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EDITORIAL INTRODUCTION

ICPCM EDUCATIONAL PROGRAM ON PERSON-CENTERED CARE: COMMUNICATION, COMMON GROUND, DIAGNOSIS, AND ASSESSMENT

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INTRODUCTION

This volume includes the second set of papers that comprise the Educational Program on Person-Centered Care of the International College of Person Centered Medicine (ICPCM).

Person-centeredness is the foundation of the patient physician relationship, which is itself at the heart of medical practice and health care. This relationship is based on the dialogue between the patient as a person and the physician as a professional person, allowing trust to develop between these two individuals so

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that the best interest of the person can be jointly sought through shared decision making within a clearly understood ethical framework. The Art of Medicine involves the application of knowledge and skills within this framework of collective conscience to make a judgment in the best interest of an individual seeking care. Communication is the life blood of this professional dialogue. Physicians and all health care professionals should always be able to cultivate empathy with a person seeking their help, respect the dignity of the individual, and demonstrate the ability to recognize and understand in the unfolding narrative the continuing interaction between psyche (mind, spirit) and soma (body).

COMMUNICATION

The theme of communication runs through each of the papers in this part of the Educational Program. Treating patients as persons, by considering their individual level of understanding, self-management skills, concerns, and care preferences, is central to our thinking. Yet, in medical practice, such an approach is not easy, as many other obligations and formalities intrude distracting attention from the person behind the patient. Many patients continue to experience barriers while communicating with their health care professionals [1]. For this reason, numerous interventions have been developed and implemented to optimize health care professionals' attitudes and communication skills to really engage with a patient, and to strengthen a patient's communication skills in order to be heard and understood.

For instance, in a detailed analysis of the interviews of patients four clinically relevant themes emerged – being treated as a person, being treated as an equal, being treated as the physician would want to be treated, and being cared about. Conducting a respectful physician–patient encounter does not necessarily involve complex interventions. Subtle, often nonverbal communicative behaviors, such as being polite, listening to the patient, being honest, and allowing a patient's input, can already turn a business-like patient encounter into a respectful, person-centered visit from which both the patient and the physician will benefit.

Medically unexplained physical symptoms (MUPS) [2] burden patients in their well-being and functioning and have a prevalence of approximately 25–50% in primary and specialist care. Physicians and other health care professionals often find patients with unexplained symptoms difficult to manage and the patients are not always understood. They are very well able to exclude diseases in case of symptoms that are not easily understood. Yet, they experience difficulties in explaining MUPS in terms of perpetuating factors and in motivating patients for therapy aimed at limiting the consequences of symptoms in case of moderate and persistent MUPS. Since there are various MUPS explanations and approaches,

patients easily get confused by different and sometimes inconsistent messages from doctors and hence clear communication at the interface between primary and secondary care is necessary. Explaining MUPS in a person-centered way, answering GPs' referral questions and patients' questions, and giving a clear advice to patient and GP could improve MUPS specialist care and positively influence patient outcomes.

Physicians must engage in a true partnership with their patients as unique individuals always considering the social determinants of health specific to each person and context. Important attributes of the physician include listening and looking attentively with the ability to adapt and personalize each anamnesis and physical examination relevant to the individual person.

THE PERSON-CENTERED PHYSICIAN

Person-centered medicine involves physicians treating patients as whole human beings rather than as a symptom, collection of symptoms or a disease [3]. He or she needs to be approachable, interested, and inspire confidence, so that showing compassion and caring may absorb people's pain and anxieties without losing focus. It takes time to listen and communicate honestly and effectively with patients, relatives, staff teams, managers, peers, and local and national dignitaries pitched at the appropriate level while putting everyone at ease. Within a supporting clinical team, it is essential to show respect for all its members, and to know their names, their capabilities, and their contribution to the team, as well as to be fair and nonjudgmental.

The evidence for the application of a physician's knowledge and technical skills must be clear within the context of the individual patient. The physician needs to be able to synthesize conflicting and incomplete information, and to deal with uncertainty before reaching a probable diagnosis. Protocols and guidelines abound but physicians often must work outside these in the best interests of patients, as they express them; for example, when the best treatment for one condition may make a coexisting condition worse.

Physicians in their everyday practice have to manage risk. Many patients are alive today because doctors took risks. Physicians need to bring all their professional experience to bear on knowing when acceptable, informed, and carefully considered risk ends and recklessness begins – and share that information openly and honestly with their patients, always respecting that the final decision is the patient's, yet carrying and accepting ultimate responsibility for their professional actions.

Physicians need to recognize that change both in medicine and society is constant and ensure that professional standards, which are fundamental, are preserved while those practices that are simply a product of their time are allowed

to lapse. They should have the ability to remain calm and proficient when under pressure and still make clear and timely decisions on behalf of their patients.

Physicians should be altruistic and visionary leaders who are competent and confident about their standards and steadfastly maintain their own and the team's professional values. They should be inspiring, always learning and teaching without fear of being proved wrong or being humiliated. They should show leadership and at the same time work collegially with all members of the health team.

THE RELEVANCE OF MEDICAL EDUCATION

In order to take positive action to implement a return to person-centered medicine, it is important to focus particularly on all stages of a physician's education including the selection of medical students. The selection of medical students has been conventionally done almost exclusively on the basis of measurements of knowledge and skills relevant to purely scientific disciplines. Indeed, a recently published statement on the core values and attributes needed to study medicine in the United Kingdom entitled "Selecting for Excellence" [4] itemizes 17 key skills and attributes – 16th in the list is "empathy and the ability to care for others" and at the bottom of the list is "honesty" – an attribute essential for a physician's integrity!

There needs to be a shift to a greater emphasis on the student's humanistic values and aptitude, recognizing the key importance of the ethical basis of the patient–physician relationship, the autonomy of the person seeking professional help, and each person's biological, psychosocial, and spiritual dimensions.

The WMA Statement on Medical Education and the Selection of Medical Students [5] states that following:

> "A general liberal education is beneficial for anyone embarking on the study of medicine. A broad cultural education in the arts, humanities, and social sciences, as well as biological and physical sciences, is advantageous. Students should be chosen for the study of medicine on the basis of their intellectual ability, motivation, previous experiences, and character and integrity. The numbers admitted for training must meet the needs of the population and be matched by appropriate resources. Selection of students should not be influenced by age, sex, race, creed, political persuasion or national origin, although the mix of students should reflect the population."

The focus of student selection should shift to the student's humanistic values and aptitude, respect for the human rights of all people, attention to the important dynamic of a person's "flesh and spirit," its relation to families and professional environment, and the patient's autonomy and freedom of choice recognizing the

centrality of the dialogue between the physician and the patient with shared decision making. The disciplines of sociology and philosophy should be given equal emphasis as the purely scientific disciplines. Learning from patients is an essential part of a physician's early and continuing education and the person-centered approach should be mandatory since the early professional years before proceeding to specializations.

The doctor–patient relationship demands the constant improvement of a physician's interpersonal skills, enabling the appropriate application of a physician's knowledge and skills. Person-centeredness based on the medical profession's ethical commitments must permeate all aspects of a physician's continuing education so that it becomes an internalized ethical duty for all practitioners of medicine.

THE QUALITY OF HEALTH CARE

Effective person-centered communication is the cornerstone of patient safety and the quality of health care. Poor physician–patient and health team communication is the underlying cause for nearly 66% of all medical errors [6]. This "patient as a person" communication diminishes the number and type of complaints and claims to physicians [7], producing in physicians greater well-being and less professional exhaustion. There is evidence that patients' perception of and satisfaction with the quality of the health care they experience depends on the quality of interactions with their health care professional. This relational approach also improves other clinical outcomes, referred to as diagnostic and therapeutic effectiveness – especially in chronic and cancer patients [8].

There is evidence of strong person-centered relationships between a health care team member's communication skills and a patient's capacity to adhere to medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors. Effective person-centered care skills and attitudes among health care team members influence the quality of working relationships and job satisfaction [9]. When communication about tasks and responsibilities is done well, there is a significant reduction in nurse turnover and improved job satisfaction because it facilitates a culture of mutual support.

CLINICAL COMMUNICATION AND EMPATHY

In the first of the four papers included in this issue of the journal, Michel Botbol [10] emphasizes the relational and contextual elements of person-centered practice, the importance of empathy, attentiveness, and dialogue participation and empowerment. He asserts that clinical communication and empathy are essential

in person-centered medicine being the conditions that recognize the patients' feelings, values, and expectations.

It is important to reflect on the processes allowing a professional to access these crucial dimensions through the development of a communication involving not only conscious or objective aspects, but also unconscious or subjective aspects. Empathy and narrative are the corner stone of this process.

The health professional should be trained to listen and attend to the verbal and nonverbal communication from patients and to build, in interaction with them, narratives giving access to their subjective dimensions.

COMMON GROUND FOR COLLABORATIVE CARE

The second paper Setting a Common Ground for Collaborative Care and Clinical Interviewing by Juan E. Mezzich [11] aims at articulating the place, features, and value of relationships and collaboration for organizing all clinical care, including clinical interviewing. He found from a literature review that the broadest and most compelling factor for organizing clinical care effectively in general, and concerning interviewing, assessment and diagnosis in particular, seems to be the setting up of a collaborative common ground among clinicians, patient, and family. Also, crucial concerning diagnosis is that this should be seen fundamentally as a process and not just a label or a formulation. Historical and anthropological research elucidates health care as part of social cooperation for the preservation and promotion of life. More recent research is also supportive of the positive perceptions of clinicians on procedures that are culturally informed and consider personal experience and values.

PERSON-CENTRED INTEGRATIVE DIAGNOSIS

The third paper entitled "Person-Centered Integrative Diagnosis: Concepts and Procedures" by Ihsan Salloum and Juan Mezzich [12] illustrates how the person-centered integrative diagnosis (PID) model facilitates the implementation of person-centered medicine. It reflects the importance of incorporating the patient's experience, culture, and values into the *core* of clinical diagnosis through a health experience formulation, along with more conventional diagnostic aspects such as health status and health risk and protective factors.

The design of a person-centered integrative diagnosis (PID) model was based on literature reviews and work meetings in London, Paris, Geneva, Preston, UK, and Uppsala, Sweden. The current PID model is composed of the following three broad levels: health status (from disorders and disability to well-being, all measured with standardized instruments), health contributors (risk factors and protective factors), and health experience and values. It includes categorical,

dimensional, and narrative elements and involves the interactive engagement of clinicians, patients, and families and other care givers.

The PID model provides a holistic and culturally informed model that emphasizes patients and stakeholder engagement and shared decision making and places the person in context at the center of assessment and care. Illustratively, the PID has been adopted as the basis of the Latin American Guide for Psychiatric Diagnosis published by the Latin American Psychiatric Association for the use of health professionals in that world region.

CONTINUITY AND INTEGRATION OF PERSON-CENTERED ASSESSMENT

The fourth paper "Continuity and Integration of Person-Centered Assessment and Care across the Life Cycle" [13] by J Appleyard and M Botbol reflects the importance of placing the person in the wider context of his or her life's journey recognizing that health is a consequence of multiple determinants operating in interrelated genetic, biological, behavioral, social, and economic contexts that change as a person develops. The timing and sequence of such events and experiences influence the health and development of both individuals and populations. The influence of early adverse factors has a profound effect on later stages of life.

The health and well-being of a person are complex adaptive processes related to the consequences of genetic, biological, social, cultural, behavioral, and economic determinants throughout the life course. A life course perspective offers a more joined up approach with significant implications for long-term health gain. There is an emphasis on an integrated continuum of early intervention and education rather than of disconnected and unrelated stages. Each stage in the life of a person exerts influence on the next.

Disparities in health outcomes and in the psychosocial factors contributing to them are present early in life and are expressed and compounded during a person's lifetime. Risk factors are embedded in a person's biological makeup, manifested in disparities in a population's health, and maintained by social, cultural, and economic forces. They advocate a three-dimensional picture of a person who evolves laterally in the present, longitudinally from earlier life events and likely future projections, and vertically from the advances in the medical sciences.

OTHER IMPORTANT TOPICS

The New Delhi Declaration 2018 on Person-Centered Care for Noncommunicable Diseases [14], which emerged from the 6th International Congress of Person Centered Medicine expands the significance of this person- and people-centered

approach for the prevention and treatment of noncommunicable diseases (NCDs). It points to 12 important practical recommendations ensuring the involvement and empowerment of each person in their own preventive strategies concerning NCDs.

The Summary Report of the 6th International Congress of Person Centered Medicine, prepared by Jon Snaedal and Juan Mezzich, illustrates the importance of engaging with colleagues worldwide. Ketain Desai, Past President of the World Medical Association, gave a distinguished presentation on the Ethical and Human Rights imperative, which underlies the key importance of the person-centered medicine movement [15]. A webcast discussion at the end of the Congress was sent out to over 300,000 members of the Indian Medical Association.

Fredy Canchihuaman and Juan Mezzich reported on the Second Colloquium on Heredian Spirit and Person-Centered Medicine organized by medical students of the Peruvian University Cayetano Heredia (UPCH) in September 2018. Rector Luis Varela highlighted the principles established at the UPCH and their link with person-centered science and medicine. The sharing of these values between faculty and the medical students appears to be a key factor for promoting excellence at this university.

REFERENCES

1. Van Dulmen S. 2016. Person Centered Communication in Healthcare: A Matter of Reaching Out. International Journal of Person Centered Medicine 6: 30–31.
2. Weiland A, Blankenstein AH, van Saase JL, van der Molen HT, Kosak D, Vernhout RM, Arends LR. 2016. Training Medical Specialists in Communication about Medically Unexplained Physical Symptoms: Patient Outcomes from a Randomized Controlled Trial. International Journal of Person Centered Medicine 6: 50–60.
3. Mezzich JE, Appleyard JW, Botbol M. 2017. Engagement and Empowerment in Person Centered Medicine. International Journal of Person Centered Medicine 7: 1–4.
4. Selecting for Excellence. The Final Report 2016 Medical Schools Council UK. www.medschools.ac.uk
5. WMA Statement on Medical Education 2017. www.wma.net
6. Institute for Health Communication 2011. https://healthcarecomm.org/about-us/impact-of-communication-in-healthcare
7. Levinson W, Roter DL, Mullooly JP, Dull VT, Frankel RM. 1997. Physician-Patient Communication. The Relationship with Malpractice Claims among Primary Care Physicians and Surgeons. Journal of the American Medical Association 277: 553–559.

8. Stewart M, Brown JB, Donner A, McWhinney IR, Oates J, Weston WW, Jordan J. 2000. The Impact of Patient-Centered Care on Outcomes. Journal of Family Practice 49: 796–804.
9. Ruiz-Moral R, Perula de Torres LA, Jaramillo-Martin I. 2007. The Effect of Patients' Met Expectations on Consultation Outcomes. A Study with Family Medicine Residents. Journal of General Internal Medicine 22: 86–91.
10. Botbol M, Van Dulmen S. This issue. Communication and Empathy within Person-Centered Medicine: A Developmental Point of View. International Journal of Person Centered Medicine 8(3): 17–27.
11. Mezzich JE. This issue. Setting a Common Ground for Collaborative Care and Clinical Interviewing. International Journal of Person Centered Medicine 8(3): 29–40.
12. Salloum IM, Mezzich JE. This issue. Person-Centered Integrative Diagnosis: Concepts and Procedures. International Journal of Person Centered Medicine 8(3): 41–49.
13. Appleyard J, Botbol M. This issue. Continuity and Integration of Person-Centered Assessment and Care across the Life Cycle. International Journal of Person Centered Medicine 8(3): 51–59.
14. International College of Person Centered Medicine. This issue. New Delhi Declaration 2018 on Person-Centered Care for Noncommunicable Diseases. International Journal of Person Centered Medicine 8(3): 63–65.
15. Appleyard J, Desai K. 2017. Human Rights and Person Centered Medicine: The Need of the Hour. International Journal of Person Centered Medicine 7: 160–164.