

Women's Health and Person Centered Medicine

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Introduction

In conceptual and practical terms, Women's Health involves women's emotional, social, cultural, physical and spiritual well-being and is determined by the social, political, cultural, and economic context of women's lives, as well as by biology. This definition of women's health recognizes the validity of women's life experiences and women's own beliefs about and experiences of health [1]. These perspectives enunciated in a major presentation on Person-centered Women's Health Forty Years after Alma Ata, imbricate well with a well-established conceptual structure of person-centered integrative diagnosis [2] that delineates thorough and comprehensive clinical diagnosis as covering both ill-health and positive health and also involving health contributory factors and health experience, values, and preferences. This affirms the high relevance of the key concepts of Person Centered Medicine to discuss major aspects of women's health and to help moving it forward.

Consequently, this brief statement on the relationship between Person Centered Medicine (PCM) and Women's Health (WH) will review the principles of PCM, all highly relevant to Women's Health, as well

as the value of an examination of the context of WH both cross-sectionally and longitudinally, and the challenges and promises of maternity care. Finally, an introduction will be offered to the documents and articles published in the present issue of the International Journal of Person Centered Medicine.

Principles of Person Centered Medicine and Women's Health

The development of person-centered clinical care is inscribed within an international programmatic movement towards a medicine focused on the totality of the person. This movement, with broad historical bases, has been maturing since 2008 through conferences with global health institutions, research projects and academic publications [3, 4].

A study was conducted by the International College of Person Centered Medicine with support of the World Health Organization towards the systematic conceptualization of Person Centered Medicine and the development of measures to appraise progress towards such care [5]. The above objectives have been approached through literature reviews, international consultations, and reflections on the patterns and indications obtained.

The principles of Person Centered Medicine (printed in bold italics) elucidated through the above mentioned study and strategies relevant to their implementation follow. Many of these strategies are particularly relevant to women's health.

Ethical Commitment

Respect for the dignity of the person.

Recognition of the autonomy and responsibility of the person in the care of their health

Informed consent as a dialogical ethical process.

Promotion of the person's life project.

Cultural Awareness and Responsiveness

Awareness of cultural diversity, concerning ancestry and current context, with which the person identifies.

Attention to and respect for the person's cultural explanations about health and illness.

Clinicians' awareness of their own cultural identities.

Integrative response in diagnosis and therapeutic plans to the cultural identities of the patient and the clinicians.

Holistic Framework

Attention to the biological, psychological, social, economic, ecological, cultural and spiritual aspects of diseases

Consideration of the above aspects regarding positive health and well-being.

Specific attention to the family context in the understanding of the health status of the person and in restorative and promotional health actions.

Consideration of the total and interactively dynamic integrity of the person in context.

Communicative and Relational Focus

Establish empathy as a key communication support.

Facilitate that patients express everything they want to express.

Listen to the patient attentively, with "more than two ears" [6], attuned to their conscious and sub-conscious subjectivity and narrative.

Consideration of the ethical relationship of service between clinician and patient.

Cultivate communication and effective relationships with the family and the team of professionals involved.

Individualized Care

Consideration of the individual's unique biological, psychological and social profile.

Consideration of health risk factors and protective factors.

Consideration of the patient's health experience, values and preferences

Delineation of an individualized program for care.

Establishment of a Common Ground for Diagnostic Understanding and Decision Making

Create in each case a collaborative matrix among involved clinicians, patient and family members.

Aim at joint diagnostic understanding through dialogue and shared information.

Shared decision making for care.

Organization of Integrated and People-Centered Services

Identification of community health problems and needs.

Planning, development and implementation of services in collaboration with the community.

Establishment of community mechanisms for monitoring of services.

Integration between health and social services in the community.

Medical Education and Health Research Focused on the Person

Attention to both personal and professional development of the student, teacher, and researcher.

Designing mentoring programs to promote human development.

Scientific research concerning the total person and not only illness.

Consideration of the participation of the person in the various phases of scientific investigations

Historical and Contextual References on Life and Care

A couple of historical references, quite distant from each other, document incisive perspectives on the critical relationship of life with care and health. One comes from Yuval Harari who in his *Sapiens: A Brief History of Humankind* [7] reviews how for the Neanderthals 70,000 years ago, life and survival depended on the familial support group. Other fundamental human concerns and tasks such as health and education appeared to be part and parcel of caring for life.

Another perspective comes from Jose Ortega y Gasset, who in his *Meditaciones del Quijote*, enunciated “Yo soy yo y mi circunstancia y si no la salvo a ella no me salvo yo” (I am I and my circumstance, and if I do not take care of it I do not take care of myself) [8].

Women have always had a special role in human caring. To illustrate, in a study of the person in the family that people seeking mental health care in Pittsburgh reported as feeling most comfortable with as a carer, it was the mother (among parents), it was a sister (among siblings), and it was a daughter (among children) [9, 10]. To be noted, however, sometimes carers feel ignored and even abused by society. The president of the European Federation of Associations of Families of People with Mental Illness (EUFAMI), pleaded that they (often women) are not just carers, as also they have a history and aspirations [11].

Maternity and Maternal Care: Challenges and Promises

Maternity is a distinctive and crucial aspect of women’s health. Despite the obvious importance of this topic, Webber [12] has noted that disrespectful and abusive care of women during their pregnancy represents a barrier for access to necessary and quality health care services for antenatal care and delivery in many places around the world.

Such observations have led to the design of *respectful maternity care (RMC)* [13]. Despite the relatively nascent stage of RMC, implementation studies are emerging [14] to help understand the process and its prospective extension to different countries and world regions.

Under the heading *Centering the Invisible Mother*, a 2019 The Lancet editorial [15] documents that factors that contribute to maternal mortality range from patient issues, such as poor knowledge of warning signs, to larger, more systemic issues that could affect maternal health: lack of transportation access, inadequate care, and lack of obstetric emergency knowledge from care providers. All these factors highlight a lack of attention to the health of mothers before, during and after they give birth.

Illustratively, only 6% of state and federal funding for child and maternal health in the USA focuses on the mother.

Undoubtedly, person-centered women's health must include respectful and person-centered maternity care [1].

Introduction to the articles published in the present issue of the Journal

This issue of the Journal starts with two editorials after the present Editorial Introduction. One deals with the 2018 Geneva Declaration on Person-centered Women's Health 40 Years after Alma Ata, produced by the International College of Person Centered Medicine and composed of a substantial preamble and five recommendations [16]. The other editorial involves the 2017 Lima Declaration on Person-centered Medical Education, emerging from the Third Latin American Conference on Person Centered Medicine and released by the very active Latin American Network of Person Centered Medicine [17].

The first regular article is authored by Wilson et al [18]. It notes that forty years after the Alma Ata Declaration, opportunities and challenges in achieving person-centered care for all people remain, particularly for women. This paper describes the foundations and horizons of the Geneva Declaration Person-Centered Women's Health Forty Years after Alma Ata, issued as a consensus statement of the 11th Geneva Conference on Person Centered Medicine. Women have particular health needs, partly based on reproductive health, influenced by the social context of their lives. The authors argue that there is a need for recommitment to the principles of Alma Ata if health for all is to be achieved. Equitable access to person centered integrated care for women and men throughout the life course are a human right. Universal health care, based on primary health care as a general health strategy, is a top priority.

The second article by Mezzich and Appleyard [19] is aimed at identifying contemporary international recommendations for the development of a person-centered medical education. The methodology employed has included selective reviews of the literature and international consultations, particularly in regard to the Declarations on Person-Centered Education for Health Professionals produced at recent International Congresses and Latin American Conferences of Person-centered Medicine. The main recommendations elucidated include: 1. basing it on the principles and strategies of person-centered medicine (PCM), 2. Establishment of an organizational culture centered on the person in the health services, 3. Selection of students and professors with appropriate personal and professional characteristics, 4. Development of mentoring programs towards the personal and professional formation of the students, 5. Design, implementation and curricular evaluation and educational activities focused on the person, 6. Development of professional and inter-professional training programs, using different learning environments, and 7. Cultivation of scientific research for the development of new educational methodologies and their systematic evaluation.

Glare authored the third regular article focused on a person-entered approach to oncology and palliative care [20]. It noted that the advent of evidence based medicine (EBM) saw a marked improvement in clinical decision making when compared to the “this is what works best in my experience” approach which preceded it. Aside from the fact that there is good quality evidence available for only a fraction of treatments, a limitation of EBM is that focuses primarily on identifying the best treatment of a disease and does not allow for differences in patients’ goals, priorities, and expectations or how they cope with their illness. This biomedical focus of EBM is particularly problematic for patients with chronic, incurable illnesses (which includes many cancers), for whom a person centered approach will be superior. This article explores what it means to take a person centered approach to oncology & palliative care.

Perales et al authored the fourth regular article [21]. The aim was to evaluate comparatively person-centered care at four prototype hospitals in Lima, Peru using the Person-centered Care Index (PCI). Concerning procedures, following the evaluators training, they applied the PCI to their own section (surgical and medical clinical) of a hospital. Engaged for the study were four hospitals belonging to different Peruvian health care systems: two public hospitals (one general and one oncological), one Social Security hospital, and one private hospital. Across hospitals, 240 health professionals were involved in rating the medical or surgical services of the hospital where each worked. The study yielded interesting inter-hospital comparative results and substantial content validity ratings for the PCI. The findings suggest the value of the PCI for clinical and health service evaluations and research on person centered care in Latin America.

This Journal issue ends with a summary report of the 11th Geneva Conference on Person Centered Medicine and the program of the Fourth Latin American Conference on Person Centered Medicine in La Paz, Bolivia.

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