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Editorial Introduction

Ibero-American Perspectives on Person-centered Medical Education

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Introduction

Person Centered Medical Education has been a central dimension, activity and concern in Person Centered Medicine, since its early conceptualizations [1], to systematic efforts at understanding it [2], and even being the main theme of some major events [3]. Additionally, person centered medical education has received pointed attention in the Ibero-American world, though a number of events connected to the International College of Person Centered Medicine.

Thus, this Editorial Introduction addresses broadly these regional perspectives. To do so, it starts with a brief review of Person Centered Medicine and Person Centered Medical Education. It then comments on Latin American experience and perspectives formulated by a core group of scholars from this part of the world. A major part of the paper is devoted to recommendations on person centered medical education from Internal Congresses and Conferences on Person Centered Medicine in the Ibero-American region with scholarly contributors from most Latin American countries and from the Iberian Peninsula.

This editorial introduction then comments on the papers published in the present issue of the International Journal of Person Centered Medicine, some of which are pointedly related to person-centered medical education.

Basic Concepts of Person Centered Medicine and Person-centered Medical Education

As the present century unfolds in the field of health, a programmatic movement on Person Centered Medicine has emerged [1]. The reaffirmation of medicine's central mission, recognizing the person as a fundamental center and goal rather than just as a carrier of disease is informed by the wisdom of the great ancient civilizations as well as contemporary insights from the clinic and public health. Person centered medicine values emerging biological, psychological and socio-cultural scientific advances and incorporates them within a whole person framework. Improving on reductionistic epistemological formulations, it proposes a medicine informed by evidence, experience and values, and oriented to the service and promotion of the totality of the person.

A recent study of the International College of Person Centered Medicine (ICPCM) supported by the World Health Organization was aimed at the systematic conceptualization and measurement of person-centered care. It identified the following as its key concepts: ethical commitment, holistic framework, relationship emphasis, cultural sensitivity, individualization of care, joint diagnostic understanding and shared clinical decision-making among clinicians, patient and family, community-centered planning of health services, and person-centered health education and research [2].

As noted from the last major concept listed for Person Centered Medicine, Person-centered Medical education is a major activity and concern in this new medical perspective. This includes the incorporation of person-centered thinking into medical curricula. It is increasingly recognized that professional development in medicine is fundamentally related to person-centered principles. The recognition and analysis of this relationship is important because it may offer substantial and coherent opportunities to improve medical education. Translating such opportunities into pragmatic suggestions should help promote excellence in medical education and enhance the professional standing of future physicians. It is through education that trainers and trainees combine theory and practice in a bidirectional, reflective process and it is imperative that trainers, trainees, theory and practice merge in person centered medical education [4, 5].

Scaling up and transforming health professional education resonates with current efforts towards personalizing healthcare, that is, making clinical medicine more person-centered and public health more people-centered. A continuing engagement among all stakeholders on the design and detailed methodologies aimed at translating person-centered medicine and people-centered public health into clinical and public health practice has become an urgent international priority [6].

Latin American Perspectives on Person Centered Medicine

A number of events with the participation of major Latin American universities and faculties of medicine as well as National Academies of Medicine took place since 2013 particularly in Lima and at the Second International Congress of Person Centered Medicine in Buenos Aires. These events offered substantial opportunities for the initiation and progressive maturation of person centered medicine concepts in the Latin American region. This process led to the publication of a major paper by a prestigious group of Latin American scholars on the historical and anthropological background from ancient Latin American cultures and, based on them, the crystallization of continental and regional perspectives on person centered medicine [7].

Also relevant is the development in the past decade of a major international and Latin American [8] effort to reconceptualize and reformulate clinical diagnosis in a person-centered manner. It has achieved practical application and wide regional dissemination in the form of a Latin American Guide to Psychiatric Diagnosis (GLADP-VR) [9]. This includes the following as key informational levels: a) Health Status, from illnesses, to disabilities and positive health, using WHO International Classification of Diseases (ICD) categories and descriptions with the addition of Latin American annotations, b) Health Contributors, i.e., risk and protective factors, crucial for prevention and health promotion, and c) Health Experience and Values, which ensures attention to patients' views, needs and preferences. This Latin American Guide employs categories, dimensions and narratives for the description of health diagnosis information, and engages clinicians, patients and their families for joint diagnostic formulation and shared decision making.

The GLADP-VR has been published by the Latin American Psychiatric Association for official use by health professionals in the region. It has been found by Latin American psychiatrists to be preferable to conventional diagnostic systems such as the original ICD-10 and the American Psychiatric Association's DSM-IV and DSM-5 [10]. More broadly, the GLADP affirms the identity and institutionality of Latin American medicine, emphasize a comprehensive, culturally-informed and person-centered diagnostic approach and not just a classification of diseases; and ensures international nosological consistency while including enriching Latin American annotations; and represents a critical and creative response to a current overwhelming and dehumanizing globalization.

Latin American Perspectives on Person Centered Medical Education

The broad Latin American perspectives on Person Centered Medicine by Wagner, Perales, Armas et al [7] mentioned earlier also included pointed comments on person centered medical education. The following were identified as important areas for work in order to advance person centered medical education in Latin America:

- a. Conceptual bases: ethics and person, clinical communication (in languages relevant to the people involved), integration of general, mental and public health, social sciences, and humanities.

- b. Institutional organization, culture, and health.
- c. Selection and professional and personal development of students during their formative years and throughout their lives.
- d. Selection and professional, pedagogical and personal development of teachers and mentors.
- e. Educational interactions among students, professionals, patients and families: multidisciplinary professional teams, patients and relatives as instructors, group meetings.
- f. Diversification of the clinical and community settings for medical education.
- g. Curriculum development: guiding principles focused on the person, curricular experiments, longitudinal and transversal organization of programs.
- h. Special Topics. Illustratively, it can be mentioned here the care for particularly vulnerable persons and for those requiring special care such as the elderly and those who enter the final stages of life (Juan Mendoza-Vega, personal communication, 13 January 2015).
- i. Educational methods: Communication exercises, reflective learning, group learning with patients and other people, accompanying the instructor, video recordings for feedback, community exercises, use of narratives and art, establishment of common bases for understanding and action, motivational interviews, aiming at and evaluating competence and performance.

Congress and Conference Recommendations on Person-centered Medical Education

Several Person Centered Medicine events since 2013 have produced specific recommendations on Person Centered Medical Education. These recommendations have been presented within the framework of the following Declarations, the publication of which has often been accompanied by support academic papers: the 2013 Zagreb Declaration on Person Centered Health Professional Education [11, 12], the 2015 Lima Declaration on Latin American Developments for Person Centered Medicine [13, 14], the 2016 Madrid Declaration on Person Centered Medical Education and the Goals of Healthcare [15, 16], and the 2016 Lima Declaration on Science and Humanism for Person Centered Medicine in Latin America [17, 18].

Recommendations from the Zagreb Declaration on Person Centered Health Professional Education

1. Enhancement of the conceptual bases of professional training and public education by grounding them on ethics and human rights, knowledge of the bio-psycho-socio-cultural determinants of ill health and positive health, attention to persons' values and preferences, and the flourishing of their well-being and life projects.
2. Analysis and optimization of the organization and culture of educational institutions to be supportive of person-centered health for and with students, faculty and administrative colleagues.

3. Selection of students who are suited to the goals and responsibilities required of health professionals and commitment to their personal development in addition to their broad technical training.
4. Selection of instructors and mentors who are suited to their educational responsibilities and commitment to their continuing professional and personal development.
5. Facilitation of dynamic interactions among students, instructors, patients and families by ensuring opportunities for dialogue at all levels, promoting inter-disciplinary training, and engaging patients as instructors.
6. Promoting curricular developments that have person-centered guiding principles, that include curricular experiments and mechanisms for their evaluation, that consider a balance between concentrated blocs and longitudinal integration for the achievement of educational objectives, and that incorporate the continuum of health promotion, prevention, treatment, rehabilitation and palliative care.
7. Exploring the design, implementation and evaluation of person-centered educational methods such as experiential and reflexive learning, communicational exercises, training groups with patients and families, shadowing mentors, employing video recordings for feedback purposes, community visits and practice, utilization of narratives, practice of artistic activities, motivational interviewing , establishing common ground among clinicians, patients and families for diagnosis and care, articulation of competence- and performance-training, and ability to work with patients from different cultures and social conditions in a respectful and collaborative manner.
8. Promoting health in individual patients and in society by active education of patients, addressing broad issues on determinants of health and the impact of cultural, religious and social factors on health and health care, identifying and reducing health hazards in the environment and society, and being all involved in shaping sound health policies.

Recommendations on Person Centered Medical Education from the 2015 Lima Declaration on Latin American Developments for Person Centered Medicine

1. To promote the development of a person centered medical and health education methodology that considers PCM's principles. This may include the design and evaluation of carefully thought out curricular experiments, and the selection and developments of students and professors paying attention to personal, ethical and professional goals along with the exploration of high quality mentoring programs.
2. To promote the cultivation of PCM, its principles and practices as they apply in a coordinated manner to clinical care, medical training, health education, scientific research, and public health.

Recommendations from the 2016 Madrid Declaration on Person Centered Medical Education and the Goals of Healthcare

1. Universities should assume the responsibility of making a positive and fair selection of their medical students from those candidates who show the best attitude and qualities for person-centered practice.

2. It is advisable to include early programmed clinical placements in degree studies, as they are effective in promoting the empathetic ability of students.
3. Person-centred clinical education and practice must go beyond the limitations of evidence-based medicine and towards one of holistic evidence-informed medicine, enriched by the consideration of experience and values for clinical decision-making.
4. Medical graduates should be able to resolve problems of growing complexity through basic clinical reasoning and prudent decision-making skills in uncertain situations, in which consideration of patient expectations and preferences is essential as well as attention to the values and preferences of the patient and of his or her family.
5. Primary healthcare services represent an ideal environment for this early clinical experience due to the inclusive and continuous nature of care and the establishment of prolonged clinical relationships between patients and their health carers.
6. Educational centres must have available the infrastructure and expert personnel in different technical simulations (robotic, virtual reality, experimental surgery, etc.) that provide technical support to clinical educators.
7. All universities and education providers should have access to expert medical education units, which give support to programs, train clinical teaching personnel and assess the quality of the work accomplished.
8. Person-centred medical education must include in its contents some broad criteria for assessing the outcomes of medical interventions such as clinical effectiveness, safety and costs and the patient's perspective including patient reported outcome measures (PROMs) and patient reported experience measures (PREMs).
9. The accreditation and recertification of practicing doctors must be based on high-quality and wide-ranging lifelong learning activities.
10. Research must be conducted on the most appropriate methodologies in the humanistic disciplines (anthropology, ethics, human rights, literature, history, deontology and healthcare legislation, pedagogy, the arts, etc), so that such subject areas are meaningfully, acceptably and beneficially taught to students.

Recommendation on Person Centered Medical Education from the 2016 Lima Declaration on Science and Humanism for Person Centered Medicine in Latin America

1. Medical education should include the reinforcement of the curriculum humanistic contents and the early, frequent and deep contact of the student with persons and families. Curriculum improvements should comprehend interdisciplinary integration and stress on new and crucial areas such as the health primary care.

2. Given the urgent need of team work for a whole clinical care, wide opportunities for the inter-professional learning should be included in the health professionals teaching. This must involve the most important disciplines such as medicine, nursing, obstetrics, psychology, public health, nutrition, rehabilitation, education and social work.
3. The use of promising educational methods is critical. Among them is the living model practiced by the teacher, which is crucial and not subject to substitution. In the words of Albert Einstein, "To show example is not the main way to influence others; it is the only way". Another method is the diversification of educational environments in order to train the students in the diverse clinical and community realities where they must practice professionally.
4. The ethical commitment is the first denoting characteristic of person centered medicine. In line with this, the ethical teaching of the student must be incremented by means of the core concept of educational opportunities throughout the career. Pertinent courses should be included, privileging discussion and thinking upon illustrative cases, and the irreplaceable example of morality and respect for the person of the patient and the student that teachers should offer.
5. Another main teaching area is training in clinical communication, given the deep human value of the encounter between the physician and the patient, and the opportunities offered by the growing Latin American experience with relevant methodology. Teaching on how to establish empathy is particularly key here.
6. Programs on comprehensive tutoring should be created through which the student development as a person and a professional is promoted. The participating tutors must be duly trained and their development as health professionals, university educators and upright persons must be actively promoted by their academic institution.

Consolidation Summary of the Recommendations on Person-centered Medical Education

Medical Education has consistently been a principal concern of Person Centered Medicine in Latin America. The main lines recommended in the preceding Declarations between 2013 and 2016 for the development of person centered medical education are the following:

1. Advancement of person-centered medical education should be based on the principles and strategies of person-centered medicine (PCM) such as ethical commitment, holistic framework, cultural awareness and responsibility, relational matrix, individualized care, common basis among clinicians, patient and family for collaborative diagnosis and shared decision making, integrated health services focused on the community, and person-centered health education and research.
2. An organizational culture centered on the person should be established, alien to the commercialism that in recent times has led in some countries to the proliferation of faculties of medicine of questionable quality.
3. Selection of students and teachers should consider their personal and professional characteristics.

4. Mentoring programs should be focused on the personal and professional development of the students, with the participation of professors who are medically and educationally competent and models of ethical persons.
5. Curricular design, implementation and evaluation should be focused on the person. Such curricula should include: a) courses on the humanities and social sciences complementing those on biomedicine, b) training on skills for making ethical, judicious and prudent decisions, and on attitudes respectful of the dignity and autonomy of patients, c) training on communication at all levels, pointedly including the establishment of empathy, and d) training on empowering families and communities. Such curricula must include early contact with patients and community and be subject of adequately evaluated innovations. Curricula centered on the person are necessary for the undergraduate, post-graduate (residence programs), and continuing medical education.
6. Inter-professional training programs should be developed, which ensure person-centered health care by teams that include doctors and other health professionals.
7. Worthy educational activities should be designed, implemented and evaluated. Such activities should include communication exercises, motivational interviews, collaborative sessions for diagnosis and therapeutic decisions, educational simulations, reflective learning, group work with patients and family members, teacher support sessions, video recordings, and narrative and artistic activities.
8. Diverse learning environments should be planned, reflecting the broad field of activities expected of health professionals, considering prominently primary and ambulatory care.
9. Adequate institutional infrastructure for a medical education centered on the person should be developed. This should include facilities and appropriate personnel for simulations in communication, person-centered diagnosis and treatment, and educational units to advise and evaluate professional training.
10. Research programs should be established for the development of new educational methodology and its systematic evaluation, within the framework of person-centered medicine.

Introducing the Papers in this Issue of the Journal

Person-centered Medical Education is present in various forms and extents in the papers published in the present issue of the *Journal*. They are briefly introduced below. Of note, they cover as a set contribution from Latin America, Europe, Africa and Asia.

The 2016 Madrid Declaration on Person Centered Medical Education and the Goals of health Care is published as a second Editorial. It emerged from the Fourth International Congress of Person Centered Medicine in Madrid. It highlighted the experience of the Francisco Vitoria University which graduated then its first medical school class trained under person-centered medicine principles.

The first regular article intended to accompany and support the 2016 Madrid Declaration was authored by James Appleyard, Michel Botbol, Fernando Caballero et al [16]. They point out that health is about people. The goal of physicians and all health professionals, irrespective of nationality and specialty is to

share a common global vision for the future. In this, all health professionals in all countries should be educated to gather knowledge, and to engage in critical reasoning and practice to high ethical standards so that they are competent to participate in person-centered and people-centered health systems as members of locally responsive and globally connected teams. Thus one of the driving purposes of medical education must be to enhance the performance of health systems for meeting the needs of patients and populations in an equitable and efficient way. A crucial factor in this endeavor will be the successful adaptation of professional education for local and national leadership in workforce teams that are capable of extending reach to all people. They set the purpose of their paper to explore a deeper understanding that a person centered approach is essential as to how this can be achieved.

The second regular article was prepared by Jeff Huarcaya-Victoria and Jorge de la Cruz-Oré from Lima to report on their study on Correlates of Empathy Level in Incoming Medical Residents in a Large Peruvian Hospital [20]. They noted that empathy is an important ability for interpersonal relationships, of special interest in the relationship between physician and patient. They found that medical residents who identified themselves as affiliated to a religion as well as those who had a professional mentor for treating patients obtained higher scores of empathy level. While the study reflected positively on the establishment of a research program on empathy, further studies, including longitudinal ones are warranted.

Ottomar Bahrs and his colleagues from Duesseldorf and Goettingen in Germany authored the third regular article presenting Review Dialogues as an Opportunity to Develop Life Course Specific Health Goals [21]. They observed that family physicians accompany people of all ages throughout their life span whose health situation is closely connected to missions and tasks in their family context. These tasks may be modified longitudinally and form the background for their individual health goals. They developed a specific instrument, the Review Dialogue (RD), to help in obtaining a person-related overall diagnosis and in agreeing on health goals shared by both patient and family doctor. The authors found that RDs assist in creating awareness of the meaning of the patient's biographically-based current tasks, and that they improve the capacity to reflect on the interrelationship of these tasks and the health goals.

The fourth regular article was authored by Tapas Mazumder and Ahmed Ehsanur Rahman and their colleagues in Netrokona district, Bangladesh and in Geneva, Switzerland [22]. It involved advancing person-centered maternal and newborn health care through birth preparedness and complication readiness in rural Bangladesh. They found that discussion on birth preparedness and complications readiness (BPCR) in households and courtyard meetings stimulated families' and communities' engagement in maternal-newborn health. There was significant increase across most indicators related to BPCR practice among women and husbands' involvement between baseline and endline. They concluded that carefully co-designed BPCR interventions should be further expanded within Bangladesh and beyond in order to advance person-centered care and progress toward the Sustainable Development Goals (SDGs).

Vigdis Abrahamsen Grøndahl and her colleagues from Halden and Tistedal in Norway authored the fifth regular article of the present Journal issue. It involved an intervention study and assessed the impact of person-centered care on residents' perceptions of care quality in nursing homes [23]. They found that residents' perceptions of care quality increase when person-centered care is operationalized and takes precedence over the ward's routines or is part of the ward's routines. The results indicate that it is possible to design a care system where the residents are at the centre of the health care offered.

The last regular article was written by Heena Narotam and Helen Sammons from Cape Town, South Africa. Their qualitative study explored experiences of expressive aphasia in brain injury patients in order to identify helpful recommendations for alternative communication and for promoting mental health and well-being [24]. They found that persons with new onset expressive aphasia during acute care at a large South African hospital experience negative emotions (such as feelings of frustration, entrapment and sadness) as well as inadequate responses to their desire to use alternative forms of communication. Anticipation of such negative experiences may substantially help communication. Formal training in this regard is recommended for health care professionals. Also, visitors to patients with expressive aphasia require basic instruction on the use of alternative communication.

This Journal's issue ends with information on important relevant events, i.e., a Summary Report from the 4th International Congress of Person Centered Medicine in Madrid.

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