EDITORIAL INTRODUCTION

Communication and Relationships in Person Centered Medicine

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Introduction

In the isiZulu concept of *indaba* (meeting), communication is a central purpose by itself rather than merely 'the means to an end', as pointed out by Werdie Van Staden, Nelson Mandela Professor of Philosophy and Psychiatry at the University of Pretoria [1]. It values the process of communication even more than the resulting decisions. The communication is about the respective values having bearing in a particular matter. In respecting diversity, the full spectrum of values is accommodated and including the values of all the role players, i.e., individual and collective ones. This speaks to the humanistic and ethical centrality of communication. And helps to understand why this concept and activity is so fundamental in Person Centered Medicine (PCM).

At the same time, communication represents a skill and reflects an attitude that can be cultivated, taught, and improved. Illustratively, in the *indaba* meeting [1], communication skills are used multi-directionally in creating space for both shared and divergent values. Listening and explaining are carried out by all players, all aiming to understand. Back in general, much can be achieved by employing the scientific method, as documented by a decade-long record of research on communication, as illustrated later in this paper.

In close conceptual proximity to communication are relationships. They involve activities and players that for health care happen at multiple levels, from the doctor-patient relationship to that among health professionals of different specialties and disciplines. The deep meaning and protean nature of relationships explain their crucial place in PCM.

The concept and relevance of communication and relationships in PCM are briefly addressed next in terms of historical perspective, integrative diagnosis and care, attention to inter-subjectivity, and person-centered research.

A Contemporary Historical Reference

Concerning a recent history of developments in health care, past decades have shown some significant efforts to refocus medicine on the person of the patient, the clinician and the members of the community at large, with a relational emphasis. In 1940, Paul Tournier, a Swiss

general practitioner, discovered the transformational value of critical interpersonal experiences and coined his vision as *Medicine de la Personne* [2]. Around the same time, Carl Rogers, an American psychologist, demonstrated the significance of open communication and of empowering for individuals to achieve their full potential and proceeded to develop a *person-centered approach* to therapy, counseling and education [3]. Shortly afterwards, Frans Huygen in the Netherlands [4] and Ian McWhinney in the United Kingdom and Canada [5] developed a generalist medical specialty committed to a contextualized understanding of health and focused on *patient-centered care*.

There has been also an increasing recognition of the crucial role of a collaborative clinician-patient relationship. For example, Tasman [6] has cogently pointed out that this relationship must start since the first encounter and represents the fundamental matrix for the whole of care. It must ensure empathetic listening, comprehensive diagnosis beyond symptom checklists, appreciation for symbolic meaning, broad treatment techniques and effective therapeutic partnership instead of narrow and reductionistic approaches. Likewise, Alanen and colleagues [7], through a well-known Finnish integrated model for Need-Adapted Assessment and Treatment, emphasized the active engagement of the patient as an expert of his/her own life situation within the context of family and community.

A Response from the World Psychiatric Association

Of relevance to the above developments, the World Psychiatric Association (WPA) published in 2003 the International Guidelines for Diagnostic Assessment (IGDA) at the core of which is a diagnostic model articulating standardized multiaxial (covering both mental and general medical disorders, disabilities, contextual factors, and quality of life) and idiographic personalized components. The latter proposes the interaction among clinicians, the patient and the family to formulate together a joint statement on contextualized clinical problems, the patient's positive health, and expectations on health restoration and promotion [8]. This diagnostic model has been applied in different countries as illustrated by the Latin American Guide for Psychiatric Diagnosis [9] and has been one of the starting points for the design of a Person-centered Integrative Diagnosis model [10] and its application in a Revised Version of the Latin American Guide for Psychiatric Diagnosis (GLADP-VR)[11].

Even more specifically in response to the ancient and contemporary perspectives outlined above and consistent with its constitutional purposes, the WPA adopted at its 2005 General Assembly in Cairo a strategic plan that included as one of its broad goals to strengthen WPA relations with patient/user organizations. It also established the Institutional Program on Psychiatry for the Person (IPPP) which aimed to promote a psychiatry *of* the person, *by* the person, *for* the person and, last but not least, *with* the person. This program, through its conceptual, clinical diagnosis, clinical care and public health components, represented a paradigmatic shift from a disease-oriented to a person-centered perspective in psychiatry in particular and medicine at large. It attained significant achievements and attracted wide attention throughout WPA and other major international medical and health organizations [12-14].

The fourth programmatic objective of the IPPP, *psychiatry with the person*, affirmed the personhood of the patient and an institutional commitment to work in respectful and collaborative partnership with the person who consults. This included, first and foremost, work with the consulting person which highlights the ethical underpinnings of this effort. It also encompassed interacting with patient groups including those critical of our field [15-17].

Context and Relationships at all Levels

The contextual base of PCM is clarified by its broad concept of the person. This is illustrated by Ortega y Gasset aphorism in his *Meditaciones del Quijote*, "I am I and my circumstance, and if do not care for it I do not care for myself" [18].

An extended attention to context and relationships leads to the consideration of integration and its multiple functional roles at various important levels in the health and human services field. This topic has been the main theme of the Seventh Geneva Conference on Person Centered Medicine, the 2014 Geneva Declaration on Person- and People-centered Integrated Health Care for All [19], and its accompanying paper, A Time for Action on Health Inequities [20]. These efforts have been related to the World Health Organization Program of Work 2014-2019 [21] addressing universal access to people-centered integrated care.

The most crucial integration levels appear to be the following:

a. First are the relations among the people seeking and delivering care. Particularly critical and emblematic here is the relationship or encounter between the doctor or clinician and the patient. Also important is the relationship between other health professionals and the patient.

b. Within the social network of each person one can identify the significant relations between the patient and members of his/her family, community, and society at large.

c. Health care must also be coordinated over the trajectory of each person's life. This recognizes the dynamics of human development and the networks that are at play at each of its phases.

d. The coordination required among primary care-givers and specialists is receiving increasing attention. A number of experimental models are being examined that consider the protagonists and the functional relations among care-givers.

e. A horizontal integration of health care delivery is that required across multiple sectors of society. Among these are education, social care, employment, housing, transportation, justice, finance, ecological management, and general government.
f. In order to energize and sustain the integration at the various levels listed above, there must be common values, shared vision of the future, and substantial commitment among all key stakeholders in all sectors and levels of society to nurture the development of well-being for all.

Optimizing Clinical Communication by Attending to Subjectivity and Inter-subjectivity

Advancing communication in health care cannot be restricted to considerations of integration of multiple relevant levels. Also important is paying attention to the depth of clinical communication.

Botbol [22] has pointed out that person centered medicine should not be reduced to individualization of care or respect for patients' rights, as it has higher and wider aspirations. These include the recognition of the individual subjectivity of the whole person of the patient beyond what characterizes his or her illness or the status or role of patient. What is of interest here is dealing with the inner world of a patient in his particular situation of suffering and dependence caused by illness, as propose in Aristotle's Nicomachean Ethics: "Cure of a unique person (not of a generalized nosological case), in a specific situation, within a specific, unrepeatable period of one's life" [23]. What becomes crucial here is the commitment of the mental health professional to approach the patient's subjectivity in such singular vital situation.

In addition to the attention paid to the medico-biological aspects of the person's health status, a person centered assessment needs to give enough consideration to the patient's subjective feelings [24]. Whether or not one suspects a psychic or psychosomatic causality to the disorder that a patient brings to the clinic, it is essential to keep in perspective the factors involved in the patient's health situation. Beyond reasserting this principle, one needs to utterly enhance the methodology for accessing these subjective dimensions among different partners involved in the diagnostic process and the therapeutic relationship. For health professionals, the only way to access these subjective dimensions is through what the patient and his/her carers say in words or show in acting, as long as these words or acts can trigger in the professionals enough empathy to approach the patient's subjective feelings to which these expressions are related.

Working on a person-centered diagnostic approach has become an important element to meet this methodological goal. This diagnostic model includes, besides the objective elements about the patient and his or her context, the subjective elements reported by the idiographic formulations of the person who is being cared for, their carers and assisting professionals.

This approach appears to lead to a closer examination of the role of the professional's empathy in the methodology to access the subjectivity of the patient, trying to go beyond the general assertions on the importance of this concept in therapeutic relationships and care activities [24].

At first seen as the professional's ability to listen sympathetically to the comments of the patient and to consider his wishes and needs, the notion of empathy has gradually widened to include representations that the physician (or other health professional) makes of the clinical situation in which the person in need of care is involved. In short, these are representations that the professional makes of the health situation of the person suffering through the health professional's own empathy, triggered by the words and the acts of the patients and of their carers. This mechanism is well described by the concept of "metaphorizing-empathy" proposed by Lebovici [25] from his work with babies and their mothers. It is also close to the notion of "narrative empathy" proposed by Jacques Hochmann [26] based on his work with autistic children and on the philosophical ideas brought up by Paul Ricoeur in his book "Time and Narrative" [27]. It is also consistent with Kleinman's assumptions [28] on illness narratives. This important development in person centered medicine marks the full recognition of the role of the physician's subjectivity as a diagnostic and treatment tool within the framework of the physician-patient relationship.

Attending to subjectivity and inter-subjectivity is not only relevant to optimized clinical care, but also to person-centered health research. As discussed by Botbol, person-centered health research should squarely address with the scientific method the challenging realities of the clinical situation, instead of avoiding these because they are often not "objective" enough [29].

Earlier Scholarly Work on Communication in the IJPCM

As PCM involves the articulation of science and humanism, person-centered research has been a core activity of the International College of Person Centered Medicine. In fact, the 2013 Geneva Declaration on Person Centered Health Research [30] was the second earliest one, emerging from the Sixth Geneva Conference. It was published, along with an accompanying academic paper [31], in the *International Journal of Person Centered Medicine*. One of the specific recommendations of this Geneva Declaration reads as follows: "Clinical communication research, including reciprocal understanding, empathy, engagement, information exchange as well as greater proficiency in using communication to advance the process and outcome of care".

To illustrate communication research published in the early years of the International College and the

International Journal of Person Centered Medicine one can mention the following articles from distinguished scholars who presented their work at Geneva Conferences and are also connected with the European Association for Communication in Healthcare. Arnstein Finset, from Oslo, wrote on "How to conduct international research on clinical communication" [32]. He pointed out that research-based knowledge is needed on the associations between communication behavior and the core values and desired outcomes of person-centered medicine. Given cultural diversity across the world, international studies should also include countries in Asia, Africa and Latin America. A good example of international collaboration is the Verona Network for Sequence Analysis. He listed the following six criteria of successful network building: (1) a core group of researchers and a home venue for network gatherings; (2) regularity of collaborative activities; (3) a clear aim for the network activities; (4) a modest set of ambitions to begin with; (5) a long term perspective and a realistic step-by-step progression of research activities, and (6) inclusion of both senior and junior researchers in joint collaborative efforts.

Sandra Van Dulmen, a professor on the ICPCM Board with posts in Nijmegen, Utrecht, and Drammen and her colleagues published recommendations "Towards a guideline for person-centered research in clinical communication: lessons learned from three countries" [33]. They indicated that capacity to research the crucial clinician-patient relationship has been advanced with the development of recording technology, storage and data coding. The article presents a first step in the production of a practical, person-centered guideline for clinical communication research.

Evelyn Van Weel-Baumgarten, a faculty member at the primary and community care department of Radboud University in Nijmegen, and a colleague published a reflection on best evidence teaching of person-centered basic communication skills [34]. They pointed out that adequate person-centered communication is an important cornerstone of good clinical practice and therefore requires training, just like other aspects of medicine do. The exact content of person-centeredness can vary depending on specific context and culture, but key issues mentioned frequently are: providing room for the patient's story through involvement in consultations, with an emphasis on dialogue with the physician, exploring emotional cues and showing empathy, attention to the patient's context, adjusting information and advice to that context and framing it in a positive way and involving patients in decisions on the management of illness.

Articles on Communication and other Topics Published in the Present Issue of the Journal

The current issue of the Journal features an inaugural Special Section on Communication in Healthcare. The Journal anticipates publishing Special Sections time to time. Each will include about three high quality articles on a topic of high relevance to PCM assembled and introduced by an invited guest editor.

This first Special Section was organized by Sandra Van Dulmen, a world-recognized researcher on clinical communication and IPCM Board Member from Nijmegen in the Netherlands. She invited distinguished colleagues to contribute three scientific papers that in her words make clear that there is a person-centered and respectful world to win by listening to and taking account of what matters to the patient [35]. The first study, written by Welbie and colleagues [36], investigated the perceived ease of use and the perceived usefulness of a frequently used Patient Reported Outcome Measurement questionnaire in Dutch physical therapy. The second paper written by Beach and colleagues [37] describes a qualitative study into communicating respect for patients as persons. In the final article of the Section, Weiland and colleagues [38] describe the results of a training program for medical specialists focused on communicating more effectively with patients experiencing medically unexplained physical symptoms.

The present issue of the Journal also presents three additional regular articles of high importance for PCM, and which *mutatis mutandis* also touch on communication and relationship issues. The first one by Appleyard and colleagues on Patterns and Prospects for the Implementation of Person-Centered Primary Care and People-Centered Public Health [39] provides academic support to the 2015 London Declaration on Person- and People-centered Primary Care and Public Health [40]. The London Declaration sets out a 10-point plan to articulate a shared goal of improvement in the health and well being of the population through person and people centered primary care and public health. As Appleyard et al note, person-centered primary health care is by its very nature integrative as it involves a broad knowledge of all sectors of health care and a strong understanding of community resources and other social determinants of health. At the same time, public health needs to be person- and people-centered taking into account the biomedical, social, cultural, psychological, and spiritual elements that are crucial to understanding the whole person and the community at large.

In a separate article, Van Weel discusses "Person Centered Primary Heath Care: The Role and Position of the Family Physician-Generalist and Implications for Research" [41]. The variety of health problems presented over time by a person make him/her the self-evident focus of care. The person-centered approach serves to relate the patient's agenda to professional considerations of the nature and prognosis of the health problems identified and the risks and benefits of treatment. From this, the importance can be established of continuity of care, shared decision making, individual prognostication and ascertaining individual risks from community-specific determinants of health. Priorities of research are to come to a better understanding of the mechanisms of continuity of care, the building of professional relations of trust, and strengthening the knowledge base of diagnosis,

prognostication and interventions for frequent health problems in the community.

In also a separate article, Al-Yateem investigates Providing Patient Centered Care for Adolescents with Chronic Conditions [42]. He aimed at developing relevant and feasible care guidelines that may inform more competent and patient centered services for adolescents and young adults with chronic conditions. A study phase involving in-depth interviews revealed four main themes, as follows: a current amorphous service, sharing knowledge, the need to be at the center of service, and easing the transition process to adulthood. A second study phase yielded 32 proposed guidelines that may contribute to more competent and patient centered health care.

The present Journal issue also publishes as an editorial the 2015 Lima Declaration on Latin American Developments for Person Centered Medicine that emerged from the Latin American Conference on Person Centered Medicine in Lima, December 2015, approved by the National Academies of Medicine of Colombia, Chile, Peru, and Uruguay and released for publication by the Latin American Network for Person Centered Medicine. It notes historically that a holistic conceptual framework and a personalized approach to health care were prevalent in Latin American Pre-Hispanic medicine. The Latin American bases and perspectives to develop Person Centered Medicine are getting gradually stronger through a collaborative network involving national academies of medicine and other health institutions in the region endeavoring to link together their efforts with similar others at a global level. This Declaration includes eight recommendations to deal with dehumanizing factors in medicine, advance the study of person-centered care, apply and evaluate PCM principles, promote person-centered medical and health education, carry-out person-centered health research, strive for people-centered integrated public health, and cultivate inter-institutional collaboration at Latin American and global levels.

This Journal issue ends with a summary report of the above mentioned Latin American Conference on Person Centered Medicine, and announcements of upcoming events.

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