present work we developed a questionnaire for cancer patients (the ALGA Questionnaire) that would help physicians approaching the patient and would permit to develop tools that facilitate patients' ability to cope with her difficult situation.

More specifically, the information collected by the present questionnaire (validated across different European countries) will permit to develop personalized decision support tools helping the patient to have an active role in decision-making about the care.

PSYCHOLOGICAL ISSUES ON PERSON-CENTERED CARE FOR CANCER PAIN

Marijana Bras

Pain is one of the most common and distressing symptoms in - cancer patients. Although medications and other methods for cancer pain treatment are available, a significant number of patients suffer from intolerable pain. Current conceptualizations of cancer pain adopt a person-centered perspective. The patient's emotional experiences, beliefs and expectations may determine the outcome of treatment, and are fully emphasized in the focus of treatment interventions. Complex and disabling pain conditions often require comprehensive pain treatment programs, involving interdisciplinary and multimodal treatment approaches. Psychological/psychiatric aspects have an important place in all phases of treatment, with an important role in research and education. There are many roles that the psychiatrist can perform in the assessment and treatment of patients with

cancer pain, and psychological treatment can and should be individually tailored to meet the specific needs of the patient.

Rational polypharmacy is also highly important in the treatment of cancer pain, with antidepressants and anticonvulsants being the most important adjuvant analgesic agents.

Quality of interactions between health professionals and patients, education of professionals about biopsychosocial approaches, communication skills, psychological interventions and continuing care should all be present. It is also important to help cancer patients communicate more effectively about pain and become more involved in deciding pain management treatment.

PROMOTING COMMUNICATION ON SEXUAL HEALTH WITH THE CANCER PATIENT

Lovorka Brajkovic

Sexuality involves the physical, psychological, interpersonal, and behavioural aspects of a person. Research shows that approximately 50% of women who have been treated for breast and gynaecologic cancers and nearly 70% of men who have been treated for prostate cancer experience long-term sexual dysfunction. The causes of sexual dysfunction are often both physical (loss of function due to the effects of cancer therapies, fatigue, and pain; surgery, chemotherapy and radiation therapy may have a direct physical impact on sexual function, pain medication ect.) and psychological (depression, changes in body image after surgery, anxiety, and stresses due to personal relationships). The most common sexual problems for people who have cancer are loss of desire for sexual activity, problems achieving and maintaining an erection in men, inability to ejaculate, ejaculation going backward into the bladder, or inability to reach orgasm. Women may experience a change in genital sensations due to pain, loss of sensation and numbness, or decreased ability to reach orgasm. Sexual problems are a

widespread concern among patients and survivors, but there is much variation in experiences of communication about sexual issues, and many patients do not receive the information they need from medical staff. So, if we know that sexual health is essential part of person's health, and if we know that a diagnosis of cancer can affect a human sexuality and intimacy throughout their entire life span why is so difficult to talk about sex, intimacy? Health professionals frequently express an uncertainty about not knowing where to begin or equate sexuality only with sexual intercourse even though human sexuality is more than sexual function. Some research showed that if patient didn't start to talk about sexual issues, physicians assumed that the absence of questions indicated absence of sexual issues. One of the most fundamental aspects of successful communication about sexuality is for the health professional to recognise personal barriers to discussing sexuality. If these are not recognised, they may professionally distance themselves from patients at a time when patients often feel isolated and vulnerable.

PERSON-CENTERED CARE AT THE END OF LIFE

Ted Epperly

Person-centered care at the end of life is an area of medicine we must all be familiar and comfortable with. This is the case as it will involve not only the people we care for but also our own family members, loved ones, and eventually ourselves. Forty percent of all health care dollars in the United States health care system are spent in the last two years of a person's life unless meaningful person-centered discussions occur. Providing person-centered care for the remaining months of a person's life is of extreme importance in helping

them achieve their wishes and goals, maximize palliation, comfort, dignity, and quality of life. This session will focus on maximizing person-centered approaches of active listening and discussion, advanced care planning, clear communication, timely engagement of support services, family support, and compassion. Our goal with person-centered care at the end of life is to allow as many people as possible with a good death.

Poster Session

THE CONTRIBUTION OF EASTERN ORTHODOX PSYCHOTHERAPY TO PERSON-CENTERED MENTAL HEALTH CARE

Sebastian Moldovan

The Romanian health care system undergoes a profound crisis. A recent Presidential Commission Report (2008) deplores the central administrative structure of the system, the low patient empowerment, and the financial and managerial focus on the current national reforms. However, the Report's recommendations for decentralization fall short of taking into account the personal experience of health and micro level initiatives as real centers of a complex health system reform.

In this context, and given the currency of religious values within Romanian population, several local faith-based therapeutic initiatives, especially in the field of palliative care and mental health, are to be noted. The large majority of believers adheres to the Orthodox-Christian tradition of Eastern Christendom, whose spirituality has at its center

ancient psychotherapeutic methods (ECP) of mental well-being.

The study firstly argues the ECP's account for the complexity of addictive behavior as a chronic condition, with somatic, psychological, and social multi-level dimensions. An empirical, qualitative research on the centeredness of dependent and co-dependent persons in three faith-based programs in urban areas (Lasi, Cluj, and Sibiu) tests the theoretical suppositions.

Transformational experience, coping with relapses, re-motivation and therapeutic communities are particular features that make EPC highly relevant for person-centered, recovery oriented services.

PERSON-CENTERED CARE REDUCES SELF-REPORTED UNCERTAINTY IN ILLNESS, AMONG PATIENTS WITH CHRONIC HEART FAILURE

Kerstin Dudas, Lars-Eric Olsson, Karl Swedberg, Maria Schaufelberger, Charles Taft, Axel Wolf, Inger Ekman

Introduction: Many patients with chronic heart failure (CHF) experience uncertainty regarding the treatment and

characteristics of their illness. Person-centered care (PCC) emphasizes patient involvement in care. It is still unknown

how PCC impacts self-reported uncertainty of illness in patients hospitalized for CHF.

Purpose: To evaluate if PCC reduces self-reported uncertainty in illness among patients with CHF.

Method: Patients with worsening CHF admitted for hospital care was eligible for the study, which had a controlled before and after design. The control group received conventional care and the intervention group received PCC. Uncertainty in illness was measured by the Cardiovascular Population Scale (CPS). CPS consists of two domains: 1) ambiguity; patients'

perception concerning severity of illness, 2) complexity; patients' perceptions on treatment and system of care.

Results: 248 patients were included in the study. Ambiguity was less prevalent (mean 27.8 (SD 6.6)) in the PCC-group compared to the usual care group (mean 29.8 (SD 6.9)), the difference was significant ($p = 0.041$). The PCC-group scored less regarding complexity (15.2 (SD 4.7)) than the usual care group (16.8 (SD 4.7)).

Conclusion: This result indicates that PCC can reduce self-reported uncertainty in illness among patients with CHF.

CARE EXPERIENCE IN A SWEDEN AMONGST 34.000 HOSPITALIZED PATIENTS

Axel Wolf, Lars-Eric Olsson, Charles Taft, Karl Swedberg, Inger Ekman

Background: Although patients' characteristic such as self-reported health and physical disability are good predictors of clinical outcome, there is limited information about how patients characteristic affect the care experiences. The study objective was to validate the adapted Swedish version of the Picker Patient Care Experience -15 (PPE-15) survey and to see how the patient characteristic impacts care experience.

Methods: A retrospective cross-sectional study design was used. Patients discharged from internal medicine wards at regional and university hospitals in different parts of Sweden during 2010 were invited to participate in the regularly performed national care-experience survey for hospital care.

Results: The response rate was 66.5 % ($n = 34.603$). Cronbach alpha was 0.87. There was a significant relationship between positive PPE-15 score and clinical characteristics. Patients with poor self-rated health and physical dependence reported significantly less positive care experiences (median score= 75) than patients with physical independence and self-rated good health (median= 85) ($p < 0.0001$).

Conclusion: Our findings indicate a care paradox: hospital care, as delivered by health care professionals in Sweden, provides care experiences which to a higher degree acknowledge the needs and resources of independent patients with good health, but does not provide equal satisfactory care experience for vulnerable patients.

EXPERIENCES OF PATIENTS AFFECTED BY THE "BROKEN-HEART SYNDROME" – TAKOTSUBO CARDIOMYOPATHY

Sara Wallström, Kerstin Dudas, Elmira Omerovic, Inger Ekman

Background: Takotsubo cardiomyopathy (TTC) is an increasingly recognized syndrome that mimics acute myocardial infarction and heart failure. There is a strong association with negative emotional stress and TTC mostly affects postmenopausal women. The characteristic hallmark of TTC is the development of regional left ventricular dysfunction which may lead to acute heart failure, cardiac rupture and death. Due to the limited insight into the pathogenesis and epidemiology of TTC, there are no guidelines regarding the diagnosis, treatment and follow-up of these patients. Similarly, little research attention has been directed toward the patients' perspective and their life experience.

Aim: To illuminate life experiences of patients who have been affected by TTC.

Method: A pilot study consisting of three narrative interviews has been conducted. The interviews, which lasted between 20-50 minutes, were recorded and typed verbatim, and analyzed by a phenomenological hermeneutical method.

Findings: One main theme; Captured by control, and two themes; Experience of demands; and Sense of powerlessness were found in the analysis. The interviewees desired to maintain a sense of control. This perceived control gave them a sense of safety, which was sought-after, since the unknown

was perceived as threatening. The theme; Experience of demands was characterized by the interviewees high demands on themselves. These demands seemed to come both from themselves and expectations from others. Experience of demands was formulated from four sub-themes; 1) Helping and protecting others; 2) Never having time to recuperate; 3) Feeling insufficient; and 4) Superficially happy. The second theme; Sense of powerlessness was derived from the following sub-themes; 1) Feeling sadness for close ones; 2) Fear and anxiety; 3) Injustice; and 4) Denial. The interpretation of the theme Sense of powerlessness was that the interviewees from time to time seemed to lose control of their situation. To have a feeling of powerlessness and not being able to influence the situation was a strain on the interviewees.

Conclusion: The main result from the pilot-study is that the patients experience that they are captured by a need to be in control, they cannot get out, neither by their own will nor by external circumstances. The situation is characterized by fear, anxiety of losing control and a sense of powerlessness regarding their ability to influence the situation. The constant strain and the desire to control the situation may take the physical expression of TTC.

PERSON-CENTERED CULTURE SPECIFIC PATIENTS EDUCATION IN BULGARIA

B. Levterova, D. Dimitrova, D. Stojanov, M. Orbetzova

In Bulgaria, diabetes mellitus affects more than 9% of the population (2010), with a tendency to reach 14% in 2025. Psychosocial factors often determine self-management

behavior, and psychosocial variables are often stronger predictors of medical outcomes such as hospitalization and mortality than are physiologic and metabolic measures. By

integrating cultural constructs into diabetes care and education, we may improve outcomes and increase satisfaction. The contemporary patient is expected to be aware of his rights and of the physicians' obligations. Therefore, he must be properly informed and encouraged to take an active part in recovery process, planning of diagnostic and treatment procedures. In the lack of universally accepted approach in the education of people with diabetes the efficacy depends on the cultural specifics of the targeted populations and individual personal characteristics.

The aim of the project is the development of methods for person-centered culture specific education, to patients with

diabetes mellitus type 2 in Bulgaria and its use for the increase of patients' quality of life. The current stage of the project includes audit of the present educational system for patients, evaluation of technologies used in other countries and development of adapted methods.

Expected results: person - centered model for education, instruments for quality of life assessment of diabetes mellitus patients.

Keywords: person - centered model, diabetes mellitus type 2, quality of life

ASPECTS OF HYPERTENSION – A MULTIPERSPECTIVE APPROACH ON THE WAY TOWARDS ADHERENCE AND SELF-MANAGEMENT

U. Bengtsson, K. Kjellgren, I. Hallberg

Hypertension is a long lasting condition for which a poor adherence to therapy becomes a substantial threat to the individual and public health. Major efforts have been made to explore reasons for poor adherence but few successful interventions have been designed. There is a need for effective strategies tailored for the unique needs of persons with hypertension. We set out to explore and describe relevant aspects of hypertension and hypertension treatment, from the perspective of persons with hypertension and health care providers.

Focus group interviews were performed with 12 persons with hypertension and 15 health care providers and analyzed according to thematic analysis.

Persons with hypertension perceived trust, relationship to providers, well-being and prevention of complications as important aspects of hypertension care. Further they sought to understand the interplay between symptoms and variation of blood pressure. The providers emphasized accessibility, clear and consistent counseling, prevention of complications and educational efforts but doubted patients' ability to be participating partners in care. The study presents aspects that persons with hypertension and health care providers deem important in hypertension self-management. Our findings provide input for future outcome measures and may increase the understanding of hypertension and treatment from a person-centred perspective.

CONTEXTUALISATION OF FUNCTIONAL SYMPTOMS IN PRIMARY HEALTH CARE

Dimitrios Kokkinakis, Eva Lidén, Staffan Svensson, Elisabeth Björk Brämberg and Sylvia Määttä

Background: a number of patients consulting primary health care have physical symptoms that may be labeled "medically unexplained", i.e. absence of a demonstrable organic etiology. Common functional somatic symptoms (FSS) are irritable bowel, tension headache and chronic fatigue. FSS-patients are generally frustrated with the inability of health care to alleviate their illness. Health care staff often also feel frustration. The communication between patient and care giver is the key for coming to terms with the problem.

Objective: to investigate how complex, vague and long-standing symptoms with no identified organic cause are put into context, interpreted and acted upon in primary health-care interactions. Two types of interventions are envisaged (i) methods for early identification of patients at risk of entering a vicious circle of functional symptoms and (ii) methods for re-interpreting symptoms in alternative and more purposeful ways.

Methods: the project studies interactions between patients and nurses giving advice over telephone, consultations

between patients and physicians, interviews and study patients' medical case notes. Eligible patients (18-65 y.o.) contact their primary health care centre by telephone, have had at least eight physical consultations with nurses or physicians in the last 12 months and if a majority of the symptoms within this time span had no clear organic or psychiatric cause. The project contains a number of subprojects, according to the type of data collected. Several methods of analysis will be used, mainly critical discourse analysis, phenomenologic-hermeneutic and computation linguistic analyses.

(Expected) Results: using the collected data, we describe characteristics of the communication that takes place in these settings and the way symptoms and diseases are represented. This will facilitate the development of future interventions aimed at decreasing the morbidity due to FSS and give further insights into the problem.

Workshop on Person-centered Care for Chronic Circulatory and Respiratory Diseases

PATIENTS' EXPERIENCES IN ACUTE CORONARY SYNDROMES

A. Fors, K. Dudas, I. Ekman

Background

Many patients report persistent fatigue (with or without concomitant depression) after an acute coronary syndrome (ACS), which has been shown to negatively affect daily life.

Purpose

The aim was to illuminate the meaning of lived experience of being affected by an event of acute coronary syndrome.

Methods

A qualitative method was used, 5 men and 2 women afflicted by ACS narrated their experiences during their stay at the coronary care unit. The interview texts were analyzed according to a phenomenological hermeneutic approach (naive reading, structural analysis and comprehensive understanding).

Results

One theme was "Panic and Chaos" with the subthemes: "Threatening Pain and Fear", "Feelings of Concern and Uncertainty" and "Taken by Surprise". The other theme was "Struggling to obtain a sense of security" with the subthemes: "Living life forward, understanding life backwards", "Lulled into a Doubtful Sense of Security" and "Feelings of Frailty".

Conclusions

To be affected by an event of ACS means a life-threatening and hazardous adventure where patients deal with themselves in order to find a common thread and obtain a sense of security. This turbulent situation emphasizes the importance of individual care plans and person-centred care in order to help patients regaining ordinary life pattern activities such as returning to work or other daily activities.

OUTCOME STUDIES ON PERSON-CENTERED CARDIOVASCULAR CARE

Inger Ekman

During the last 10 years a number of studies have evaluated disease-management programs and other interventions in patients with cardiovascular diseases in order to improve outcomes, care, or relieve symptoms. Outcomes in studies on interventions on person-centred care should be designed from

the patients' perspective (soft endpoints). In this presentation different intervention studies with a person-centred perspective will be discussed and the design of such studies will be reflected on.

PERSON-CENTEREDNESS FOR INTENSIVE CARE MEDICINE

Mark R. Tonelli

The provision of intensive care medicine presents particular challenges for a person-centered medicine.

Access to intensive care medicine is generally controlled by providers of the service. This locus of control, along with the fact that need for an ICU generally occurs due to acute, severe illness, means that individuals may be denied or subjected to intensive care against their will. The issue of access is particularly relevant to persons with chronic disease, who are both more likely to be excluded from ICU care and also less likely to benefit from it.

In addition, most people who require ICU level care are unable to participate directly in their own healthcare decision making.

Incorporating individual patient goals and values into decision making, then, requires explicit and active effort on the part of intensivists to elicit that information from a variety of sources.

Finally, clinical decision making in the ICU is also highly dependent upon pathophysiologic reasoning and technical knowledge that is not accessible to individual patients and families.

In sum, the provision of person-centered intensive care places a high degree of responsibility upon clinicians to ensure that care is individualized and to respect patients as persons.

Workshop on Self-Care and Integrative Approaches to Non-communicable Diseases

EDUCATION FOR PERSON-CENTERED CARE OF CHRONIC NON-COMMUNICABLE DISEASES

Salman Rawaf

In today's world chronic and non-communicable diseases are the main cause of morbidity and mortality in almost all countries around the world. Recent data from World Health Organisation shows that approximately 60% of all deaths globally is attributed to NCDs. The questions which all medical educationalists, trainers and policy makers must address: are we prepared to deal with this magnitude of the health challenge? Who should be educated about NCD? Why should PCM be at the heart of our educational programmes?

This paper will address some of the approaches needed within our health and educational systems to increase awareness and practical knowledge and skills to prevent and manage the

main common NCDs (cardiovascular disease, cancer, diabetes and chronic lung disease). Most of NCDs are preventable. Many if not all of their risks factors (smoking, obesity, physical activity, hypertension, excessive use of alcohol) can be managed if identified early. If not, these may lead to long term conditions. Prevention and control of risk factors and treatment and management of long term conditions require careful planning by the patient and the physician. All approaches to control of NCD must be person-centred as continuity of care is the determinant factor in achieving better health outcomes at individual and population level.

Plenary Symposium on Person-centered Care and Modern Clinical Practice

CASE-BASED MODELS OF PERSON CENTERED MEDICINE IN ACTION

Mark R. Tonelli

Clinical decision making must be case-based (rather than evidence-based) in order to meet the requirements of a person centered medicine. A casuistic approach to clinical decisions seeks warrants from five topics relevant to any clinical case: 1) results of clinical research, 2) pathophysiologic rationale, 3) personal experience, 4) patient goals and preferences, and 5) system features. The warrants derived from each of these five

topics must be weighed and negotiated by the clinician in order to arrive at the most appropriate decision for an individual patient. Clinical decisions are provisional and are open to rebuttal from a variety of sources, including the patient. Two cases, a woman with an acute exacerbation of cystic fibrosis and a man with multiple chronic health conditions, will be used to demonstrate the casuistic method.

EVIDENCE-BASED AND PERSON-CENTERED MODELS: TAKING LOCAL FACTORS INTO ACCOUNT

Amit Saad

Evidence-based medicine (EBM) encourages clinicians to follow recommendations derived from large trials. However, "local factor effects" are not always measured in such trials. Multicenter trials, for example, may show that certain medical interventions are generally recommended, but local factors such as genetic, environmental, cultural, and the socioeconomic background of patients, as well as the medical staff's abilities, may create an intervention-in-center effect, which would make such interventions less preferable for some patients. The growing concern regarding local factor effect gives rise to paradigms which are complimentary to EBM such as person-centered medicine (PCM). Nevertheless, to date it

has not been determined how clinicians should integrate data from large trials with local factor effects.

In this paper we present a theoretical Bayesian model which integrates data from multicenter trials with local observations. We prove that the model provides more accurate estimations of the intervention effect in each center than the ones provided by using data solely either from multicenter trials or from local observations.

Our model enables both clinicians and patients to integrate results from large trials with local factors and choose the preferred intervention. We believe this may play a role in the desired coalescence of EBM and PCM.

Plenary Symposium on Transformative Education for Person- and People-centered Care

TRANSFORMING AND SCALING UP HEALTH PROFESSIONAL EDUCATION AND TRAINING

Erica Wheeler

The World Health Report of 2006 pointed to the severe shortages of health professionals around the globe. This has left millions of people without access to appropriate health services and is hampering the attainment of the millennium development goals. Estimates indicate that in 2006, an additional 2.4 million doctors, nurses and midwives were needed. Focusing on the workforce shortage alone will not resolve the crisis. In many settings, both rich and poor, the education of health professionals has been isolated from health service delivery needs and has not adapted to match rapidly changing population health needs.

Systematic failures in health professional education and training for decades has included: the mismatch of health

professional competencies to population and local health needs; poor teamwork and weak leadership, including leadership for health system performance; the preference for a hospital focus which dominates over the needs of primary care; health worker and gender imbalances; and professional silos or segregation.

More health professionals are therefore needed, but not more of the same. A transformation of health professional education should put population health needs and expectations at the centre and should be directed by the reality of health service delivery. This is the focus of the policy guidelines that are being developed by the WHO initiative on transforming and scaling up health professional education and training.

WORLD HEALTH PROFESSIONAL ALLIANCE PERSONALIZED CARD ON PREVENTING CHRONIC DISEASES

Julia Seyer

The World Health Professions Alliance WHPA, which brings together the global organizations representing the world's dentists, nurses, pharmacists, physical therapists and physicians and speaks for more than 26 million health care professionals in more than 130 countries, has developed a Health Improvement Card that seeks to motivate individual behaviour change and empower health improvement.

People are increasingly exposed to a multiplicity of environmental and social influences, which frequently leads them to adopt unhealthy lifestyles/ behaviours, resulting in a higher risk of NCDs and poor health.

The WHPA Health Improvement Card is a simple, universal educational tool, which will allow everyone to assess and record their lifestyle/behavioural and biometric risk factors. It also enables individuals and their health professional to take a proactive approach to prevent NCDs and associated disability.

The information obtained through using the Health Improvement Card can help the individual and health

professional develop specific interventions to address that individual's risk factors and actively improve their health and well being.

The Health Improvement Card is also viewed as an advocacy tool that might foster socially accountable health systems.

PROFESSIONAL TRAINING AND THE CRUCIALITY OF TEAM WORK FOR PERSON- AND PEOPLE- CENTERED CARE

Tesfamicael Ghebrehiwet

The world is facing a global epidemic of noncommunicable and chronic diseases. The current landscape of health care is witnessing a shortage of nurses, doctors and other health professionals. This calls for improving performance of available human resources to provide integrated and person-centred care. One solution lies in a health team approach to care delivery. However, current education of health professionals does not provide opportunity to learn together and interact more during their training.

Health professionals are challenged to find answers to some perplexing questions:

- What does team approach mean to health professionals?
- What are the benefits of team approach to patients and populations?
- Can we achieve person-centred care without a team approach?

Objectives

The session will address key issues and challenges in health team approach. More specifically the session will:

- Explore the definition, elements, characteristics and implications of team approach in health care within the context of chronic care and person-centred care.
- Make a case for team approach in today's health care system.
- Highlight characteristics of team approach.
- Outline expected outcomes and benefits.
- Discuss factors that could foster or hinder team functioning.
- Summarise the way forward

The overall goal of this session is to contribute to innovative and strategic development of team approach in health care.

BUILDING UP PERSON-CENTERED MEDICAL EDUCATION AND TRAINING

Salman Rawaf

Medicine in Europe is rapidly changing with emphasis more emphasis on the person in a holistic way than the disease a person has. We are learning that the person's perspective always has a meaningful story to learn from, plan and act on. Their health and any problem might be associated with are in the story. Our medical school curricula, our teaching methods and the interactions between students, persons and teachers are changing too. Such changes require major attitudinal adjustment and development on both the learners and the teachers in all clinical settings promotive, preventive as well as treatment and care.

Groups learning with persons and patients, shadowing, video-recording, use of simulations, digital technology and role plays, working with families, community approaches away from sophisticated hospital approaches are some of many medical learning strategies medical schools are adopting rapidly.

This paper will highly some of the modern approached to improved learning and ensure that the person and the patient is at the centre of such learning strategies. How staff are prepared and how the learners are adapting to these modern approaches. The paper will also highlight some of the practical problems and the challenges and how to address it.

Plenary Symposium on Spirituality and Health

SPIRITUALITY AND HEALTH: A PERSON-CENTERED MODEL OF CARE

Christina Puchalski

Person centered care recognizes "individuals exist within their circumstances...as well as in [their] own internal milieu."¹ This symposium examines evidence that addressing patients' and caregivers' spirituality, broadly defined as the "*aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred*" is key to the delivery of whole

person-centered care. Recognition of spiritual health as part of whole health can lead to better health outcomes, coping mechanism, and quality of life for patients and caregivers. Speakers will address the role of spirituality in person centered care in medical, religious, and cultural contexts along with consensus-derived interdisciplinary care models and recommendations for integrating spiritual care in the clinical

setting from the 2009 National Consensus Conference for Quality Spiritual Care in Palliative Care.²

¹Miles A and Mezzich JE (2011). Advancing the global communication of scholarship and research for personalized healthcare: The International Journal of Person Centered

Medicine. *The International Journal of Person Centered Medicine*, 1(1). Available at <http://ijpcm.org/index.php/IJPCM/article/view/10/3>.

²Puchalski CM, Ferrell B, et. al. (2009). Improving the quality of spiritual care as a dimension of palliative care: The report of the consensus conference. *J Palliat Med*, 12(10), 885-904.

INTEGRATING SPIRITUALITY INTO HEALTH CARE: CLINICAL APPLICATIONS

Christina Puchalski

Spirituality is a critical element of person-centered care but it is often neglected in clinical care. Spirituality is a difficult concept to understand, clinicians, often under time pressure in their clinical settings, imagine it to be non-essential and many clinicians have no training in spiritual assessment. Research has demonstrated that spirituality, in its broadest sense, can have an impact on the way people understand illness and the way they cope with suffering. Spirituality has also been shown to impact patient quality of life. Increasing, spiritual health is being regarded as part of whole health. The speaker will focus

on a consensus derived model of Interprofessional Spiritual Care, which is premised on the ethical obligation of all clinicians to attend to patients' spiritual suffering but with the Board Certified Chaplain recognized as the expert in spiritual care. The model proposes a new way to assess and integrate spirituality into a patient's treatment plan in what is called a Biopsychosocialspiritual Assessment and Plan. The goal of this body of work is to improve patient care through the recognition of spirituality as an essential element of compassionate person centered care.

HEALING THE BODY AND SPIRIT: INTEGRAL TO THE MISSION OF FAITH TRADITIONS

Robert Vitillo

Attention to the physical, emotional, and spiritual needs of the more vulnerable members of the human family is a fundamental philosophical, theological, and practical element of most major faith traditions. During this presentation, the speaker will examine common values and beliefs that underlie such religious teaching and action. He will focus more specifically on the extent and engagement of the Catholic

Church in this regard and will share the "lessons learned" from its response to people living with and affected with HIV and AIDS, as one example of an integrated approach to "healing the body and spirit". Finally, he will share the expressed desires of persons who seek such attention from those engaged in faith-based health care.

RELIGIOUS AND SECULAR COUNSELING: THE RELEVANCE OF FAITH, THE NEED FOR SCIENCE AND THE VARIETY OF VALUES

John Cox

This presentation is based on my familiarity with the results of controlled studies showing the effectiveness of counselling/attentive listening in the treatment of depression post-partum, and with the increasingly uncertain boundaries between Pastoral/Christian counselling and so-called secular Counselling.

With reference to the thinking of Taylor, Tournier and Campbell I will suggest that the appropriate use of Self, when construed as an integrated whole, is a therapeutic asset that is often overlooked.

It will be suggested that health professionals, even when working in 'secular' institutions, such as the National Health Service, should be more aware of the spiritual resources derived from Faith traditions, such as the image of the Wounded Healer, the Journeying Companion and the Good Shepherd.

My familiarity with the changing roles of psychiatrists and the unrecognized contribution of the churches to public health will underpin the presentation.

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Workshop on Conceptualization and Measurement of Person- and People-centered Care

CONCEPTUALIZING PERSON- AND PEOPLE CENTEREDNESS IN PRIMARY HEALTH CARE: A LITERATURE REVIEW

Christine Leyns, Jan De Maeseneer, Sara Willems, Pauline Boeckxstaens, Peter Decat, Lieve Daeren, Veerle Vyncke

This review elaborates further on our paper, 'from "patient" to "person" to "people": the need for integrated, people-centred health care'. Both concepts "person" and "people" are explored within primary health care as defined in the declaration of Alma-Ata (1978) and the WHR 2008. They share common values e.g. respect and features e.g. empowerment, beside some seemingly contradictory elements. It is important to emphasize the importance of and to make the distinction between the two concepts for a multitude of reasons. Among those are values like equity and social justice (Marmot 2010), the necessity to address the upstream causes of ill health (CSDH, WHO 2008), the need to integrate primary care and public health (Lancet, JDM and CVW 2008; IOM 2012), the urge for a health systems approach (PLOS, Swanson 2010)

and the importance of 'social cohesion' and the role of 'social capital' (De Clercq 2012). As a prerequisite for the systematic development of a tool to measure the progress that is made at service, local, national and international level with regard to this topic, an international consensus on this framework is mandatory. The main results of this review could inform international Delphi rounds in the coming months. These rounds are complementary to prior conceptualization, in the sense that it is tailored to the primary health care system, draws on the integration of person- and people centeredness and includes public health professionals apart from a multidisciplinary set of primary care clinicians.

CONCEPTUAL REFINEMENT AND FURTHER DEVELOPMENT OF THE PERSON-CENTERED CARE INDEX (PCI)

Juan Mezzich, Neal Adams, Janet Wallcraft, Jitendra Trivedi, Ihsan Salloum, and Levent Kirisci

In November 2010, The International Network for Person-centered Medicine and the World Health Organization agreed to collaborate on an effort to better conceptualize person- and people-centered care and to the design measures aimed at assessing progress towards such care. The specific objectives of the initial study and the methods used to approach them follow: a) Exploration through systematic literature reviews of the historical, clinical, public health and ethical bases of person- and people-centered health care systems in terms of distinctive procedures, services and policies, b) Identification and delineation of the key conceptual elements of person and people-centered health care through interactive collaborative discussions with a Core Workgroup and a modified Delphi technique with a broad Consultation Group, both composed of international experts, c) Application of the key elements in the development of a Person-centered Care Index (PCI), to assess progress in person- and people-centered health systems development d) Preliminary validation of the Person-centered Care Index in terms of its content or face validity and its applicability to health systems available to the participants.

In the most recent phase of this work,, the PCI was modestly revised to improve the wording of its items and refine its four-point scale. The current version of the Index's 33 items were organized into 8 broad categories as follows: 1) Ethical

Commitment, 2) Cultural Sensitivity, 3) Holistic scope, 4) Relational Focus, 5) Individualized Care, 6) Common Ground for Diagnosis and Care, 7) People-centered Systems of Care, and 8) Person-centered Education and Research. The four-point scale to measure the presence of key activities in person-centered care were reworded as follows: never, occasionally, frequently and always.

This paper outlines the following investigations: a) Exploration of the correlational structure of the PCI by analyzing the PCI profiles of accessible health systems completed by members of the Consultation Group, which led to the elucidation of the factorial structure and dimensionality of the PCI, b) the determination of the correlations of each of the PCI broad categories and individual items with the global average score, and the identification of promising subsets of broad categories and specific items to predict the global average score, c) Pilot assessment of the inter-rater reliability of the PCI in Lucknow, India and Santa Cruz, California, and d) Determination of the content validity of the PCI among mental health service users in London, UK. The findings from these activities are summarized in separate reports for each site's activities. It is hoped that this work will advance the reliability, validity and utility of the PCI and suggest further studies.

DEVELOPMENTAL VALIDATION OF THE PERSON CENTERED CARE INDEX

Levent Kirisci, Ihsan Salloum, Juan Mezzich

This presentation has two components. The first is to summarize of the 2011 initial validation study of the Person-centered Care Index (PCI). More specifically, a preliminary validation of the PCI in terms of its content or face validity and its applicability to available health systems is presented. The study core group included 17 experts involved in the planning and designing of the development of the PCI. They identified, on the basis of an extensive literature review a set of key domains relevant to person-and people centeredness in health systems. They drafted a Person-centered care index (PCI)

including 33 items under 8 broad categories. These categories are: (1) Ethical Commitment, (2) Cultural Sensitivity, (3) Holistic Scope, (4) Relational Focus, (5) Individualized Care, (6) Common Ground for Diagnosis and Care, (7) People-centered Systems of Care, and (8) Person-centered Education, Training, and Research. A four-point scale (never, occasionally, frequently, always) was used to mark the level of presence of each item or indicator in a given health system. The PCI also provided a global average score. The Consultation group included broader group of experts from

around the world. Twenty-four of them participated in a study of the content validity of the PCI, and then evaluated the application exercise. On average, 8 items scored between 2 (occasionally) and 3 (frequently) on the presence of each broad categories in all accessible health systems. The global average score was 2.38. With respect to evaluation of content validity, the consultation group found that the broad categories, the specific items, the 4-point scale (none, moderate, substantial, high), the global average score and the overall PCI were substantially useful (mean=3.27). Finally, the Consultation Group expressed considerable satisfaction (mean=3.22) with the PCI application exercise.

The second presents a study aimed at exploring the correlational structure of the PCI and the possibility of deriving shorter versions of the PCI. A best set of specific items and a best set of broad categories were identified using regression analyses. Results were based on the 2011 data from the application of the PCI to health systems available to the Consultation Group raters. First, a principal component analysis of the PCI was conducted. The first factor extracted

explained 69% of the total variance which revealed the unidimensionality of the PCI. Factor loadings ranged between .55 (Cultural Sensitivity) to .93 (Individualized Care). The Cronbach internal consistency was .95. Next, correlations were computed between broad categories and global average score. They ranged between .62 (Cultural Sensitivity) to .87 (Common Ground for Diagnosis and Care). The 8 broad categories were then entered into a stepwise linear regression to predict the global average score, and all 8 were retained in the model. Looking at the specific items, the one attaining the highest correlation with the global average score was "fulfillment of the person's life project" (0.88), and substantial correlations were obtained for at least one of the items from all the broad categories. Finally, six items were retained in a stepwise regression analysis to predict the global average score. Three items (1.3, 1.5, 1.6) were from Ethical Commitment, one (5.3) from Individualized Care and two (7.2, 7.7) from People-centered Systems of Care. These results reveal the strong correlational structure of the PCI and are promising for the derivation of more efficient PCI versions.

A PILOT RELIABILITY STUDY OF THE PCI IN INDIA

Jitendra Trivedi, Sujit Kar, Levent Kirisci

Background- person centered approach is a positive and proactive approach which protects the rights of the person and strengthens the support system. It focuses on appropriate clinical communication^{1,2}.

Aims & objectives- To assess the inter-rater reliability of the tool PCI and to assess the person centeredness of different health care facilities by applying Person Centered Care Index.

Study design- A two way random model approach to estimate the intra-class correlation coefficients (ICCs) between different health care facilities and different raters in relation to the person centered care in an Indian setup.

Methodology – A brief sensitizing presentation (for 30 minutes) on person centered approach was conducted for 20 post graduate residents of psychiatry, at the department of psychiatry, C.S.M.Medical University U.P., Lucknow, India. After the presentation, residents rated the person centered approach of the departments of psychiatry, neurology, general medicine and emergency services (trauma center) in dealing with the subjects who came for help in relation to their health problems at the medical university by applying the tool Person centered Care Index(PCI). The residents i.e. the raters completed their ratings independently from each other. The

facilities and raters were assumed as random effects. In addition, average measures option was used in computing ICCs where ICC was an index for the reliability of different rates averaged together.

Result - The data was analyzed to find intra class correlation coefficient (ICC) values for the PCI. All the items of the "PCI" were individually compared. However, the intra-class correlation coefficients (ICCs) in most of the comparisons suggest excellent PCI inter-rate reliability (ICC > 0.8).

Conclusion - The inter-rater reliability of the PCI appears to be quite promising, as it attained high values, but probably because of the small sample sizes the reliability figures were unstable. Further studies with larger samples would be advisable.

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INTER-RATER RELIABILITY OF THE PERSON-CENTERED CARE INDEX: A PILOT EVALUATION OF 5 COMMUNITY MENTAL HEALTH PROGRAMS IN SANTA CRUZ CALIFORNIA

Neal Adams, J Mezzich, L Kirisci, Y Jacobs, B Clark

A convenience sample of 5 unique community mental health services/programs offered by Santa Cruz County (California) Department of Mental Health were evaluated by two independent raters using the Person-centered Care Index (PCI). Programs and raters were randomly chosen from a larger set of facilities and raters. A two way random model was used to estimate intra-class correlation coefficients (ICCs) and facilities, raters were assumed as random effects and systematic differences were assumed to be irrelevant among

the raters (consistency agreement), and the average measures option was used in computing ICCs. A high degree of inter-rater reliability was observed. While there are significant limitations to this study given its small size, it is an initial exploration of the PCI reliability through a field-based application of the Index. The commitment of resources to a study which could include a larger sample and improved sampling procedures is warranted.

Workshop on Swedish Clinical Research on Person-centered Care

EFFECTS OF PERSON CENTERED CARE IN HIP FRACTURE

Lars-Eric Olsson

Objective

Two studies to evaluate the effectiveness of person centered care (PCC) in patients undergoing hip fracture surgery and total hip replacement surgery

Design

Consecutive inclusions of patients using quasi-experimental before-and-after designs.

Participants

In study one, 112 independently living participants, aged 65 years or older and admitted to hospital with a hip fracture, were included. In study two, 280 patients admitted for a total hip replacement surgery will be included.

Results In study one, the intervention group had shorter length of stay (12.2 vs. 26.3 days; $p < 0.000$), fewer medical

complications (5 vs. 14; $p = 0.003$), and 40% reduction in the average total cost ($p = 0.000$). No readmissions occurred within 30 days post-intervention in either group.

In study two, 140 patients in the control group have been included and the intervention has started. A preliminary analysis indicates that a similar result could be achieved also in this study.

Conclusion

Our research so far indicates that PCC is less expensive and yields better results. In study one; the physical function was significantly improved and achieved much faster which may be the most important result.

PATIENT REPORTED OUTCOMES – APPLICATIONS IN PERSON CENTERED CARE

Charles Taft

Nearly a third of all adults treated for hypertension have uncontrolled blood pressure (BP). Poor adherence to prescribed antihypertensive medications has been identified as one of the major contributors to uncontrolled BP. As individuals perform their own cost-benefit analyses in choosing to take medications as prescribed, a major challenge for health care is to help and support them in making informed decisions. Providing direct and personal feedback about how their medication and lifestyle behaviors affect their BP, hypertension-related symptoms and general wellbeing may help in this endeavour.

The overall aim of our research program is to design and examine if a mobile phone-based self-report system, in combination with internet feedback can improve treatment and contribute to increased adherence, and in turn alleviate

symptoms and improve wellbeing. Focus group interviews with persons with hypertension, as well as physicians, nurses and pharmacists were conducted to ascertain significant determinants of adherence. Both hypertensive persons and health providers considered regular monitoring of BP and symptoms to be of critical importance. Based on the interviews, a brief protocol was developed for mobile phone-based self-report of home-measured BP, medication intake, symptoms, lifestyle behaviors, etc. An internet graphical feedback system was designed to enable both the hypertensive persons and health providers to freely explore relationships of BP and hypertension symptoms with medication intake, lifestyle behaviors, etc. The value of this system in improving adherence is currently being evaluated in a pilot study.

IMPLEMENTATION OF PERSON CENTERED CARE

Henrik Rosén

Translating person-centered care into practical implementation is a core mission of the Gothenburg University Center for Person Centred Care (GPCC). The center integrates all facets of the 'knowledge triangle' (education, research and innovation) to drive practical change in the care system, building on evidence-based research.

The challenges to implementing person-centered care research in practice relate to the difficulties of achieving scalability, i.e. allowing successful implementation to be replicated, expanded, and transferred, as well as sustainability, i.e. building the necessary support systems, incentives for changes, and quality assurance systems. In addition, the existing innovation support systems in many countries are inequipped to provide the level of support for

care science implementation that is available for natural sciences.

Overcoming these challenges requires utilization and innovation strategies that are adapted to the clinical context of person-centered care. GPCC pursues a translational, multi-disciplinary approach to research which favors research projects close to practice. GPCC is also building capacity to identify research projects/outcomes with high utilization potential, and to integrate utilization scenarios into research. Additionally, GPCC actively pursues close stakeholder collaboration, involving public care, regional authorities, and industry partners directly in the task of bringing research to practice, whether in commercial or non-commercial forms.

ORGANIZATION OF PERSON CENTERED CARE

Erik Carlström

OBJECTIVE:

This study identifies barriers as well as driving forces when implementing person-centered care (PCC) in three different types of clinics in public hospitals.

DESIGN:

A quantitative framework based on questionnaires was used in order to test the covariation of organizational cultures and resistance to change. The design was based on the assumption that the organizational culture, i.e. the collective characteristics has impact on the implementation process.

SETTINGS:

Staff from four different hospitals in western Sweden was asked to participate in the study. In all, 353 personnel from 11 hospital wards (general medicine, orthopedics, and psychiatry) did agree to participate by answering the questionnaire. All the wards were in an initial stage of implementing PCC.

MEASUREMENTS:

The cultural characteristics of the hospital wards were measured. They were based on a dichotomy of the extremes of, on one hand, cohesion, flexibility and trust, and on the other hand, stability, control and routines. The opposite characteristics were used as variables measuring the effects on resistance to change.

RESULTS:

The results revealed a dominance of flexibility, cohesion and trust in the wards. Such a culture proved to decrease resistance to change. Opposite to this, planning, routines and control proved to increase a change resistant behavior. The results did however differ between clinics and hospital wards.

CONCLUSION:

The study points out optimal collective characteristics prior to implementing PCC and indicates different strategies during the change process. An instrument that pinpoints the conditions of a particular healthcare setting may be a useful tool in order to improve the outcome from a change project.

Oral Presentations Session on Conceptual Studies on Person-centered Care

TOWARDS PERSON-CENTERED CARE: NEUROSCIENCE PERSPECTIVE

Lukasz Konopka, Elizabeth Zimmerman

Classically, neuroscience-based approaches focus on defining relationships between biology and normal as well as abnormal behaviors. The neurobiology of human behavior is a relatively new science preceded by efforts to identify biological markers for psychiatric disorders. The search for the biological markers of psychiatric disorders failed in providing us with clear specific and sensitive measures that might have potentially defined disease states. In the past, studies were based on the assumptions that well-characterized behaviors would be directly represented by biological alterations. This premise did not result in the development of biological markers defining diagnostically identifiable psychiatric conditions. Approaching patients as individuals with objective assessments driven by brain physiology as related to behavior leads to personalized treatments; however precise, these treatments still focus primarily on symptom reduction. In order

to provide optimal opportunity for therapeutic efficacy, we must consider the whole person. This concept should involve the bio-psycho-social-spiritual approach. With this comprehensive assessment of each individual patient, this integrative approach may provide for optimal reduction of symptoms and/or enhancement of the quality of life for individual patients and their families reducing the social burden. The neuroscientific approach provides an empirically substantiated way of thinking leading to the development of new testable theories and the flexibility to adjust theoretical approaches based on accumulated data. Thus, investing in the development of open source databases may lead to novel ideas, the development of new concepts, new analytical tools, a cross-fertilization of clinical and research ideas, and a universal language leading to the improvement of human existence.

PERSONALIZING EDUCATION AND MENTAL HEALTH THROUGH NEUROSCIENCE AND NEUROESTHETICS

Patricia Scherer

Throughout the centuries the fields of education and mental health have formulated countless numbers of theories about how children learn and how emotional disorders develop in both children and adults. Although each theory offered new information which often led to new treatment forms, the proponents of these theories rarely warned their followers that individuals differ and therefore it is not possible to develop one treatment based on a current theory that will serve all of humanity. As a result the research laboratory rarely came in touch with the practitioner causing the methodology of trial and error to prevail.

As the field of neuroscience developed and its research labs began to spread the scientific based evidence concerning the plasticity of the brain, the circuitry of the brain and how it functions, and how the technology of imaging could

communicate the individual story for each child and adult, many fields became interested. Medicine, general and special education, the arts, and mental health along with many others began to explore ways to better understand the findings of neuroscience. The neuroscientist equipped with new knowledge and the practitioner seeking application of that knowledge began to reach out to each other resulting in the formation of teams producing new evidence based findings in each field.

This presentation tells the story of an organization who worked with deaf and hard of hearing children for over 30 years in theater and arts programs and how their work led them to seek neuroscience to better understand their students, The findings and work conducted by the team representing neuroscience,

neurodiagnostics, art and education is presented to model the benefits and value of neuroscientific teamwork.

ISLAMIC HERITAGE AND TRADITIONS AND PERSON-CENTERED MEDICINE

M. Abou-Saleh

Islam is a universal Abrahamic religion with roots in Christianity and Judaism. It is an affirmative all encompassing whole of life religion that embraces human diversity, unity, plurality and equality. Medicine as science and practice flourished in medieval Islam and was expressed in great heritage and humane values and traditions transmitting and enhancing the equally great Greek heritage and traditions.

Traditional Islamic perspectives on culture and mental health are deeply rooted in the humane values, traditions and the practice of Islamic physicians and healers since the dawn of Islam. There is great heritage exemplified in the establishment of the first 4 mental hospitals since 700 AD with mental health units integrated with general medical units antedating modern integrated medical hospitals by many centuries providing good, humane and holistic care. Another expression of holistic care is in the development of Prophetic Medicine which

promotes positive health and hygiene and integrates physical, mental and spiritual health. Islamic traditions in health embrace of person-centred, family-centred and community-centred care: the belonging of man and individuality not individualism.

In Islam, man is defined in relation to God and all mankind, living in His image in being gracious, compassionate and merciful.

The presentation aims to distil out from Islamic heritage and traditions, its contribution to the making of Person-centred Medicine. In the words of A-Razi (925 AD) "Truth in medicine is an unattainable goal, and the art as described in books is far beneath the knowledge of an experienced and thoughtful physician. When you can cure by regimen, avoid having recourse to medicine; and when you can effect a cure by means of a single medicine, avoid using a compound one"

PERSONALITY IN RUSSIAN PSYCHOLOGY AND PSYCHIATRY

Valery Krasnov

Psychological schools, specifically in cultural-historical concept of mental development (L. Vygotsky) and the activity theory (A. Leontyev) had a strong influence on clinical approaches in Russian psychiatry. This cooperation were quite productive in so called labor rehabilitation by psychiatrist D. Melekhov after the WW II and in the development of psychosocial work at

different clinical forms of mental pathology during last decades. It supposed to present the special experience of long-term therapeutic partnership with patients with moderate organic psychosyndrome in former rescue team workers after Chernobyl nuclear disaster in 1986.

BRINGING CHILD-CENTERED HOSPITAL CARE TO SERBIAN CHILDREN: A RIGHTS BASED APPROACH TO CHANGE PROVIDER PRACTICES

D. Nikolic, B. Schwethelm, P. Brylske

Children's hospital experiences are often traumatic and violate the UN Convention of the Rights of the Child. Based on results of a comprehensive survey of 22 pediatric hospitals, a Swiss and Serbian NGO, with the Johns Hopkins Child Life Department developed and implemented a multi-media child and family-centered care training package for health workers that has been adopted by the Ministry of Health. The approach covers child rights, child development, preparation and coping, pain assessment and cognitive pain control, play, and family-centered communication, focusing on provider attitude and practice changes.

After a 2010 multi-disciplinary trainer course for 8 hospital teams, the approach is being introduced hospital-by-hospital

targeting nurses (pre- and in-service) and hospital teachers. 100 staff and 60 last year nursing students have been trained so far in seven modules and received monitoring. Training at one of the two main pediatric centers in Belgrade begins in January 2012. Based on parent input, family information materials are being developed.

The trainings have been received with enthusiasm, since they are gradually improving quality of care and provider/parent satisfaction. This approach is still an isolated one in this region, but has great relevance to other low and middle-income countries. It is in line with the 2011 Council of Europe guidance on child-friendly healthcare.

BUILDING A PERSON-CENTERED CULTURE IN A PSYCHIATRIC PREVENTION AND RECOVERY CARE SERVICE (PARCS)

Wendy Cross

The aim and direction of recovery care services incorporated into public mental health brings with it various challenges, especially the ability to balance care within a least restrictive environment whilst fostering recovery. Prevention and Recovery Care Services

(PARCS) operate in partnership between Adult Mental Health Services and Psychiatric Disability Rehabilitation and Support Services (PDRSS). The effectiveness of the environment and

the factors seen as helpful or unhelpful in the client's recovery journey have not been previously examined.

Overall, the service is based on the common themes of recovery: social connectedness and social inclusion. This model enables the PARCS program to show sensitivity to the experience of living with a mental illness and client's narrative stories, providing a

holistic picture. Nursing interventions are designed to promote social inclusion and a sense of connection within the program

as well as within their community.

A ROLE FOR TRADITIONAL BIRTH ATTENDANTS IN PROMOTING PERSON-CENTERED CARE IN NETROKONA DISTRICT, BANGLADESH

J. Perkins, C. Capello, A. Muzahid, C. Santarelli

Within the context of a maternal and newborn health (MNH) programme, PARI, a local NGO, and Ministry of Health, supported by the Swiss NGO Enfants du Monde, are working with traditional birth attendants (TBAs) in Netrokona district, Bangladesh, to assist them in defining and exercising a new role in MNH. A recent programme review found that while women's and families' birth attendant preference is shifting toward skilled care, particularly in the form of homebirths assisted by community-based skilled birth attendants, TBAs are still highly respected and trusted as community authorities and are consulted regularly by pregnant women and families.

TBAs are enthusiastic to participate in the programme and have come to see education, referral and support of women as primary and important responsibilities. They accompany women to health facilities and feel they are well received by health personnel. However, the review revealed that health personnel are hesitant to collaborate with TBAs. In a unique position to promote women's health and given tools and resources, TBA's can provide critical social and educational support for women and families. To maximize their potential further action must be taken to ensure their integration into the health system and acceptance by health services.

A PARADIGM IN PEDIATRICS TO DELIVER FAMILY AND CHILD-CENTERED CARE

Paul Rosen

An overview of person-centered care in pediatrics is presented. The model includes: 1. *communication* 2. *access to care* 3. *flow* 4. *individualization* 5. *coordination of care* and 6. *connectedness*. Effective communication should occur between families and medical staff. Experiences with the health care system should be designed to eliminate bottlenecks and minimize waiting. The child and family should be treated with respect for diverse social and cultural backgrounds. The family should not have to expend effort to navigate a complex health care system. Connecting families to other families struggling with the same diagnosis can help break down feelings of isolation.

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Workshop on Person-centered Pain Management

WORKSHOP OVERALL PRESENTATION

Marijana Braš

The main aim of this workshop is to explore the concepts of person-centered medicine in the area of chronic pain research and management. Probably the most widely used definition of pain is derived from taxonomy and defined by the International Association for Study of Pain (IASP) as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage" (1994). Another widely used paradigm is the concept of "total pain" introduced by Dame Cecily Saunders, which describes cancer pain consisting of the physical, mental, social and spiritual components to distress and suffering in terminally ill cancer patients. This term can be extrapolated to other chronic pain states. Such definition is much broader because it introduces other aspects of pain, which could translate into the modern term "quality of life," the ultimate outcome in pain management. However, with the rise and development of

neuroscience by advances in medical technology, various behavioral, cognitive and mental patterns in chronic pain are increasingly correlated to specific brain circuits. Through several definitions and paradigms of pain, the authors will introduce the complexity of pain phenomenology in order to establish the challenge of person-centered medicine in everyday practice. By providing deeper insight into different chronic pain syndromes, its presentation, biology and treatment, several questions are addressed, ranging from person-centered diagnosis to personalizing the various processes of the chronic pain spectrum. By reviewing current treatment options and evaluating treatment pitfalls derived from methodological flaws in current research, the authors discuss various possibilities of personalizing treatment and, therefore, propose how the use of person-centered paradigm could enhance outcomes in chronic pain management.

PERSON-CENTERED INVASIVE PAIN MANAGEMENT IN PATIENTS WITH CANCER

Rudolf Likar

Indications for subcutaneous continuous opioid administration are clear when oral transdermal administration is not possible due to therapy-resistant side effects or insufficient effects. One of the main reasons is often the occurrence of breakthrough pain. Using a pump system is recommended. The pump system can be filled with up to 4% morphine. When the need for morphine is more than 200mg per day, it is recommended to add S-Ketamin dosages of up to 50-100 mg per day to the mixture.

It is of utmost importance that continuous the patients and their families are trained in the use of the pump. The patient gets a continual rate of morphine per hour through the pump, but can press an additional bolus – usually every 15 minutes, whereby the amount of the bolus averages 50-100% of the hourly dosage.

Further care of the patient should be in the hands of the family physician together with a home care service.

Morphine can also be administered subcutaneously. In this case a local histamine release resulting in the formation of papules or tubercles can occur. These papules or tubercles can develop secondary infections. Thus it is advisable to implant a Port-a-Cath and to administer the morphine through this. The patient should be regularly examined for effects and side-effects.

Indications for epidural or intrathecal administration close to the spinal cord are clear when systemic analgesia remains ineffective due to therapy-resistant side-effects. Epidural administration is indicated when local anaesthesia can be applied. Local anaesthesia is necessary when several intercostal nerves are infiltrated by a mesothelioma resulting in severe pain. (1)

The intrathecal administration of opioids is used for therapy-resistant pain that occurs in several places. The advantage here is that with intrathecal administration, for example, of morphine only a hundredth of the dosage is necessary. With intrathecal administration one must often combine several medications like morphine + clonidine + bupivacaine. With massive neuropathic pain we also today have Ziconotide as a new substance at our disposal. Ziconotide works through the N-type of the calcium channel.

Before a pain pump is implanted it is recommended to conduct an intrathecal test using an intrathecal catheter with port. Once the testing phase is positive, then a pain pump can be implanted under the skin.

Neurolysis

The prerequisites for neurolysis are given when a causal therapy is no longer possible or when medication therapy is not sufficient. It also has to concern only locally restricted pain.

Before a neurolytic block is performed, a prognostic block should be performed under local anaesthesia to see whether the patient can even benefit from it.

Appropriate Structures are:

- sensitive nerves
- intercostal nerves
- posterior roots – spinal nerves
- celiac plexus
- lumbar plexus

Indicators for a celiac plexus blockade are tumor pain due to upper abdominal carcinomas, for example, pancreas or colon carcinomas.

A metaanalysis by Eisenberg *et al.* showed that patients who underwent a neurolysis of the celiac plexus had a 70% reduction in pain for over 3 months or until death. Side-effects that could occur are local pain, diarrhea, hypotension. Also difficult complications could occur, for example, injuries to the organs, pneumothorax. (2 / 3)

In performing a celiac plexus block, a prognostic block with local anaesthesia is first performed. When this procedure shows successful results a therapeutic block with a 95% alcohol solution is attached.

It is recommended to perform a celiac block in the early stages as the patient then needs fewer opioids and so fewer side effects occur with medication therapy, which then leads to an increase in the quality of life.

A further possibility is an intrathecal neurolysis. Indications are neuropathic, therapy-resistant pain (for example, perianal pain due to an infiltration of the os sacrum caused by a rectal carcinoma). Also in this case, before doing an intrathecal neurolysis, a prognostic block with a hyperbaric local anaesthesia should also be performed then followed by an intrathecal neurolysis with a 6% phenol solution.

Advantages of neurolysis:

- strong effect in instable pain
- it is also effective with neuropathic pain
- it is independent of drugs

Disadvantages of neurolysis:

- no differential blockade
- no lasting effect
- side effect like neuralgia could occur
- side effects like nerve damage, paresis and bladder dysfunction could occur

With invasive procedures it is important that the wishes of the patient are taken into consideration. An increase in the quality of life and the autonomy of the patients should always be in the foreground. With an increase in the quality of life the possibility of social integration also increases.

Even an optimal pain therapy does not always lead to pain-free situations. The treatment of tumor pain is an interdisciplinary task. When new pain appears, it has to be clarified primarily whether there is a causal treatment of the pain, as for example, a surgical removal of metastases, radiation treatment or a hormonal/chemotherapeutic treatment is possible. With strong pain, however, a sufficient medication pain therapy, or if necessary an invasive pain therapy should be initiated parallel to a diagnostic investigation. (4 / 5)

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THE ROLE OF CULTURE AND SPIRIT IN PAIN MANAGEMENT

Alexey Danilov

Pain is bio-psycho-social phenomenon and pain management depends on understanding of pain mechanisms and existing attitudes to pain in certain cultural environment. In many societies in old days and in some cultures nowadays pain is considered not only as harm, punishment for sins but also as a resource to strengthen the spirit. In modern western world chronic pain is unambiguously estimated as harm and many efforts are directed to combat pain. Unfortunately, despite these efforts the chronic pain is becoming one of the most widespread medical and social problem.

According to bio-psycho-social model pain consists of sensory unpleasant sensation and negative emotional tone (suffering). In our clinical practice we notice and in recent studies it is confirmed that final perception of pain can be dramatically

modulated (facilitated or reduced) in people with the same pain syndrome (similar tissue damage) depending of previous experience, expectations, beliefs and cultural attitudes to pain and pain management.

One of the effective ways to reduce the social impact of pain may be the attempt to shift the cultural attitudes in society regarding pain and strengthen the spirit not only in persons who are already in trouble (pain) but in the whole population in order to reduce pain suffering.

The arsenal of effective coping strategies, physical exercises, spiritual techniques and lifestyle changes that may strengthen the spirit and reduce suffering from pain be presented at the workshop.

PERSON-CENTERED PAIN REHABILITATION

Roberto Casale

In 2004, a European survey conducted in the area of Pain Medicine dramatically demonstrated several alarming data: The first data evidenced the enormous percentage of European citizens (27%) who suffer or have suffered from chronic pain and how this constitutes a social burden. The second data which emerged from the survey showed that 32% of the respondents had used various forms of rehabilitation and physical therapy against their pain (Brievik et al 2006). The third data showed a complete lack of any person oriented pain management. Indeed chronic pain is one of the most common complaints seen in general practitioners' offices as

well as in a rehabilitation setting. As it is now the management of pain and related disability poses challenges for health care providers when the current treatment of choice for chronic pain is pharmacological management and when no appropriate rehabilitation strategies are matched.

After considering these numbers, several questions should be posed on the awareness of the problem of chronic pain as a disease in its own right, if there are designated diagnostic and therapeutic guidelines, as well as if there is any person centered activate control and management strategies to control pain and the related disability.

Workshop on Shared Care Plan and Person-centered Integrative Diagnosis

SHARED CARE PLAN AND PERSON-CENTERED INTEGRATIVE DIAGNOSIS

Neal Adams, Diane Grieder

Chronic medical conditions are often complicated by comorbid psychiatric disorders. Person-centered approaches to care should be based on an integrative holistic diagnosis that is focused on the inter-relationship of somatic and mental health for the individual. While there is good appreciation of the idea that there is no health without mental health, the converse is equally true. As there is increasing international focus on integrating mental health into primary care, there is a growing need for practical strategies to help providers develop strengths-based treatment plans that address an

understanding of each individual's physical and mental health needs.

There is much interest in the idea of a Shared Care Plan, but

limited experience in translating a person-centered integrative diagnosis into a holistic treatment plan. This workshop will focus on the structure of a treatment plan with particular attention to the development of whole-health objectives and the integration of medical, psychological and social interventions to promote wellness outcomes.

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Oral Presentations Session on Experimental Studies on Person-centered Care

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

Christine Low, M Rubes, R Annunziato, E Shemesh, D Rode, J Mezzich, J Forman

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

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

Results: Mean scores on the Attitudes measure significantly improved after the session from 22.71 to 25.84. Similarly,

Knowledge scores also significantly improved from a mean of 1.86 to 3.14. 100% adherence to the protocol did require minor redirection from senior faculty. Descriptive statistics from the resident assessment of acceptability and usefulness were high and are further evidence of the success of the pilot project. Participant feedback resulted in the addition and refinement of discussion topics to the manualized training.

Discussion: The study results are very encouraging, as it seems that the use of parents to teach residents leads to greater acceptance of the centrality of the patient and family in providing care.

EFFECTS OF AN EARLY CLINICAL EXPERIENCE PROGRAM IN MEDICAL SCHOOL

Fernando Caballero, C Garcia de Leonardo, D. Monge, R. Ruiz, J. Pérez, I. Salinas, JM Blanco, J. Gutiérrez, F. León

Introduction: In traditional medical schools, patients' exposure to students is deferred to the last courses of the curriculum path. Moreover, this contact is made through specialized clinical services that provide the students with a fragmented view of the medicine. Under these conditions it is difficult for future doctors to get a style of person-centered practice, combining both the scientific and humanistic aspects of the profession (relational and communication skills, professional attitudes, ethical criteria ...).

There are international experiences that confirm the benefits of early contact of the medical student with clinical practice, particularly if this contact is early in the first year of College, when students do not already have medical knowledge that conditions their observation. At that time it's even easy to adopt the patient's point of view and share their experience as a user of the system.

For many patients, the main shortage of modern medicine is not related to scientific-technical problems but correctable deficiencies in the relationship with health professionals or the organization of health services. It is these issues which can be identified and be reflected in early clinical placements.

Goals: The University Francisco de Vitoria (Spain, Madrid) launched in the 2010-2011 academic year an Early Clinical Experience Program (ECE) for their first year students in health services. The goals of this experiment were to raise awareness of the relational and communicative needs of clinical practice, to provide a more direct knowledge about the organization of all areas of health system care, and to expose students to clinical situations of personal-emotional content.

Additional aim has been to help the student for identifying strengths and weaknesses in the health system that should respectively be reinforced or corrected.

Methods: *Subjects:* 50 students of first year of College. *Time lasting:* 80 hours (A clerkship: four days in hospitals, four for primary care centers and one outpatient emergency session (mobile ICU). *Program Dates:* March-May 2011. *Materials:* observation and guide book for reflection. Evaluation method: each student prepared a written report with the results of their individual and group reflection on the experience. The findings will be later defended at a public-academic session.

Results: After completing the clerkships, group discussions were organized among the students to expand their individual experiences. They were invited to express reflection on strengths and weaknesses of the health system in Madrid on six topics: doctor-patient relationship, doctor-patient communication, patients and family involvement in clinical decision making, interprofessional relationship, organization of health care in the institutions visited, and the care work pre-hospital emergency services. Each student completed the program by submitting an individual report containing a reflection on their personal experience as well as a program for improvement. This was submitted to the health services' managers. Students' satisfaction degree was evaluated according to ECE program, reaching a median overall score of 5.1 (on a 1 to 6 scale). They considered this experience as a key complement to their health professional training (mean 5.8 pts. on 6).

RISK ASSESSMENT FOR TYPE 2 DIABETES IN UK GENERAL PRACTICES: IMPLICATIONS FOR PRACTITIONERS AND PATIENTS

Maxine Johnson

Background: Targeted risk assessment for individuals at high risk of developing type 2 diabetes has been explored in a number of studies. We carried out a review of qualitative studies to identify barriers and facilitators in the implementation and take up of risk assessment strategies in UK based general practice.

Methods: We searched medical and social science databases from 1990-2011. From an initial 1414 titles and abstracts we identified seven papers that met the inclusion criteria. All included papers used interview or focus group methods with patients and / or health care professionals.

Findings: Synthesised data suggest that patients regard the risk assessment process as positive, and have low

expectations of receiving a diagnosis of type 2 diabetes. Low anxiety levels may be due to low expectations; these rose slightly with each progressive test in the assessment strategy. There were mixed opinions from practitioners about the appropriateness of the primary care setting for carrying out risk assessment, with potential health benefits weighed against increasing workload. Practitioner knowledge about pre-diabetes was shown to be lacking.

Conclusions: Guidelines and toolkits designed to help professionals increase their own understanding of pre-diabetes and the needs of their patients may prove beneficial to both groups.

A SYSTEMATIC REVIEW OF BARRIERS AND FACILITATORS IN LIFE STYLE MODIFICATIONS FOR THE PREVENTION OF TYPE 2 DIABETES IN AT RISK POPULATIONS

Josie Messina, M. Johnson, H.B. Woods, N. Payne, E. Goyder

Objective: To determine the potential barriers and facilitators of carrying out lifestyle change for the prevention of type 2 diabetes in at risk patients.

Methods: This project originates from work produced as Public Health Guidance for the National Institute for Health and Clinical Excellence (NICE) in the UK. Searches identified 5725 papers which were screened for inclusion, resulting in seven included papers. These papers were quality assessed, and thematically analysed.

Findings: The seven studies included in this review were from developed nations, and all focussed on lifestyle modifications in the target population of at risk patients. Barriers to lifestyle change reflected both personal factors (health, habits, lifestyle,

beliefs, costs) and wider contextual factors (health systems, information, environmental). Facilitators for lifestyle change were also determined by a set of personal factors (beliefs, support, personal control), and these factors were set within a wider context of the physical environment and health systems in which people are interacting.

Conclusion: The barriers and facilitators identified in this review would be of use to health practitioners and educators so that they can understand the various factors that can enhance or hinder a patient's success in behaviour change. The quantity of papers in this field was limited, and a call for more qualitative studies focusing on lifestyle modifications for diabetes prevention is required.

A COMPARISON OF PAIN SCORES WITH AND WITHOUT ANESTHESIA FOR NEONATAL CIRCUMCISION USING PLASTIBELL TECHNIQUE

Aminu Fikin

OBJECTIVES: To determine whether or not local anaesthesia was required for neonatal circumcision.

DESIGN: Randomized sample design.

SETTINGS: Secondary and Tertiary healthcare State institution.

PATIENTS: 72 Neonates for circumcision with or without local Anaesthesia.

INTERVENTION: Local Anaesthesia.

OUTCOME MEASURES: Patient centred outcomes, comparison of mean pain scores with or without local anaesthesia.

RESULTS: Overall, neonatal circumcision was successful, the mean neonatal pain scores were lower in those that received local anaesthesia and higher in those that did not receive local anaesthesia. Therefore, local anaesthesia usage during

circumcision is associated with low neonatal pains scores compared to those who had no local anaesthesia.

CONCLUSION: The resultant highlights importance of assessing the parent's view of successful outcome of the circumcision. The neonates that had local anaesthesia cried a little or no cry compare to those that had no anaesthesia. The comparison indicated that those without local anaesthesia had higher mean pain scores, heart rate, lower oxygen saturation and, increased mean respiratory rate than those that had local anaesthesia. Recognizing parents pain reduction criteria and expectation for neonatal circumcision encourages discussion and development of individual parent circumcision goals, and wider implementation of individualized parent's circumcision plan is encouraged.

ORGANIZATIONAL CULTURE AND THE IMPLEMENTATION OF PERSON-CENTERED CARE: RESULTS FROM A CHANGE PROCESS IN SWEDISH HOSPITAL CARE

Tarik Saleem Alharbi, Inger Ekman, Lars-Eric Olsson, Kerstin Dudas, Eric Carlström

Sweden has one of the oldest, most coherent and stable healthcare systems in the world. The culture in this healthcare system has been described as conservative and backward looking. The influence of organizational culture on patient experience was tested during a change process reflecting the change to person centered care in a Swedish hospital. The purpose of the study was to explore the link between different organizational cultures and the employees' change behavior. Data from 220 hospitalized patients who completed the Uncertainty Cardiovascular Population Scale (UCPS) and 117 nurses who completed the Organizational Values

Questionnaire (OVQ) were investigated with regression analysis.

The results revealed that in hospitals where the culture promotes stability, control and goal setting, patient uncertainty is reduced. In contrast to previous studies suggesting that a culture of flexibility, cohesion and trust is positive, a culture of stability can better

sustain a desired outcome of reform or implementation of new care models such as person centered care. It is essential for health managers to be aware of what characterizes their organizational culture before attempting to implement any sort of new healthcare model.

THE POTENTIAL OF PERSON CENTRED MEDICINE IN DEMENTIA

Sophia Michaelidou and Nikos Christodoulou

Behavioral disturbances are a common manifestation in patients with dementia, causing a broad variety of problems for the patient, as well as their carers. There is significant evidence that, apart from administration of psychotropic agents, broad-based psychotherapeutic and psychosocial interventions are effective in addressing this complex

challenge. This constitutes a field on which the person centered approach can have an important clinical impact. This presentation focuses on analyzing and evaluating the implementation of PCM principles in treating patients with dementia.

THE PATIENT WITH MULTIPLE CHRONIC CONDITIONS: ALTERING MEDICATION PRESCRIPTIONS

Allison Williams

Introduction: Taking medications as prescribed is a principal component of the management of chronic conditions. People make decisions regarding whether to take their medications based on their beliefs about the treatment and their illnesses. The aim of this paper is to explore why people with multiple chronic conditions alter their medication prescriptions.

Method: A qualitative analysis was conducted on a series of motivational interviewing telephone calls with 67 patients with co-existing diabetes, chronic kidney disease and hypertension, 47 of whose first language was not English. Patients aged ≥ 18 years of age were recruited from nephrology and diabetes outpatients' clinics of two Australian metropolitan hospitals in 2009.

Results: Thematic analysis of why people altered their medication prescriptions revealed five major themes: medication side effects, health literacy issues, the perceived importance of the medication, ability to manage medications independently, and experimentation.

Conclusion: People who manage complex chronic conditions require ongoing interdisciplinary support to manage their medications for optimal health outcomes. A greater understanding of adherence to prescribed medications is critical due to the increasing quantity of medications prescribed. Person-centred approaches require a revisioning on how ill-health is currently managed, and consideration of quality of life in pharmacological treatments of chronic illnesses.

RELIABILITY AND VALIDITY OF AMBROSIANA'S PERSON CENTERED MEDICINE CLINICAL METHOD

Giuseppe Brera

Reliability and validity of Person Centered Medicine Clinical Method for a Person and People Centered Care: a survey on 144 clinical reports of physicians prepared to apply Person Centered Clinical Method to adolescents from the Academic Year 1997 to 2002 at the Milan School of Medicine of the University Ambrosiana.

Person Centered Medicine is the new paradigm of Medical Science, based on the interactionism subjectivity-biology-environment well corroborated by basic science, interpreted and elaborated in a teleological way by the person. PCM theory is born through the Person Centered Clinical Method (PCCM) teaching new objectives and necessary skills in clinical practice from 1997-1998 AY at the University Ambrosiana Milan School of Medicine introducing acceptance, empathy, resilience and vulnerability, person's diagnosis, clinical finalization, portrait.

To our knowledge, medicine and medical science didn't ever submit to an investigation the clinical method reliability and validity. Reliability means reproducibility of its application in N clinical contexts; its validity means its clinical effectiveness in practice. The investigation introduces in Research and in Medical Education two indexes: the Clinical Method Reliability Index (CMRI) and the Clinical Method Validity Index. (CMVI). CMRI and CMVI of the Person Centered Clinical Method were assessed from 144 clinical written reports by 72 trained Physicians at the third year in Clinical Adolescentology assessed through the application of the Person Centered Clinical Method Assessment Protocol (PCCMAP). The Person Centered Clinical Method CMRI resulted to be = 0,81 and CMVI 0,80. These results confirm the high Reliability and Validity of PCCM.

Workshop on Person-centered Health Systems

PERSON-CENTERED REPRODUCTIVE HEALTH

Alfredo Fort

The paper will use components embedded in the 1994 definition of reproductive health: information and services for family planning, maternal and perinatal health, prevention of unsafe abortion, control of sexually transmitted infections (including HIV), and sexual health, including respect for rights and prevention of harmful practices and intimate partner violence.

It argues that a person-centered approach is of utmost need to attain reproductive health because a) most decisions related to reproductive health are crucial, and extremely sensitive and of private nature (e.g., family planning or abortion); b) pregnancy places the woman in a physically and emotionally vulnerable status; and c) several conditions associated with reproduction can be avoided if a humanistic approach had been utilized.

The paper will present examples of violations to dignity, equality, privacy and life. A pharmacist refusal to provide

contraception to a sexually active adolescent or life-saving interventions for post-abortion care, violence and abuse during delivery, unduly procedures for raped adolescents are illustrations of dehumanized care. There are other frequent occurrences often overlooked, such as providers conducting invasive procedures without full disclosure of alternative therapies, convincing a woman to a medically unjustified operative or inductive procedure, excessive examinations or applications of sensors to patients to defuse litigation, and providers and parents providing insufficient information to adolescents. Adoption of a person-centered approach will often preclude the need for sophisticated checklists and contribute greatly to improving quality of care and patient satisfaction.

PERSON-CENTERED APPROACH TO HUMAN RESOURCES MANAGEMENT IN HEALTH CARE: A CONTRIBUTION TO EARLY ASSESSMENT AND PREVENTION OF BURNOUT

D. Stoyanov, D. Dimitrova, R. Raycheva

Healthcare professions have long been considered prone to work-related stress, yet recent research in Bulgaria indicates alarmingly high levels of burnout. The ongoing effects of the global economics crisis along with the ineffective system reforms jeopardize the fulfilment of public healthcare mission and contribute to redefining the concept of managerial social responsibility in healthcare thus implying the necessity for adoption of a novel approach in human resources management to sustain organization effectiveness.

Aim: The paper presents pilot results of elaborating a model for early diagnostics of burnout syndrome studying the correlation between personality characteristics, psychological climate and degree of syndrome manifestation in the studied groups (professionals in oncology, psychiatry, intensive care, general practice, emergency care and palliative care) ultimately enabling policies for effective risk assessment of burnout syndrome and its modality and early diagnostics and prevention.

Methods: psychobiological profiling of personality and psychosocial well-being with Cloninger's tests (TCI; permission courtesy of C.R. Cloninger, 2010); control setting values of burnout syndrome established by a standardized test of Maslach and evaluation of organizational and psychological climate are compared against analyses of administrative records to test for correlation between burnout syndrome as a causal factor and administrative indicators (sickness absence, staff turnover, etc.)

Results: The pilot results on causal relationship of personality and administrative indicators in 80 healthcare professionals confirm the effectiveness of the evaluation model adopted and bring forward the challenge of the development of adequate preventive strategies based on the vulnerability profiles and their extension to the system of professional education, recruitment and subsequent debriefing; individual psychotherapy; training in leadership techniques and communication skills on the work place.

EDUCATIONAL FACTORS IN HEALTH SYSTEMS

James Appleyard

A Health system consists of all organisations, people and actions whose primary intent is to promote restore or maintain Health. It is more than a pyramidal construct of publicly funded facilities that deliver public and personal services.

The three fundamental colas of a Health System are to improve health, respond to the expectations of the population and to assure fairness. Responsiveness involves respect for persons and putting their needs at the centre of the system eg appropriate access to care, support and choice. Fairness means that everyone has some protection from the financial risks due to health care.

A health system cannot be reduced to its 'supply side' component services such as financing, human resources, technology, hospitals and clinics. Most important are their

human interactions and the per they serve in the local population. 'People' play five complementary parts – as patients with specific needs requiring care, as consumers with expectations of how they will be treated, as the source of funding either through their taxes, insurance or direct and co payments, as citizens with their 'rights' and as co producers of health through lifestyle changes, good or harmful behaviours (including the effect of secondary cigarette smoking), care seeking and therapeutic compliance.

Education plays a key role in a health system as a whole in the Institutions themselves, the workforce and the health professions.

Physicians are an integral part of a health system be they employed by third parties or independent practitioners. They

increasingly work in association with multidisciplinary teams. As a profession, physicians are responsible for their shared knowledge, skills and ethical behavior. Their fund of knowledge requires constant review and research and for standards to be set for all the stages of medical education. The takeover by a Government of their professional regulation significantly changes the emphasis from the individual person to a self sustaining hierarchical State system.

For instance during Soviet times with State' controlled education there was poor research, very few advances and depersonalised care.

There is however an important positive interdependency between a health system and medical education as the World Federation for Medical Education has illustrated in their approach to the three main phases of medical education. Learning opportunities are embedded in a Health system's facilities. An operational linkage needs a clear definition and description of the elements and their interrelationship in the various stages of training and practice and should pay attention to local, national and global contexts.

The diversity of medical schools needs to be fostered within agreed international standards Prof. John Morris, a leading medical educator at Oxford for 30 years of his expectation for physicians – an ability to interact effectively and ethically with

patients and other professionals think from basic principles and solve problems develop competence in an increasingly broad area of medicine develop from this specialist skills in their chosen area of work continue self directed learning and adaptation.

Setting standards is a matter for each University and their accreditation needs to be given by a process of peer review rather than a Government.

The International Association of Medical Colleges aims to provide just that in a global context.

Maintaining the independent professional responsibility in medical education ensures that the ethical focus will remain on the individual within a wider community.

Core References

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Workshop on Internet and Person-centered Medicine

INTERNET AND PERSON-CENTERED MEDICINE

Francesco Bollorino

The author will expose the evolution of the web magazine POL.it Psychiatry on line Italia from a traditional structure to the new one based on the development of a social context and social network among its professional readers. An example of evolution based on the changes of web fruition and adapt to

be used also by other web scientific magazine on the net. The future of scientific professional communication is on the web and the editor must evolve in the evaluation of the way they offer contents.

Session on Region and Country Experiences on Person- and People- centered Care

MEASUREMENT OF RESPONSIVENESS AS PART OF PERSON-CENTERED CARE OF THE THAI HEALTH CARE SYSTEM

Yongyuth Pongsupap, Aungsumalee Pholpark, Wichai Aekplakorn, Samrit Srithamrongsawat

Background: Responsiveness is a concept, has been developed by the World Health Organization since the year of 2000. It is considered as part of people-centred as well as person-centred care because it is divided into two categories leads to eight diverse domains: dignity, autonomy, confidentiality and communication categorized jointly as respect for persons and access to prompt attention, basic amenities, opportunities for choice, and family and community involvement jointly termed client orientation.

Objectives: To develop a measurement method by using a set of questionnaires and a set of vignettes of different domains of responsiveness; and to compare level of responsiveness of the 3 schemes in the Thai health care system: universal coverage, social security and civil service medical benefit schemes.

Method: Analysis of 6507 interviews with patients during an exit survey (UC: n=2446; SSS: n=2253; CSMBS: n=1808): the

method involved the use of vignettes. The respondent was asked to report on the level of dignity for example, with which the person in the vignette as being treated and using the same scale that was used in the questionnaires.

Results: Level of responsiveness was not different in the different schemes. However, it was found that settings (district hospital, general/regional hospital, and university hospital), age, level of education, and level of income affected levels of responsiveness in different domains.

Conclusions: The use of a set of questionnaires and a set of vignettes was feasible to measure what happened when a system and the persons it served interact. It moved away from finding out whether a person is satisfied with their care toward more reporting of the experience of the person with the health system against objective set standards that could be used to adjust all respondents' responses onto a common response scale.

PROMOTING PERSON-CENTERED CARE FOR DIABETES AND DEPRESSION IN AFRICA

Helen Millar (Dundee, Scotland), S. Bahendeka, T. Ghebrehiwet, R. Holt, A. Jalang'o, A. Joubert, B Majikela-Diagamandla, H. McGuire, A. van derMerwe, S. Rataemane, N. Sartorius, I. Westmore.

The Diabetes and Depression Dialogue (DDD) is an international collaborative initiative involving a number of non-governmental organisations including the World Federation for Mental Health (WFMH). The participation in this programme demonstrates the longstanding commitment of the WFMH to promote a more holistic approach to patient care and wellbeing in areas of low/middle income and high disease burden.

The DDD in collaboration with the International Council of Nurses (ICN) African Nurse Training Programme embarked on the African Nurse Training Programme, a project to improve capacity and capability of nurses to deal with comorbid diabetes and depression.. The aim was to improve the recognition and management of these co-morbid conditions in Sub saharan African countries by providing training to teachers of nurses in order to introduce a long term

educational programme concerning the management of comorbidity in their countries.

The programme was rolled out in 5 African countries namely South Africa, Lesotho, Botswana, Swaziland and Uganda with a total of 146 participants trained in a total of 5 workshops. Preliminary evaluation has proved that the programme was well received with formal outcomes measure in terms of exchange of knowledge, values and skills.

Whilst there are focused programmes in developed health care systems to manage these conditions effectively, within African countries barriers still remain hindering access to effective treatments. This educational programme demonstrates by promoting a more holistic person centered approach both the recognition and management of diabetes and depression can be improved leading to better outcomes for this population within countries with a high burden of disease and limited health care resources.

AFRICAN CONTRIBUTIONS TO DECISION MAKING IN PERSON-CENTRED HEALTH PRACTICE

Werdie Van Staden

Drawing on indigenous knowledge elevated through the "people first" skills development project for health professionals in South Africa, I outline in this paper how African ways of conducting a meeting afford person-centred substance to decision making in health practice.

A meeting between a health service provider and a service user may be considered as being the means to an end - the end being the decision made "ultimately" by the service user. Similar to institutional meetings, they may be conducted through the making of proposals, followed by (an exposition of) debates on pre-set options or proposals, defending of potential stances, leading to the adoption or rejection of a proposal by vote or by consensus. This process is principally driven by an anticipation of an outcome. When the health provider and service user approach their meeting in this way, some person-centredness may be attained provided there is sufficient participation. However, more substantive person-centredness may be attained in approaching the meeting between them not merely as an executive event, as merely a means to an end, but as a substantive event that is an end in itself.

An African way of approaching a meeting substantively, that is, as an end in itself, is expressed in the isiZulu term "indaba"

or the isiZwazi term "Indzaba". The worth of an indaba does not depend on whether a decision is or is not made. The process is not principally driven by the anticipation of an outcome. It proceeds without proposals necessarily being put forward, and may proceed even without potential decisions or outcomes in mind. Rather, it is a discursive opportunity for all participants to raise one's uncertainties, doubts, fears, issues, and points of view – and expectantly both those shared (communal) and those that are uniquely yours (individual). One may even invest in the meeting through testing your thinking and change your mind unapologetically. The meeting as an end in itself creates a jointly constructed story that accounts for the contents that arose in that specific time and spatial context, including content derived by both consensus and disagreement. Should a decision be part of the newly indaba-generated story, that decision is substantively shared, since the story is owned by the participants. The decision is thereby not "ultimately" or solely the service user's, yet it is person-centred by deriving substance in a process that entails understanding and support, accounting for much more than merely the user's choice in the end (that is, the outcome).

Workshop on Dance Therapy in Person-centered Medicine

Workshop on Dance Therapy in Person Centered Medicine

Sigrid Steffen and Janet Wallcraft

Dance therapy relies on the belief that state of mind can affect overall health.

Dance means fun, exuberance, improvisation and concentration. Dance gives more impact to our lives and we can experience its wealth and depth.

Numerous studies give witness to the comprehensive and positive effects of dancing; among other things it strengthens health and well-being and promotes a better self-perception

and perception of others, improves body control and deportment, powers of concentration and memory. Topics such as posture, group behavior, social forms or grooming are included in dance therapy.

From the two presenters we will get to know the concept and the theoretical principles of Integrative Dance Therapy, linked to theoretical and practical aspects of the work. Neurobiological findings can be transferred to Psychotherapy.

Working with feelings is particularly important; mentally ill people frequently cannot express feelings. The effectiveness of the Integrative Therapy will be illustrated by examples of

working with feelings using the interventions, methods and working procedures of Integrative Dance Therapy.

INTEGRATIVE DANCE/MOVEMENT PSYCHOTHERAPY AND PERSON-CENTERED HEALTH

Elena Gayvoronskaya

Integrative psychotherapeutic approaches to health promotion are closely linked to the principles of person-centered medicine. Such psychotherapeutic approaches are directly aimed at connecting psyche and soma through a fluid therapeutic process exemplified by Dance/Movement Psychotherapy.

One of the important aspects of person-centered health is the fulfillment of the person's life project. The concept of the fulfillment of a life project as central to the person's health has been highlighted only recently in the scientific literature (Mezzich et al, 2011). Research in this area is starting in the form of conceptual clarification.

In due course, construction of a workable outline for the assessment of a person's life project may prove helpful for the development of dynamic and contextualized diagnostics as well as for monitoring the correction of maladaptive and pathological behavioral patterns. The application of Integrative Dance/Movement Psychotherapy towards the stimulation and facilitation of the person's life project may increase quality of life and enhance the individualization and effectiveness of clinical care.

Reference

Mezzich JE, Snaedal J, van Weel C, Botbol M, Salloum IM: Introduction to Person-centered Medicine: From Concepts to Practice. *Journal of Evaluation in Clinical Practice* 17: 330-332, 2011.

EXPRESSIVE-PSYCHOANALYTIC DANCE THERAPY

Maria Ammon, Margit Schmolke

In this experimentally oriented workshop a short oral presentation will be incorporated at the beginning.

The analytic dance provides the possibility – beyond verbal communication – for the growth of identity, a free flow of the interplay of body experience, feeling and thinking. The dancer establishes contact both with himself and with the group. Thus he gets the possibility to change and to develop himself.

Fundamental aspects of psychoanalytic dance are: the individual spontaneous dance in the centre of the surrounding

group, the communication through body and movement of the dancer, dress chosen by the dancer himself, dance with or without music or with drums, the meditation in the group at the beginning and at the end of a dance therapy session and the feedback of the group.

In the workshop there will be the possibility to experience the different aspects of the analytic dance therapy practically.

The participants should bring along their own music!

Special Session on Stakeholders' Policies and Contributions for Person- and People- centered Care

THE AGENDA FOR SOCIAL WORK AND SOCIAL DEVELOPMENT

Rory Truell

At the heart of social work experience is the understanding that the state of people's health is linked to the state of their environment; equitable access to resources; capacity to participate in society; their connection to sustainable social networks, and their ability to have influence over their own wellbeing. Social Workers throughout the world advocate for these social conditions as a basic human right to health and wellbeing.

In March 2012 the International Federation of Social Workers, along with other international bodies launched, 'The Global Agenda for Social Work and Social Development', (The Agenda) at various United Nations sites. The Agenda was formally received by Helen Clark on behalf of the whole United

Nations and Assane Diop on behalf of the International Labour Organization. The Agenda platform binds the international profession of social work together to work alongside others, to take practical action in promoting the social determinants of health at country, regional and international levels.

In this presentation The Agenda will be discussed, along with the IFSW statement on the need for the strategic alignment of health and social policies to form a holistic framework for sustainable wellbeing. Participants will be invited to form links with social work organizations to take a further step in making the vision of: 'Social health - as a basic human right', a reality.

EUFAMI'S PERSPECTIVE ON PERSON-CENTERED MEDICINE AND PEOPLE-CENTERED PUBLIC HEALTH
FOR CHRONIC DISEASES

Alessandro Svetini

Especially when dealing with chronic diseases (like schizophrenia for instance), it's not possible to talk about person-centered medicine and people-centered public health and wellbeing without considering the roles and needs of people who closely live around the patient: his/her family and carers.

They are very often the ones to meet the chronically ill person primary needs and represent the primary source of companionship, involvement in activities and assistance in coping with day-to-day problems, ensuring continuity of support and advocacy for the ill person.

But family members have several needs too, often overlooked and neglected: they need to be informed and educated on the

nature of the illness and its therapeutic possibilities, trained in order to develop skills to cope with symptoms and disabilities, supported in their caring role and given respite opportunities, involved and empowered in shared information and decision-making together with patient and professionals.

Families must have the opportunity to state their needs and define the role they are willing and able to play.

Relatives gain much experience and expertise, which should be acknowledged and valued integrating them in the patient's treatment plan as well as in person-centered education and training of medical staff.