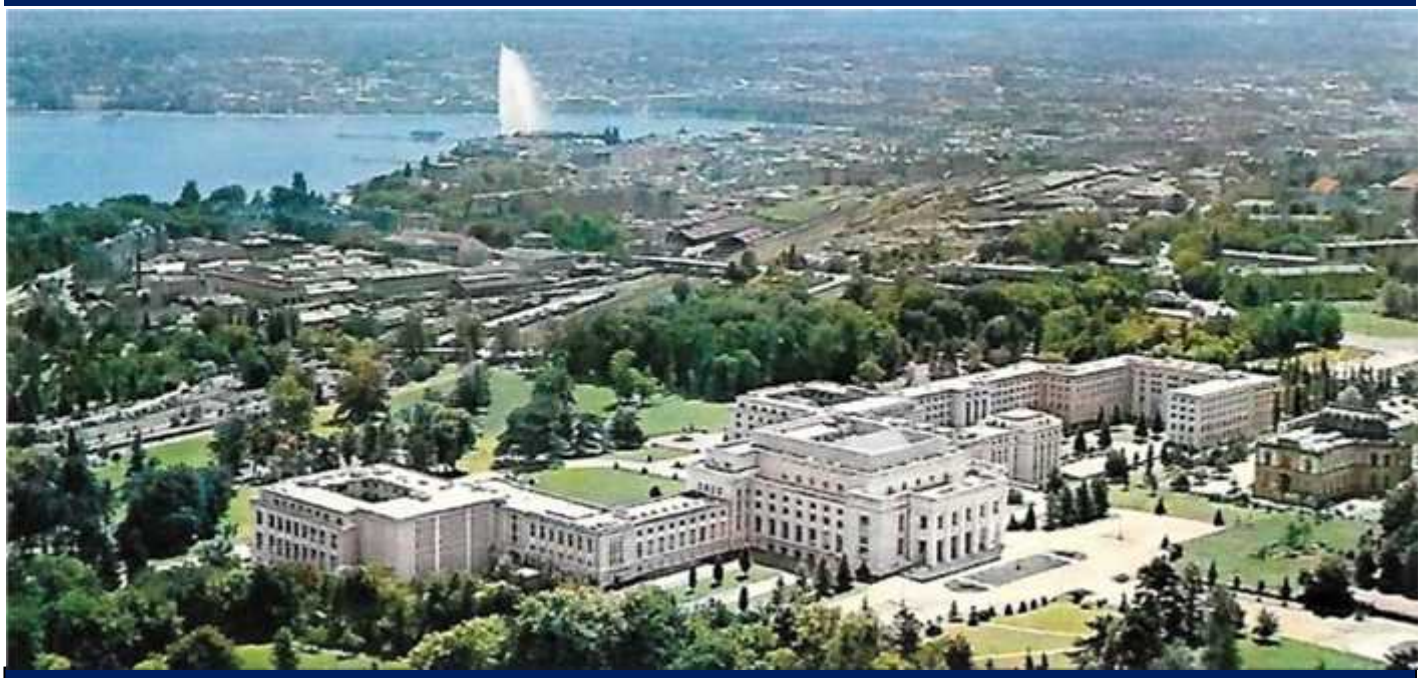
INTERNATIONAL COLLEGE OF PERSON CENTERED MEDICINE

JIM APPLEYARD MEMORIAL 14th GENEVA CONFERENCE
ON PERSON CENTERED MEDICINE

Optimizing Clinical Care through Person Centered Medicine

A Virtual Event on 18-20 April 2022



Conference Booklet

PRESENTATION

PROGRAM **GALLERY**

ABSTRACTS

ICPCMsecretariat@aol.com www.personcenteredmedicine.org

Conference Organization

Organizing Committee: Ihsan Salloum (President, International College of Person Centered Medicine, ICPCM), Mohammed Abou-Saleh and Paul Glare (Conference Program Co-Directors), Juan E. Mezzich (Secretary General, ICPCM), Michel Botbol, Tesfamicael Ghebrehiwet, Hellen Millar, Werdie Van Staden, Salman Rawaf and Christine Leyns (ICPCM Board members), Jon Snaedal (ICPCM Board Advisor).

Expected Participants and Registration: The Conference is intended for clinicians, scholars and all interested in person-centered healthcare. The nominal registration fee is 50 Euros for persons residing in World Bank Group A (High Income Countries) and 30 Euros for persons in other countries. Non-professional patients and family representatives, and full time health professional students will pay half-rate discounted fees. All participants, including speakers, are expected to register and pay a registration fee. Upon registration, a link to connect to the Conference will be provided.

ICPCM Continuing Professional Development (CME) Certificates will be issued.

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

Conference Program

FIRST CONFERENCE DAY: Monday 18 April 2022, Geneva Time

14:00 OPENING SESSION

Coordinator: C. Leyns

Chairs: M. Abou-Saleh, Paul Glare

Words of Welcome: I Salloum (ICPCM President), O Kloiber (WMA Sec Gral), S Asma (WHO Ass Direc Gral)

Memorial Lecture for Jim Appleyard: Seeking the Person at the Center of Medicine**:** Juan Mezzich (USA/Peru)

14:30: SYMPOSIUM 1: Conceptual Framework, Guiding Principles and Models of Care

Coordinator: Helen Millar

Chairs: Michel Botbol, Tesfa Ghebrehiwet

- Juan Mezzich (USA/Peru): International core principles of PCM and Person-centred Care Index
- Ihsan Salloum (USA): International person-centered diagnostic models
- Janet Clark (USA): Whole-Health Whole-Person Care Models
- Mohammed Abou-Saleh (UK): British models of person-centered care

Q&A and Conclusions

15:30 SYMPOSIUM 2: Indicators of Quality Person-Centred Care by Health Specialities and Fields

Coordinator: Ihsan Salloum

Chairs: Helen Millar, Salman Rawaf

- Christine Leyns (Bolivia): Primary care
- Carlos Salcedo (Peru): Intensive care medicine
- Dante Manyari (Canada): Cardiology
- Paul Glare (Australia): Palliative and pain medicine
- Q&A and Conclusions

16:30 SYMPOSIUM 3: Value of Precision Medicine for Person-Centered Care

Coordinator: C. Leyns

Chairs: Ihsan Salloum, Werdie Van Staden

- Robert Cloninger(USA): Harnessing genomics for person-centered care
- Drossi Stoyanov (Bulgaria): Conceptual issues on precision medicine and whole person medicine.
- Eduardo Ticona (Peru): Precision person-centered care for infectious diseases
- Clare Fiala and Eleftherios Diamandis (Canada): Big System Data and Hippocratic Medicine
- Q&A and Conclusions

17:30 SYMPOSIUM 4 ON JIM APPLEYARD 'S LIFE AND LEGACY

Coordinator: Ihsan Salloum

Chairs: Juan Mezzich, Salman Rawaf

Panelists: Salman Rawaf, Michel Botbol, Tesfamicael Ghebrehiwet, Christine Leyns, Juan E. Mezzich, Helen Millar, Ihsan Salloum, Jon Snaedal, Werdie Van Staden, Sandra Van Dulmen.

18:30 – 19:15 PAUL TOURNIER PRIZE SESSION

Coordinator: Mohammed Abou-Saleh

Chairs: Ihsan Salloum, Frederic Von Orelli, HR Pfeifer, Allan Tournier

Laudatio to Paul Tournier Prize Winner: Michel Botbol (France)

Paul Tournier Prize Lecture: Sandra Van Dulmen (The Netherlands)

19:15 – 20:00 ICPCM GENERAL ASSEMBLY

Coordinator: Christine Leyns

Chairs: Ihsan Salloum, Juan Mezzich

- Reports: Ihsan Salloum
- Introduction to the Geneva Declaration 2022: Mohammed Abou-Saleh and Paul Glare
- Action Plans: Juan Mezzich

SECOND CONFERENCE DAY: Tuesday 19 April 2022, Geneva Time

14:00 SYMPOSIUM 5: The role of professional, health systems and governmental organizations in developing, leading and delivering person-centered care

Coordinator: Ihsan Salloum

Chairs: Juan Mezzich, Tesfa Ghebrehiwet

- Michel Botbol (France): Governmental and Ministerial Perspectives on Person-centered Care
- Maricarmen Calle (Organización Andina de Salud, Peru): Person-centered medicine programs in the Community of Andean Countries
- Osahon Enabulele (WMA President Elect, Nigeria): World Medical Association perspectives
- Jon Snaedal (Iceland): World Health Professional Alliance Perspectives

Q&A and Conclusions

15:00-19:00 PROFESSIONAL GROUPS PANELS
Quality indicators of Person-centered Care in general and in pandemic times by professional groups
Coordinator: Werdie Van Staden (South Africa)

15:00 Panel 1: Family Doctors and General Practitioners

Chairs: Robert Phillips (USA), Galileo Perez (Mexico)

- Robert Phillips (USA)
- Christine Leyns (Bolivia)

- Imelda Medina (USA)
- Galileo Perez (Mexico)

Brief Discussion and Conclusions

16:00 Panel 2: Mental Health Professionals

Chairs: Mohammed Abou-Saleh, Michel Botbol

- Afzal Javed (WPA, UK): Person-centered care in WPA's global action plan
- Marijana Bras (Croatia): Mental health in palliative medicine
- Elena Gayvoronskaya (Russia), M Bugubaeva (Kyrgyzstan): Enhancing quality of life and human development through the life project.
- Roy Kallivayalil (India): Persons-centered social psychiatry
- Michael Wong (Hong Kong, China): Hermeneutics for MH care
- Vlad Novakovic (USA): Person-centered Comprehensive Care
- Norman Sartorius (Switzerland): International mental health programing

Brief Discussion and Conclusions

17:00 Panel 3: Nurses

Chairs: Tesfa Ghebrehiwet, Howard Catton (International Council of Nurses, Geneva)

- Olga Castillo (Ecuador)
- Julio Mendigure (Peru)
- Claudia Bartz (USA)
- Mariela Lara (Chile and Norway)

Brief Discussion and Conclusions

18:00 Panel 4: Public Health

Chairs: Salman Rawaf (UK), Fredy Canchihuaman (Peru)

- Carol Rivas (UK): Participatory research for complex interventions
- Giovanni Escalante (PAHO, El Salvador)
- Carlos Arosquipa (PAHO, Peru)
- Otomar Bahrs (Germany)
- Wolfgang Rutz (Sweden)
- Eugenio Villar (Peru)

Brief Discussion and Conclusions

19:00-20:00 SESSION ON SPECIAL INTERNATIONAL PERSPECTIVES

Coordinator: Christine Leyns

Chairs: John Cox and Hans Rudolf-Pfeifer

Olga Marega (Argentina): Indicators of Optimal Person-centered Care in Sexual Health

Thomas Ihde (Switzerland): The role of peers in mental health care

Elena Gayvoronskaya (Russia), Amantur Abdraimov (Kyrgyzstan): Sensory Correction as a Factor Contributing to the Strengthening of Mental Health.

Ines Monica Sarmiento-Archer (USA): Review of the Work of Artists and Writers on Health and Illness towards Person-centered Positive Health.

THIRD CONFERENCE DAY: Wednesday 20 April 2022, Geneva Time

14:00 Symposium 6: Addressing Quality Indicators of Person Centered Care in Health Education and Research

Coordinator: Hellen Millar

Chairs: Salman Rawaf, Jon Snaedal

- Luis Salvador (Australia) and Ihsan Salloum (USA): Research priorities for quality indicators for person-centered care
- Maria-Jose Santana (Canada), Improving the quality of person-centred healthcare: development of person-centred quality indicators
- Juan Perez-Miranda (Spain): Quality indicators for person-centered medical education
- Levent Kirisci (USA): Quantitative methodology for identifying person-centered quality indicators

Q&A and Conclusions

15:00 Symposium 7: Towards the development, implementation, and evaluation of optimal models of person-centred care

Coordinator: Ihsan Salloum

Chairs: Christine Leyns, M. Abou-Saleh

- Werdie Van Staden (South Africa) Person-centered optimizing of planning in the consultation and clinical notes
- Miquel À. Mas: Designing a Person-Centred Integrated Care Programme for People with Complex Chronic Conditions: A Case Study from Catalonia
- Hellen Millar UK: Optimizing models of Person centered care for comorbid conditions
- Fredy Canchihuaman (Peru): Implementation and evaluation science for person-centered care programs

Q&A and Conclusions

16:00 –16:30 CLOSING SESSION

Coordinator: Werdie Van Staden (South Africa)

Chairs: Jon Snaedal (Iceland) and Alberto Perales (Peru)

Geneva Declaration 2022: Mohammed Abou-Saleh and Paul Glare

Conference Conclusions: Ihsan Salloum

Next Steps: Juan Mezzich

16:30- 18:30 ICPCM INSTITUTIONAL MEETINGS (By invitation only)

Coordinator: Christine Leyns

16:30 ICPCM Work Group Towards Optimized Person-centred Care Models: Review of Conference results and planning of research.

Chairs: J Mezzich, I Salloum, M Abou-Saleh, P Glare

18:30-19:00 ICPCM Board Meeting. Chair: Ihsan Salloum, ICPCM Board Members

19:00-19:30 International Journal of Person Centered Medicine Editorial Board Meeting.
Chief Editor: J. Mezzich. Co-Editors: R. Cloninger (USA), C Leyns (Bolivia), S. Van Dulmen (The Netherlands), W. Van Staden (South Africa), M. Wong (Hong Kong, China), P. Glare (Australia), L Kirisci (Statistical Editor, USA); Publisher: T. Chalmers and C. Müller (University of Buckingham Press, London); ICPCM Board Members.

13th GENEVA CONFERENCE ON PERSON CENTERED MEDICINE

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FOURTEENTH GENEVA CONFERENCE ON PERSON CENTERED MEDICINE

ABSTRACTS

Opening Session:

JIM APPLEYARD MEMORIAL LECTURE: SEEKING THE PERSON AT THE CENTER OF MEDICINE

Juan Mezzich (USA & Peru)

This memorial lecture intends to be a conversational reflection on Jim Appleyard's life and legacy. It would involve visiting landmarks of his life journey. These touches on his family, his general education at Oxford, his medical studies at London's Guy Hospital, his choice of child's health as initial medical path his fights for the health and wellbeing of human beings and social institutions, his long standing dedication to education as a fundamental strategy for human growth. And linking and underpinning all these endeavors, Jim cultivated a deep, Aristotelian commitment to ethics and eudaimonia [1], Hippocratic caring, and his own fearless eagerness for life and commitment to people. All these found coherence and integration in Person Centered Medicine during the last decade of his life. How telling of this was his crafting Seeking the Person at the Center of Medicine [2] as title of his final book. His commitment to the person-centered approach in medicine and health was not only a well-articulated concept but a life project that by the power of example he encouraged people to consider. And thus, his legacy more than a list of accomplishments, represents an invitation and an opportunity for fearless, solidarious, and creative flourishing extended to all of us whose lives he indelibly touched.

References

1. Appleyard WJ, Christodoulou G, Leon F: Human rights, ethics and values in Person Centered Medicine. In Mezzich JE, Appleyard J, Glare P, Snaedal J, Wilson R (eds): Person Centered Medicine. Springer, Switzerland, in press.
2. Appleyard WJ, Mezzich JE: Seeking the Person at the Center of Medicine. University of Buckingham Press, London, 2021.

SYMPOSIUM 1: Conceptual Framework, Guiding Principles and Models of Care

INTERNATIONAL PRINCIPLES OF PERSON CENTERED MEDICINE AND THE PERSON-CENTERED CARE INDEX

Juan Mezzich (USA & Peru)

Background: A global programmatic movement towards a medicine focused on the totality of the person, with broad historical bases, has been collaboratively maturing since 2005 through conferences with international health institutions, research projects and academic publications [1, 2]. A key challenge in the application of Person Centered Medicine (PCM) to the practice of medicine and public health has been the systematic elucidation of its core principles and the development of operationalized measures of person-centeredness in medicine and health.

Objectives: The aim of this paper is to present the conceptual maturation and systematic elucidation of core international principles of what is understood as PCM and to present the development of an index for its measurement.

Methods: In order to elucidate the core PCM concepts, the following main approaches were employed: A systematic review of the literature and consultation exercises with broad international panels of health professionals and representatives of patient and family organizations. A Person-centered Care Index (PCI) was then developed from identified core concepts and its acceptability, reliability and validity were tested in three international sites, California, USA; London, England, and Lucknow, India [3].

Results: The following eight principles of PCM were identified: 1) Ethical Commitment; 2) Cultural Awareness and Responsiveness; 3) Holistic Approach; 4) Relational Focus; 5) Individualization of Care; 6) Collaborative Diagnosis and Shared Decision-making; 7) People-centered Organization of Services; and 8) Person-centered Education and Research. The PCI includes 33 items under the 8 principles of PCM. Its validation showed high internal consistency, uni-dimensional factorial structure, and substantial interrater reliability, acceptability and content validity.

Discussion: The presented principles and strategies are consistent with suggestions offered in the literature and may serve as bases for the design of educational programs and research instruments. Their continuous refinement is proposed through future international and local studies to clarify the key concepts of the movement as well as strategies for their practical clinical application.

Conclusions: The elucidation of key concepts of person-centered health care has provided greater clarity to the field on the key ingredients for the practice of person-centered medicine and public health. The PCI provides an operationalized measure to assess the degree of person-centeredness in health care and health systems and heralds a new paradigm for measuring optimized, person-centered care.

References

1. White H, Cox J, Christodoulou G, Appleyard WJ: Historical development of person centered medicine. In: Mezzich JE, Appleyard WJ, Glare P, Snaedal J, Wilson CR: Person Centered Medicine. Springer, Switzerland, in press.

2. Thornton T: Ontological and epistemological bases of person centered medicine. In: Mezzich JE, Appleyard WJ, Glare P, Snaedal J, Wilson CR: Person Centered Medicine. Springer, Switzerland, in press.
3. Mezzich JE, Kirisci L, Salloum IM, Trivedi JK, Kar SK, Adams N, Wallcraft J: Systematic Conceptualization of Person Centered Medicine and Development and Validation of a Person-centered Care Index. International Journal of Person Centered Medicine, 6: 219-247, 2016.

BRITISH MODELS OF PERSON-CENTRED CARE

Mohammed Abou-Saleh (UK)

The National Health Service (NHS) was established in 1948 as a publicly funded healthcare system in the UK providing universal health coverage that is comprehensive, equitable and free at the point of delivery. The British experience of person-centred medicine (PCM) is enshrined in the NHS constitution. Examples of PCM initiatives include guidelines produced by the National Institute for Health and Care Excellence; innovations in person-centred coordinated care in England (Lloyd et al, 2017); the introduction of person-centred experiential therapy delivered in the English Improving Access to Psychological Therapies service and person-centred nursing and person-centred practice frameworks in Scotland and Northern Ireland (McCormack and McCance, 2006).
There have been person-centred innovations in undergraduate and postgraduate medical education including the new framework to promote person-centred approaches in healthcare, a core skills, education and training framework by Health Education England. The landmark development was the production by the Royal College of Psychiatrists in the UK of the first blue print for a postgraduate psychiatric curriculum that is in tune with person-centred psychiatry. It is envisaged that the NHS will evolve and increasingly promote, adopt, codesign and implement person-centred care approaches adapted to the local, regional and national contexts including services redesign, health education and applied health research. These innovations contribute to universal development of person-centred healthcare and health education.

References

Lloyd HM et al, Collaborative action for person-centred coordinated care (P3C): an approach to support the development of a comprehensive system-wide solution to fragmented care. Health Res Policy Syst. 2017 Nov 22;15(1):98.

McCormack B, McCance TV. Development of a framework for person-centred nursing. J Adv Nurs. 2006 Dec;56(5):472-9.

SYMPOSIUM 2: Indicators of Quality Person-Centred Care by Health Specialities and Fields.

HOW PERSON- AND PEOPLE CENTERED IS OUR PRIMARY HEALTH CARE?

Christine Leyns (Bolivia & Belgium)

Introduction: A health system is a complex dynamic system. The transition to a more people centered (PC) system can start at various points in this system and a change in one aspect generates changes in other aspects. The Donabedian model is one of the models to visualize this change by dividing it in structures, processes, and outcomes at the micro, meso and macro level. Beside understanding the whole, it is necessary to identify essential quality indicators to work towards PC primary health services.

Methods: A continuous explorative literature review since 2012 on person- and people centered care in primary health care was complemented with field and research experiences to generate this analysis.

Results: Indicators are needed at four levels: 1. The community: health literacy and social capital; 2. The health care provider: people skills and resolution capacity; 3. Health care organization: Community oriented, comprehensive, coordinated (intra and intersectoral) and equity focused; 4. Health care system: integration of PHC and public health, bottom- up approach and proportionate universalism.

Discussion: Different countries can learn from each other's successes and obstacles in working towards a health system based on people's needs, with their maximum participation (selfcare and intercare). Primary health care is situated at the frontier of people centered health care as the link between the community and the health care system. At this level the balance is made between human skills and technology, towards an equity focused humanized cost-effective sustainable strategy.

Conclusions: Measuring health literacy, social capital, the level of proportionate universalism at different policy levels as the degree in which primary health care providers function as change agents, can be quality indicators for people centered primary health care.

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OPTIMIZED CLINICAL CARE IN CRITICAL AREAS THROUGH PERSON-CENTERED MEDICINE

Carlos Salcedo (Lima, Peru)

Of the varied and complex health-care places, where Person-Centered Medicine (PCM) is aggravated as a necessity, are the areas of care for critical patients, especially intensive care services (ICU), the most demanding and challenging.
OBJECTIVE: To design and document key critical indicators for optimized clinical care through person-centered medicine is an elusive achievement.

METHOD: Quality indicators endorsed by operations research work carried out in various ICUs in Lima Peru are presented.
Indicator 1: Open-door ICU
Indicator 2: Improve communication
Indicator 3: Patient well-being in ICU
Indicator 4: Care for health professionals
Indicator 5: Post Intensive Care Syndrome
Indicator 6: End-of-life care, pending task.
Indicator 7: Humanized infrastructure
Compliance with some of the indicators is presented
DISCUSSION: The following factors are considered:
1. Type of patient, always in a limit state of health, so much so that saving life is the primary north and achieving that often determines the lack of concern to comply with the quality of care, impaired by compliance with productivity and performance indicators.
2. Patient condition, almost always compromised in the extreme, so much so that the health professional (PF) – patient relationship becomes unheathed and withdrawn to very little verbal communication.
3. Internal scenario, crowded with technological signals, people in a hurry, schedules impossible to be fulfilled, place where the unforeseen is the rule.
4. Human context, diminished by the rupture of the social context in which a person operates and which is suspended during the patient's stay in the ICU.

FINDINGS: We found in quality-of-CARE MCP in ICU the following:
1. Halting progress in CCM
2. Intensification of objectification
3. Severe decline in CCM-directed and dedicated education

CONCLUSIONS
1. It is essential to resume the dissemination and training in CCM
2. Resume the dissemination of CCM
3. Strive to present evidence regarding quality of care and CCM in critical areas

IN SEARCH OF INDICATORS OF QUALITY PERSON-CENTERED CARE IN CARDIOLOGY

Dante Manyari (Canada)

Person-Centered Care (PCC) in the field of cardiology is recommended in all contemporary cardiology guidelines. A few randomized investigations and many uncontrolled observations on clinical outcomes give some scientific validity to the fact that PCC is not just ethical and associated with patient satisfaction, but it may be associated with better cardiology clinical outcomes.
Evidence-based therapies are generally delivered following the Picker Institute's eight principles of care by several cardiology teams, such as the heart failure clinic. However, in other cardiology settings PCC is a work-in-progress.

Practicing PCC has unique challenges owning to the variety of clinical scenarios the cardiologist encounters in day to day practice. In some, there is need for urgent care, when each minute counts. In others, delays in effective treatment do not significant affects long-term outcomes. Thus, time constraints and the varying degrees of scientific certainty on the therapeutic options, make it challenging to deliver quality and effective PCC. The cardiologist needs superior organization, communication, and interpersonal skills, and the necessary human and technical support tools, to work as a member of a skilled and motivated multidisciplinary team to reach quality PCC in each clinical scenario. There are potential barriers at each step from time availability, to education, and resources that need to be addressed differently in each different setting. Although small studies have suggested beneficial effects of PCC such as enhanced treatment adherence, better clinical outcomes, lesser medication misuse, less use of diagnostic procedures, and lower health related costs, there is need for more robust randomized clinical trials to accumulate sound additional data on the scientific validity of PCC. Perhaps then PCC and methods to accomplish it would be placed more prominently in all cardiology guidelines.

PAIN MEDICINE AND PALLIATIVE MEDICINE

Paul Glare (Australia)

Objective: to describe indicators of quality person centered care in Pain Medicine and Hospice/Palliative Care illustrate the clinical application of the person-centered medicine.

Methods: narrative review

Findings: Pain Medicine and Palliative Medicine are new specialties that aim to relieve the suffering caused by disease, rather than treating the disease itself. In the case of chronic non-malignant pain, many patients have conditions such as fibromyalgia, migraine, tempo mandibular joint disorder, irritable bowel syndrome, chronic low back pain, chronic pelvic pain for which no underlying disease process is identifiable, or they have an underlying incurable medical disease, e.g. osteoarthritis, spondylosis. The opioid epidemic illustrates the failure of biomedical interventions to solve chronic pain. It is now appreciated that much of the disability and distress caused by chronic pain is due to the individual having unhelpful thoughts and beliefs about pain (pain catastrophizing; low pain self-efficacy) and these should be evaluated, ideally by a multidisciplinary team including physicians, nurses, psychologists and physiotherapists. Non-pharmacological treatments such as cognitive-behavioral therapy utilized (1) In the case of hospice and palliative care, a biomedical approach is essentially futile when the disease process is incurable, advanced, progressive and ultimately fatal. In that situation, suffering is not only driven by pain, but other symptoms such as dyspnea, nausea, depression. Pharmacological interventions have a place but are ineffective in people with "total pain" due to the psychologic, social and spiritual dimensions of dying. A multidimensional understanding of personhood is the basis of

providing individually tailored care, (2) and the findings documented. A multidisciplinary team is needed, with the chaplain and social worker added.

Conclusion: Indicators for person centred Pain Medicine and Hospice/Palliative Care will measure, structure, process and outcomes.

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SYMPOSIUM 3: Value of Precision Medicine for Person-Centered Care.

HARNESSING GENOMICS FOR PERSON-CENTERED CARE

Robert Cloninger (St. Louis, USA)

Objectives: Precision medicine is an emerging approach for disease treatment and prevention that considers individual variability in genes, environment, and lifestyle for each person. Its goal is match treatment to specific phenotypes in subgroups of people to predict what is most beneficial, rather than selecting what works on average, as in "evidence-based" medicine. Person-centered care is concerned with health promotion as well as disease treatment and prevention, which all depend most strongly on an individual's personality. Unfortunately, individual genes or risk factors provide only weak and inconsistent prediction of what promotes overall health and well-being.

Methods: We carried out genome-wide association studies to identify clusters of genes, environments, and phenotypes associated with personality that predict a person's positive health, including physical, mental, and social well-being, as well as their ill health.

Findings: Individual genes and other risk factors are weak and inconsistent predictors of health, but multi-genic clusters were able to predict health strongly. Health was most strongly predicted by combinations of multi-genic clusters combined with specific profiles of temperament and character.

Conclusions: Three systems of learning and memory underlying human personality regulate gene expression dynamically to maintain healthy functioning despite variable environmental conditions.

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SYMPOSIUM 4 ON JIM APPLEYARD 'S LIFE AND LEGACY

PAUL TOURNIER PRIZE SESSION

SYMPOSIUM 5: The role of professional, health systems and governmental organizations in developing, leading and delivering person-centered care.

GOVERNMENTAL AND MINISTERIAL PERSPECTIVE ON PERSON-CENTERED CARES

Michel Botbol (France)

After considering, in France as in many other developed countries, the complexity of governmental and ministerial bodies in charge of health-related issues, this presentation will notice that their dependence to challenging professional, academic and business' and users' lobbies, limits drastically their ability to promote good practices. On this ground we will then discuss the contrast between the successful dissemination of most of the key principles of Person-Centered perspective in health care and the rather disappointing limitation of their implementation in the public offer of healthcare. Arguing that this gap is related to the inherent contradictions opposing wishful principles and their concrete operationalization it will conclude in suggesting that, rather than asking from government and ministers more than what they can offer (the enhancement of a widely shared ideal of healthcare values), person-centered medicine and cares should focus on the patient promotion of minuscule revolutions provided by tiny local healthcare projects in various types of health setting

WORLD HEALTH PROFESSIONAL ALLIANCE PERSPECTIVE

Jon Snaedal (Reykjavík, Iceland)

The World Health Professions Alliance (WHPA)1) was established in 1999, an alliance of five international bodies of health professionals. These are World Medical Association (WMA), World Dental Federation (FDI), International Pharmaceutical Federation (FIP), International Council of Nurses (ICN) and World Physiotherapy. The WHPA speaks for more than 41 million health care professionals worldwide in 130 countries.

The WHPA works to facilitate collaboration among the health professions and major stakeholders such as governments and international organizations, including the World Health Organization. By working in collaboration, instead of along parallel tracks, patients and health care systems benefit.

Obviously, WHPA is more focused on people centered care rather than person centered care. However, person centeredness is found in some of its projects aiming at the health and security of health professionals. An example of this is the initiative of "Safeguarding Health Professionals' Mental Health". Like most people, health professionals experience illness and have family obligations and other commitments outside their professional lives that can affect their mental health. Unlike most people, however, health professionals are also exposed to a particular mix of occupational pressures that can pose additional risks to their mental well-being2). One aspect of this initiative was a webinar on 23. September 2021 in the midst of the Covid-19 pandemic.

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PROFESSIONAL GROUPS PANELS
Quality indicators of Person-centered Care in general and in pandemic times by professional groups

PANEL 1: Family Doctors and General Practitioners.

BOLIVIAN PRIMARY HEALTH CARE PROVIDERS

Christine Leyns (Bolivia)

Introduction: Although Bolivian health policy (SAFCI, 2008) is based on community oriented primary health care, the country still suffers to fully implement these policies. Traditionally, public primary health care was limited to vertical programs and mother and child health. Only recently (2019), a universal health insurance, including the whole population was introduced. Which challenges face primary health care providers in Bolivia.
Methods: Analysis of local laws and regulations complemented with field experience
Results: At the beginning of the COVID-19 pandemic, the health response was hospital centric and primary health care services were reduced including outreach. This strategy was evaluated as ineffective after the first lethal wave and primary health care was incorporated as part of the pandemic response. Most primary health care providers are largely formed in hospital. A group of young physicians, recruited from rural areas, were trained in Cuba and a small batch of physicians was trained as family physicians (SAFCI). The community legally participates in the planning, organization and evaluation of its health center in local health committees.
Discussion and conclusion: The different types of primary health care providers (Cuba, SAFCI, basic physicians) with different types of contracts and different social rights hinder teamwork in health care centers. It is necessary to invest in the formation of family physicians, based on local, regional and national needs, formed to resolve the majority of prevalent and health problems with strong people skills. Find ways to optimize the formation and participation of health committees is another challenge.

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ACHIEVING "HEALTH FOR ALL" THROUGH PERSON-CENTERED CARE AND SELF-MANAGEMENT

Imelda Medina (USA)

The Declaration of Alma-Ata made by WHO in 1978 called primary care providers to come together to deliver better health for all. It indicated that persons have the right and duty to participate individually and collectively in the planning and implementation of their health care. However, forty years later, that vision has gone largely unfulfilled. The traditional model of health care, in which patients are encouraged to be passive recipients of treatment, can result in suboptimal health outcomes.

The Chronic Care model emphasizes the fundamental role of the person-provider relationship, which is described as "productive interactions between the informed, activated person, and the prepared, proactive practice team." In this regard, care planning for chronic illness should be person-centered, and fundamental is the role self-management support plays in increasing the confidence, skills and knowledge of a person in managing their condition(s) effectively in their everyday life. Together with good quality clinical care, assistance with self-management ensures that every person receives the full range of help they need to manage the physical, emotional and social impact of their long-term health conditions on a daily basis. This collaborative relationship is necessary to achieve the Alma-Ata goal of "Health for All."

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PANEL 2: Mental Health Professionals.

ENHANCING QUALITY OF LIFE AND HUMAN DEVELOPMENT THROUGH LIFE PROJECT CONSIDERATION AND CREATIVITY

Elena Gayvoronskaya (Voronezh, Russia), M Bugubaeva (Kyrgyzstan)

The most difficult part of the mental health professionals' work is to assess the dynamic personality traits on which an individual's adaptation depends at a particular point in time. Dynamic changes in the work of various personality substructures are designed to maintain a sufficient level of adaptation for life. When the external and internal living conditions change, dynamic personality characteristics, such as a change in personality orientation, contribute to the activation of adaptive reactions. It follows that the dynamics of personality acts as a regulator of adaptive human behavior.

The criteria for effective functioning of personality can be the quality of life and the implementation of life project [1]. These categories also have dynamics over time, especially during critical age periods, disease periods, changing of social conditions, stressful and situations of choice. Effective implementation of life project has many regulators of human behavior, for example, the inclusion of will-acts at the conscious level. Mental health professionals can help regulate adaptive human behavior through consideration of the individual's life project, his life context and conscious behavioral activity.

The most effective personal dynamic can be facilitated by creativity as the supreme mechanism of learning [2]. Creativity becomes the regulator of the implementation of the life project by the person, contributing to the activation of the necessary mechanisms of changing that support human adaptation in any age period. As a factor in the development of the culture of human needs, creativity contributes to the preservation of humanity for future generations. That is why it is so important to develop and preserve a person's creativity in any field of activity. Rehabilitation programs for people with a wide range of diseases need to be based on the development of the individual creative potential as a regulator of adaptive human behavior.

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PERSON CENTERED SOCIAL PSYCHIATRY

Roy Kallivayalil (Kerala, India)

Social Psychiatry has always been concerned with health inequalities. This has particularly become important in the context of COVID-19. Social determinants of health and illness needs our focused attention, which is essentially an important aspect of person-centred psychiatry. Inequalities in society is affecting medical care and health delivery across the world. There needs to be a clear call for action since the COVID-19 has further worsened the inequalities. The global landscape has always been deeply unequal; however, over the years, these inequalities have dominated the way societies function and organize. Inequalities based on income, gender, race, religion, place of residence, access to healthcare, opportunities, and ability to live a life people value have all become clearer in the past decade. The unnecessary disease and suffering of the disadvantaged, whether in poor countries or rich, result from the way we organize our affairs in society.

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HERMENEUTICS FOR MENTAL HEALTH CARE

Michael Wong (Hong King, China)

Objective
To demonstrate the relevance of hermeneutics to the practice of mental health care

Method
To highlight how the key concepts of hermeneutics address crucial issues in mental health care delivery

Findings
Mental illnesses are not only neuropsychiatric spectrum disorders but also disorders of social relationship and environmental/ecological adaptation. Mental health care as a clinical neuroscience per se lacks the semantics to address the rich interactions between the physical psychological social and spiritual in the illness experience of our patients.

Discussion
Hermeneutics helps organize clinical information of different nature (categories, dimensions, narratives ie objective vs subjective, personal vs interpersonal, the physical vs psychological vs social vs spiritual) into a coherent and comprehensible account of the illness and wellness history of our patients. This promotes a "therapeutic hermeneutic circle" of "explanation vs understanding" and "the whole vs the parts" to facilitate dialogue between mental health professionals, the patient and the family.

Conclusion
Mental health care informed by hermeneutics facilitates person-centered practice and may lead to effective shared decision making for diagnosis and care.

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PANEL 3: Nurses.

QUALITY INDICATORS AND OPTIMIZATION OF CLINICAL CARE THROUGH PERSON-CENTERED MEDICINE

Olga Castillo (Loja, Ecuador)

Introduction: The COVID -19 pandemic, which is powerfully challenging the world, caused sudden changes in lifestyle, violating the integrity of the person, forcing rethinking and strengthening the Health System and its operation, at the same time implementing actions of mental health necessary to address the problem, considering care as an essential service during this time, and, that requiring that continuity be given as, Dr. Mezzich proclaims in: "Conceptual Bases and International Implications for COVID-19. As early as the 1960s, Carlos Alberto Seguín affirmed in his San Marcos classes that Psychiatry should be a basic science of Medicine and every doctor should involve a bit of psychiatry aimed at caring for the patient as a person. What has been described leads us to reflect and apply innovative tools in health care, prioritizing Person-Centered Medicine.

Objective: Analyze and contribute experiences of health professionals and use of quality indicators of person-centered care, in general, and in times of pandemic. This is consistent with the historical aspiration to provide comprehensive health care to the person.

Methods: Through review, critical analysis of guidelines issued by the WHO, PAHO, MSP and other documents related to the problem. In addition, it was based on experiences that involve the collection and analysis of information from health professionals during professional care in recent years of marked changes in the world. The information is confronted with the scientific literature of national and international organizations, from these relevant contributions are presented in the field of health.

Results: The main health problems in this last decade are revealed, adding the COVID-19 pandemic, with a high mortality rate and its respective consequences that violate personal, family, and community well-being.
Health teams are strengthened, emphasizing the inclusion of scientific-technical competencies facing cultural diversity. Promotes a vision of professional cooperation between teams. New guidelines issued by the MSP in clinical care were applied, which apparently meet the care needs in times of pandemic. Care protocols for patients with COVID-19 were developed. In addition, psychosocial care is sought.

Conclusions: The concepts and strategies of Person-Centered Medicine, Public Health and the application of Quality Indicators for care that supplies the integrity of the person are clarified and validated.
Problems are observed such as: a high mortality rate, traffic accidents, teenage pregnancies, domestic violence, suicides, violent deaths, among others, that emerge from the imbalance of the integral context of the person. It is necessary to strengthen the health system with its processes of care and sociocultural support, as well as comprehensive professional training.

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TELEHEALTH NURSING RESEARCH EVIDENCE FOR PERSON – CENTERED CARE

Claudia Bartz (USA)

Nursing is a holistic profession, giving priority to the whole person, family or community. Nurses assess, educate and protect while giving direct care. Telehealth nursing research using applications for people with care needs demonstrates advances in care delivery over distances and barriers.

Objective. To describe evidence for care from a literature review of telehealth nursing research.

Methods. A medical librarian carries out weekly reviews of English language nursing, medicine and healthcare journals for papers related to telehealth and digital health. The author then identifies papers that have a nurse as first-author and further divides these into research and systematic reviews or non-research (e.g., descriptive, quality improvement). The research and systematic review papers are then analyzed for evidence for person-centered care.

Findings. 29 nurse-led research papers were analyzed. Six were randomized studies and 15 were systematic reviews. The most common target populations were people with cardiovascular disease (6) or type 2 diabetes (3). Evidence examples are findings of self-care efficacy with respect to foot care (T2D) and medication adherence with a smartphone APP (CVD).

Discussion. Telehealth nurse researchers are adding to the body of knowledge for digital applications in care settings.
Conclusion. More controlled trials are needed to advance person-centered care among nurses.

MEASURING NURSES' QUALITY OF LIFE AND EVALUATING COVID-19'S IMPACT WITH THE MULTICULTURAL QUALITY OF LIFE INDEX

Mariela L. Lara-Cabrera (Chile and Norway)

Background: In many countries, before the pandemic, many nurses were working under already difficult conditions. The emergency response to COVID-19 resulted in an increasing workload for nurses, made worse by the lack of protective equipment. In addition, at the beginning of the pandemic, scenes of rejection and social discrimination against nurses were observed in Mexico. Working in these circumstances may have put the nurse's mental well-being and QoL at risk. However, despite the importance of examining the QoL of nurses working under normal and critical conditions, studies investigating this are scarce.

Objectives: The study aimed to assess the impact of the COVID-19 outbreak on nurses QoL, depression and work engagement. It was hypothesized that the QoL, assessed with MQLI, would be correlated with work engagement (UWES-3) and depression (PHQ-2).

Methods: The study included two cross-sectional investigations in which nurses completed the scale before (n = 11) and during the first wave of the pandemic (n = 105). Descriptive statistics and hypothesis testing approaches were used.

Findings: Preliminary findings will be presented.

Preliminary conclusions: Our findings not only support our pre-defined hypothesis regarding QoL, but also highlight the negative impact of the current pandemic on nurses' QoL and mental health.

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PANEL 4: Public Health.

PARTICIPATORY RESEARCH FOR COMPLEX INTERVENTIONS: INVOLVING UNDOCUMENTED AND RECENT MIGRANTS

Carol Rivas (UK)

Objectives: The CICADA study is exploring the pandemic's impact on health conditions, service access, social support and mental well-being for people from minoritised ethnic groups with disabilities living in the UK.

Methods
This intersectional mixed-methods study includes a three-wave survey (5,000 respondents), and semi-structured qualitative interviews (229 completed) with follow-up workshops. Our approach to including diverse migrants of different migration status in the interviews and workshops, as a particular objective, is the focus of this talk. Specifically, we deployed assets-based participatory qualitative methods. These incorporated members of our focal communities as lay co-researchers and participants as the co-designers of pragmatic interventions to improve their health and wellbeing.

Results
Our approach enabled the collection of rich data, including from groups often excluded from public health research, such as disabled migrants arriving in the UK since the pandemic or without documents. Data show the extent, diversity and intersecting nature of various determinants of health and inequalities, discrimination (ableism, disablism, racism) and also successful coping strategies used.

Conclusions
A participatory approach with community members as co-researchers is practical, effective, and efficient. Our work should contribute to enhanced social, health and wellbeing outcomes for migrant groups.

DEVELOPING PEOPLE CENTERED HEALTH CARE AS PUBLIC HEALTH POLICY IN EL SALVADOR

Giovanni Escalante (PAHO, El Salvador)

Background: Person-centered care is a holistic and integrative public health policy for the well-being and quality of life as it includes key ingredients of care, individual, the caregivers, their families and community. El Salvador has developed this policy and it is in a process of implementing nationwide.

Objectives:
Present El Salvador country experience of scaling up the people centered care as a public health policy.
Method: A systematic literature review and consultation process has been undertaken.

Results and Conclusions:
The Ministry of Health, as part of the Government of El Salvador, has implemented a comprehensive health care utilizing a people center care approach, as a public health policy, which is shaping all the strategies at the three levels of care. One of its major developments is the implementation of the Newborn with Love Act ("Ley Nacer Con Cariño·) that establishes processes and protocols for quality, people centered and humanized care for mothers are their newborns. This public health policy considered timeliness, effectiveness, efficiency, and equity during the whole process of healthcare provision for mothers and their newborns. The approach is reshaping the whole health care system in El Salvador. WHO/PAHO in El Salvador has provided technical cooperation on its development.

PRIORITY FOR HEALTH PROMOTION? THE LONG MARCH OF PUBLIC HEALTH IN GERMANY

Ottomar Bahrs (Göttingen, Germany)

Public health and social medicine were prominent in Germany in the first third of the 20th century, but later on they have been relatively marginal. In the 1980s, a "New Public Health" developed, especially outside the medical field. However, health care remained characterised by the predominance of curative medicine and interface problems between parallel providers and outpatient, inpatient and rehabilitative care and health promotion.

Currently, proposals are being made for fundamental restructuring, which can be described as networking, interprofessional, cooperation, regionality and patient orientation. Examples are briefly outlined.

In the Corona crisis, the need for a public health orientation became abundantly clear. However, its influence on political action remained limited. The renaissance of a biomedically interventionist oriented political practice, impeding relational medical and health promotion related activities, goes hand in hand with structurally changing concentration processes, which correspond more to the logic of the health economy than to that of health promotion. These processes are currently taking place below the level of public perception, dominated by the Corona crisis and the Ukraine war and its consequences. Democratic negotiation processes are limited, so the necessary discussion about whether value-based medicine should refer to health costs or the lifeworld-related benefits for patients (and health care providers) could also be missing.

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SESSION ON SPECIAL INTERNATIONAL PERSPECTIVES

INDICATORS OF OPTIMAL SEXUAL HEALTH CARE THROUGH PERSON-CENTERED MEDICINE

Olga Beatriz Marega (Buenos Aires, Argentina)

The objective of this presentation is to reflect on the indicators of optimal person-centered sexual healthcare.

All people, from their diverse cultural backgrounds, develop a unique and unrepeatable sexual personality with individual needs.

This principle should be taken into account when approaching their sexual health care, respecting the basic principles of ethical commitment, within a holistic framework, taking into account cultural, communicative and relational sensitivity; and especially individualizing the person's health care. It is also important to maintain fluid communication between the health professional, the person and their family to facilitate diagnostic understanding and therapeutic action.

It is essential to organize integrated health services centered on people and their individual needs, as well as to facilitate permanent medical education and health research.

Conclusions: Most important to achieve optimal person-centered sexual healthcare is to focus on respect for universal sexual rights that protect human dignity. This corresponds to the Ethical Commitment principle of Person Centered Medicine.

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THE ROLE OF PEERS IN MENTAL HEALTH CARE

Thomas Ihde (Unterseen, Switzerland)

Mental health care systems in the U.S.A. und U.K. started in the 1990ies to integrate peer support workers or specialists into regular mental health teams. Peers have a lived experience of a mental health problem or illness and have received a specific training in which they learn to share their own experience of recovery with others. While peer workers receive highly positive feedback from patients and families/carers, research on the effect of peer support has been inconclusive (1). Peers have most likely an effect on internalized stigma in patients and increase hope for recovery. Even less is known about the effect of peer workers on mental health teams or systems. Thomas Ihde postulates that one of the main effects is a transition of care towards a person centered care model in mental health.

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SENSORY CORRECTION AS A FACTOR CONTRIBUTING TO THE STRENGTHENING OF MENTAL HEALTH

Elena Gayvoronskaya (Voronezh, Russia), Amantur Abdraimov (Kyrgyzstan)

Sensory correction as a method of rehabilitation can be used in a wide range of pathological conditions both in children's practice and in adults reflecting the person-centered approach [3]. A number of studies have considered the use of sensory correction in the development of psychosomatic disadaptation as well as in mental pathology [1, 2].

We studied 60 patients with anxiety and depressive disorders divided into 2 groups. Patients of the first group received classical treatment provided for persons with this pathology. A course of sensory correction was included in the rehabilitation process of patients of the second group. Using the experimental - psychological method the dynamics of indicators characterizing mental health after the implementation of the treatment and rehabilitation program was evaluated.

The results of the study showed a significant reduction in the level of anxiety and depression in patients of the second group compared with the first group. Also patients, who underwent a course of sensory correction providing them with a greater number of additional corrective stimuli, demonstrated the normalization of social and psychological adaptation.

Thus, it can be concluded that the method of sensory correction contributes to strengthening mental health and improving social and psychological adaptation in people suffering from anxiety and depressive disorders.

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REVIEW OF THE WORK OF ARTISTS AND WRITERS ON HEALTH AND ILLNESS TOWARDS PERSON-CENTERED POSITIVE HEALTH

Ines Monica Sarmiento-Archer (USA)

Introduction: In this last century research and literary review of prominent artists shows that artistic activity, writing, painting, music, dance, has been shown to support and improve psychological and physical outcomes and therefore alleviate disease. It is important to be aware of the context and traditions of each individual's community and culture to learn how to care, promote positive health and improve their quality of life. This review explores the processes that contribute to improving mental and physical health through various therapies and traditional medicine [1] based on creative expression: writing, visual arts, music, and movement. An attempt is made to clarify an artistic approach to health centered on the person. The current generation has been part of a global transformation. From 2020 to 2022, the global society has suffered a mental health crisis caused by the covid pandemic. This article makes a brief historical overview of different studies related to artistic activities and health. During this investigation, the positive effects that the arts, in general, have on people's mental and physical health are verified [2].

Objective: To study and analyze cases of famous artists throughout history to determine the positive influence of creative activities on mental health. By studying these cases, we can evaluate how others may benefit from artistic meaning in the complexities of health and wellness to alleviate illness and promote a better quality of life.

Methods: A literature review of the work of artists and writers on health and disease using inductive, historical and descriptive analysis of research by academic and medical professionals on famous artists and their diseases.

Results: Investigating the disease process of renowned artists led us to understand that creative activities are a model of self-healing, starting from the individual's own conscience towards inter-care and promoting person-centered health.

Conclusion: The experiences and cases presented reinforce the idea that the different artistic activities [3] such as literature, painting, music, dance favor healing, the person focuses the emotions on artistic and constructive practices, helping to alleviate the disease by self-healing and increase the healing power through traditional medicine.

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SYMPOSIUM 6: Addressing Quality Indicators of Person Centered Care in Health Education and Research

IMPROVING THE QUALITY OF PERSON-CENTRED HEALTHCARE: DEVELOPMENT OF PERSON-CENTRED QUALITY INDICATORS

Maria-Jose Santana (Canada)

Background
International efforts are being made towards a person- centred care (PCC) model, but there are currently no standardized mechanisms to measure and monitor PCC at a healthcare system level. The use of metrics to measure PCC can help to drive the changes needed to improve the quality of healthcare that is person centred.

Objective
To develop and validate person- centred care quality indicators (PC- QIs) measuring PCC at a healthcare system level through a synthesis of the evidence, consultation with patients and communities, and a person- centred consensus approach to ensure the PC- QIs reflect what matters most to people in their care.

Methods
Existing indicators were first identified through a scoping review of the literature and an international environmental scan. Focus group discussions with diverse patients and caregivers and interviews with clinicians and experts in quality improvement allowed us to identify gaps in current measurement of PCC and inform the development of new PC- QIs. A set of identified and newly developed PC- QIs were subsequently refined by Delphi consensus process using a modified RAND/UCLA Appropriateness Method. The international consensus panel consisted of patients, family members, community representatives, clinicians, researchers and healthcare quality experts.

Results
From an initial 39 unique evidence- based PC- QIs identified and developed, the consensus process yielded 26 final PC- QIs. These included 7 related to structure, 16 related to process, 2 related to outcome and 1 overall global PC- QI.

Conclusions
The final 26 evidence- based and person- informed PC- QIs can be used to measure and evaluate quality incorporating patient perspectives, empowering jurisdictions to monitor healthcare system performance and evaluate policy and practice related to PCC.

QUALITY INDICATORS FOR PERSON-CENTERED MEDICAL EDUCATION

Juan Perez-Miranda (Spain)

Objectives
UFV medical education model covers not only theoretical knowledge and clinical skills training, but also offers students opportunities for the development of an integral professional competence, including an emphasis in communication skills, clinical reasoning, the natural integration of social and ethical aspects of the medical profession as well as a humanistic view of medicine.

Methods
Our curricular model promotes ethical and professional values in the student training following the recommendations of systematic literature reviews (1). The model focuses on five main areas: student selection, curriculum design, role modeling, new teaching and learning methods as well as assessment methods.

Findings
Our students, who were selected with a predicting behavior Tool (Vipscan) assuring humanistic qualities, are exposed to a person-centered curriculum which encourages respect and empathy for the human condition of the patient. We have measured students' empathy (2), and also measured specific competences in our final practical examination (OSCE) as well as the effectivity using standardized medical

encounters. We are in the process of measuring the impact in clinical settings using an evaluation tool based on clinical tutor's inputs (EMMA study).

Conclusions

Our experience confirms the idea of structuring a formal program for the development of Person-Centered professionalism in medical students. After eleven years of implementation, our model has a strong formative influence with great potential benefits for medical students. Among the expected benefits of this approach, medical students learn to develop appropriate attitudes towards their current studies and future practice.

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QUANTITATIVE METHODOLOGY FOR IDENTIFYING QUALITY OF PERSON-CENTERED INDICATORS

Levent Kirisci (USA), Alberto Perales (Peru), Juan E. Mezzich (USA & Peru)

Abstract Body: Many instruments have been developed to measure person-centered care. However, they focus on patient satisfaction in a healthcare setting which does not include feelings, values, or experiences of a person. Studies examining the psychometric quality of these instruments were limited to certain clinical patients. Furthermore, these instruments were not standardized across populations.
Based on these concerns Person-centered Care Index (PCI) was developed by the International College of Person-centered Medicine with the support of the World Health Organization. This instrument includes 33 items under eight broad categories.

To further establish the psychometric quality of PCI, a more comprehensive study is warranted that includes a wide range of healthcare settings, a large clinical patient population, and healthcare providers. Two hundred forty health professionals (nurses and physicians) used PCI to rate the medical and surgical services of the four prototype hospitals in Lima, Peru. Item response theory methodology is applied to identify the psychometric quality of PCI items. Results will be discussed.

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SYMPOSIUM 7: Towards the development, implementation, and evaluation of optimal models of person-centred care.

PERSON-CENTERED OPTIMIZING OF PLANNING IN THE CONSULTATION AND CLINICAL NOTES

Werdie van Staden (Pretoria, South Africa)

Background: The concluding part of a clinical consultation and its recording in clinical notes typically comprises the "plan" or "further management", which guides further actions regarding tests and investigations, treatments, counselling, referrals, and follow-up (1). Objective: The objective is to consider how this part of the consultation and clinical notes may be structured in an explicitly person-centered way. Methods: The tenets of Person-centered Medicine are applied to the standard objectives of the planning section of the clinical consultation.
Results: The planning section is conventionally structured in biopsychosocial domains, but it is typically formulated as the clinician's plan and is rather unilateral in presenting the clinician's perspective. Although at times implicitly incorporating the patient's contributions, the patient's voice does not necessarily feature explicitly and may be absent all too often. In contrast, the planning section may be structured explicitly in a person-centred way and reflect co-production and shared-decision-making (2). Five headings are proposed to this end, all qualified as "co-decide(d)". This qualification captures an engaging creative interpersonal communicative process that accounts for both the common and the uncommon ground, both shared and conflicting values, and that yields the best decisions for the person in that individual's specific circumstances even if not the best by medical values (2).
Conclusion: Clinicians and medical educators should optimize "the plan" section of the consultation and the clinical notes by which to foster a routine that is more person-centred and that lives up to the requirements of shared decision-making and co-production.

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DESIGNING A PERSON-CENTRED INTEGRATED CARE PROGRAMME FOR PEOPLE WITH COMPLEX CHRONIC CONDITIONS: A CASE STUDY FROM CATALONIA

Miquel À. Mas (Catalonia, Spain)

Objectives
The aim of this presentation is to share our experience on designing and implementing the ProPCC project, held by the Metropolitana Nord Chronic Care Management Team, from the Catalan Health Institute, as a strategic quality improvement initiative in our public institution, to urge person-centred integrated care for people living with frailty, complex or advanced chronic conditions.

Methods
We present the methodology used in the development of the ProPCC clinical programme. We aimed to draw on people's experience with healthcare (users and caregivers), in order that their priorities and views could be integrated with evidence-based clinical actions proposed by clinicians.

Findings
Patients' and caregivers' main priorities were to ensure (a) comprehension of information provided by healthcare professionals; (b) coordination between patients, caregivers, and professionals; (c) access to social services; (d) support to caregivers in managing situations; (e) perceived support throughout the healthcare process; (f) home care, when available; and (d) a patient-centred approach.

Discussion
The creation of the programme was used to engage actors and to urge future organizational changes oriented towards the achievement of the adapted model of care emerged from this process.

Conclusions
Patients' and caregivers priorities were used to build person-centred care plans for the whole care trajectory.

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OPTIMIZING CARE THROUGH A PERSON CENTERED APPROACH: CO-MORBIDITY IN THE MENTALLY ILL

Helen Millar (Scotland, UK)

Background
Evidence for the excess burden of co-morbidity in the mentally ill has been highlighted over the past two decades with the mortality gap continuing to widen, and life expectancy reduced by 15-20 years in this population. The cause of premature death is complex, including links between biological, psychological, behavioural and genetic mechanisms. Emerging evidence is now promoting a more integrated person centered approach in order to address risk factors and optimise care to improve patient outcomes and life expectancy.

Aim and methods
This short presentation highlights recent studies/guidance in the field of co-morbidity in the mentally ill and demonstrates a pragmatic example of delivering a person centered approach within current resources.

Findings and Conclusions
The need to adopt person centered care, in order to improve patient outcomes, is becoming increasingly evident with the growing body of research in this field. Genuine engagement, along with shared decision making and an understanding of common realistic goals are vital. The challenge of co-morbidity in the mentally ill demands a radical shift to an efficient seamless integrated, person centered model of care encompassing early intervention, prevention and a co-ordinated multidisciplinary approach to improve patient outcomes and increase life expectancy in this population.

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CLOSSING SESSION

FAREWELL TO JIM APPLEYARD

Alberto Perales (Lima, Peru)

Drs. Werdi Van Staden, Coordinator, John Snaedal, Co-Chair of this closing ceremony, Dear Family of Dr. Jim Apellyard, Esteemed Colleagues, Ladies and Gentlemen.

Be my first words of thanks to the Organizing Committee of the Jim Appleyard Memorial, Fourteenth Geneva Conference on Person Centered Medicine, that allows me to give these brief words of posthumous tribute to Dr. Jim Appleyard on behalf of the Latin American Person Centered Medicine movement.

I met Jim, in 2014, at a Congress on the subject held in the city of Buenos Aires, Argentina. There, I could appreciate how deeply involved he was in this international movement.

Easy to contact, with a receptive smile, humble with his knowledge but incisive in his criticism, he clearly demonstrated what he really was: a caring pediatrician, a restless thinker and a good person.

Not many years passed before I knew he was suffering from a painful illness; which, despite its seriousness, never bowed his desire to live; that is, to live as he understood life, as a deep vocation of service, dedicated to others, to humanity in general and to human institutions in particular.

For this reason, I think it was only logical to verify that in Latin America, he left a trail of an affable and understanding leader, a professional of solid knowledge and a morally upright person.

On giving a final farewell to you Jim, I want to tell you how sure I am that everyone who has dealt with you would be grateful of having met you.

Alberto Perales. M.D
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