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Editorial Introduction

ICPCM Educational Program on Person Centered Care: General Concepts and Organization

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Introduction to the ICPCM Educational Program on Person Centered Care

The International College of Person Centered Medicine's Educational programme is being developed in collaboration with our colleagues from the Indian Medical Association from a series of three symposia held during the ICPCM's 6th International Congress of Person Centered Medicine in New Delhi, 2018. The purpose of the program is to spread understanding of the principles underlying person centred medicine and to address strategies and procedures for person-centered care in terms of knowledge, skills and attitudes. [1] The program emphasises the centrality of the individual person in medical practice and the need for a person and people centered approach to Health Care [2]. To achieve this goal, medical professionalism within an interprofessional environment which is based on values inherent in medical ethics and human rights form the foundations of Person Centered Care [3]. The skills and attitudes developed for the person-centered management of clinical problems and health promotion need to be renewed in everyday clinical practice for the promotion of wellbeing and the management of Illness [4].

Health systems have fragmented and depersonalised clinical care, subjecting it to heavy commercialisation and bureaucratisation, depending on the country. Increased specialisation has given rise to increasingly narrower medical subspecialties. There is a growing dissatisfaction amongst the medical profession with their professional role. [5] As a consequence of this 'hyper-technification' there is a major 'scientistic' reduction in medical care, which tends to distance doctors from giving care rooted in genuinely human encounters and many doctors experience a loss of meaning in their work life. Such professional burnout, affecting the emotions, mentality, behaviour and sociability of doctors, has a proven negative impact on

work teams and patient care. At the same time, the public health is being endangered by new infectious, environmental, and behavioural threats superimposed upon rapid demographic and epidemiological transitions. As health systems struggle to keep up with demand and are becoming more complex and costlier, additional stress is placed on health workers.

In many countries, professionals are encountering more socially diverse patients with chronic conditions, who are more proactive in their health-seeking behaviour. Patient management requires coordinated care across time and space, demanding unprecedented teamwork. Professionals have to integrate the explosive growth of knowledge and technologies while grappling with expanding functions—super-specialisation, prevention, and complex care management in many sites, including different types of facilities alongside home-based and community-based care [6]. Alongside the rapid pace of change in health, there is a parallel revolution in education. The explosive increase not only in total volume of information, but also in ease of access to it, means that the role of universities and other educational institutions needs to be rethought. [7] Learning, of course, has always been experienced outside formal instruction through all types of interactions, but the informational content and learning potential are today without precedent. In this rapidly evolving context, universities and educational institutions are broadening their traditional role as places where people go to obtain information (eg, by consulting books in libraries or listening to expert faculty members) and to incorporate novel forms of learning that transcend the confines of the classroom. The new generations of learners need the capacity to discriminate vast amounts of information and extract and synthesise knowledge that is necessary for clinical and population-based decision-making. These developments point toward new opportunities for the methods, means, and meaning of a person centred medical education [8].

The language we use of patient involvement in healthcare is important. Currently it is both confusing and controversial. Language transmits values and beliefs, reflecting and shaping social perceptions and power relationships in the current use of the language of patient involvement in healthcare, individuals are labeled in different ways which are descriptive not *of a person* but *of a relationship* and likely never will reflect the wide diversity of each individual That is why the prefix *person centered* is so important

The word ***patient*** is limited in its descriptiveness. By definition a patient is “a sufferer- one who suffers patiently and one who is under medical treatment”. This implies a lack of autonomy, passivity and dependency [9] The words people use to describe themselves reflect their relationship with their illness or disability and can therefore have personal and emotional significance.

In the UK, the terms ‘user’, ‘service user’, consumer, and client have increasingly replaced ‘patient’ in relation to involvement in health and social care service delivery, research or education. Service user, however, defines a person by a single narrow aspect of their life (using a specific service) and can be pejorative, demeaning and stigmatizing. It neglects those who do not or cannot access services, and it does not devolve power or respect to the people who use services. Many ‘patients’ or ‘service users’ involved in health professional education are not ill or currently receiving medical care. The prefix ‘lay’ defines people in terms of who or what they are **not** (eg, a professional). It implies a lack of expertise when many patients will themselves be experts in their own illnesses.

Person Centered Medicine does not recognize an obligation to care for their ‘patient’s’ solely on their own terms – the clinician just being a provider of goods - but rather within the context of two people, the person as a patient and the physician as a person engage in a dialogical process of shared decision making focused on the patient as a person, and his/her best interests, in a caring atmosphere within a relationship of engagement, trust, and responsibility.

The two foundational components of medical practice, the science and the art of medicine, should be applied within an ethical and humanistic framework [10]. There is therefore a need to move towards more personalised, integrated and contextualized models of clinical practice with the active involvement of 'patients' as persons, and with members of their families.

Current ***evidence based medicine*** overemphasizes the value of scientific standardization, its compartmentalism of knowledge, fragmentation of services, and relative neglect of patients' personal concerns, needs and values, while ***patient centered medicine*** overemphasizes patient's choice. In contrast, ***person centered medicine***, with its biological, social, psychological, and spiritual model brings both science and art together. Person centered medicine ensures that patients are known as persons in the context of their own social worlds, listened to, informed, respected, and involved in their care and having their wishes honoured during their health care journey.

Person centered care fosters a feeling of connectedness with an interpersonal outlook of unity which promotes attitudes of hope, empathy and respect. One of the key aspects of clinical care is reaching a diagnosis in its widest sense which provides the fundamental basis for planning therapy and care. The *person centered integrative diagnosis model* is designed to do this [11]. It assesses informational domains of both ill and positive aspects of health on a three level schema – the first is the health status, the second the experience of health and illness, and the third the contributors to health and illness. With an enhancement of wellbeing, the rates of relapse and recurrence of physical and mental disorders tend to be reduced.

Program Organization

The structure of the ICPCM Educational Program on Person Centered Care involves three components. The first one corresponds to general concepts of person centered medicine and the organization of the educational program. The second component involves communication, interviewing and comprehensive diagnosis. And the third component involves care planning and shared decision making in general and in major conditions as well as inter-professional collaboration and health services organization.

Introducing the Papers in this Issue of the Journal

The present issue of the Journal is dedicated to the first set of the Educatonal Program.

In the first article, Person Centered Medicine Foundations for Medical Education, Mezzich et al trace the ICPCM's institutional journey which, from its beginning, was defined as an approach that places the person in context as the center of health and as the goal of health care. As a theory of medicine, and in contrast to reductionist perspectives, person centeredness involves medicine informed by evidence, experience and values, and oriented to promote the health and well-being of the whole person. [12]) Through a critical review of the literature and broad international consultation a study on the systematic conceptualization and measurement of PCM was undertaken by the International College of Person Centered Medicine with support from the World Health Organization. [13]

This elucidated the key concepts of PCM to be 1) Ethical commitment, 2) Cultural awareness and responsiveness, 3) Holistic scope, 4) Relational and communicational focus, 5) Individualized programming of care, 6) Common Ground among clinicians, patient and family for collaborative diagnosis and shared decision-making, 7) People-centered and integrated organization of services, and 8) Person-centered health education and research.

The collegial environment if the ICPCM fosters collaboration at all levels, creativity and the development of ideas through its annual Geneva Conferences and also annual International Congresses in different world locations. [14]

In the second article on “Medical Professionalism and Ethical and Human Rights Foundations of Person Centered Care”, Snaedal argues that humanistic and scientific medicine must take into consideration the whole person, whether healthy or during disease, as well as his or her family and immediate surrounding. It is thus inherently centered on the person (15) and it must be based on general ethical and human rights as declared in various international documents. As the foundations of medical professionalism and competence, it is of profound importance for successful outcomes in health care [16]. The policies adopted by the World Medical Association (WMA) representing more than 9 million physicians worldwide are therefore having a central role in physicians’ everyday work and their ethical conduct [17].

One of the first policies to be adopted by the WMA when it was founded in 1948 after World War 2, was the physician’s oath or pledge named the Declaration of Geneva (DoG) [18]. The pledge is still considered to be the modern version of the Hippocratic oath and is intended to be addressed to and accepted by medical students when they enter the profession. The WMA Declaration of Seoul on Professional Autonomy, states that professional autonomy and clinical independence are core elements of medical professionalism and are essential for the delivery of high-quality health care and therefore benefit patients and society. The WMA laid out the basis for the rights of patients in its Declaration of Lisbon. [19] In its preamble it is stated: “while a physician should always act according to his/her conscience, and always in the best interests of the patient, equal effort must be made to guarantee patient autonomy and justice.”

As Person Centered Medicine is inherently centered on the person in contrast to Evidence Based Medicine (EBM) that to great extent focuses on standardized groups, it is broadly consistent with policies adopted by the United Nations (UN) and the World Medical Association (WMA).

The third paper on "The Making of a Physician: a Person Centered Approach" by Sharma and Sharma from New Delhi emphasises that the essence of medicine lies in the therapeutic relationship between the doctor and the patient as a person in totality in both health and disease. The relief of suffering and the cure of a person must be seen as the twin obligations of the profession with true dedication to the cure of the sick. The cure of disease is influenced by our scientific knowledge and growth of an evidence base while the relief of suffering is guided by our compassion and consolation skills.

There is no such thing as valueless Medicine. All physicians in medicine practice need to carry shared professional values, standards, aims and goals over their lifetime of medical practice. The value of human life is to be respected whether patients are in the developed or developing countries. In Sharma and Sharma’s view the final answer lies in the conscience of the doctor, a universal respect for human values, and the ideology of humanism. There is an urgent need to incorporate and re-emphasise "value" and "compassion" in the care of patients within medical education and integrating person-centred care into daily medical practice. An ethical and value-based approach must also be regarded as an essential part of health service management

In the fourth paper on „Concepts and strategies of people-centered public health”, which includes social determinants of health, prevention and health promotion, Canchihuaman et al contend that in order to consolidate the advancement of public health worldwide, a wider and holistic approach is necessary. A people-centered public health could address this in association with person-centered clinical medicine as two sides of the same coin [20].

The person-centered approach is rooted in the recognition that both the right of liberty and the right to welfare are fundamental. This means to value the liberty of a person as well as the responsibility of a person to the welfare of others and the environment. This approach implies a natural commitment to principles and values of "equity, social justice, sustainable development and those of medical ethics" and to a holist conception of persons with its different elements spiritual, biological, social, cultural, and psychological. Furthermore, it has been recommended that both clinical care and public health practices "should share these values" [20]. In the case of public health, a shift to a people-centered public health approach will mean then to follow these principles, values and concepts while performing public health activities through organized community efforts. A people-centered approach to public health may lead to more efficient public health actions by enhancing prevention, promotion, protection and prolonging life. It also addresses social and environmental determinants of health and the organization of community efforts by developing sustained, continuous and integrated services throughout the different stages of a person life. Ultimately, it promotes sustainable development through the articulation of public health and primary care within universal health coverage [21].

The issue also includes an editorial and informational items coming from Person Centered Medicine Conferences in Latin America, one of the most active world regions in the cultivation of this growing medical perspective.

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