FROM THE THIRD GENEVA CONFERENCE ON PERSON-CENTERED MEDICINE: PERSON-CENTERED CLINICAL CARE ACTIVITIES

Conceptual Appraisal of the Person-centered Integrative Diagnosis Model

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Abstract

The Person-centered Integrative Diagnosis (PID) is an emerging model of conceptualizing the process and formulation of clinical diagnosis. It aims at implementing into regular clinical practice the principles and vision of Person-centered Medicine, which proposes the whole person in context as the centre and goal of clinical care and public health. The Person-centered Integrative Diagnosis entails a broader and deeper notion of diagnosis, beyond the restricted concept of nosological diagnoses. The PID multilevel schema intends to provide the informational basis for person-centered integration of health care. It involves a formulation of health status through interactive participation and engagement of clinicians, patients, and families using all relevant descriptive tools (categorization, dimensions, and narratives). The PID model, as part of the Person-centered Psychiatry program, is intended to be used in diverse settings across the world and to serve multiple needs in clinical care, education, research, and public health. This paper focuses on the validation of the PID model by assessing its acceptability among practitioners and other stakeholders through international survey and discussion groups. The results of these surveys indicate high levels of conceptual acceptability of the PID model.

Keywords
Person-centered Medicine, Person-centered Integrative Diagnosis; Diagnosis.

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Introduction

Person-centered Medicine aims at articulating science and humanism for a medicine of the person (of the totality of the person's health, both ill and positive aspects), by the person (with clinicians extending themselves as full human beings), for the person (assisting the fulfillment of the person's health aspirations and life project), and with the person (in respectful and empowering relationship with the person who consults) [1]. Person-centered Medicine endorses a holistic concept of health that are rooted in ancient medical traditions and the recent emergence of multiple perspectives from around the world. These perspectives call for the need to pay greater attention to the totality of the person seeking care, the integration of health and social services, and to aspire towards personalized approach to care [2-9].

The Person-centered Integrative Diagnosis (PID) is an emerging model of conceptualizing the process and formulation of clinical diagnosis. It aims at implementing into regular clinical practice the principles and vision of Person-centered Medicine, which proposes the whole person in context, as the centre and goal of clinical care and public health. The Person-centered Integrative Diagnosis entails a broader and deeper notion of diagnosis, beyond the restricted concept of nosological diagnoses.

The PID multilevel schema intends to provide the informational basis for person-centered integration of health care. The primary purposes of the PID Model are to

provide a diagnosis of Health Status (Ill & Positive), to serve as informational bases for clinical care and public health, to enhance clinical care and outcome, to promote recovery and health restoration and to promote prevention and health promotion. It involves a formulation of health status through interactive participation and engagement of clinicians, patients and families using all relevant descriptive tools (categorization, dimensions, and narratives) [10].

The PID model is intended to be used in diverse settings across the world and to serve multiple needs in clinical care, education, research and public health. Validation of this model may be initiated by first assessing its conceptual acceptability by indented users. This paper focuses on assessing the acceptability of the principles and domains of the PID among practitioners, users, and stakeholders across geographical settings through survey and discussion groups.

The PID model domains:

The organizational schema of the emerging multilevel PID model assesses the health status of the person presenting for care, including presenting pathology. The two broad domains of the PID cover ill health and positive aspects of health. The PID schema provides for a standardized component and for a narrative, idiographic personalized component for each of these domains. The informational bases for intervention and care, such as developing treatment plans, is derived from the integration of the assessment of the PID domains and components. The PID also aims at providing the informational bases for education, public health planning and for administrative functions [10].

The PID model has currently three main levels within each health status domain (Ill health versus positive health status domains) [11-13]. Ill health and its burden is the first level within the ill health status domain. This is further divided into two sublevels: clinical disorders (mental and general health) and disabilities (regarding self-care, occupational functioning, functioning with family and participation in community activities). The idiographic personalized narrative covering the experience of illness represents the second level of the ill health domain. This narrative addresses sufferings, values and cultural experience of illness and care. Risk factors and contributors to ill health is the third level within the ill health domain. Risk factors include inner risk, such as genetic vulnerability and external risk, such as stressors. These factors are conceptualized within a biopsychosocial framework.

The first level of the positive health status domain is Wellness. Wellness is further divided into two sublevels. These include remission/recovery (health restoration and growth) and functioning. Idiographic personalized narrative covering the experience of health is the second level of positive health domain. This may include quality of life, values and cultural formulation of identity and context. Protective factors and contributors to positive health conceptualized in a biopsychosocial framework represent the third level in the positive health status domain. Examples of protective factors may include inner protective factors, such as resilience, and external protective factors, such as social support. (See Figure 1).

Figure 1: Person-centered Integrative Diagnosis Model Domains

PID validation: acceptability

a. Survey of Global Network of National Classification and Diagnosis Groups:

The conceptual acceptability and applicability of the PID domains were assessed through a survey and discussion groups of international health practitioners and other health stakeholders, such as users, families and advocates. Building on its long experience in developing diagnostic models, [14-15] the World Psychiatric Association (WPA) Section on Classification, Diagnostic Assessment and Nomenclature has conducted a survey among the members of the 43-country Global Network of National Classification and Diagnosis Groups. The survey was constructed in consultation with network members and aimed at surveying the most important domains to consider in the development of future diagnostic classification for psychiatric disorders. Prominent topics of the Survey included the following areas: (i) key purpose of diagnosis: important areas of information to be covered; (ii) suitable number of categories in the classification; (iii) diagnostic descriptive tools or approaches; (iv) contributors to diagnostic evaluation; (v) most problematic ICD disorder categories; and (vi) additional issues to improve future systems.

Seventy four per cent of the groups responded. We discuss here responses to items most relevant to the PID. Treatment planning was most frequently chosen as the key role of diagnosis. Communication among clinicians and diagnosis as a mean to enhance illness understanding were also identified as key roles of diagnosis. The survey also highlighted the areas of information judged important to be covered by psychiatric diagnosis. These included disorders (100%), disabilities (74%), and risk factors (61%), experience of illness (58%), protective factors (55%), and experience of health (52%). These responses suggest that in addition to the recognized importance of nosological diagnosis, subjective explanatory narratives of illness and health are also deemed quite valuable. The survey responses also highlighted the importance of utilizing a variety of descriptive tools including categories (81%), dimensions (74%) and narratives (45%). An important result of the survey is that 80% of responders choose clinicians, patients, and carers together as key players in diagnostic evaluation process as compared to clinicians alone (20%).

b. International Discussion Groups

A number of discussion groups were undertaken in 2009 with a variety of health stakeholders conducted at international events in Athens (Greece), Uppsala (Sweden), and Timisoara (Romania). The discussion groups included 57 participants from 9 countries. The composition of the groups included mental health practitioners, general practitioners, users, family members, and advocates. The groups addressed the following eight questions: Should Diagnosis 1) Go beyond disease? 2) Include dysfunctions? 3) Include positive aspects of health? 4) Include experience of health? 5) Include contributing factors? 6) Use dimensions too? 7) Use narratives too? 8) Be an interactive process and not only a formulation?

In an overwhelming manner, the participants in the three settings considered that diagnosis should go beyond just disease. Participants unanimously responded that diagnosis should cover dysfunctions and a great majority of them felt it is very important to include positive aspects of health. Over 83% of the participants endorsed the inclusion of experience of health in the diagnosis. Furthermore, there was a unanimous agreement on incorporating contributing factors (including risk and protective factors), and the use of descriptive methods, including dimensions and narratives in addition to conventional categories. Participants also emphasized diagnosis as being a process and not only a formulation and also highlighted the partnership among carers and users as fundamental.

Discussion

The results of the survey and discussion groups indicate the high acceptability of the domains and conceptual framework of the PID among a diverse group of clinicians and stakeholders. The ill-health domains of the PID were unanimously indicated as important to be included in the diagnostic model. This is expected given that these domains constitute a key traditional role in medicine. They are also directly connected to suffering and are a central focus of help-seeking behavior and request for care by patients.

It was encouraging that non-traditional aspects of the present model had high acceptance by diverse international group of participants from across the globe. High acceptance was expressed for the broader conceptual and paradigmatic shifts that are embodied in the PID. This includes the broadening concept of diagnosis, which has traditionally focused only on ill health and related aspects. There was high acceptance for the inclusion of positive aspects of health. This has broad implications for the role of the physician and of how care is viewed by stakeholders and users.

The enhanced focus on positive aspects of health will promote a more active role for the health care provider, users and other carers in health promotion, prevention, recovery and health restoration efforts. Along with this broadening of the perspective role and active involvements, it is also encouraging that areas that usually encourage patients' expression of their experiences of health and ill health have also received broad acceptance by the groups participating in the survey and discussion groups.

The results of the survey and discussion groups further validate the acceptability of the conceptual model and framework of the PID domains. These results may also indicate an emerging paradigm shift regarding the role of the health care provider, along with that of persons seeking care and other stakeholders on what is expected of the process of diagnosis and care. Future efforts should be directed to evaluating the clinical validity of the PID through its application and evaluation of its processes and resulting outcomes.

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