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EDITORIAL INTRODUCTION

Person Centered Medicine: Core and Diversity

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Introduction

In the conceptualization of Person Centered Medicine (PCM) one can recognize core concepts as well as diversity at multiple levels. The core concepts convey vision and depth. Diversity displays plurality, richness and scope. And both are intertwined and articulated through the unfolding process and journey that the construction of PCM represents.

This paper briefly elaborates on these complementary perspectives of PCM. And ends introducing a set of papers that illustrate its core and diversity.

The Core of Person Centered Medicine

From the beginning of its institutional journey, PCM has been referred to as an approach that places the person in context (and not organs or disease) at the center and as the goal of medicine and health care [1]. It has also been emphasized that PCM seeks fundamentally to articulate science and humanism in medicine and health care and refocusing these on the whole person [1].

Furthermore, it has been posited that PCM is dedicated to the promotion of health as a state of physical, mental, socio-cultural and spiritual wellbeing as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person [2].

The purposes of the PCM have been also summarized as promoting a medicine *of the person* (of the totality of the person's health, including its ill and positive aspects), *for the person* (promoting the fulfillment of the person's life project), *by the person* (with clinicians extending themselves as full human beings with high ethical aspirations) and *with the person* (working respectfully, in collaboration and in an empowering manner) [3, 4].

Concerning the identification of key concepts underlying PCM, the one that seems to have been most emphasized is its ethical base. This indicating that ethics is fundamental for all medical activities, including clinical care, education and research [5]. It has also been argued by two recent presidents of the World Medical Association that PCM represents an ethical imperative for the medical profession [6].

Along the lines of such inquiries, a recent bibliographic and consultation study to explore the systematic conceptualization of person centered medicine [7], has elucidated the following key concepts: ethical commitment, holistic scope, cultural awareness and responsiveness, communication and relationship focus, individualized treatment, common ground for diagnosis and care, people-centered systems of care, and person-centered health education and research.

The Diversity of Person Centered Medicine

Multiple dimensions, domains, and levels display the diversity of PCM. Some of the most significant will be briefly summarized here.

One refers to the plurality of medical specialties and health care disciplines involved. The medical specialties that at present seem to be most prominently participating in the development of PCM are family medicine [8], pediatrics [9], internal medicine [10], old age medicine [11], and psychiatry [12]. In addition to medicine, among the most involved health care disciplines, are, first, nursing [13, 14], but also social work [15], and pharmacy [16].

Another plurality encompasses health stakeholders. Prominent among these, besides health professionals, is the International Alliance of Patients' Organizations [17], which has participated in the construction of PCM from the beginning of the Geneva Conferences of Person Centered Medicine and has a representative seating on the Board of the International College of Person Centered Medicine. Another frequently participating stakeholder refers to associations of patients' families [18].

A major source of diversity and international learning is that afforded by the International Congresses of Person Centered Medicine held annually since 2013. The first one was in Zagreb, Croatia in November 2013 [19]. The Second International Congress took place in Buenos Aires, Argentina in November [20]. The Third International Congress was celebrated in London, United Kingdom in October 2015 [21].

Also noteworthy is the range in domain, from individual clinical care to public health. Most of the initial activities and publications in PCM refer to clinical care. More recently, PCM work has extended to public health, often under the term of people-centered care. The latter has been largely related to the World Health Assembly 2009 Declaration which included People-centered Care as one of its pivots [22]. This has been followed by WHO's Global Strategies such as the one on People-centered Integrated Health Services.

Introducing the Papers Published in this Journal Issue

The set of papers published in the present issue of the Journal illustrate the core and diversity of Person Centered Medicine (PCM). They are briefly summarized below.

Published as an editorial is the 2015 London Declaration on Person- and People-centered Primary Care and Public Health released by International College of Person Centered Medicine [23]. In its preamble it argues that sustainable improvement in the health and well being the of the people of all nations will be achieved with a shared vision, understanding and action through the integration of primary care and public health. This should contribute to access to and coverage for universal health care services. It then calls for action on ten items from " Establish a shared goal of improvement in the health and well being of the population through person- and people-centered primary care and public health" to "The integration of health and social care should recognize that both are part of complex adaptive systems with many components that reciprocally influence one another in dynamic ways".

The first regular article comes from Denmark, where Hoegh and colleagues present a well documented and analyzed study on "A Year in the Life of a Person Recently Diagnosed with Atrial Fibrillation" [24]. They report that healthcare services target delivery of a connected patient journey as an indicator of a high quality of care, but knowledge of the patients' experience is sparse. This case study explores the lived experience of the quality of life and perception of health during the first year of the journey of a person recently diagnosed with atrial fibrillation. Data sources include field notes, transcripts, medical records, letters, and scores from standardized questionnaires. A phenomenologically inspired approach for qualitative data analysis and a descriptive approach for discovering exceptional changes in scores from questionnaires are used. The patient journey in the study consists of; 38 visits to general practice, five visits to the outpatient clinic, and two radio frequency ablations at hospital. Four central themes; balancing responsibilities, navigating the system, adjusting to the situation, and recognizing bodily reactions, are elaborated. In conclusion, hope for a better future is evident throughout the journey. Difficulties of balancing responsibility, conflicting information and lack of support and connection between general practice and the hospital result in putting the participant's dignity at stake. Despite two ablations the participant is affected in his daily life and family life due to physical limitations. Along the study adjustment to the situation is seen, and his new status as grandfather is surprisingly seen to facilitate this adjustment.

The second regular article by Cinar presents a Health Coaching Person Centered Approach for Healthy Lifestyles [25]. She reports that Health Coaching (HC), a patient-empowerment focused approach, is guided and supported by medical professionals to facilitate patients to explore, unlock and activate their self-potential to adopt healthy lifestyles. HC, a whole person and also a population-based approach, can be defined as a system-wide innovation aiming to positive social change. A National Health Service review showed that there is promising evidence about HC, particularly for supporting behaviour change. HC in this international intervention project appears to have been used for the first time as a holistic health promotion approach for oral health and diabetes type 2 (T2DM) management, in line with IDF-FDI (2007) declaration stating that oral health promotion should be part of diabetes management. The aim of the present study is to assess the effectiveness of HC on oral health and T2DM management among T2DM patients. This prospective international project was conducted in Turkey (2010-2012, 2015) and Denmark (2012 and 2014). The study consists of 2 stages [initiation-maintenance (6 months) and a 6-month follow-up]. Outcomes measures were clinical (HbA1c as diabetes index, and periodontal health) and subjective (satisfaction with access to health care, frequency of physical activity, toothbrushing and dental visit). Preliminary results show that at post-intervention there was a significant reduction of HbA1c (Turkey:0.8%, Denmark:0.4%, p=0.001) in HC groups. The figures for HE groups were non-significant. Daily toothbrushing was correlated with change at HbA1c and regular physical activity in HC groups. A person-centered health coaching approach focusing on multidisciplinary collaboration appears valuable to improve daily life health, particularly oral health, in diabetic patients.

The third regular article comes from London, where Joanna Groves, a former executive officer of the International Alliance of Patients' Organizations, presents "Person-centred Communications: How do People as

Patients Want to Be Spoken to?" [26]. She shares with us that the World Health Organization's (WHO) World Health Report of 2008 titled, "*Primary Health Care – Now More Than Ever"* put renewed emphasis on the values of achieving health for all and putting people at the centre of healthcare . In order to do this it is necessary to understand what people expect and want from healthcare and pertinent communications so that health systems can be designed that can respond to patients' needs, wishes and preferences. The paper's objective is to consider the initiatives which are being taken forward by numerous national and global initiatives to further person-centred healthcare and consideration of the evidence for this approach with particular regard to the role of communication in enabling healthcare to meet people's needs, wishes and preferences. To this effect, she reviews person-centred healthcare initiatives and evidence for impact and consideration of principles of person-centred care as they relate to healthcare communications. There is evidence for a person-centred approach to healthcare. There are fundamental principles relating to how communications can impact on patients being empowered to make informed decisions about their healthcare. Patient experiences and outcomes are improved when they have the opportunity for their wishes and preferences to inform shared decision-making in mutually trusting and equal partnerships with health professionals about their health and well being. She concludes that person-centred healthcare requires communication which enables respect for people's needs, preferences, dignity, values, autonomy and independence. Empowering patients and health professionals so that they can work in partnership to reach an informed decision on what the patient wants and expects from treatment should be the priority for policy-makers, health professionals and patients. There are some fundamental principles and many tools and initiatives that can support good communication and enable shared decision-making.

The fourth article is written by Yukiko Kusano and Erica Erhardt, officers of the International Council of Nurses in Geneva. It deals with the Nursing Profession's Contribution to Person- and People-Centered Primary Health Care [27]. They report that equity and access to primary health care (PHC) services, particularly nursing services, are key to improving the health and well-being of all people. Nurses, as the largest group of healthcare professionals delivering services wherever people are, have a unique opportunity to put people at the centre of care, making services more effective, efficient and equitable.

The paper intends to assess contributions of nurses to person and people-centered PHC. To this effect, they conduct an *a*nalysis of nursing contributions under each of the four sets of the PHC reforms set by the World Health Organization. Evidence and examples of nursing contributions are found in all of the four PHC reform areas. These include: expanding access; addressing problems through prevention; coordination and integration of care; and supporting the development of appropriate, effective and healthy public policies; and linking field-based innovations and policy development to inform evidence-based policy decision making. They conclude that *n*urses have significant contributions in each of the four PHC reform areas. The focus of nursing care on people-centeredness, continuity of care, comprehensiveness and integration of services, which are fundamental to holistic care, is an essential contribution of nurses to people-centered PHC. Nurses' contributions can be optimised through positive practice environments, appropriate workforce planning and implementation and adequate education and quality control though strong regulatory principles and frameworks. People-centered approaches need to be considered both in health and non-health sectors as part of people-centered society. A strategic role of nurses as partners in services planning and decision-making is one of the key elements to achieve people-centered PHC.

The fifth article represents a creative exploration from psychiatrists at the University of Miami on a Person-centered Yoga Therapeutic Approach for Adult Attention Deficit-Hyperactivity Disorder (ADHD) [28]. They report that ADHD affects 2.5% to 5% of the adult population, is often under-diagnosed and poorly managed with few treatment options. Limited pharmacotherapeutic options are available, and many patients and clinicians are reluctant to use them for fear of side effects or concerns about substance abuse liability. Very limited psychotherapeutic options are available for ADHD. Cognitive behavioral group therapy (CBTg) is the only approach with some preliminary promising results, however there is no individual CBT option for this population. There is a growing popularity of yoga as a therapeutic technique in psychiatric disorders and it may offer distinct advantages for adult ADHD. The objectives of this paper is to discuss the benefit of yoga as a person-centered individualized intervention for adults with ADHD. They discuss the therapeutic utility of a more encompassing and systematic application of yoga practices, including their physical and philosophical, meditative and spiritual aspects to address the symptoms of ADHD and to enhance wellness through lifelong growth and skill building yoga for adults with ADHD. They also present a systematic comparison between yoga practices and the standard CBTg therapy to demonstrate that the proposed yoga intervention is able to address ADHD symptoms areas targeted by CBTg. Interventions based on a systematic application of yoga practices may offer targeted interventions to match ADHD patients' symptoms and needs and compares positively with CBTg. Furthermore, yoga therapy may be superior to CBTg in terms of convenience, person-centeredness and individualized care. They conclude that Yoga may offer a valuable option to meet patients' needs by integrating both physical and philosophical aspects to dynamically targeting specific areas of emotional, behavioral and cognitive dysfunctions as well as the hyperactivity symptoms.

The final sixth regular article involves a philosophical analysis from a seasoned family doctor and philosopher from New Zealand. He presents Postmodern Perspectives on Evidence-based Medicine through a penetrating analysis of the works of Barthes, Heidegger, Deleuze and Guattari, and Derrida. As he reports,

The language of an Evidence Medicine Based (EBM) paper claims *objectivity*. The personal interests of the authors are skilfully expunged, as these are presented as men and women of science. Taken out altogether are the drivers of such projects—desire, interest, professional advancement, financial gain. *The EBM paper presents an image.* The present paper interrogates the objectivity of the subject-object distinction, arguing that it is based on the subject, from Descartes, "I think, therefore I am". The subject-object distinction, fundamental to science / EBM, is not used by *Martin Heidegger.* He depicts people immersed in the environment, coping, they hope. Their world is a world that *matters*, a world of joy and sorrow. Absent is the contrived distinction between subject and object, yielding a detached, "objective" universe, set up for scientists to study and gain knowledge of. *Deleuze and Guattari* do not read an EBM paper to ascertain its meaning. Rather they analyse how meaning is set up. They would note how the conceptual structure and language created an *experimental subject* depicted in biomedical terms. They would note the use of fixed terms, fossilised, such as *experimental subject*, rather than as a continually evolving process. *Derrida* tells us that, although God and metaphysics have been pushed off the conceptual cliff in our scientific age, we *still* read with misty, metaphysical eyes. We *read in* the myth of truth, based on origins and centres, about the real universe. We *read in* the coherence of the paper, and the reliability of reason. We think that words have fixed meanings, and that all readers understand the same as all authors intend.

This Journal issue ends with program outlines from a Latin American Network for Person Centered Medicine Conference and the Ninth Geneva Conference on Person Centered Medicine.

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