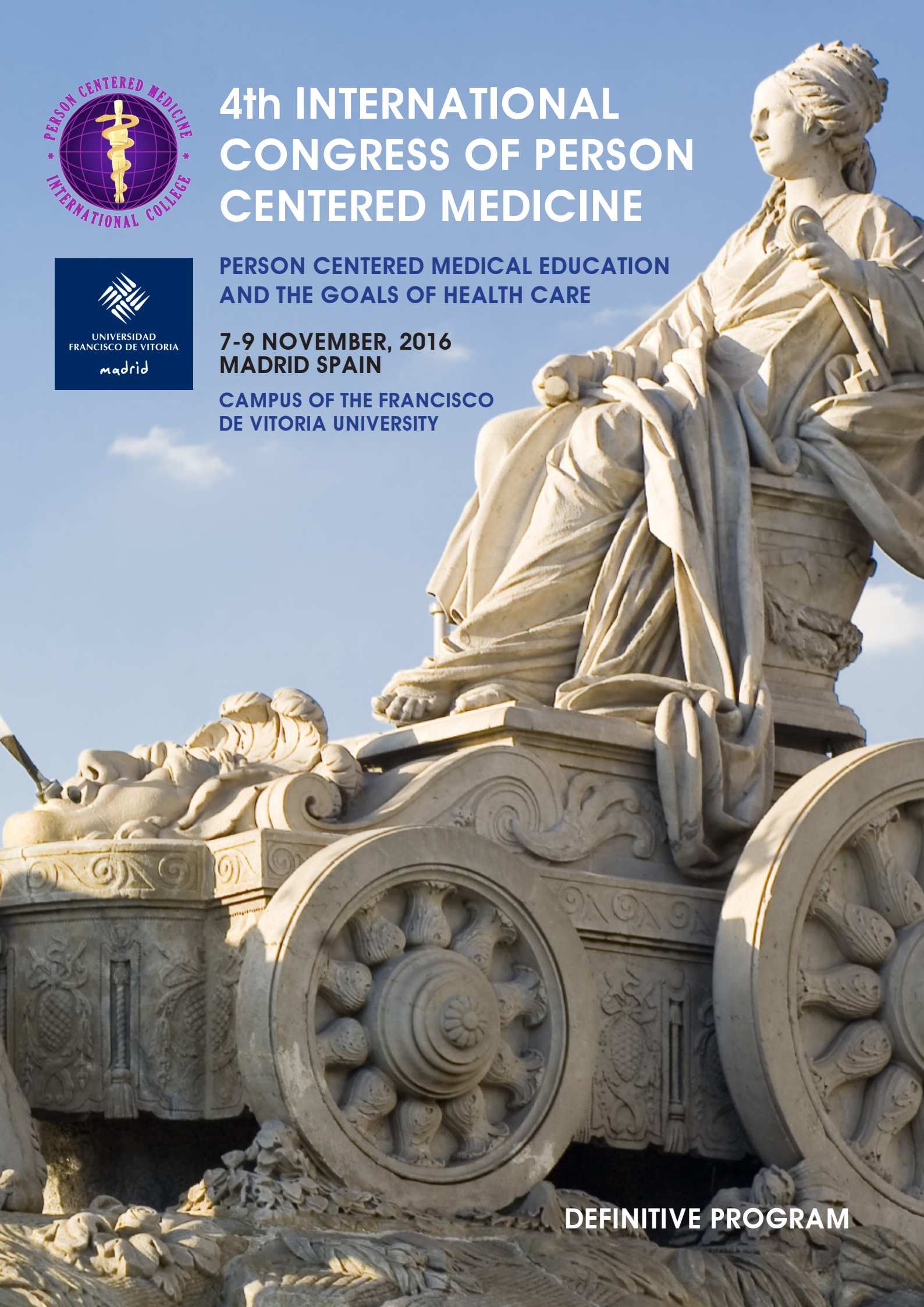
4th INTERNATIONAL CONGRESS OF PERSON CENTERED MEDICINE

PERSON CENTERED MEDICAL EDUCATION AND THE GOALS OF HEALTH CARE

7-9 NOVEMBER, 2016
MADRID SPAIN

CAMPUS OF THE FRANCISCO DE VITORIA UNIVERSITY



DEFINITIVE PROGRAM


PERSON CENTERED MEDICINE
INTERNATIONAL COLLEGE


UNIVERSIDAD
FRANCISCO DE VITORIA
madrid

INDEX

4TH INTERNATIONAL CONGRESS OF PERSON CENTERED MEDICINE

Universidad Francisco de Vitoria
UFV Madrid

PERSON CENTERED MEDICAL EDUCATION AND THE GOALS OF HEALTH CARE

7-9 NOVEMBER, 2016 - MADRID, SPAIN

CAMPUS OF THE FRANCISCO DE VITORIA UNIVERSITY

WELCOME

Dear Colleagues and Friends,

Greetings! We are writing to invite you warmly to join us at the 4th International Congress of Person Centered Medicine to take place in Madrid on 7th to 9th November 2016. The Conference is organized by the International College of Person Centered Medicine in collaboration with the Francisco de Vitoria University which is graduating this year its first medical student class educated according to person centered medicine principles.

The Conference main theme will be Person Centered Medical Education and the Goals of Healthcare. Under it, a range of lectures, roundtables, practical workshops, and oral and poster sessions will be held and a Madrid Declaration on this topic will be issued. Full opportunities for friendly and collegial interaction and networking will be facilitated as we meet in the exciting city of Madrid to build person centered medicine and optimize medical education.

Looking forward to hearing from you soon and greeting you personally in Madrid.

Registration and abstract submission links are available at our website: www.icpcmmadrid2016.com

With warm regards,

Professor Jim Appleyard
President, International College of Person Centered Medicine
Former President, World Medical Association

Professor Juan Mezzich
Secretary General, International College of Person Centered Medicine
Former President, World Psychiatric Association

Professor Fernando Caballero
Dean, Medical School, Francisco de Vitoria University, Madrid, Spain.

INVITED SPEAKERS

Dr. Ricardo Abengózar Muela
Doctor en medicina. Alergólogo. Master en Bioética.
Profesor de Medicina y Humanidades en la Universidad Francisco de Vitoria.
Director del Instituto de Bioética Francisco de Vitoria.
Profesor de Bioética en varios másters de varias universidades.

Prof. Rogelio Altisent Trota
Presidente del Comité de Bioética de Aragón.
Cátedra de Profesionalismo y Ética Clínica de la Universidad de Zaragoza

Santiago Álvarez
UFV
Madrid

Prof. James Appleyard
President, International College of Person-centered Medicine
Former President, World Medical Association
London, United Kingdom

Dr. Florentino de Araujo Cardoso
President of the Brazilian Medical Association
Clinical Manager at Monte Klinikum Hospital (Fortaleza, Ceará)
Former President Ceará Medical Association
Fortaleza, Brazil

Prof. Michel Botbol
Board Director, Int'l College of Person Centered Medicine
Co-Chair, WPA Section on Psychoanalysis in Psychiatry
Professor of Child and Adolescent Psychiatry,
University of Western Brittany, Brest, France.

Marijana Bras
Zagreb University
Croatia

Prof. Fernando Caballero
Dean, School of Medicine
Francisco de Vitoria University
Madrid, Spain

INVITED SPEAKERS

Prof. Patricia Campos
Prof. of Neuro-pediatrics
Rector, Santo Toribio de Mogrovejo University
Chiclayo, Peru

Freddy Canchihuaman
Nat Inst Health
Peru

Ayce Cinar
Dundee, UK

María Cruz Martín
Torrejón University Hospital
Madrid

Prof. Sandra Van Dulmen
Board Director, International College of Person-centered Medicine
Professor, Netherlands Institute for Health Services Research and Radboud University,
Nijmegen, The Netherlands

Veljko Djordjevic
Zagreb University
Croatia

Prof. Ronald Epstein
Professor of Family Medicine, Psychiatry, and Oncology
University of Rochester Medical Center
Rochester, NY, USA

Prof. Cristina Garcia de Leonardo
Academic Vice-Dean, Faculty of Medicine,
Francisco de Vitoria University
Madrid, Spain

INVITED SPEAKERS

Pedro Gargantilla
Madrid

Tesfamicael Ghebrehiwet, MPH, Ph.D.
Board Director, Int'l College of Person Centered Medicine
Former Consultant, Nursing and Health Policy
International Council of Nurses
Alberta, Canada

Cristina González del Yerro
Regional Health Department, Madrid

Joanna Groves B.Sc., M.Sc.
Board Director, Int'l College of Person Centered Medicine
Former Executive Director,
Int'l Alliance of Patients' Organizations (IAPO)
London, United Kingdom

Jeff Huarcaya
Lima

Alejandro Iñarra Navarro
CEEM. Spanish Confederation of Medical Students

Brigida Lilia Marta, MD,
Public Health Specialist
Researcher at the Centre for International and Intercultural Health, University of Bologna, Italy
Collaborator at the Health Authority, Republic of San Marino

Prof. Juan E. Mezzich
Editor, International Journal of Person-centered Medicine
Former President, World Psychiatric Association
Professor of Psychiatry, Icahn School of Medicine at
Mount Sinai, New York, USA

INVITED SPEAKERS

Prof. Jesús Millán Núñez-Cortés
MD, PhD, PharmD, FRCP, FACP
Catedrático-Jefe de Servicio de Medicina Interna
Jefe de Estudios. Presidente de la Comisión de Docencia
Hospital General Universitario Gregorio Marañón.
Facultad de Medicina de la Universidad Complutense

Prof. Diana Monge Martin
Research Vice-Dean, Faculty of Medicine,
Francisco de Vitoria University
Madrid, Spain

Belén Navarro
UFV Medical Student
Madrid

Prof. Alberto Perales
President, Latin American Network of Person Centered Medicine
Past President, National Academy of Medicine of Peru
Professor of Psychiatry and Ethics in Health,
San Marcos National University, Lima, Peru

Prof. Juan Pérez-Miranda
Vice-Rector for International Relations
Francisco de Vitoria University
Madrid, Spain

Gerardo Ronceros
Lima

Prof. Roger Ruiz-Moral
Professor of Medicine,
Director, Clinical Communication,
Francisco de Vitoria University, Madrid, Spain

INVITED SPEAKERS

Prof. Antonio Ruiz Sánchez
Licenciado en Medicina y Cirugia por la Universidad de Salamanca.
Especialista en Medicina Familiar y Comunitaria (Area 6, Madrid)
Médico de Atención Primaria en el centro de salud de Colmenarejo. (Área Noroeste del SERMAS).
Profesor de Métodos Clínicos en la Universidad Francisco de Vitoria (Madrid)

Ernesto Sáez de Buruaga
Madrid

Prof. Luis Salvador-Carulla
Centre for Disability Research and Policy,
Faculty of Health Sciences, University of Sydney
Sydney, Australia

Prof. Ihsan M. Salloum
Board Director, Int'l College of Person Centered Medicine
Chair, WPA Section on Class & Diagnostic Assessment
Professor of Psychiatry and Behavioral Sciences,
University of Miami, Florida, USA

Prof. Werdie (C.W.) van Staden
Professor of Philosophy and Psychiatry, and Director of the Centre for Ethics and Philosophy of Health Sciences at the University of Pretoria
Pretoria, South Africa

E. Taratuknin
Moscow

M. Volero-Marcet
Barcelona

Everlyn Waweru
Antwerp, Belgium

GENERAL INFORMATION

Congress President
James Appleyard (UK)

Organizing Committee:
Chairs:
Juan Perez Miranda (Spain) and Juan Mezzich USA)

Members
Fernando Caballero (Spain)
Roger Ruiz-Moral (Spain)
Michel Botbol (France)
Tesfamicael Ghebrehiwet (Canada)
Joanna Groves (UK)
Ihsan Salloum (USA)
Sandra Van Dulmen (The Netherlands)
Jon Snaedal (Iceland).

Congress Participants
physicians, nurses, psychologists, social workers, pharmacists, dentists, policy makers, educators, students, patients, families, advocates, industry representatives, and other health stakeholders.

Presentation Formats
Lectures, round tables, workshops, brief oral and poster presentations.

Languages
English and Spanish.

Registration fees
500€ for World Bank Class A Countries,
350€ for other countries. Spanish participants and documented full time students pay discounted half rates.

Event Partially Suported by and Educational Grant from:

SCIENTIFIC PROGRAM

MONDAY, NOVEMBER 7, 2016

Campus of the Francisco de Vitoria University

09:00 - 10:00 h **Registration** Hall Ed H

10:00 - 10:30 h **Opening of the Congress** Aula Magna

Welcoming Words from officers of the International College of Person Centered Medicine
(Jim Appleyard, Juan Mezzich) and the Francisco de Vitoria University
(Rector, Fernando Caballero and Juan Perez-Miranda)

10:30 - 11:00 h **Inaugural Conferences** Aula Magna

Person Centered Medical Education: Need for a new Model
Fernando Caballero (Madrid)

11:00 - 11:30 h Break Pecera Ed H

11:30 - 13:00 h **Round Table 1** Pecera Ed H

Humanism, Humanities and Person Centered Medical Education
Chairs: Ricardo Abengozar (Madrid), Alberto Perales (Lima)

- Humanism and Humanities
  Ricardo Abengozar (Bioethical Institute, UFV, Madrid)
- The Ethical Bases of Person Centered Medical Education
  Jim Appleyard (London)
- Holistic Framework of Person Centered Medical Education
  Pedro Gargantilla. (Madrid)
- Patient Centered Medical Education.
  Jesus Millan. (Madrid)

13:00 - 14:00 h Lunch break Hall Ed H

14:00 - 15:30 h **Parallel Sessions 1**

1.A. Workshop on the Madrid Declaration on Person Centered Medical Education and the Goals of Healthcare Pecera Ed H

Chairs: Fernando Caballero (Madrid), Jim Appleyard (London)
Fernando Caballero (UFV, Madrid)
Santiago Alvarez (UFV, Madrid)

1.B. Workshop on Clinical Complexity and Contextualization Sala Conferencias - 2nd floor

Chairs: Roger Ruiz Moral (Madrid), Michel Botlbol (Brest, France)
Ihsan Salloum (Miami)
Tesfa Ghebrehiwet (Alberta, Canada)
Antonio Ruiz (Primary Care, UFV, Madrid)
Luis Salvador-Carulla (Sidney, Australia)

15:30 - 15:45 h Break

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15:45 - 17:15 h **Parallel Sessions 2**

2.A. Workshop on the Practical Elements of the UFV Person Centered Medical Education Model: Student and Patient Experiences Pecera Ed H

Chairs: Cristina Garcia de Leonardo (Madrid), Tesfa Ghebrehiwet (Alberta, Canada)
Cristina Garcia de Leonardo. (Academic Vice-Dean, UFV, Madrid)
Diana Monge. (Research Vice-Dean, UFV, Madrid)
Belen Navarro. (UFV Medical Student, Madrid

2.B. Workshop on Bioethical Dilemmas Sala Conferencias - 2nd floor

Chairs: Ricardo Abengozar (Madrid), Ihsan Salloum (Miami)
Rogelio Altisent (Bioethics Committee. Aragon, Spain)
Patricia Campos (Chiclayo, Peru)
Werdie Van Staden (Pretoria, South Africa)

17:15 - 17:45 h Break Pecera Ed H

17:45 - 19:15 h **Round Table 2** Pecera Ed H

People-centered Public Health, Ecology and Social Determinants of Health

Chairs: Diana Monge (Madrid), Sandra Van Dulmen (Nijmegen, The Netherlands)

- Introduction to the session's theme
  D. Monge (Madrid), S. Van Dulmen (Nijmegen)
- Perspectives from SubSaharan Africa
  Werdie Van Staden (Pretoria)
- Perspectives from the Americas
  Freddy Canchihuaman (Nat Inst Health, Peru)
- Perspectives from Asia & Oceania
  Luis Salvador-Carulla (Sidney)

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TUESDAY, NOVEMBER 8, 2016

Campus of the Francisco de Vitoria University

08:30 - 10:00 h **Round Table 3** Pecera Ed H

The Doctor-Patient Relationship as the Core of Humanizing Clinical Practice

Chairs: Roger Ruiz Moral (Madrid), Joanna Groves (London)

- The Role of Physicians and other Health Professionals in the Humanization of Clinical Care.
  Alberto Perales (Lima, Peru)
- Humanism and Humanities for the Doctor-Patient Relationship
  Florentino de Araujo Cardoso (Brazilian Medical Association)
- Communicational Approaches to Enhance Doctor-Patient Relationship
  Ronald Epstein. (Rochester NY, USA)
- Clinical Communication and Doctor-Patient Relationship
  Sandra Van Dulmen (Nijmegen, The Netherlands)
- Setting a Common Ground for Joint Diagnostic Understanding and Shared Decision Making
  Juan Mezzich (New York)

10:00 - 10:30 h Break Pecera Ed H

10:30 - 12:00 h **Round Table 4** Pecera Ed H

Clinical Communication and Simulation Methods in Medical Education

Chairs: Fernando Caballero (Madrid), Jim Appleyard (London)

- Patient Safety and Clinical Simulation.
  Maria Cruz Martin. (Torrejon University Hospital, Madrid)
- Experience on Clinical Simulation in Undergraduate Medical Education
  Roger Ruiz Moral. (UFV, Madrid)
- Core Curriculum on Clinical Communication: The Ibero-American Project
  Cristina Garcia de Leonardo. (UFV, Madrid)
- Evaluated Experience on Clinical Skills Training
  Veljko Djordjevic and Marijana Bras (Zagreb University, Croatia)
- Inter-professional Communication and Collaboration
  Tesfa Ghebrehiwet (Alberta, Canada)

12:00 - 13:00 h **Special Inter-Institutional Colloquium on Ibero American Perspectives on Person Centered Medicine.** Pecera Ed H

Conductor: Ernesto Saez de Buruaga (Spain)

Spanish Royal Academy of Medicine, Spanish Royal College of Medical Doctors, Spanish National Medical Deans Conference,Brazilian Medical Association, Latin American Association of National Academies of Medicine, Latin American Network of Person Centered Medicine, International College of Person Centered Medicine

13:00 - 13:45 h Lunch break Pecera H

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13:45 - 15:15 h **Parallel Sessions 3**

3.A. Session on Brief Oral Presentations Pecera Ed H

Chair: Ihsan Salloum (Miami), Gerardo Ronceros (Lima)

- Health coaching and medical student curriculum
  Ayce Cinar (Dundee, UK)
- Evaluating empathy in medical residency applicants
  Jeff Huarcaya et al (Lima)
- Questionnaire on humanism in healthcare
  Alberto Perales et al (Lima)
- Medical student training on empathy
  Roger Ruiz Moral (UFV, Madrid)
- Person-cent. interviewing for non-expressed experiences
  E. Taratukhin et al (Moscow)
- Mentorship for professionalism & personal growth:
  M. Volero-Marcet et al (Barcelona)
- Contextualizing pat.-cent. primary care in Uganda
  Everlyn Waweru (Antwerp, Belgium)
- Person-cent. services from academia to prisons
  Ayse Cinar (Dundee, UK)

3.B. Workshop on Empathy and Narrative Training to Engage Patient's Subjectivity in Clinical Practice Sala Conferencias - 2nd floor

Chairs: Sandra Van Dulmen (Nijmegen, the Netherlands), Ronald Epstein (Rochester, New York)
Presenter: Michel Botbol (Brest, France)

15:15 - 16:45 h **Parallel Sessions 4**

4.A. Workshop on Mindfulness Pecera Ed H

Chairs: Michel Botbol (Brest, France), Roger Ruiz Moral (Madrid)
Ronald Epstein (University of Rochester Medical Center, Rochester, New York, USA)
Ihsan Salloum (Miami)

4.B. Workshop on Student and Patient Feedback on Communication Sala Conferencias - 2nd floor

Chairs: Sophia Denizon (Madrid), Tesfa Ghebrehiwet (Alberta, Canada)
Joanna Groves (London)
Sandra Van Dulmen (Nijmegen, The Netherlands)

16:45 - 17:15 h Break

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17:15 - 18:45 h **Round Table 5** Pecera Ed H

Articulating Person Centered Medical Education and the Goals of Health Care

Chairs: Juan Perez-Miranda (Madrid), Juan Mezzich (New York)

- Medical Schools Perspectives
  Jim Appleyard (ICPCM, IAMC, London)
- Educators Perspectives
  Brigida Marta (Univ Bologna, Italy)
- Health Planners Perspectives
  Cristina González del Yerro (Regional Health Department, Madrid)
- Students Perspectives
  Alejandro Iñarra Navarro (CEEM.Spanish Confederation of Medical Students)
- Patient Associations Perspectives
  Joanna Groves (London)

18:45 - 19:15 h **Closing Lecture** Pecera Ed H

Chairs: Luis Salvador-Carulla (Sydney), Werdie Van Staden (Pretoria, South Africa)

Equitable, Sustainable, Integrative and Person-centered Health Systems Informing Medical Education

19:15 - 20:00 h **Closing Session** Pecera Ed H

Chairs: F. Caballero (Madrid)
J. Perez Miranda (Madrid)
J. Appleyard (London)
J. Mezzich (New York)

- Congress conclusions
  J. Perez Miranda (Madrid)
- Adoption of the Madrid Declaration
  F. Caballero (Madrid)
- Invitation to the 5th Int'l Congress PCM, Zagreb 2017
  V. Djordjevic, M. Bras (Zagreb)
- Final remarks
  J. Appleyard (London), J. Mezzich (New York)

19:30 - 22:00 h **Closing Dinner (by invitation)**

SCIENTIFIC PROGRAM

WEDNESDAY NOVEMBER 9, 2016

Working Session on Person Centered Medicine, Hotel Tirol (Central Madrid)

09:00 - 12:00 h Colloquium on Advancing Person Centered Medicine and Implementing the Conclusions of the Congress and the Madrid Declaration

Chairs: J. Appleyard (London)
J. Mezzich (New York)
Francisco de Vitoria University officer

ROUND TABLE 1 - 11:30 - 13:00 · MONDAY, NOVEMBER 7

Humanism, Humanities and Person Centered Medical Education Medical Education

HUMANISMO Y HUMANIDADES

R. Abengózar Muela. Director del Instituto de Bioética Francisco de Vitoria

El significado de estas palabras no es unívoco. En la actualidad no parecen gozar de mucho prestigio. Durante la historia han tenido diferentes acepciones que han podido contribuir a la confusión.

Inicialmente se puede considerar un humanismo teológico que va a defender que la razón humana precisa de la ayuda divina, por lo que sin teología no hay humanismo.

A partir del Renacimiento, probablemente por la crisis de la razón especulativa medieval, se impulsa el humanismo. En el siglo XVII los avances científicos de Galileo o Newton impulsaron el prestigio de las ciencias como el mejor método del conocimiento de la realidad. La Filosofía es seducida por las ciencias y trata de imitar su método. A partir de este momento comienza a hablarse de "ciencias duras" y "humanidades blandas".

En el siglo XIX, el positivismo consideró que el saber riguroso ha de ser el que se base en los hechos, en los hechos positivos, en los hechos científicos. El positivismo sometió a los valores a ser tratados como hechos.

Estas versiones del humanismo tienen su correlato en el humanismo médico. Se habla de un humanismo médico basado en las creencias religiosas, cuyo correlato actual sería el hipocratismo. Pero en la actualidad predomina el humanismo positivista, mediante las "nuevas humanidades médicas" que tratan los valores como hechos y no como valores.

Es evidente la deshumanización actual de la medicina. Se describen someramente los factores que contribuyen a dicha deshumanización de la medicina.

Proponemos la necesidad de recuperar las "viejas humanidades" en la formación de los médicos y de los estudiantes de medicina. Son las que se ocupan de los valores en tanto valores. Son las que siempre se han hecho preguntas importantes como premisa necesaria para obtener respuestas. El hombre humanista y, por tanto, el médico humanista, debería ser precisamente hombre cultivado en este sentido.

Planteamos nuestro modelo de formación en humanidades médicas, con un itinerario durante los 6 cursos de la carrera. Por un lado mediante distintas asignaturas como antropología, ética, deontología, historia de la medicina, bioética, seminarios de bioética clínica. Por otro mediante actividades fuera del aula como el seminario itinerante por lugares de memoria de la medicina nazi, la inmersión clínica precoz, actividades de voluntariado de acción social en países en desarrollo, ciclo de cine y medicina, leprosario de Fontilles, asistencia y participación mediante posters y comunicaciones a congresos nacionales de Bioética.

ROUND TABLE 1 - 11:30 - 13:00 · MONDAY, NOVEMBER 7

Humanism, Humanities and Person Centered Medical Education Medical Education

THE ETHICAL BASES OF PERSON CENTERED MEDICAL EDUCATION

Prof. James Appleyard
President, International College of Person-centered Medicine, Former President, World Medical Association
London, United Kingdom.

The relationship between a person and their physician or surgeon is based on trust and empathy within a framework of values that form the basis of medical ethical practice Physicians are confronted by ethical issues every day of their working lives so medical education and training must ensure they are equipped with the knowledge, skills and confidence needed to deal with clinical challenges in a trustworthy way.

Learning medicine requires assimilating the core professional values and acquiring the skills to implement those values in clinical practice. To cope with the increasing complexities posed by scientific advances and the resultant specialization, fragmentation and depersonalization of health care the teaching of medical ethics is now recognized to be an essential core component of the medical curriculum. A person-centered bio medical psychosocial, mental cultural and spiritual approach re enforces these throughout the medical curriculum so that the knowledge, skills and understanding are acquired within this wider perspective and applied with the growth of professional responsibility

The World Medical Association stresses the importance of medical ethics as an essential part of medical Education The World Federation for Medical Education has set a Basic Standard for Undergraduate Medical Education that 'The Medical School must identify and incorporate in the curriculum the contributions of the behavioral sciences, social sciences, medical ethics and medical jurisprudence that ensure effective communication, clinical decision making and ethical practices'.

Of all the Standards required for a Medical School to be accredited in the US, the Deans of US medical schools have ranked ethical behavior as the highest of all in importance. In the White Coat Ceremony, which originated at Columbia University, medical students publicly commit themselves to the professions ethics. . The ceremony also reinforces the professional culture amongst the teaching faculty and administration of the School. Some medical schools have found it helpful to link these concepts with the students 'code of conduct' and the disciplinary procedures required to re-enforce them The social milieu or 'informal' curriculum of a medical school has a great influence on the values and professional identities acquired by its students through loyalty to the Institution and identification with their values On Graduation publicly professing the same ethical principles helps to reinforce the importance of maintaining and developing the ethical standards expected of members of the medical profession throughout their careers

References

Appleyard W J, Frank J, Morrein H, Shuster B Sonnino R (2006) The essence of Medical Professionalism. International Association of Medical Colleges (www.iaomc.org/ec.htm)

Mezzich J E et al , 2013 Ethics in Person Centered Medicine: Conceptual Place and Ongoing Developments International Journal of Person Centered medicine Vol 3 4 255-257

PARALLEL SESSIONS 1 - 14:00 - 15:30 · MONDAY, NOVEMBER 7

1.B. Workshop on Clinical Complexity and Contextualization

STRUCTURE OF THE PRESENTATION OF THE WORKSHOP ON CLINICAL COMPLEXITY AND CONTEXTUALIZATION

Antonio Ruiz Sánchez.
Licenciado en Medicina y Cirugia por la Universidad de Salamanca.
Especialista en Medicina Familiar y Comunitaria (Area 6, Madrid)
Médico de Atención Primaria en el centro de salud de Colmenarejo. (Área Noroeste del SERMAS).
Profesor de Métodos Clínicos en la Universidad Francisco de Vitoria (Madrid).

- Introduction of complex patients.

- Definition and characteristics of the complex patient.

- Experience in the Francisco de Vitoria University in teaching the complex patient. Subject "Clinical Scenarios".

- Some key points:
    1. The evidence-based medicine and contextualization,
    2. The health system response in complex patients.
    3. The social determinants of health.
    4. The overdiagnosis and medicalization.

- Open questions.

PARALLEL SESSIONS 1 - 14:00 - 15:30 · MONDAY, NOVEMBER 7

1.B. Workshop on Clinical Complexity and Contextualization

CLINICAL COMPLEXITY AND DIAGNOSTIC MODELS IN PSYCHIATRY

Prof. Ihsan M. Salloum
Board Director, Int'l College of Person Centered Medicine
Chair, WPA Section on Class & Diagnostic Assessment
Professor of Psychiatry and Behavioral Sciences,
University of Miami, Florida, USA.

Clinical complexity, broadly defined by the presence of multiple clinical conditions, by illness stage and severity and associated dysfunctions and disabilities is emerging as key challenge in modern medicine and psychiatry. Social disadvantage, poverty, disasters, individual and political violence and traumas substantially augment what is already a substantial challenge to mental health care. Mental health clinicians are increasingly faced with the burden of caring for complex clinical presentations across the life span such as higher frequency of chronic non-communicable diseases among the elderly and severely mentally ill and high frequency of substance use disorders and associated communicable diseases in younger age groups. This challenge is rendered more urgent by the inadequacy of health care models that have been developed to address mostly acute, specialized, disease-focused, care. The need for a broader approach to care has long been felt and advocated in several areas of medicine. This presentation will discuss the challenges presented by clinical complexity and will review current psychiatric diagnostic models including the person-centered integrated diagnostic model which emphasizes prevention and health promotion and highlights a broader concept of health that involves the totality of the persons including well-being in addition to a disease-free state.

PARALLEL SESSIONS 2 - 15:45 - 17:15 · MONDAY, NOVEMBER 7

2.B. Workshop on Bioethical Dilemmas

LAS CUESTIONES ÉTICAS QUE SE PLANTEAN EN ESPAÑA ¿SE AGOTA LA ÉTICA EN LOS DILEMAS?

Rogelio Altisent Trota
Presidente del Comité de Bioética de Aragón.
Cátedra de Profesionalismo y Ética Clínica de la Universidad de Zaragoza

En sus primeras décadas la bioética se ha desarrollado al ritmo de dilemas o problemas éticos dramáticos relacionados con la alta tecnología y el comienzo y final de la vida, lo cual ha favorecido un cierto alejamiento de esta disciplina de la mayoría de los profesionales sanitarios que no se enfrentan a menudo a estas decisiones. Esto ha abierto una brecha intelectual entre los "expertos" y los profesionales que atienden pacientes a diario en sus consultas, viéndo la bioética como un mundo elitista de eruditos no siempre conectados con las auténticas preocupaciones éticas del día a día, que quizá consideran de menos categoría como para ser dignas de atención.

En un estudio realizado entre médicos de familia españoles, contra todo pronóstico, al hacer un ranking de problemas éticos según frecuencia y dificultad, el primer puesto del top ten fue para las cuestiones éticas generadas en la relación entre niveles asistenciales, es decir, en la interacción que se produce al compartir pacientes entre la atención primaria y la atención hospitalaria o especializada. Esto no se explica en los libros clásicos de bioética y, sin embargo, es lo que más preocupa a la mayoría de los médicos de familia.

Esta investigación también nos ha permitido explicar que es un error reducir la bioética a los dilemas o problemas éticos. Existen además las cuestiones éticas de actitud y las cuestiones éticas operativas, que son decisivas para la calidad asistencial. En la docencia de la ética es muy importantes diferenciar estos tres tipos de cuestiones éticas porque van a tener diferente abordaje

La actitud profesional se relaciona directamente con el compromiso personal a la hora de afrontar la relación clínica con cada paciente o con el modo de entender la gestión de los recursos. En el desarrollo de las actitudes profesionales es fácil situar el respeto por las personas, la compasión, la equidad, y una larga lista de cualidades, sin la cuales no se puede llegar a ser un buen profesional.

Las cuestiones éticas operativas están vinculadas a la aptitud del profesional. Es decir, a la adquisición de habilidades y cualidades que, cuando fallan, inmediatamente se generan problemas éticos. Dos ejemplos: la comunicación y el trabajo en equipo.

Los dilemas o problemas de decisión plantean dudas a la hora de tomar decisiones que obligan a subir una escalera de tres peldaños: 1º reflexión personal, 2º consultar al equipo 3º consultar a un comité de ética. Es importante respetar esta secuencia, de modo que solo deben llegar a un comité los casos que no se han resuelto en los dos primeros escalones.

PARALLEL SESSIONS 2 - 15:45 - 17:15 · MONDAY, NOVEMBER 7

2.B. Workshop on Bioethical Dilemmas

ANALYSIS AND ETHICAL APPROACH TO THE SOLUTION OF BIOETHICAL DILEMMAS IN THE CONTEXT OF MEDICINE CENTERED ON THE PERSON.

Patricia Campos Olazábal

Universidad Católica Santo Toribio de Mogrovejo, Chiclayo, Peru

Title of Broader Activity

With the advent of the model of evidence-based medicine (EBM) cut clearly positivist, was left aside the humanity of the patient; years later with humanism "rescued" by medicine centered on the person (MCP), we had to give clinicians the difficult task of building bridges between both paradigms. Ethics as the center of the moral duty of the doctor should be the basis on which to rest all the new knowledge acquired as a result of the new technological models.

Method

We will discuss what a "bioethical dilemma" from its definition and possible methods to elucidate, taking as a model, two of them: The proposed by the Mexican School in 2009 and the method of the Triangle of Sgreccia. Then we will work on ethical dilemmas in the therapeutic limitation in pediatrics, that is to say, it comes to treatments whose non-implementation will have the effect of hastening the death of a seriously ill patient

References

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2.- Sgreccia E. Manual de Bioética I: Fundamentos y Ética Biomédica, 2007; Ed. Biblioteca de Autores Cristianos. Madrid

PARALLEL SESSIONS 2 - 15:45 - 17:15 · MONDAY, NOVEMBER 7

2.B. Workshop on Bioethical Dilemmas

TEACHING A PERSON-CENTRED APPROACH TO ETHICAL DILEMMAS THAT DEFIES INDIVIDUAL LIBERALISM AND ETHICS RELATIVISM: THE DILEMMA OF TREATMENT NON-ADHERENCE

Werdie Van Staden

University of Pretoria, Pretoria, South Africa

Objectives

This presentation takes issue with the problematic (mis)understanding of a person-centred ethic, even if in the name of the principle "respect for personal autonomy", by which the health worker would be a mere puppet strung to do whatever the patient wants.

Methods

Treatment NON-adherence is considered as case in point, which alarmingly may be seen as a sign of success by the mentioned (mis)understanding.

Findings

The implications of this (mis)understanding would be that the health worker has to defy his professional values by which best health practice is determined and treatment adherence is considered a good pursuit.

Discussion

Instead, a person-centred ethic should be taught that engages with the relevant values of ALL the persons involved in decision making, by which all these values are accounted for in a context-specific, constructive and participatory process of deliberation. Rejecting liberal individualism in this way does not amount to ethics relativism, for practically exercising respect for diversity means that no role player needs to give up, or make equally important, his values. The health worker may participate in this deliberation true to the professional values that determine which health practice is best and that treatment adherence is desirable; and in turn the patient does not have to conform to these medical values and may stick to his values even if conflicting with medical values.

Conclusions

All role players may co-construct a shared decision in partnership that accounts for the common ground as well as the divergence(s), being then the best decision afforded in that very situation.

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2) Van Staden CW. African approaches to an enriched ethics of person-centred health practice. The International Journal of Person-Centered Medicine. 2011, 1:11-17

ROUND TABLE 2 - 17:45 - 19:15 · MONDAY, NOVEMBER 8

People-centered Public Health, Ecology and Social Determinants of Health

HOW SHOULD WE BRIDGE PEOPLE- AND PERSON-CENTRED INTERESTS IN RISK ASSESSMENTS FOR DISEASE PREVENTION?

Werdie Van Staden
University of Pretoria, Pretoria, South Africa

Objectives

The presentation challenges the utilitarian underpinnings in the ethical question on how should we bridge people- and person-centred practice in risk assessments for disease prevention.

Methods

Committed to a person-centred ethic, the paper advocates for a careful PROCESS when using risk assessments for disease prevention – a process that surpasses the tenets of utilitarianism.

Findings

When committed to a person-centred ethic, utilitarian tenets are crucial yet inadequate in risk assessments for disease prevention. The inadequacy stems from utilitarian theory that defines anticipated consequence necessarily by a common standard irrespective of whether the risk pertains to people or an individual. That is, utilitarian ethics does thus not provide for what would be a good (or bad) consequence "for me" when that deviates from the common standard. This inadequacy is in defiance of a person-centre ethic by which authority of judgment in the first place resides in the specific individual.

Discussion

A remedy for this inadequacy, the presentation advocates, is a careful and substantive process that a) draws on the critical distinction between actuarial and case specific risk; b) accounts for case specific risks by both common and uncommon standards; c) accounts for the limitations and myths in risk assessment; d) recognises and accounts for the values driving risk assessment; and e) averts the lures of a totalitarian coup by the pursuits of risk assessment.

Conclusions

Such process serves the interests of both people and the individual in a people- and person-centred way.

References

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2) Christodoulou GN, Van Staden CW, Jousset D, Schwartz M, Mishara A, Mezzich JE. Ethics in Person-Centred Psychiatry. In Person-Centered Psychiatry. Mezzich JE, Botbol M, Christodoulou G, Cloninger CR, Salloum I (Eds). Heidelberg: Springer Verlag (in press).

ROUND TABLE 2 - 17:45 - 19:15 · MONDAY, NOVEMBER 8

People-centered Public Health, Ecology and Social Determinants of Health

LATIN-AMERICAN PERSPECTIVES ON PERSON-CENTERED PUBLIC HEALTH AND HEALTH SECURITY: ONE LEVEL MORE

Freddy Canchihuamán, MD MPH PhD
Nat. Inst. Health, Peru

The person-centered approach is a new paradigm —as the evidence-based medicine was in the past—that it is questioning the status quo and the bases of the current health system and promoting its transformation. Under the person-centered framework, where the center is the person and the community, it is expect that medicine, public health and its disciplines redirect their own approaches. In the field of health security, emerging diseases such as SARS, Ebola and Zika have shown the fragility of the public health response system worldwide. To address the threats that represent to the global public health these and other diseases and risks, a comprehensive, inter-disciplinary and trans-disciplinary strategies have been proposed, including those such as the "One Health". These strategies should not be exempt of the person-centered approach. In this presentation, first a brief historical background about the person-centered approach and public health is presented, second its current role on public health is described and finally the approach's particular relevance on health security is discussed, that is at the level of prevention, detection and response to public health threats. The last issue is discussed on the context of the National Public Health Institutes.

ROUND TABLE 3 - 08:30 - 10:00 · TUESDAY, NOVEMBER 8

The Doctor-Patient Relationshio as the Core of Humanizing Clinical Practice

THE ROLE OF PHYSICIANS AND OTHER HEALTH PROFESSIONALS IN THE HUMANIZATION OF CLINICAL CARE

Alberto Perales1,2, Javier Saavedra2, Guillermo Quiroz2, Patrick Wagner2, Enrique Cipriani2 (†), Raúl Morales2, Alberto Cazorla2, Saúl Peña2.

(1) President Latin American Network For PCM

(2) National Academy Of Medicine (Peru).

Title of Broader Activity

At a world level, medicine has been increasingly accused of dehumanized professional practice (1). However, physicians are only one component of clinical care system in which other professionals and variables participate (2).

Objectives

To evaluate deficiencies in this respect we need: a) To specify the patients´ perception of humanistic clinical care received in health institutions; and, b) In case that such perception be negative, to elucidate which component of the health care system is more frequently involved.

Methods

With those purposes in mind the authors carried out a pilot test applying a validated questionnaire to 50 public hospital and community centers´ outpatients of Lima, Peru.

Findings

Findings are reported

Discussion

Is made.

Conclusions

Humanization of health care is a complex phenomenon in which physicians, other health professionals, the patients themselves and other variables participate. To specify and monitor these aspects at different levels of the health care system is of great importance to introduce the necessary corrections.

References

1. John Harley Warner. The humanising power of medical history: responses to biomedicine in the 20th century United States Med Humanit 2011;37:91e96. doi:10.1136/medhum-2011-010034

2. Perales A. ¿Se puede enfermar un hospital ? Editorial. Rev.Medicina. Interna, 2008.

ROUND TABLE 3 - 08:30 - 10:00 · TUESDAY, NOVEMBER 8

The Doctor-Patient Relationshio as the Core of Humanizing Clinical Practice

COMMUNICATIONAL APPROACHES TO ENHANCE DOCTOR-PATIENT RELATIONSHIP

Ronald Epstein
University of Rochester, Rochester, Ny, United States

Patients seeking health care (and their family members) seek to know and understand, to be known and understood, and to participate in their own health care with guidance from (but not domination by) health professionals. More than merely enacting of a set of communication skills, skilled communication in clinical settings aims to achieve "shared mind," in which two or more individuals collaborate and coordinate based on shared frames of reference and interpersonal resonance, even when their perspectives differ. This session will explore how shared mind can be achieved and enhance the tailoring of care to individual needs and contexts, patient autonomy, and the deeper goal of respect for persons. In this session, I will also consider some methods for sharing information while avoiding information overload, empowering but not burdening patients with deliberations about their care, and choosing which decisions to address in the face of uncertainty and complexity.

ROUND TABLE 3 - 08:30 - 10:00 · TUESDAY, NOVEMBER 8

The Doctor-Patient Relationshio as the Core of Humanizing Clinical Practice

CLINICAL COMMUNICATION AND DOCTOR-PATIENT RELATIONSHIP WHEN PEOPLE MEET IN HEALTHCARE...

Prof. Dr. Sandra van Dulmen

NIVEL (Netherlands institute for health services research) and Radboud University Medical Center, the Netherlands

Before seeing a doctor, a person has usually gone through a longer period of physical and/or psychological or emotional discomfort that worries and hinders him. When entering the consulting room these concerns prevail and often hamper effective information exchange and recall. Attending to a person's concerns should therefore be put higher on the agenda of the health care provider. However, research indicates that for many patients it is difficult to express their concerns; they often feel ashamed to do so and result expressing their concerns as rather vague and implicit cues to an underlying emotion. As a result, many of these implicit concerns remain unnoticed and patients' negative thoughts and emotions keep standing in the way of effective communication. The question is how doctors can attend to patients' emotions without prolonging the visit or losing track of the consultation.

ROUND TABLE 3 - 08:30 - 10:00 · TUESDAY, NOVEMBER 8

The Doctor-Patient Relationshio as the Core of Humanizing Clinical Practice

SETTING A COMMON GROUND FOR JOINT DIAGNOSTIC UNDERSTANDING AND SHARED DECISION MAKING.

Juan Enriquje Mezzich

Icahn School of Medicine at Mount Sinai, New York, United States

Title of Broader Activity

Round Table 3: The Doctor-Patient Relationship as the Core of Humanizing Clinical Practice

Objective

To present concepts and patterns for Joint Diagnosis and Shared decision making.

Method

Selective literature review

Findings

There are currently workable guides for both person-centered diagnosis and shared decision making.

Discussion

Recent developments on these topics need to be evaluated

Conclusions

This is an important and central area for person-centered care. Recent developments are encouraging. More research is needed along important lines.

References

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Mezzich JE, Salloum IM, Cloninger CR, Salvador-Carulla L, Kirmayer L, Banzato CE, Wallcraft J, Botbol M (2010): Person-centered Integrative Diagnosis: Conceptual Bases and Structural Model. Canadian Journal of Psychiatry 55:701-708.

ROUND TABLE 4 - 10:30 - 12:00 · TUESDAY, NOVEMBER 8

Clinical Communicatio and Simulation Methods in Medical Education

INTERPROFESSIONAL COLLABORATION AND COMMUNICATION

Ghebrehiwet Tesfamicael, PhD, MPH

Objectives

The presentation aims to highlight key issues in interdisciplinary collaboration and communication as underlying factors for effectiveness of health teams and improved patient outcomes.

Methods

The presentation is based on literature review.

Findings

Coordination of care and teamwork reduce errors; improve quality of care, patient outcomes, and patient safety (Institute of Medicine 1999). For example, positive nurse-physician relationship is one of the attributes of the Magnet hospitals that produce an empowering environment and job satisfaction in nurses resulting in quality care (Laschinger, et al., 2003). On the other hand ineffective health team communication is the root cause for nearly 66 percent of all medical errors (Institute for Health Communication, 2011).

Furthermore, the evidence indicates that there are positive relationships between a healthcare team member's communication skills and a patient's capacity to follow medical recommendations, self-manage a chronic medical condition, and adopt preventive health behaviors (Institute for Health Communication, 2011). And when communication about tasks and responsibilities are done well, there is a significant reduction in nurse turnover and improved job satisfaction because it facilitates a culture of mutual support (Lein & Wills, 2007).

Discussion

In today's complex health systems it is impossible for a single health professional group to provide a continuum of person-centred and cost-effective care. Interdisciplinary collaboration and communication are largely achieved through interprofessional education during certain periods of their training.

Conclusions

Team approach - with collaboration and communication at its core - offers a viable solution to the service delivery challenges facing health care systems worldwide.

References

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[2] Laschinger, H.K.S, Almost, J, & Tuer-Hodes, J. (2003). Workplace Empowerment and Magnet Hospital Characteristics: Making the Link. JONA, 33 (7/8)

[3] Institute for Health Care Communication. Impact of Communication in Healthcare.

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

TOWARDS A PERSON-CENTRED CURRICULUM?: HEALTH COACHING AS PART OF UNDERGRADUATE MEDICAL EDUCATION TO EMPOWER THE PATIENTS

Ayse Basak Cinar

Dundee University, Dundee, United Kingdom

Objectives

Person-centered health-care focuses on the need, expectations, and values of the whole person in their well-being and life, rather than their medical conditions/disease(1), in line with WHO-2020 targets. Evidence shows that Health Coaching (HC), a whole-person approach, is one of the most effective approaches to better manage health, in particular chronic diseases(2). However, integration of HC to undergraduate medical curriculum is a neglected issue. The present study's objective was to assess and the undergraduate elective course "Patient-focused Coaching and Communication Skills" by evaluation of the students.

Methods

One-week course included 40 training hours in the classroom (10 hours theoretical, 30 hours experiential learning), 5 hours of practice by the patients/peers. Evaluation included self-coaching practices, the assignments, evaluation by the trainer and the participants. The present data comes from the students` evaluations (Copenhagen Dental School, 2012-2014, n=50; Dundee Dental School, 2016, n=2) by structured- and semi-structured questions.

Findings

Majority of students reported (94%) that tools to motivate and guide patients to adopt health practices are missing at compulsory education, and HC can provide those tools, therefore HC should be part of the curriculum. Some students highlighted that they learned how to empower patients, to avoid conflict, to change a negative situation to positive during patient communication in the clinics.

Conclusions

There seems to be a need for new approaches, such as coaching training, to be part of the medical curriculum. One way can be integration of coaching into communication skills training; such that is currently running as a pilot at the University of Dundee.

References

1. 2014 Geneva Declaration on Person- and People centered Integrated Health Care for All. (2014) Available at: http://www.personcenteredmedicine.org/doc/2014_Geneva_Declaration_Released_May_27.

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

EVALUACIÓN DE LOS NIVELES DE EMPATÍA EN MÉDICOS INGRESANTES AL PROGRAMA DE RESIDENTADO MÉDICO DEL HOSPITAL NACIONAL GUILLERMO ALMENARA IRIGOYEN EN EL AÑO 2016

Jeff David Huarcaya, Jorge De La Cruz Oré
Hospital Nacional Guillermo Almenara Irigoyen, Lima, Peru

Objectives

Evaluar los niveles de empatía de los médicos residentes ingresantes al Hospital Nacional Guillermo Almenara Irigoyen (HNGAI), así como su relación con algunas variables que intervienen en su desarrollo.

Methods

Estudio observacional, transversal; realizado en 107 médicos ingresantes al programa de residentado médico del HNGAI. Se utilizó la Escala de Empatía Médica de Jefferson y se recolectaron variables sociodemográficas, profesionales y académicas.

Findings

La puntuación media de los niveles de empatía fue de 116,07. Se hallaron diferencias no significativas en los niveles de empatía relacionadas con la elección de especialidad (vinculada al paciente: 116,28, vinculada a la tecnología: 115,65; p=0.837); género (varones: 114,74, mujeres: 117,43; p=0,341); y el deseo de estudiar la especialidad de ingreso (deseo: 116,37, no deseo: 111,17; p=0,333). Se encontraron diferencias significativas en los niveles de empatía relacionados con haber contado con un modelo profesional en el trato al paciente (p=0,024) y tener una religión cristiana (p=0,025).

Discussion

Identificarse con una religión se asocia a mayores niveles de empatía, esto tal vez se debió a que una de las funciones de la religión es extender las conductas altruistas fuera de nuestro círculo familiar. Los residentes que informaron haber contado con un modelo profesional mostraron una diferencia en la dimensión toma de perspectiva. El cuidado con compasión y el ponerse en los zapatos del paciente pudieran estar relacionados más con factores internos del residente.

Conclusions

Los residentes católicos y evangélicos presentaron mayores puntajes de empatía, así como aquellos que contaron con un modelo profesional en el trato al paciente.

References

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

DEVELOPMENT OF A QUESTIONNAIRE ON HUMANISM IN HEALTH CARE

Alberto Perales[1], Javier Saavedra[2], Guillermo Quiroz[2], Patrick Wagner[2], Raul Morales[2], Enrique Cipriani[3], Alberto Cazorla[2], Saúl Peña[2]

1. Red Latino Americana de MCP y Academia Nacional de Medicina., Lima, Peru

2. Academia Nacional de Medicina., Lima, Peru

3. Fallecido, Spain

Objectives

Humanism has always played a fundamental role in medical practice as a result of conceptualizing human beings as a totality and the patient beyond illness (1).Besides, it has also been claimed that the accelerated technology and biomedicine development is dehumanizing medicine forcing it into a scientific reductionism and a professional market in which health has been converted in a commodity (2). However humanism as a concept lacks objectivity in health care being in need of more factual evidence.

Objective

Development and validation of a questionnaire to estimate the level of perceived humanism by patients of public health system regarding the health care received.

Methods

The questionnaire was constructed in base of related literature review, academic deliberations and expert´s judgement. A pilot test was carried out on health public hospitals and Community Centers` outpatients which helped to assess time duration, improve the question´s understanding and to evaluate the questionnaire´s internal consistency. The psychometric values of the questionnaire application to a large sample as part of a mental health problems prevalence study on health public hospitals and Community Centers` outpatients of Lima city are presented. Internal consistency was established by Cronbach`s alfa. Construct validity was analyzed by categorical principle components

Findings

The questionnaire shows good reliability with alpha over 85%

Discussion

To generate new instruments to evaluate the level of humanism in health care is fundamental to guarantee a comprehensive person centered medicine

Conclusions

The questionnaire is useful to increase objectivity on the concept of humanism in health care.

References

1. Patwardhan B, Warude D, Pushpangadan P, et al. Ayurveda and traditional Chinese medicine: a comparative overview. Evid Based Complement Alternat Med. 2005;2{4):465-473.

2. Perales A, Mendoza A, Ortiz P. El mercado profesional como determinante de inconducta médica. Anales de la Facultad de Medicina, 2000, 61 (3):207-218

PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

EFFECTIVITY OF A TRAINING PROGRAM TO MEDICAL STUDENTS FOR EMPATHYZING WITH PATIENTS

Roger Ruiz Moral, Fernando Caballero, Cristina Garcia De Leonardo, Diana Monge
UFV, Madrid, Spain

Objectives

1) increase the ability of students to detect contextual and emotional cues in a medical consultation, 2) enhance their ability to respond empathetically following the detection of these cues

Methods

Students in their third year prior to their clerkships (115) received a course to enable them to use communicative skills and make a person centered approach. The course include different educational activities (didactic, reflective and interactive: workshops and meetings with simulated patients) and was evaluated by an external observer (EO) and the 3 simulated patients (SP) in 2/3 videotaped encounters. Intra-rater reliability was assessed with 30 interviews by Intraclass Correlation Coefficient (ICC) (global and per ítem)

Findings

Students improved significantly from baseline to the last interview in all domains and communicative skills and in both the OE (32.4%) ($p<0.001$) as the SP measures (38.3%) ($p<0.001$). At the end of the course students detected significantly more clues (from 2.22 to 3.79, $p<0.001$); and made more empathetic expressions (from 1.13 to 2.57, $p<0.001$).

Discussion

The course appears to improve the ability of students to explore the patients illness experiences and for showing empathy in a realistic -10 minutes- consultation context. The effectiveness of the course and its feasibility seems to be apply in our usual training context

Conclusions

Further research is needed to assess whether these results are applicable to students in more advanced educational levels and if they influence other additional outcomes

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

PERSON-CENTERED INTERVIEWING TO ADDRESS NON-EXPRESSED EXPERIENCES IN MALE PATIENTS WITH FIRST MYOCARDIAL INFARCTION

Evgeny O. Taratukhin, Ivan G. Gordeev
Pirogov RNRMU, Moscow, Russia

Objectives

Person-centeredness in somatic setting can hardly be achieved unless non-explicit experiences become of physician awareness. Epistemology of Rogerian PCA is of interest as a tool for such way of doctor-patient interaction. Aim of the study was to conduct and to analyze data from person-centered interview with MI patients.

Methods

Investigator, cardiologist with MSc Psychology training in PCA/CCT, performed in-depth interviewing of 41-57 year old males hospitalized for acute myocardial infarction (3-5th day, n=14). Interviews were recorded and transcribed verbatim. Transcripts were analyzed using descriptive and interpretive phenomenological approach reconstructing implicit experiences under circumstances of the disease.

Findings

Data reveals a consistent range of experiences not expressed by patients, hence not being adequately addressed during medical care. Basic components are feeling of a life reached threshold, discourage and self-blaming, puzzlement with what has happened, loss of independence and hope for better in the future, etc. Self-image changed, as the view on the world, and "self—society", "me—myself" shifts. Somatic markers are crucial for the period studied, with bodily sensations being ascribed to the disease.

Patterns of Rogerian incongruence assessed with characteristics of the "frame of reference" responsible for social stress: intents shifts, stereotypy of thinking, rigidity, absence of the present in "past-future" way of thinking. Propensity to ruminate is marked.

Conclusions

Person-centered interviewing as epistemic tool provides specific data on patients' frame of reference that is "stress-prone" and is a trait to address as cardiovascular risk factor. Non-expressed experiences require specific ways of the health information provision, including the informed consent to be truly informed.

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

FOMENTAR EL PROFESIONALISMO MEDIANTE UNA TUTORIZACIÓN ACADÉMICA CENTRADA EN LA REFLEXIÓN Y EL CRECIMIENTO PERSONAL DEL ALUMNO

Mireia Valero-Marcet, Beatriz Cabrejas, Marta Elorduy
Facultat de Medicina i Ciències de la Salut. Universitat Internacional de Barcelona., Sant Cugat Del Vallès, Spain

Introducción:

El día que un estudiante entra en la Facultad de Medicina comienza el proceso personal para llegar a ser un profesional. Esto significa identificar y desarrollar unos valores, comportarse acorde una correcta práctica médica y responsabilizarse de los pacientes a los que sirve conformando así una determinada identidad profesional.

La práctica de una educación centrada en la persona del estudiante mediante la reflexión personal de sus actitudes, emociones y creencias, en el ejercicio de la profesión, favorece la auto-conciencia y la gestión personal, base de su futura identidad profesional y el ejercicio de una atención centrada en la persona.

Objetivo:

Introducir la formación en auto-conocimiento y auto-gestión personal durante los estudios de Medicina, como parte de una educación centrada en la persona y base para el futuro profesionalismo.

Methods

En la Facultad de Medicina se ha iniciado un programa de tutorización académica a lo largo de 3º a 5º curso, como soporte a la estructuración y crecimiento personal del estudiante.

El programa incluye una dinámica de Portafolio "Personal" supervisado. La actividad se realiza en talleres grupales (trimestrales) que incluyen ejercicios de identificación de valores, fortalezas, tipos de comunicación, gestión de emociones y construcción de la identidad.

La evaluación de la actividad tiene una discreta contingencia en las asignaturas de prácticas, consistente en la entrega de una serie de ejercicios.

La evaluación docente se realizará a través del análisis del contenido de los portafolios, una encuesta estructurada y los cuestionarios BEEGC y SWLS, al inicio y final de cada curso académico.

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

CONTEXTUALISING PATIENT-CENTRED CARE APPROACHES AT PRIMARY HEALTH CARE LEVEL IN SUB-SAHARAN AFRICA: THE CASE OF UGANDA

Everlyn Wanjiku Waweru

Institute of Tropical Medicine, PhD Student, Antwerp, Belgium

Objectives

The main aim of the study is to explore current initiatives, opportunities and challenges in the delivery of PCC in primary health care services in Uganda. A participatory action research approach will support stakeholders in designing implementing and evaluating an intervention revolving around training of health workers on communication based on the Jeroen et.al framework.

Methods

The proposed study is a multi-phase case study using transformative mixed methods and a transdisciplinary approach to involve relevant stakeholders in the design and implementation of an appropriate PCC intervention; and evaluate its impact on the quality of care offered at both public and private primary health facilities in Uganda.

Findings

Findings from this study will contribute to knowledge on the need for PCC approaches in primary care level in the sub-Saharan context. Interactions with stakeholders will illuminate the processes, challenges and opportunities in implementing PCC approaches. Evaluation of such a PCC approach designed and implemented with stakeholders will provide evidence of the process and impact of PCC approaches on quality of care and other health outcome indicators.

Discussion

This is protocol for a PhD study beginning in early 2017.

Conclusions

Patient centred-care (PCC) offers an opportunity for African health systems to build on progress made in primary health care reforms and universal health coverage initiatives, by involving both providers and consumers of services in the identification and implementation of health goals. Considering different social, political, and economic differences in sub-Saharan African countries, patient-centred care strategies and initiatives need to be contextualised for them to be feasible.

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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.A. Session on Brief Oral Presentations

FROM ACADEMIA TO PRISONS: A NEW HEALTH SETTING FOR PEOPLE-CENTERED AND INTEGRATED HEALTH SERVICES

Ayse Basak Cinar
Dundee University, Dundee, United Kingdom

Title of Broader Activity

Training Workshop

Objectives

WHO`s global strategy on people-centered and integrated health services (PCHS), a vision for 2020, is an approach to health-care that adopts the perspectives of individuals, families and communities, and sees them as participants of health systems responding to their needs and preferences in holistic ways(1). In line with this, WHO underlines the need for an PCHS-oriented intervention for people in prison (PEP), including the creation of a supportive and capacity-building environment, specific health promotion initiatives addressing the individual's health needs and expectations via focusing on empowerment and positive health(2). Our session is about presenting a new PCHS-focused coaching approach for PEP as a method to meet this need. The approach focusing on empowerment and engagement of PEP to adopt health lifestyles is a multidisciplinary collaborative intervention.

Methods

In our project, both prisoners and residential officers are trained together as health coaches to unlock, explore and activate their potential to adopt positive health behaviours first for themselves and then for others. This training stems from a coaching training model for undergraduate medical students and coaching intervention for diabetes type 2 patients (Denmark 2011-2014).
Workshop will present this "know-how" through theoretical and experiential learning.

Findings

Findings from implementation of PHCS-focused coaching at academia, clinics, and prison to be presented

Conclusions

At the end of the session, participants will be able to explore and discuss:1.How a PCHS-focused approach can be transferred from clinics and academia to a new health setting, namely prisons. 2.Can PHCS make really a DIFFERENCE to patient`s life?:Yes, IT CAN: PeP-SCOT

References

1. WHO. (2015). WHO global strategy on people-centered and integrated health services. Interim report Geneva, Switzerland: WHO Document Production Services. http://apps.who.int/iris/bitstream/10665/155002/1/WHO_HIS_SDS_2015.6_eng.pdf?ua=1&ua=1
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PARALLEL SESSIONS 3 - 13:45 - 15:15 · TUESDAY, NOVEMBER 8

3.B. Workshop

EMPATHY AND NARRATIVE TRAINING TO ENGAGE PATIENT'S SUBJECTIVITY IN CLINICAL PRACTICE

Prof. Michel Botbol

Subjectivity is a major dimension of the person-centered-medicine's appraisal of the patients' health status; it is also crucial to tailor and implement person-centered integrated cares in all medical setting. The problem is that the technical approach currently dominant in medicine and health sciences, tends to favor a disorder-centered perspectives inducing in the health professionals a type of training ignoring this major dimension it sees as a mere noise in the concert of health treatments and researches. Because of the particular nature of subjectivity and the difficulties to access, scientifically, this hidden dimension, because of the many competing theories about the psychological functioning underpinning this dimension, disorder-centered perspective generally neglect this key aspect of the person's psychological life status, in order to mimic the paradigm on which are based the biomedical findings and training. The first stake of a person-centered perspective is to fight against this abusive reductionism.

One of the main findings when adopting this point of view, is that the patients' perception, values and experiences of illness and health are key components of their health status and can be provided only if dimensions and narratives (idiosyncratic formulations) are added to traditional descriptive procedures. Through narratives, the professional has to access the patient's conscious and unconscious feelings and representations. He does not rely only on what he observes of the patient's behavior or physical condition. The aim of this workshop is to show that empathy (narrative empathy rather than mirror empathy) is the only tool access the patient's subjectivity in many clinical situations and to consider how the health professionals must be trained accordingly, if we want them develop, in themselves individually and in the team-work in which they are involved, their capacity to engage patient's subjectivity in Clinical Practice

References

1. Botbol M, Banzato C and Salvador-Carulla L: Categories, Dimensions and Narratives for Person-centered Diagnostic Assessment. International Journal for Person-Centered Medicine, 2 (2), pp 196-200
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4. Ricoeur P (1983) Temps et récit [Time and narrative]. Paris, Le Seuil.

PARALLEL SESSIONS 4 - 15:15 - 16:45 · TUESDAY, NOVEMBER 8

4.A. Workshop on Mindfulness

THE INNER LIVES OF PHYSICIANS: ADDRESSING QUALITY OF CARE, CLINICIAN WELL-BEING AND THE GOALS OF MEDICINE

Ronald Epstein
University of Rochester, Rochester, Ny, United States

Title of Broader Activity

Workshop on Mindfulness, Mental Health and Integrative Approaches

Discussion

Using the framework of Mindful Practice, this participatory workshop will explore how to be more self-aware, mindful and responsive during everyday clinical practice to act with greater clarity and compassion. Clinicians' inner lives – including cognitive biases, habits of mind, emotional intelligence and social awareness – have powerful effects on clinical decision-making, allocation of healthcare resources, emotional support that they offer to patients and colleagues and their own well-being and resilience in their work lives. While this is self-evident, the methods for achieving greater self-awareness, self-monitoring and self-regulation have not been widely adopted in medicine. In this introductory session, I will propose ways in which individual clinicians – and the health care institutions –can promote more mindful practice that will ultimately support person-centered care.

PARALLEL SESSIONS 4 - 15:15 - 16:45 · TUESDAY, NOVEMBER 8

4.A. Workshop on Mindfulness

A MOTIVATIONAL, PERSON-CENTERED APPROACH TO ENHANCING TREATMENT ADHERENCE FOR SEVERE MENTAL DISORDERS OF COMORBID BIPOLAR DISORDER AND ALCOHOLISM

Prof. Ihsan M. Salloum
Board Director, Int'l College of Person Centered Medicine
Chair, WPA Section on Class & Diagnostic Assessment
Professor of Psychiatry and Behavioral Sciences,
University of Miami, Florida, USA.

Treatment adherence is a major clinical problem for patients with severe psychopathology and is particularly acute for complex conditions with comorbid psychiatric and substance use disorders. This workshop will discuss a novel, motivationally informed psychotherapeutic approach aimed at enhancing treatment adherence for patients with comorbid bipolar disorder and alcoholism. This model integrates motivational counseling principles consonant with person-centered models of care with disease management approaches used for bipolar disorder. The primary aim of of this therapy is to enhance treatment adherence during the early recovery phase from an acute episode. Theoretical bases, treatment development and application along with pilot results will be reviewed.

ROUND TABLE 5 - 17:15 - 18:45 · TUESDAY, NOVEMBER 8

Articulating Person Centered Medical Education and the Goals of Health Care:

MULTISITE AND MULTILOCAL STRATEGIES FOR ARTICULATING EDUCATIONAL PROGRAMS AND HEALTH CARE GOALS AT THE UNIVERSITY OF BOLOGNA

Ardigò Martino, Brigida Lilia Marta, Francesco Sintoni

Centre for International and Intercultural Health, University of Bologna, Bologna, Italy

Objectives

As demonstred in international literature, the future professional workforce will need a diverse, sustainable and context sensitive mix of skills to update technical capacity whilst reinvesting in the human and community dimensions of health care, widening the focus of health interventions from diseases to person. Starting from these premises, the Centre for International Health-UNIBO realizes educational activities to innovate the training of future health professionals involving community actors, health services and universities, in close connection with other international experiences.

Methods

The multisite and multilocal research-training-intervention methodology combines context and system based learning with evaluation-research, self reflexivity and experiences exchange. The methodology aims on the one hand at creating local inter and intra-institutional networks through the involvement of different stakeholders, on the other hand at building international partnerships among institutions, sharing experiences, testing curriculum contents and methods for education in multidisciplinary teams.

Findings

Since 2013 a multidisciplinary and community-based training for students from medicine, nursing, anthropology, psychology, social service, physical education sciences has been formalized, in cooperation with other international experiences.

Discussion

Defining elements of these activities are the strong connection between self-reflexivity and practices; the direct contact among professionals, health planners, students and researchers at international and local level; the development of an ethical-political-pedagogical process involving all the dimensions of care.

Conclusions

The methodology adopted helps to identify new professionals competences in a globalized society and innovative learning tools and strategies. The involvement of institutional stakeholders allows to incorporate experimental paths within structured training processes, involving undergraduate, post-graduate and continuing education.

References

http://www.who.int/hrh/resources/transf_scaling_hpet/en/

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ROUND TABLE 5 - 17:15 - 18:45 · TUESDAY, NOVEMBER 8

Articulating Person Centered Medical Education and the Goals of Health Care:

PERSPECTIVAS EN LOS PLANES DE SALUD

Regional Health Department, Madrid

La humanización de la sanidad es una preocupación en alza por parte de las organizaciones sanitarias y la Consejería de Sanidad de la Comunidad de Madrid no ha permanecido ajena. Ha apostado por ello incorporando en su estructura una Unidad Directiva específica entre cuyas funciones se encuentran las de promoción, desarrollo y despliegue de aquellas actuaciones institucionales que garanticen la humanización de la asistencia sanitaria a través de la personalización de la atención en los diferentes niveles y a lo largo de todo el proceso asistencial. De este modo se ha forjado euna propuesta basada en la re-humanización de la asistencia. Se trata de potenciar una asistencia de "humanos hacia humanos", una asistencia centrada en la persona.

Queremos avanzar, crecer y fortalecer nuestro sistema sanitario, añadiendo y poniendo en valor, el compromiso, entrega y voluntad de servicio que tienen nuestros profesionales y que son valores del ser humano encaminados a garantizar la dignidad de las personas. En el Plan de Humanización de la Asistencia Sanitaria recientemente presentado, la voz del ciudadano ha sido activa y determinante, como también lo ha sido la voz de los directivos y profesionales. En él se definen las líneas y programas de actuación enfocados a mejorar, que no iniciar, la humanización en todos los centros, servicios y unidades del Servicio Madrileño de Salud y de la Consejería de Sanidad.

El destinatario de los servicios sanitarios es el ser humano, y la consideración de su dignidad y unicidad es inherente al servicio y a la relación. La humanización se produce cuando se atiende a la persona teniendo en cuenta no solo su corporeidad, sino sus sentimientos, sus emociones y su entorno, porque cada persona es única y por tanto la respuesta a sus necesidades también lo es, y para ello es imprescindible que el conocimiento científico de los profesionales se vea complementado con una formación humanística que lo facilite.

Entre los retos que con el Plan de Humanización se plantea estratégicamente la Consejería de Sanidad, destacan los de transformar las necesidades de los pacientes/usuarios/ciudadanos, en propuestas de valor atractivas y sostenibles mediante el respeto y consideración a su dignidad, singularidad, libertad y autonomía; la transmisión de la cultura y los valores de la humanización; el desarrollo de las habilidades y capacidades de los profesionales; el desarrollar procesos asistenciales fundamentados en las necesidades y expectativas de los ciudadanos; el alcanzar, sostener y mejorar los resultados relacionados con la humanización de la asistencia.

ROUND TABLE 5 - 17:15 - 18:45 · TUESDAY, NOVEMBER 8

Articulating Person Centered Medical Education and the Goals of Health Care:

El cambio de cultura que se tiene que producir para alcanzar estos retos, y en definitiva para que avancemos en la mejora de la humanización ya existente es imprescindible gestionarlo a través de los directivos de nuestra organización. Unos directivos que día a día muestran su compromiso, que son transmisores de la misión, visión y valores de la organización, facilitadores del despliegue del Plan y lideres en la gestión de ese cambio de cultura en sus centros. El Plan de Humanización de la Asistencia Sanitaria consta de 10 líneas estratégicas que abarcan diferentes momentos del ciclo vital de la persona: "Humanización en las primeras etapas de la vida" y "Humanización en el final de la vida"; contemplando los diferentes momentos de los procesos asistenciales: "Información personalizada y acompañamiento", "Humanización en hospitalización", "Humanización en urgencias" y "Humanización en UCI". Incluye además estrategias de "Cultura de Humanización" y "Escuela Madrileña de Salud", a lo que se añaden la "Humanización y paciente oncológico" y "Humanización en la atención de la Salud Mental", por sus características de especial carga de vulnerabilidad. En todas ellas la apersona es el eje de actuación.

ROUND TABLE 5 - 17:15 - 18:45 · TUESDAY, NOVEMBER 8

Articulating Person Centered Medical Education and the Goals of Health Care:

PATIENT ASSOCIATION PERSPECTIVES

Joanna Groves, BSc, MSc
Board Director, International College of Person Centered Medicine

Medical education is critical to the development of how health care is practiced and developed to meet the needs and wishes of patients. Amongst its goals are that the health professional will have the necessary knowledge and skills to improve or assist in the management of a person's health and well-being, use resources effectively and protect patient and health professional safety. It is essential, therefore, that medical education takes a person centered approach in order for health professionals to understand and practice person centered health care.

Person centered health care requires respect for people's needs, preferences, dignity, values, autonomy and independence . There is not a 'one size fits all approach' to person centred health care but there are some fundamental principles. As is increasingly recognised the patient, as well as the health professional, has their own unique valuable knowledge. They have knowledge of how their condition affects their life, what their goals are for their health and well being and in what way they would like to work with health professionals in partnership in the management of their health and well being. This presentation will consider the role of patient involvement in medical education considering methods of and evidence for involvement and some current initiatives.

References

As outlined in, for example, the International College of Person-Centered Medicine By-laws (http://personcenteredmedicine.org/about-us.php) and the International Alliance of Patients' Organizations Declaration on Patient-Centred Healthcare (http://iapo.org.uk/sites/default/filesfiles/IAPO_declaration_English.pdf)

International College of Person Centered Medicine (ICPCM)

Continuing Professional Development Program and Credits

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Title of event: Fourth International Congress of Person Centered Medicine, Madrid

Organized by the ICPCM and the Francisco de Vitoria University

Place and Dates: Madrid, 7 and 8 November 2016

Please use this form to mark your attendance at the **Fourth International Congress of Person Centered Medicine, Madrid** approved sessions and add up at the end the number of credits earned. One credit is equivalent to approximately 60 minutes of approved learning experience. After the event, complete and sign this form, scan it and e-mail it to <maro@torrespardo.com> and ICPCMsecretariat@aol.com. On the basis of this information, a CPDP Certificate will be e-mailed to you.

Dates	Session Periods	Session Titles	Session times and credits earned	Check-off attendance
7. Nov.2016	10:00 – 11:00	Opening & Inaug Lecture	60 minutes: 1.0 credit	
	11:30 – 13:00	Round table 1	90 minutes: 1.5 credits	
	14:00 – 15:30	Parallel Sessions 1	90 minutes: 1.5 credits	
	15:45- 17:15	Parallel Sessions 2	90 minutes: 1.5 credits	
	17:45- 19:15	Round table 2	90 minutes: 1.5 credits	
8. Nov.2016	8:30 – 10:00	Round Table 3	90 minutes: 1.5 credits	
	10:30 – 12:00	Round Table 4:	90 minutes: 1.5 credits	
	12:00 - 13:00	IberoAmerican Colloquium	60 minutes: 1.0 credit	
	13:45 - 15:15	Parallel Sessions 3	90 minutes: 1.5 credits	
	15:15 – 16:45	Parallel Sessions 4	90 minutes: 1.5 credits	
	17:15 -18:45	Round Table 5	90 minutes: 1.5 credits	
	18:45 – 20:00	Closing Lecture & Session	75 minutes: 1.0 credit	
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