EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

THE SECOND ANNUAL CONFERENCE AND AWARDS CEREMONY

DELEGATE BROCHURE

18-19 JUNE 2015

Francisco de Vitoria University, Madrid, Spain

fundación Lilly Bupa Universidad Francisco de Vitoria UFV Madrid

Index

Dear Conference Delegates, Speakers, Chairmen and Friends

Introduction

We are delighted that it has proved possible for you to join us in Madrid for the Second Annual Conference and Awards Ceremony of the European Society for Person Centered Healthcare. On behalf of the Society we welcome you to this great city, the third largest in Europe, the Capital of Spain. We are confident that you will enjoy your time here, meeting existing colleagues and making new ones. We, ourselves, look forward to making your acquaintance over the full two days of the Conference.

This Second Annual Conference and Awards Ceremony of the Society brings together a stellar line up of distinguished speakers from the United States of America, Canada, Australia, New Zealand, South America, Hong Kong, the Middle East, Turkey, the United Kingdom, France, Italy, Spain, Germany, Norway, Demark and Sweden. We are privileged to have secured the participation of such prominent scholars and clinicians, all of whom are actively working in the field of PCH and who have travelled to Madrid for the Society´s Meeting from all over the world. We are equally delighted to welcome our delegates who, by lending their voices to the Conference discussions, debates and proceedings, will assist the ESPCH, a young and dynamic Society, to advance its primarily European, but also international Mission.

The growing global epidemic of long term, multi-morbid, socially complex illness, is placing enormous clinical and financial burdens on individual patients and health systems. Here, the classic formula of diagnose, treat, cure and discharge is inapplicable and the effective management of these conditions requires an altogether different and substantially more complex approach. The use of accumulated science and of ongoing advances in biomedicine and technology remains vital here – that is axiomatic. But a purely science-based approach is now recognised to be inadequate in the management of these patients and in accompanying them during the course of their illness trajectory. Indeed, a growing number of world leaders now argue for what has been termed a ´science plus´ approach: the combination of science plus humanism. The fruits of such a marriage, they argue, between the clinician as applied scientist and the clinician as humanist, has the very real potential to form truly person-centered clinicians who use their science to ameliorate, attenuate and cure and their skills in humanism to care, comfort and console.
As part of this vision, PCH places great emphasis on the need to attend to the patient´s subjective experience of illness alongside the imperative to address the biological dysfunction of disease in the objective scientific manner. It argues, therefore, for the direct application of science in the care of the patient, but equally advocates the use, in clinical decision-making, of a knowledge of the patient´s narratives, values, preferences, psychology, emotionality, existential and spiritual concerns and cultural context and of his or her worries, fears, anxieties, goals and ambitions - etc. To yoke these two approaches together in the service of the patient - and not in any way artificially to hold them apart – is described as the essence of an authentically person-centered healthcare. Importantly, a growing empirical research base is demonstrating that PCH approaches actually reduce healthcare costs while increasing their quality, providing the ´holy grail´ of modern healthcare.

If it is agreed that this is a vision of an optimal, rather than a simply an ´adequate´ care, then how can PCH be achieved in practice? It is this signal question that the Conference will directly consider. Following the Presidential Address and a description of the Society´s progress to date, the Conference will briefly consider the nature of some ongoing debates of relevance to PCH within the Philosophy of Medicine. From there, we will move, over some 8 presentations, to a detailed discussion of how the best principles of evidence-based medicine (EBM) can be fully contextualised by the person-centered healthcare approach in an effort to assist the ongoing synthesis of science and humanism that is increasingly forming the ethos of modern healthcare. Day One concludes with a direct focus on ongoing developments in PCH, including a consideration of who is doing what within this new global movement and what it is that these colleagues are trying to achieve.

Following the Conclusion of Day One, the Society will hold its Annual Awards Ceremony and Dinner, where the Platinum, Gold, Silver and Bronze medals will be conferred alongside the award of the Presidential Medal and the Senior Vice Presidential Medal and the presentation of the Society´s Book Prize and Essay Prize. The Society´s first

postgraduate Master´s Degree research studentship will be awarded to the recently successful candidate and the Ceremony closes with the formal confirmation of the recently appointed Chairmen of the Society´s extensive Special Interest Group Network.

Day Two of the Conference opens with a continuing discussion of the relevance of PCH to clinical practice and healthcare systems, including debates on relationship-based care, multi-morbid illness, challenging conditions and the utility of PCH in mediating the allocation of increasingly scarce healthcare resources. The Conference will then continue with a review of the aims and ongoing work of the Patient-centered Outcomes Research Institute (PCORI) of the Federal Government of the USA, followed by illustrations of the practical implementation of PCH approaches to care within Europe and the power of digital approaches to patient care in this context. From these specific considerations, we move to a discussion of how to build a person-centered medical school, how to halt declines in student empathy scores and the challenge of training practising clinicians in PCH principles and practice. Following these debates, the Conference turns to other areas of key relevance to PCH implementation: What is family-centered care? What are the means through which patients can become more engaged in their care? How do we identify and respond to the emotional distress and burnout in those who care for patients? The Conference ends by posing two frequently asked, but rarely well answered questions. Can physician-assisted suicide be part of the PCH framework or not? And what of complementary and alternative medicine (CAM)? Is it to be disregarded or does it have some sort of place? Following undoubtedly animated debate on these highly controversial but entirely necessary questions, the Conference turns to a brief consideration of the way ahead: ´PCH – Quo Vadis? Opportunities and Horizons´. The Conference then closes in preparation for a Meeting of the Council of the Society, chaired by the President, at which the Society will consider its draft Constitution and Terms of Reference and its draft 10 Year Strategic Plan.

In conclusion, we confirm the Society´s determination to continue to contribute energetically and with great enthusiasm to the advancement of person-centered healthcare. In this Second Annual Conference and Awards Ceremony of the Society we argue that the time has come to move PCH away from a simple and tired rhetorical advocacy into the reality of operational clinical and health system practice. Such a process is undeniably complex and will take time, indeed it may well take several decades. If successfully achieved, however, we have little doubt that this new way of ´thinking and doing´ in clinical practice will return to the clinical professions a definitive ambition to treat patients as persons thus elevating clinical competence into clinical excellence.

We wish you a highly enjoyable Conference and we remain, collegially,

Professor Andrew Miles MSc MPhil PhD DSc (hc)
Senior Vice President & Secretary General

Professor Sir Jonathan Asbridge DSc (hc)
President and Chairman of Council

Recommended reading

[1]. Miles, A., & Asbridge, J. E. (2014). The European Society for Person Centered Healthcare (ESPCH) – raising the bar of health care quality in the Century of the Patient. Journal of Evaluation in Clinical Practice 20, 729–733

[2]. Miles, A., Asbridge, J. E., & Caballero, F. (2015). Towards a person-centered medical education: challenges and imperatives – I. Educación Médica 16, 25-33

{3]. Miles, A., & Asbridge, J. E. (2014). Clarifying the concepts, epistemology and lexicon of person-centeredness: an essential pre-requisite for the effective operationalization of PCH within modern healthcare systems. European Journal for Person Centered Healthcare 2, 1-15

[4]. Miles, A., & Asbridge, J. E. (2014). On the need for transformational leadership in the delivery of person-centered clinical practice within 21st Century healthcare systems. European Journal for Person Centered Healthcare 2, 261-264

[5]. Miles, A., & Asbridge, J. E. (2015). Person-centered Healthcare: Theory and Practice. European Journal for Person Centered Healthcare In Press.

[6]. Miles, A., & Asbridge, J. E. (2015). A Preliminary Lexicon and Dictionary of Terms for Person-centered Healthcare. European Journal for Person Centered Healthcare In Press.

Day 1, 18 June 2015
Schedule of Sessions & Events

08:00 **REGISTRATION AND MORNING COFFEE**

09:00 **WELCOME**
Dr Daniel Sada Castaño,
Rector, Francisco de Vitoria University, Madrid, Spain

Session 1, Early Morning Session
PRESIDENTIAL ADDRESS, PROGRESS OF THE SOCIETY AND ONGOING DEBATES IN THE PHILOSOPHY OF MEDICINE AND HEALTHCARE

09:05 **EARLY MORNING CHAIRMAN**
Dr. Juan Perez Miranda
Vice Rector for International Relations, Francisco de Vitoria University, Madrid, Spain

09:10 **PRESIDENTIAL ADDRESS**
Professor Sir Jonathan Asbridge DSc (hc)
President and Chairman of Council, European Society for Person Centered Healthcare, Oxford & London UK and Madrid, Spain

09:20 **The European Society for Person Centered Healthcare: Overview of Progress July 2014 – June 2015**
Professor Andrew Miles
Senior Vice President and Secretary General, European Society for Person Centered Healthcare, Madrid, Spain and London UK
Assisted by:
Mr. Andrew Williamson
ESPCH Senior Production Editor, European Journal for Person Centered Healthcare (EJPCH) (London, UK)
Dr. Vivian Mounir
ESPCH Senior Project Manager (Madrid, Spain)
Mr. Enrique Martin
ESPCH Project Manager (Events, External Communications and PR) (Madrid, Spain)

09:50 **Healthcare personalism and the nature of the Person. How can personalist thought advance the conceptual basis of person-centered healthcare?**
Dr. James A. Marcum
Professor, Department of Philosophy & Director, Medical Humanities Program, Baylor University, Texas, United States of America

10:10 **Person-centered healthcare and the ontology of value**
Professor Michael Loughlin
Professor, Applied Philosophy, Manchester Metropolitan University, England UK & Chairman, ESPCH SIG on Health Philosophy

10:30 **CauseHealth: creating a new ontological foundation for person-centered healthcare**
Dr. Rani Lill Anjum
Research Fellow & Director of CauseHealth , School of Economics and Business , Norwegian University of Life Science, Oslo, Norway

10:50 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Dr. Mark Tonelli, USA)

11:10 BREAK WITH REFRESHMENTS

Session 2, Late Morning Session

PERSON-CENTERED HEALTHCARE AND THE CONTEXTUALIZATION OF EVIDENCE-BASED MEDICINE - I

11:40 **LATE MORNING CHAIRMAN**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

11:50 **What's In A Name? The Myth of ´Evidence-Based Medicine´**
Dr. Peter C. Wyer
Associate Clinical Professor of Medicine at Columbia University College of Physicians and Surgeons, Emergency Medicine Department, Columbia University Medical Center, Chair of the Section on Evidence Based Health Care at the New York Academy of Medicine, New York, United States of America & Co-chairman, ESPCH SIG on PCH and EBM

12:10 **Person-centred healthcare requires a re-conception, not a renaissance of evidence-based practice**
Professor Jack Dowie
Emeritus Professor of Health Impact Analysis, Department of Social & Environmental Health Research, Faculty of Public Health & Policy, London School of Hygiene and Tropical Medicine, London UK & Chairman, ESPCH SIG on Health Impact Analysis

12:30 **Negotiating Clinical Knowledge without Hierarchies**
Dr. Mark Tonelli
Professor of Medicine, Division of Pulmonary and Critical Care Medicine & Adjunct Professor of Bioethics and Humanities, University of Washington, Seattle, United States of America & Chairman, ESPCH SIG on Case-based Decision Making

12:50 **Beware of cognitive biases 'plus'! How the brain undermines our decision-making and its relevance to EBM**
Dr. Michael Makhinson
Associate Clinical Professor, Department of Psychiatry and Biobehavioral Science, David Geffen School of Medicine, University of California, Los Angeles & Co-Director of Inpatient Psychiatry and Attending Psychiatrist, Department of Psychiatry, Harbor-UCLA Medical Center, Torrance, California, United States of America

13:10 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Professor Brian Broom, Auckland, New Zealand)

13:30 LUNCHEON

Session 3, Early Afternoon Session

PERSON-CENTERED HEALTHCARE AND THE CONTEXTUALIZATION OF EVIDENCE-BASED MEDICINE - II

14:00 **EARLY AFTERNOON CHAIRMAN**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

14:10 **Evidence-informed person-centered healthcare, 'cognitive biases plus,' the EBM paradigm and healthcare organizations: exploration of a hypothesis**
Dr. Shashi S. Seshia
Clinical Professor, Department of Pediatrics, Division of Pediatric Neurology, University of Saskatchewan, Saskatoon, Saskatchewan, Canada.

14:30 **Rational decision-making and person-centered healthcare**
Dr. Benjamin Djulbegovic
Distinguished Professor & Associate Dean for Evidence-based Medicine & Comparative Effectiveness Research, University of South Florida and H. Lee Moffitt Cancer Center & Research Institute, Florida, United States of America

14:50 **Assessing decision quality in person-centered care requires a preference-sensitive measure**
Ms. Mette Kjer Kaltoft MPH
Research Unit of General Practice, Institute of Public Health, University of Southern Denmark, & Odense University Hospital Svendborg Sygehus, Denmark

15:10 **SIMPLE Integration of Social Process and Evidence in Healthcare: A Brazilian Anecdote**
Dr. Suzana Alves Silva
Senior Researcher & Clinical Cardiologist, National Institute of Cardiology and Amil Assistencia Medica Internacional, Rio de Janeiro and Hospital do Coração (HCor), São Paolo, Brazil & Co-chairman, ESPCH SIG on PCH and EBM

15:30 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Dr. Peter Wyer, New York, USA)

15:50 BREAK WITH REFRESHMENTS

Session 4, Late Afternoon Session

PERSON-CENTERED HEALTHCARE – WHAT ARE THE WAYS FORWARD? – I

16:10 **LATE AFTERNOON CHAIRMAN**
Dr. Mark Tonelli
Professor of Medicine, Division of Pulmonary and Critical Care Medicine & Adjunct Professor of Bioethics and Humanities, University of Washington, Seattle, United States of America & Chairman, ESPCH SIG on Case-based Decision Making

16:20 **Who is doing what worldwide in person-centered healthcare? The concept and results of The Health Foundation International Environment Scan**
Mr. Ed Harding
Director, The Health Policy Partnership, London, UK

16:50 **Person-centered care: what it is and what it isn´t – building upon the 2014 Reflection**
Dr. Stephen Buetow
Associate Professor, Department of General Practice and Primary Health Care, University of Auckland, New Zealand, Sabbatical Fellow, King´s College, University of London & Chairman, ESPCH SIG on Research in PCH

Day 1, 18 June 2015
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17:10 **Big Data and Person-Centred Healthcare: Opportunities and Threats**
Dr. Carmel M Martin
Associate Professor of Family Medicine, Northern Ontario School of Medicine, Ontario, Canada & Visiting Academic, Department of Public Health and Primary Care, Trinity College Dublin, Republic of Ireland & Co-Chairman, ESPCH SIG on Complexity and Health

17:30 **Does an update of the Biopsychosocial Model improve its applicability for person-centered healthcare?**
Dr. Dr. Thomas Frohlich MD PhD
Physician, Heidelberg, Germany & ESPCH Vice President (Western Europe)

17:50 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Professor Jack Dowie, London and Denmark)

18:10 **CONCLUSION OF DAY 1 – Closing Remarks**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

Day 1, 18 June 2015
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18:20 **RECEPTION**
The Society invites delegates registered for the Awards Ceremony and Conference Dinner to a cocktail in advance of the Awards Ceremony

ANNUAL AWARDS CEREMONY OF THE EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE & CONFERENCE DINNER

Dear Reader

The Society´s awards are intended to recognise various degrees of achievement and excellence in person-centered healthcare advocacy, scholarship, research, teaching and in the design, delivery, evaluation and measurement of PCH-driven clinical services.

This year´s international consultation exercise was conducted (as were the 2014 inaugural awards consultations) via a simple nomination form requesting recommendations supported by an accompanying justification. The 2015 consultation produced an excellent result, generating a grand total of 382 suggestions. It is from these nominations that the President and I were able to select winners – with difficulty - given the outstanding nature of the large number of recommendations received.

The President will confer the Society´s medals and prizes at the formal Awards Ceremony prior to the Conference Dinner on the evening of Thursday 18 June 2015. I am delighted to confirm that the winners of the Platinum, Gold, Silver and Bronze Medals will all be present at the Ceremony, as will the winners of the Presidential Medal, the Senior Vice Presidential Medal and the winners of the Society´s Book Prize and Essay Prize. The Society´s first postgraduate Master´s Degree studentship will be conferred in absentia.

On the suggestion of Professor Linn Getz, the Society´s Vice President for Northern Europe, the Society´s 2016 awards will be extended to include a range of recognitions for young clinicians and young scientists (less than 35 years) working in the research and teaching of person-centered healthcare.

The winners of the Society´s 2015 awards are detailed in the ESPCH-2015 AWARDS Section

Professor Andrew Miles MSc MPhil PhD DSc (hc)
ESPCH Senior Vice President & Secretary General

18:50 **Introduction to the Awards Ceremony**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

19:00 **Annual Oration of the Society and the Presentation of Medals, Prizes, Awards and Confirmation of Society Special Interest Group (SIG) Chairmen**
Professor Sir Jonathan Asbridge DSc (hc)
President and Chairman of Council, European Society for Person Centered Healthcare, Oxford & London UK and Madrid, Spain

19:20 **Presentation of the Platinum, Gold, Silver and Bronze Medals of the Society**

19:30 **Presentation of the Presidential Medal and the Senior Vice Presidential Medal for Excellence in the Advancement of PCH**

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19:40 **Presentation of the Book Prize and Essay Prize of the Society**

19:50 **Award of the Society´s First Postgraduate Master´s Degree Studentship**

19:55 **Confirmation of elections to Chairmanships of the ESPCH Special Interest Group Network**

20:15 **Conclusion**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

20:30 **CONFERENCE DINNER**

Day 2, 19 June 2015
Schedule of Sessions & Events

08:00 **REGISTRATION AND MORNING COFFEE**

09:00 **Welcome to Day 2 of the Conference**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

Session 5, Early Morning Session
PERSON-CENTERED HEALTHCARE – WHAT ARE THE WAYS FORWARD? – II

09:10 **EARLY MORNING CHAIRMAN**
Dr. Suzana Alves Silva
Senior Researcher & Clinical Cardiologist, National Institute of Cardiology and Amil Assistencia Medica Internacional, Rio de Janeiro and Hospital do Coração (HCor), São Paolo, Brazil & ESPCH SIG Co-chairman PCH and EBM

09:20 **The power of 'story', symbolic illness, relationship-based healing and person-centred healthcare**
Professor Brian Broom
Consultant Physician (Clinical Immunology), Department of Immunology, Auckland City Hospital and Adjunct Professor, Department of Psychotherapy, Auckland University of Technology, New Zealand & Chairman, ESPCH SIG on Personhood and the Dynamics of Healing

09:40 **A person-centered approach to the understanding and management of multi-morbid, socially complex illness**
Dr. Joachim Sturmberg
Associate Professor of General Practice, Monash University, Melbourne, Australia and Co-joint Associate Professor of General Practice, University of Newcastle, Newcastle, Australia & Co-Chairman, ESPCH SIG on Complexity and Health

10:00 **Better Lives through Personalization – the example of PCH for those with challenging learning difficulties**
Professor Roger Ellis OBE
Director, Social and Health Evaluation Unit & Emeritus Professor of Psychology, Universities of Chester and Ulster & Chairman, ESPCH SIG for Learning Difficulties

10:20 **Setting Limits: Can PCH assist clinicians in the allocation of increasingly limited resources?**
Dr. Mark Tonelli
Professor of Medicine, Division of Pulmonary and Critical Care Medicine & Adjunct Professor of Bioethics and Humanities, University of Washington, Seattle, United States of America & ESPCH Chairman, Case-based Decision Making

10:40 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Dr. Sandra Tanenbaum, USA)

11:00 **BREAK WITH REFRESHMENTS**

Session 6, Late Morning Session
PERSPECTIVES ON IMPLEMENTATION – I. EVOLVING HEALTH POLICY, RESOURCE ALLOCATION AND DIGITAL AND mHEALTH

11:30 **LATE MORNING CHAIRMAN**
Dr. Peter C. Wyer
Associate Clinical Professor of Medicine at Columbia University College of Physicians and Surgeons, Emergency Medicine Department, Columbia University Medical Center, Chair of the Section on Evidence Based Health Care at the New York Academy of Medicine, New York, United States of America & Co-chairman, ESPCH SIG on PCH and EBM

11:40 **Person-Centered Health Policy: The Case of the Patient-Centered Outcomes Research Institute (PCORI) of the United States of America**
Dr. Sandra Tanenbaum
Professor, Health Services Management and Policy, College of Public Health, Ohio State University, Ohio, United States of America & Chairman ESPCH SIG on PCH and Health Policy

12:00 **Implementing Person-Centred journeys through hospital stays and home and community care in 3 European Countries: Conceptual and practical challenges**
Dr. Carmel M Martin
Associate Professor of Family Medicine, Northern Ontario School of Medicine, Ontario, Canada & Visiting Academic, Department of Public Health Primary Care, Trinity College Dublin, Republic of Ireland & Co-chairman, ESPCH SIG on Complexity and Health

12:20 **Is Digital Health a Viable Pathway to Advance Person-Centered Healthcare?**
Dr. Dwight McNeill
Instructor of Health Policy and Population Health, Suffolk University, Boston, Massachusetts, United States of America (Winner of the ESPCH 2015 Book Prize)

12:40 **Promoting PCH-mediated patient adherence via mHealth**
Mr. Kevin Dolgin MBA
President, Observia, Associate Professor at IAE de Paris, Université Paris I (Panthéon-Sorbonne), Paris, France & Chairman, ESPCH SIG in Patient Behavioural Studies

13:00 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Dr. Carlos Martín Saborido, Spain & Chairman, ESPCH SIG on Health Technology Economics and Assessment)

13:20 LUNCHEON

Session 7, Early Afternoon Session
PERSPECTIVES ON EDUCATION AND TRAINING

13:50 **EARLY AFTERNOON CHAIRMAN**
Dr. Mark Tonelli
Professor of Medicine, Division of Pulmonary and Critical Care Medicine & Adjunct Professor of Bioethics and Humanities, University of Washington, Seattle, United States of America & Chairman, ESPCH SIG on Case-based Decision Making

14:00 **Building a person-centered medical school. Why? How? What remains to be done?**
Dr. Fernando Caballero Martinez
Dean of Medicine, Francisco de Vitoria University, Madrid, Spain & Chairman, ESPCH SIG on Undergraduate Medical Education

14:20 **Empathy in graduate medical education milestones**
Dr. Nathan Schou Bertelsen
Visiting Assistant Professor, Koç University School of Medicine, Istanbul, Turkey, and Assistant Professor of Medicine and Population Health, Bellevue Hospital, New York University School of Medicine, United States of America

14:40 **The challenges of training clinicians towards person-centred care in hospitals, private practice, general practice, allied health disciplines and psychotherapy**
Professor Brian Broom
Consultant Physician (Clinical Immunology), Department of Immunology, Auckland City Hospital and Adjunct Professor, Department of Psychotherapy, Auckland University of Technology, New Zealand & Chairman, & Chairman, ESPCH SIG on Personhood and the Dynamics of Healing

15:00 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Dr. Joachim Sturmberg, Australia)

Session 8, Mid Afternoon Session - A
FAMILY CENTERED CARE & PATIENT COMMUNICATION

15:20 **MID AFTERNOON CHAIRMAN**
Professor Bernie Carter
Professor of Children's Nursing at the University of Central Lancashire UK & Director of the Children's Nursing Research Unit (CNRU) at Alder Hey Children's NHS Foundation Trust UK & Clinical Professor, University of Tasmania & Visiting Professor, Edge Hill University & Editor-in-Chief, Journal of Child Health Care [Winner of the ESPCH 2015 Presidential Medal for Excellence in the Advancement of Person-Centered Healthcare]

15:30 **Family-centered care: history, application and subversion**
Professor Linda Shields
Professor of Nursing, Tropical Health Research Unit, James Cook University and Townsville Hospital and Health Service, College of Healthcare Sciences, James Cook University, Townsville, & Honorary Professor, School of Medicine, The University of Queensland, Australia & ESPCH SIG Chairman on Child and Family Centered Care

15:50 **Engaging Patients in Communication about their Care Transitions**
Professor Wendy Chaboyer
Director, NHMRC Centre of Research Excellence in Nursing Interventions for Hospitalised Patients (NCREN) & Centre for Health Practice Innovation (HPI), Menzies Health Institute Queensland, Griffith University, Queensland, Australia & Professor, Institute of Health and Care Sciences, Gothenburg University, Sweden

16:10 BREAK WITH REFRESHMENTS

Session 8, Mid Afternoon Session - B (continued)
FAMILY CENTERED CARE & PATIENT COMMUNICATION

16:40 **Patients' and Nurses' Preferences for Patient Participation in Nursing Care**
Ms. Georgia Tobiano RN
Doctoral Candidate, Centre for Health Practice Innovation, Menzies Health Institute, Griffith University, Queensland, Australia

17:00 **Caring for carers: Spanish perspective in palliative care**
Ms. Macarena Quesada Rojas MA
Data Manager, Clinical Trials Department, Health Research Foundation (FFIS), Virgen de la Arrixaca Hospital & Doctoral Candidate, Department of Social Health Sciences, Faculty of Medicine, University of Murcia, Spain

17:20 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**
(with invited Panel Discussant Professor Sir Jonathan Asbridge)

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Session 9, Late Afternoon Session
CONTROVERSIES AND HORIZONS

17:40 **LATE AFTERNOON CHAIRMAN**
Professor Sir Jonathan Asbridge DSc (hc)
President and Chairman of Council, European Society for Person Centered Healthcare, Oxford & London UK and Madrid, Spain

17:50 **Assisted Dying or Assisted Living? Can physician assisted suicide form part of the person-centered healthcare framework?**
Mr. Harry van Bommel
Founding Member, Canadian Hospice Palliative Care Association and Hospice Palliative Care Association of Ontario, Canada & Executive Director, Resources Supporting Family and Community Legacies Inc, Founder of Canada 150 Project, Co-Founder navCare Canada

18:10 **Scientific evidence and patient-reported outcomes. Can Traditional, Complementary and Alternative Medicine (CAM) form part of the person-centered healthcare framework?**
Professor Paolo Roberti di Sarsina
Specialist in Psychiatry & President, Charity for Person Centred Medicine (Moral Entity), Bologna, Italy, Member, Observatory and Methods for Health & Coordinator Master´s Course "Health Systems, Traditional and Non-Conventional Medicine", University of Milano-Bicocca, Milano, Italy & Chairman, ESPCH SIG on Traditional, Complementary and Alternative Medicine

18:30 **Person-centered Healthcare – Quo Vadis?**
Professor Andrew Miles
Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

18:40 **PANEL DISCUSSION WITH AUDIENCE PARTICIPATION**

Session 10
Closing Session

19:00 **President´s Closing Remarks**
Professor Sir Jonathan Asbridge DSc (hc)
President and Chairman of Council, European Society for Person Centered Healthcare, Oxford & London UK and Madrid, Spain

19:15 **CLOSE OF THE SECOND ANNUAL CONFERENCE AND AWARDS CEREMONY OF THE EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE**

20:00 MEETING OF COUNCIL OF THE SOCIETY [CENTRAL MADRID]
Professor Sir Jonathan Asbridge DSc (hc), ESPCH President & Chairman of Council
[Council Members only, with observers in attendance by Special Invitation]

Day 1, 18 June 2015

Note to the Reader

The Abstracts published here are provided without associated bibliographic referencing in order to minimize the size and complexity of this Abstracts Section and to reduce the overall size of the Conference Brochure. All conference speakers have been invited to write a formal academic paper based on their conference presentation and these will be published as a set within a forthcoming issue of the European Journal for Person Centered Healthcare, the official journal of the European Society.

Professor Andrew Miles MSc MPhil PhD DSc (hc)

Session 1, Early Morning Session
PRESIDENTIAL ADDRESS, PROGRESS OF THE SOCIETY AND ONGOING DEBATES IN THE PHILOSOPHY OF MEDICINE AND HEALTHCARE

09:20 The European Society for Person Centered Healthcare: Overview of Progress July 2014 – June 2015

Professor Andrew Miles, Senior Vice President & Secretary General, European Society for Person Centered Healthcare (ESPCH), Faculty of Medicine, Francisco de Vitoria University Madrid Spain and Faculty of Medicine, Imperial College, London UK. Assisted by: Mr. Andrew Williamson, ESPCH Senior Production Editor of the European Journal for Person Centered Healthcare, Dr. Vivian Mounir, ESPCH Senior Project Manager & Mr. Enrique Martin, ESPCH Project Manager.

The ESPCH is an independent, learned society of clinicians, academics, scholars and teachers, healthcare managers, health policymakers, members of the healthcare Industry and patients themselves. The Society´s principal interests span: (a) the ongoing conceptual clarification of what PCH is and what it isn´t, (b) undergraduate and postgraduate medical and clinical education in PCH, (c) the practical training of practitioners in PCH skills, (d) the development of PCH-driven models of care and (e) the stimulation of broad research into PCH: conceptual, qualitative, quantitative and economic.
The Society was conceptualized in shadow form in mid-2013 and became operational in London UK in January 2014. Since its inception, the Society has:

- established a functional infrastructure through the creation of: (a) A President/Chairman of Council; (b) A Senior Vice President/Secretary General; (c) Four Vice Presidents (For i. Western Europe, ii. Northern Europe, iii. Eastern Europe & iv. Southern Europe), (d) 88 Special Interest Groups spanning all areas of relevance to the advancement of PCH (which work both singly and in cross collaboration wherever appropriate)
- established a Headquarters split between two major European cities: Madrid (Strategy, Conference Organization and External Relations/Affairs and Collaborations) and London (Publications, Finance)
- appointed 4 full time staff (3 in Madrid, 1 in London)
- established an official journal, the European Journal for Person Centered Healthcare (EJPCH) (At the time of writing the EJPCH has published Volume 3 Issue 2 one month ahead of schedule in effort to accelerate the entry into print of a very large number of papers awaiting publication)
- appointed Chairmen to 40 of its 88 Special Interest Groups, drawn from a range of institutions worldwide with further appointments pending
- organised two annual conferences and awards ceremonies of the Society (3 & 4 July 2014, 18 & 19 June 2015) to progress the Society´s work with a third already planned for June 2016

- scheduled 3 further conferences for 2015 (Increasing the Person-centeredness of the Care of the Frail Elderly; October 2015, Increasing the Person-centeredness of Care of People Living with HIV/AIDS: November 2015 & The Person-centered Care of Long Term Multi-morbid and Socially Complex Illnesses: December 2015)

- scheduling further condition specific conferences to be held throughout 2016 focussed on increasing the person-centeredness of care for diabetes, the common cancers, the common neurodegenerative diseases in addition to a major medical education conference and also the Society´s Third Annual Conference and Awards Ceremony

- is currently scheduling the first two 7-day intensive training courses for 2016 (Course 1: Basic PCH for Beginners, Course 2: Advanced PCH for Teachers, Mentors and Transformational Leaders)

- established the e-Bulletin of the Society to enable communication of the Society´s news and events to members and interested others

- established social media activities, including a FaceBook page, a Twitter Account

- entered into the process of producing major scholarly publications. Examples include; (a) The 55 chapter seminal textbook Person-centered Healthcare: How to Practise and Teach PCH, (b) The EJPCH Special Supplement Series documenting in detail the proceedings from the Society Conferences, (c) The Clinical Handbook Series – a series of handbooks being produced by the SIG Network which will provide practical knowledge and clinical advice on PCH and thus complement the Special Supplement Series as described in ´b´ above, (d) The major 50,000 word EJPCH thesis ´Person-centered Healthcare: Theory and Practice´ & (e) the 250,000 word EJPCH Lexicon and Dictionary of Terms of Person-centered Healthcare

- entered into discussion with key European medical schools to provide PCH teaching in for introduction into undergraduate and postgraduate medical and clinical curricula

- entered into discussion with the management studies departments of key European universities in order to teach the skills of transformational health leadership to future managers and executive managers of European health services

- established a growing membership of the Society at the level of (a) Distinguished Fellow, (b) Fellow, (c) Member, (d) Associate and (e) Student. Members elected at any such grade must join one (or multiple) SIGs of the Society in order to learn from and contribute to their work.

- appointed its first postgraduate Master´s Degree studentship in May 2015 in collaboration with Manchester Metropolitan University in the UK (Applied Philosophy of PCH) with plans in place for the advertising of the second (PCH-mediated changes in patient behavior and clinical service responsivity) and third (economic assessment) such research studentships in early 2016.

In order to consolidate these early strides in progress, the Society is putting into place formal structures and processes of good governance. It has recently articulated a draft (a) Formal Constitution, (b) Terms of Reference and (c) 10 Year Strategic Plan for initial discussion at the Meeting of Council of the Society, chaired by the President, following the close of the Second Annual Conference and Awards Ceremony on 19 June 2015. When agreed, the system of governance will be formally adopted and subsequently implemented.

09:50 Healthcare personalism and the nature of the Person. How can personalist thought advance the conceptual basis of person-centered healthcare?

Dr. James A. Marcum, Professor, Department of Philosophy & Director, Medical Humanities Program, Baylor University, Texas, United States of America

Healthcare personalism represents a multifaceted approach to modern healthcare and its delivery that champions the centrality of the person. As such, it is predicated on the philosophical notion of personalism in which the person per se plays a central role in analyzing the nature and function of individuals and their social institutions. In this paper, the nature of the person is examined in terms of its ontological, epistemological and ethical dimensions, especially with respect to the delivery of quality healthcare.

Ontologically, the person is an embodied agent, who is embedded holistically within biological and social contexts. For healthcare personalism, the value that underlies this ontological dimension of the person is health, i.e. the proper functioning of the embodied agent within a given context—whether biological or social. Illness, on the other hand, represents an improper functioning or a dysfunction of the person within a given context.

Epistemologically the person is a cognitive or rational/logical agent, who can discern fact from fiction. For healthcare personalism, the virtues animating the epistemic agent are phronesis or practical wisdom and sophia or theoretical wisdom, especially on the part of the healthcare provider. For the patient, additional virtues include patience and perseverance to ensure that the healthcare provider hears and understands the patient's illness story.

Ethically, the person is a relational agent with respect to other persons and to their given context. For healthcare personalism, the chief virtue of the ethical agent, especially healthcare providers, is care, along with two associated virtues compassion and competence. Through caring for the patient qua person the provider is able to take care of the patient's healthcare needs. The chief virtue of the patient is gratitude for the healthcare providers who strive to reduce the suffering associated with illness.

Finally, the value animating healthcare personalism overall is the dignity of each person involved in the healthcare encounter. For healthcare personalism, then, the notion of person in terms of its ontological, epistemological, and ethical dimensions is crucial for providing a philosophical framework to explicate quality healthcare and its delivery.

10:10 Person-centered healthcare and the ontology of value

Professor Michael Loughlin, Professor, Applied Philosophy, Manchester Metropolitan University, England UK & Chairman, ESPCH SIG on Health Philosophy

Debates about how we conceptualise health, disease and illness are still beset by the suspicion that 'value judgements' are in some special sense 'subjective'. A motivation for defending biomedical definitions of health and disease that are 'value-neutral' is to defend the objectivity of diagnosis. There are background assumptions at work here about the relationship between knowledge, truth, objectivity, science, value and reality that require urgent analysis. The movement towards 'person-centred' healthcare is frequently associated with the idea that medical diagnosis is inevitably value-laden. Until these background assumptions are brought to the fore and examined, this idea will raise concerns that the movement is driving an approach to health that is anti-science and associated with relativist accounts of health and illness.

The clearest illustration of the assumptions at work here can be found in the history of the debate about the reality of mental illness, where there has historically been a divide between those who accept that diagnosis is 'value-laden' and therefore accept a relativist/subjectivist account of mental illness, and those who feel the need to deny the value-laden nature of diagnosis to defend the reality of mental illness. More nuanced analyses note that (a) all medical diagnosis is arguably value-laden & (b) this does not imply that medical conditions are unreal. All judgement (about value or fact) requires a subject, but it does not follow that it is 'subjective' in any sense implying ontological relativity. The implications are substantial: either all medical judgement is relative (a thesis many

– quite correctly – regard as counter-intuitive and deeply problematic) or realism about value is true. To justify our claims in diagnosis, we need to discuss and defend our value-judgements. We must reject 'scientism' for an openly value-laden account of human functioning. Medical epistemology requires value-realism.

10:30 CauseHealth: creating a new ontological foundation for person-centered healthcare

Dr. Rani Lill Anjum, Research Fellow & Director of CauseHealth, School of Economics and Business, Norwegian University of Life Science, Oslo, Norway

There is a move within the medical paradigm: from evidence-based medicine and practice towards a more person-centred healthcare. But the criticisms of the current medical paradigm is to a large degree divided into many separate debates: on methods (RCTs, statistical methods, qualitative studies, patient stories), models (biomedical model, biopsychosocial model), ontology (reductionism, dualism, holism), causation (mono-causal, multi-factorial, mechanisms) and practice (EBP, person-centred, empowerment).

It is a sign of a crisis in a paradigm when its members start participating in philosophical and metaphysical discussions, which many of these debates seem to involve. In this paper, I argue that we need to consider these criticisms in unison, pointing in the same direction. Instead of adding person-centred healthcare on top of the existing paradigm of evidence-based medicine, we should make a more radical change that includes practice, methods, concepts and ontology.

By introducing a new philosophical framework, including an ontology of dispositions and a new theory of causation, we can offer a new ontological foundation for person-centred healthcare. This foundation would have clear implications for a change in methodology and practice, promoting (1) holism over fractionism, (2) genuine complexity and interaction of causal factors over mereological compositions of parts, (3) context-sensitivity and heterogeneity over robust correlations, (4) medical uniqueness over homogeneity, (5) singular propensities over statistical frequencies, (6) level-specific intervention over reductionism and medicalisation and, finally, (7) person-centred healthcare over evidence-based practice.

Session 2, Late Morning Session

PERSON-CENTERED HEALTHCARE AND THE CONTEXTUALIZATION OF EVIDENCE-BASED MEDICINE - I

11:50 What's In A Name? The Myth of ´Evidence-Based Medicine´

Dr. Peter C. Wyer, Associate Clinical Professor of Medicine at Columbia University College of Physicians and Surgeons, Emergency Medicine Department, Columbia University Medical Center; Chair of the Section on Evidence Based Health Care at the New York Academy of Medicine, New York, United States of America & Co-chairman, ESPCH SIG on PCH and EBM

Recently, discourse regarding epistemological and philosophical informants of healthcare relevant to evidence-based medicine (EBM) has elicited responses from the EBM community. Some of these suggest that resolution may fruitfully be sought via dialogues and skirmishes between divided scholastic communities identified with constructs such as nominalism, realism, constructivism, evidentialism and reliabilism. However, integration of potentially conflicting healthcare domains calls for deeper consideration of the foundations of medical knowledge and the relationships between evidence, knowledge, decisions and policies. The term 'evidence-based medicine' has become an obstacle to addressing those issues, partly because it is frequently used in an overly broad fashion and partly because of the way it was branded in 1992. In the latter, information from clinical research was to be dominant over other domains in the care of individual patients and in the training of clinicians. Negative responses led to formulations that acknowledged the importance of patient perspectives and circumstances, but in a fashion that suggested that EBM subsumes them. One such formulation included patient-centered considerations and information from research and practice context within a single two-dimensional plane within which the clinician presides as the interpreter and arbiter of decisions, i.e. as a kind of 'fact finder' in charge of compiling data from intersecting spheres.

If the term 'evidence-based' did not already connote a non-viable construct when it was conjoined to the term 'medicine', it certainly has since come to do so at the hands of its defenders. If, on the other hand, we recognize that knowledge, properly defined, serves a purpose within the mission of healthcare, we find ourselves in a more liberating framework, particularly if our understanding of knowledge is aligned with that of the renowned Brazilian educator Paulo Freire. Freire's 'constructivism', (not to be confused with 'anti-realism'), resonates with the conceptual framework developed by the Chilean school of Maturana and Varela and appears to offer a viable platform for complex integration, as opposed to linear reductionism. Recognition of this conceptual framework may, in turn, be used as a metric against which claims regarding the potential viability of approaches to integration of humanist and scientific dimensions of healthcare may be evaluated. For example, relationship centered care (RCC), posited in 1994, embraces this epistemological current. The proponents of RCC posit relational process as the primary unit of action in healthcare and as the key to viable incorporation of the fruits of EBM into practice. Epistemological clarity allows us to recognize the premonitory alignment of the Balints' concept of 'patient-centered care (PCC)' (8)with the tenets of RCC, and also that their original understanding of PCC importantly differed from that of many who attempted to follow their lead. On the other hand, the proposed metric allows an easy identification of non-person, non-relationship centered approaches to, for example, shared decision making (SDM). Such can be found in the literature on the GRADE system for evidence synthesis in the context of guideline development. The latter espouses that evocation of SDM in clinical practice be dictated by epidemiologically driven assessments of risk and benefit of interventions as applied to populations.

12:10 Person-centred healthcare requires a re-conception, not a renaissance of evidence-based practice

Professor Jack Dowie (Presenter), Emeritus Professor of Health Impact Analysis, Department of Social & Environmental Health Research, Faculty of Public Health & Policy, London School of Hygiene and Tropical Medicine, London UK & Chairman, ESPCH SIG on Health Impact Analysis (with Abstract Co-authors: Kaltoft, M, K., Nielsen, J. B., Eiring, O., & Salkeld, G.).

The call for a renaissance in Evidence-Based Medicine will not result in the delivery of person-centred healthcare. In person-centred healthcare the relative importance of the considerations that matter to the person is elicited and combined, at the point of decision, with the best estimates available on the performance of the available options on those criteria. Prior option evaluations based on average preferences that constitute the conventional 'evidence base' cannot be part of this process, even if some of the underlying data may be of use. The ethics of transparent person-centered care require the evidence base to be reconceptualised as the unsynthesized matrix of option performance rates on person-important criteria. Abdicating in the face of the challenges resulting from this reconception is a case of the methodological tail wagging the ethical dog.

In our conception of best practice and ethical person-centred healthcare it is accepted (i) that the individual person has multiple outcomes and other considerations that matter to them and (ii) that the clinical decision making process is committed to explicitly eliciting the person's values and preferences in regard to these multiple criteria and integrating them into the decision in a transparent way. But person-centred decision making is not solely about the incorporation of the person's values and preferences. These need to be integrated with 'evidence' at the Point of Decision (POD), so that the concepts of 'evidence-base' and 'evidence-based' are central to any discussion of person-centred healthcare.

We can distinguish two main senses of 'evidence-base' and hence of 'evidence-based':

The first sense, currently dominant through the efforts of institutions such as the Cochrane Collaboration, is not compatible with person-centred healthcare at the POD. In It, the evidence-base consists of the synthesised results of comparative option evaluations carried out by methods such as RCTs. Typically, because of the demands of methodological rigour, these evaluations have considered only the performance rates of a limited number of options on a single or very limited number of criteria, inevitably omitting some person-important outcomes except as qualifications of the analysis. Because of such omissions, these comparative option evaluations are of unknown

relevance to the individual person in the clinical situation, as well as being of acknowledges uncertain relevance, as a result of differences between the person and those included in the study populations.

In the second sense, compatible with person-centred healthcare, the evidence-base consists simply of a matrix of the Best Estimates Available Now (the BEANs) of the relevant option-criteria performance rates. In other words the 'evidence' base comprises the full set of individual numbers representing how well each option performs on each of the criteria important to the person. The individual cells in the matrix are not compared with one another, nor are they synthesised in any way before the clinical decision process. At the POD they are integrated with the individual person's values and preferences in respect of the criteria in order to generate a decision. Or an opinion on the decision, if the process is one of providing decision support.

The task of storing all the individual pieces of evidence and integrating them with the person's values and preferences at the POD is cognitively beyond the human being or human team, absent time and resource constraints, let alone with them. That person-centred healthcare requires highly effective and efficient decision support is therefore a no-brainer.

The actual implementation of person-centred healthcare at the individual level will often be limited by the legal standards in operation in the jurisdiction as well as economic and equity issues. Only person-centred healthcare as we have defined it, can, in our view, provide 'perfected' - and documented - informed consent. Person-centred healthcare clearly requires the 'subjective patient standard', as opposed to either the 'reasonable (ordinary prudent) patient' or 'reasonable physician' standard. It is not up to the clinician to decide whether a 'risk' is 'material' or 'immaterial', because the concept of risk as a compound of probability and harm is now literally out-lawed. The interesting issue is not whether person-centred care is compatible with the current legal standard in this or that jurisdiction. It is whether that current legal standard is compatible with person-centred care.

The call for a renaissance in Evidence-Based Medicine will not result in the delivery of person-centred healthcare. We end this input into the debate by stressing the difference between patient-centred medical care in the clinic and person-centred healthcare in the community. Rather than seeing the future as patient-centred medical care delivered within the 'medical home' - the medical facility expanded to embrace the person's home - we see it as person-centred healthcare that 'flips the clinic', expanding the person's home to embrace the medical facility.

12:30 Negotiating Clinical Knowledge without Hierarchies

Dr. Mark Tonelli, Professor of Medicine, Division of Pulmonary and Critical Care Medicine & Adjunct Professor of Bioethics and Humanities, University of Washington, Seattle, United States of America & Chairman, ESPCH SIG on Case-based Decision Making

Multiple hierarchies of evidence have been promulgated by proponents of evidence-based medicine, but none has proven useful for clinical decision-making. Clinicians must utilize medical knowledge from a variety of sources, including clinical research, clinical experience and pathophysiologic understanding – these differ in kind not degree. This understanding renders hierarchies of medical knowledge either incomplete or epistemically untenable. Warrants supporting a clinical decision or recommendation derive from and find backing in these sources of medical knowledge. Beyond medical knowledge, the experiences, values and goals of individual patients also provide compelling warrants for clinical choices. Clearly, patient-derived warrants do not belong on a hierarchy of evidence or medical knowledge. Incorporating these warrants into clinical decisions requires inquiry and empathy on the part of clinicians, as the presence of and backing for such warrants may not always be clear. Clinical reasoning, then, necessitates the evaluation and weighting of multiple, and potentially conflicting, warrants from a variety of sources, scientific and otherwise.

Clinical judgment, as noted by Upshur and Colak, more closely resembles the process of argumentation than of deductive reasoning. The clinical argument not only involves the clinician and the patient, but may include input from other medical professionals, the patient's family, and payers. Hierarchies of evidence or knowledge hold no sway, as warrants derived from any source may be more compelling in a particular case. Medical reasoning then, is

a casuistic endeavor, requiring practical wisdom and resulting in only probable conclusions. Clinicians are responsible for elucidating all relevant warrants for all appropriate sources and should be able to make their reasoning explicit, rendering conclusions subject to rebuttal from a variety of sources. The product of clinical reasoning may be a decision, a recommendation, or a list of options, depending upon the strength of the argument and the skill of the clinician in incorporating patient-derived warrants.

12:50 Beware of cognitive biases 'plus'! How the brain undermines our decision-making and its relevance to EBM

Dr. Michael Makhinson (Presenter), Associate Clinical Professor, Department of Psychiatry and Biobehavioral Science, David Geffen School of Medicine, University of California, Los Angeles & Co-Director of Inpatient Psychiatry and Attending Psychiatrist, Department of Psychiatry, Harbor-UCLA Medical Center, Torrance, California, United States of America (with Abstract Co-authors Seshia, S. S., Young, G.B ., & Phillips, D. F.).

Cognitive biases 'plus' are a set of universal, systematic imperfections in human decision-making processes, reasoning, and behavior which are rooted in a complex confluence of evolutionary, social and psychological influences. They cause irrational judgments and behaviors that may undermine decisional paradigms in evidence-based medicine (EBM) and in healthcare organizations. Cognitive biases 'plus' are comprised of four categories of cognitive-based processes. i) Cognitive biases represent faulty systematic information processing errors that cause deviations from rational decision-making. ii) Fallacies are logical errors in reasoning. iii) Conflicts of interest (CoIs) are, according to the Institute of Medicine, "sets of circumstances that create a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest."

CoIs are closely associated with self-serving bias, and create a risk of swaying behavior toward iv) ethical violations, which range from subtle cheating to outright fraud. CoIs, self-serving bias, and self-deception are strong catalysts for unethical behavior; this cascade of cognition and behavior erodes the quality of the healthcare evidence landscape. This presentation will also highlight additional cognitive biases 'plus' that are of particular importance in healthcare evidence. These include authority bias, automation bias, in-group conformity, groupthink, and herd behavior. These processes have a neuro-anatomic and evolutionary basis, which render them intrinsic to both individuals and groups and difficult to recognize and correct. We suggest that an understanding of cognitive biases 'plus' can help us not only to understand their potential detrimental impact on healthcare evidence and the integrity of the EBM paradigm, but also to formulate preventive and remedial measures.

Session 3, Early Afternoon Session

PERSON-CENTERED HEALTHCARE AND THE CONTEXTUALIZATION OF EVIDENCE-BASED MEDICINE - II

14:10 Evidence-informed person-centered healthcare, 'cognitive biases plus,' the EBM paradigm and healthcare organizations: exploration of a hypothesis

Dr. Shashi S. Seshia (Presenter), Clinical Professor, Department of Pediatrics, Division of Pediatric Neurology, University of Saskatchewan, Saskatoon, Saskatchewan, Canada. (with Absract Co-authors Makhinson, M., Young, G. B., & Phillips, D. F.).

"Much published research …is not useful, may be misleading, wasteful and even harmful."
"Evidence-based Medicine is a failed model."

There is increasing concern about the reliability and applicability of evidence and the Evidence-based Medicine (EBM) paradigm, particularly in relation to person-centered healthcare (1-4).

Cognitive biases 'plus' jeopardize quality of decisions, and even experts are vulnerable to them. We propose that cognitive biases 'plus' (i) in those involved in creating and promoting the EBM paradigm are responsible for its long standing shortcomings and also (ii) affect opinions and policies of organizations that influence healthcare. Consequently, both healthcare delivery and the evidence that informs person-centered care are often compro-

mised.

EBM is founded on “assumptions” (sic) and the tenets: (i) the hierarchy, (ii) biostatistical methods & (iii) primacy of systematic reviews and pre-appraised evidence, are also opinion-based. Each tenet has limitations that impact evidence. We suggest that intellectual bias (a non-financial conflict of interest-CoI), planning and sunk cost fallacies at individual and EBM expert group levels, together with scientific inbreeding and groupthink are major (but not exclusive) contributors to the failure of EBM experts to anticipate, prevent, recognize and correct the limitations . Critiques were countered with fallacies. The tenets were adopted by all organizations without reservation (herd effect), potentiating and entrenching shortcomings.

The organizations studied were: industry, political bodies, regulators, non-industry funders, researchers, universities, hospital/health administration authorities, professionals and societies, publication industry and advocacy groups. Elements of cognitive biases ‘plus’ co-occur, and are inherent in all the organizations and the individuals belonging to them. Some are more organization-relevant than others. Potentially, both financial and non-financial CoIs are common to all; CoIs are catalysts for self-serving bias. Healthcare industries are the epicentres of financial CoIs that often involve all the other organizations, to varying degrees. Biases of health regulatory agencies result in treatments being approved without robust evidence of effectiveness and harm. Scientific inbreeding among researchers and publication biases can result in validating erroneous information. CoIs and biases of physicians and their societies result in inappropriate guidelines and treatment. Ethical misconduct, including subtle manipulation of statistics and selective publication by industry and researchers, can have serious consequences. Cognitive biases ‘plus’ in high impact publications can result in ratification and dissemination of “misleading…” evidence, through authority bias. Thus, cognitive biases ‘plus’ underlying EBM and within organizations are at the core of a complex cascade, sequentially ‘flawing’ evidence to the point of care.

The involvement of ethicists and behavioral researchers may help: (i) Minimize cognitive biases ‘plus,’ especially CoIs, in relevant organizations, and promote critical and logical thinking & (ii) Rectify shortcomings of EBM; biases of scientific inbreeding and groupthink among its experts must be neutralized for effective reform.
Most importantly, integrity must be restored and valued universally in all organizations.

14:30 Rational decision-making and person-centered healthcare

Dr. Benjamin Djulbegovic, Distinguished Professor & Associate Dean for Evidence-based Medicine & Comparative Effectiveness Research, University of South Florida and H. Lee Moffitt Cancer Center & Research Institute, Florida, United States of America

Evidence is necessary but not sufficient for decision-making. The former exists on the continuum of credibility, while the latter represents a categorical exercise (we decide to act or not act). To date, numerous theories have been described proposing how to derive the optimal course of action. Most these theories can be divided in so called expected-utility theories (EUT) and non-EUTs. EUT is the only theory of choice that satisfies all mathematical axioms of rational decision making. According to EUT, rational choice is associated with selection of the alternative with higher expected utility, such as choosing treatment that is expected to yield higher quality-adjusted life years. However, decades of research have shown that people routinely violate EUT. I argue that this is because EUT (and most non-EUTs) do not lend themselves well to person-centered care, which requires integration all aspects of medical practice – medical, humanistic and socio-economic – within a coherent reasoning system. That is, traditional criteria of rationality are not applicable to the practice of medicine. While I challenge the medical community to define more suitable criteria for rationality for practice of medicine, I endorse Rawls’ “reflective equilibrium/considered judgment” as a platform for rational choice in the era of person-centered medicine.

14:50 Assessing decision quality in person-centered care requires a preference-sensitive measure

Ms. Mette Kjer Kaltoft MPH, Research Unit of General Practice, Institute of Public Health, University of Southern Denmark, & Odense University Hospital Svendborg Sygehus, Denmark

The investment in decision aids to facilitate person-centred healthcare has revealed the need for a patient-reported outcome measure of decision quality. Current instruments using the term ‘decision quality’ have adopted a decision- and thus condition-specific approach. It is argued that patient-centred care requires decision quality to be regarded as both preference-sensitive across multiple relevant criteria and generic across all conditions and decisions.

The increase in the range of options available for health and disease management, coupled with the shift towards greater patient involvement in recent years, has led to a profusion of decision aids and related support systems aimed at the patient, clinician and the medical team. There is a need for evaluation measures that address the overall quality of decisions, as distinct from measures that address particular aspects of decision-making. The person-centered philosophy necessitates that decision quality be regarded as preference-sensitive and that the relevant preferences are those of the patient facing the decision, as opposed to the average preferences of a group of patients with the same condition or those of the health professional(s) involved in the decision.

MyDecisionQuality (MDQ) is presented as a web-based generic and preference-sensitive instrument which can constitute a Patient-Reported Outcome Measure (PROM), documenting the patient-centredness of healthcare services as well as providing a clinical practice measure. MDQ is grounded in Multi-Criteria Decision Analysis (MCDA) and employs a simple expected value algorithm to calculate a score for the quality of a decision that combines, in the clinical case, the patient’s individual preferences for eight quality criteria (expressed as importance weights) and their ratings of the decision just taken on each of these criteria (expressed as performance rates). It is thus dually-personalised.

The development of MDQ followed an assessment of the available instruments for evaluating decision-aids which established that none of these instruments generated a generic and preference-based index of overall decision quality; as opposed to ones that were: (i) condition-, setting- or decision- specific; or (ii) measured one or more possible aspects of decision-making such as preferred involvement in decision, satisfaction with the decision or decision conflict experienced, rather than overall decision quality; or (iii) did not weight their components to produce an index measure (i.e. were profile instruments) or, if they did enable weighting, did not elicit weights from the specific patient on the specific decision occasion.

The 8 criteria making up the two-part MDQ are phrased as below in the Ratings part. (The Weightings part replaces ‘I was clear…’ by ‘The importance of…’)

1. OPTIONS: I was clear about the possible options for me and what they involve.
2. EFFECTS: I was clear about the possible effects and outcomes of each of the options for me.
3. IMPORTANCE: I was clear about the relative importance of the different effects and outcomes for me.
4. CHANCES: I was clear about the chances of the different effects and outcomes happening to me, including the uncertainties surrounding the best estimates.
5. TRUST: I trusted the information I have been given is the best possible.
6. SUPPORT: I was satisfied with the level of support and consideration I received throughout the decision process, especially in regard to communicating at my level.
7. CONTROL: I felt in control of the decision to the extent I wish.
8. COMMITMENT: I was committed to acting on the decision.

MDQ also provides patients with help in prioritising the quality criteria for future decision making by calculating, for each criterion, the Incremental Value of Perfect Rating, i.e. the increase in their decision quality score that would result if their performance rating on the criterion had been 100%, importance weightings unchanged.

If the consultant is willing to enter their perception of the patient's weights and their own ratings into a parallel version of the MDQ instrument, we have the basis for a decomposable measure of concordance indicating how future decision quality could be improved; that is, a measure which can be broken down element by element for clinician and patient separately.

The challenge of validating a generic, patient-specific, preference-based instrument such as MDQ does not appear to have been addressed in the literature thus far and we continue to seek assistance in this respect. Given the personalised character of MDQ, we are particularly interested in exploring the use of N of 1 study designs.

15:10 SIMPLE Integration of Social Process and Evidence in Healthcare: A Brazilian Anecdote

Dr. Suzana Alves Silva, Senior Researcher & Clinical Cardiologist, National Institute of Cardiology and Amil Assistencia Medica Internacional, Rio de Janeiro and Hospital do Coração (HCor), São Paolo, Brazil & Co-chairman, ESPCH SIG on PCH and EBM

There is widespread agreement that person-centered healthcare needs to reflect successful integration of the requirement that healthcare serve and respect the needs of patients as persons with the ability to maximize the value of research in so doing. "Scientifically Informed Medical Practice and Learning (SIMPLE)" is one published representation of what an integrated model needs to look like. SIMPLE does not attempt to propose a formula for deriving healthcare decisions from values, circumstances, research findings and other categories of information and knowledge. Nor is it a 'reconstitution of evidence-based medicine (EBM)'. It attempts, rather, to put the elements where they belong, in a fashion that illustrates why they all are critically necessary. The SIMPLE construction might be compared to the relationship between a person's brain and their circulatory system. The brain ultimately dominates the personhood of the individual. However, without the circulation, the brain, and the person, must wither and die. An example from the Brazilian healthcare system illustrates the consequences of cutting off what is represented as the "relational field" in the SIMPLE model from nourishment by information from clinical research. The Brazilian healthcare system is largely unregulated by agencies such as NICE in the UK or comparable agencies in North America. As a result, political, and other relational processes, largely dictate health practice and policy with minimal attention to relevant research.

Obstetric practice is one useful example. There is ample research indicating that natural childbirth, in general, is associated with better maternal and fetal outcomes. However, over 90% of births in the Brazilian private system and up to 50% in the public system are cesarean. A combination of limited standing resources and patient reluctance to be served by an unknown delivery team, particularly among private patients, largely precludes preference for spontaneous delivery. Hence deliveries are largely planned in advance, via cesarian section.

Within the entire context, inputs from relevant published outcomes research and also from practice-based outcomes tracking in Brazil are minimal. Although the public sector of the Brazilian healthcare system maintains a central Health Technology Assessment agency staffed by not more than 20 analysts and 50 regional divisions, this resource is largely occupied by applications for approval of new drug therapies and high cost procedures and has little involvement with other types of medical intervention. The Brazilian judicial system arbitrates coverage and access to all types of clinical care, including tests, hospital admissions, procedures and other treatments, in response to patient initiated complaints. All such appeals are approved based only upon the submission of a physician's prescription. These actions come before all judges in the system and the decisions usually do not require consideration of the scientific merit of the interventions.

Within Brazil, there is minimal regulation of the quality of care within either public or private sectors. Furthermore, private patients are routinely forced to go to specific hospitals for the care of their conditions, including pregnancy, based only upon contractual arrangements on the part of their insurers, rather than on the existence or absence of qualified specialty services in those facilities. Obstetric care in Brazil offers an example of a system that operates almost exclusively within the relational field and is largely oblivious to relevant information from outcomes research

either within or without the country. The resulting context does not offer a formula for bringing different categories of knowledge and information to bear on healthcare decisions. It is therefore a poignant example of the consequences of constructing decisions and actions exclusively within the relational field in the absence of nourishment by the best available scientific information.

Session 4, Late Afternoon Session

PERSON-CENTERED HEALTHCARE – WHAT ARE THE WAYS FORWARD? – I

16:20 Who is doing what worldwide in person-centered healthcare? The concept and results of The Health Foundation International Environment Scan

Mr. Ed Harding, Director, The Health Policy Partnership, London, UK

This presentation will offer an overarching 'state of play' narrative in the research, implementation of measurement of person-centred care, illustrated through key examples of recent and ongoing work and materials. This synthesis has been drawn together from a pragmatic search of recent literature, including the perspectives of a selected key commentators in the field. The final report is due for publication in July 2015. Some interim findings are offered below:

An international community of key contributors:

- Beyond some core principles, person-centred care is understood in many different ways by many different people.
- A substantial international body of work currently exists across a heterogeneous and evolving community, with complex synergy between 'person-centred care' and other associated groupings (e.g. 'patient centred-care', 'patient engagement', etc.)
- 'Person-centred care' is term rooted in culture and context. Diversity appears to reflect the different needs of different populations and healthcare settings.
- Commentators give different emphasis and priority to different qualities of person-centred care. These are not necessarily exclusive, but include:

A 'first order' grouping of concepts: person-centred care as an overarching framework which orders a number of distinct concepts and practices, such as shared decision-making, care planning, information and self-management support.

Personhood and anti-reductionism– promoting a deeper existential and philosophical understanding of personhood to better engage with the patient and address their unique needs.

Diology, co-production: an understanding that through symbiosis and mutual respect a clincian´s expertise and patient's self-knowledge combine for maximum benefit.

Some strategic research issues identified by the scan:

- A lack of common definitions is frequently cited as barrier to the aggregation of research and replication of studies.
- Research 'hotspots' in different settings and diseases are encouraging but siloed activity may slow diffusion of good practice, and risk divergent concepts.
- Behind some promising evidence of impact there are still questions about differentiating processes, outcomes and indicators, and what is to be counted as 'success'.

- Patient involvement in helping to shape research priorities is rare.

Some strategic implementation issues identified by the scan:

- There is a significant presence of 'person-centred care' in health care policy in English speaking and Northern European countries, however implementation lags a considerable way behind.
- The implementation challenge will require a 'whole system response', for example organisational change models, formal education and training for healthcare professionals, but also efforts to tackle resistance and misunderstanding, and to connect and explore with deeper, ethical and personal values at the individual level.
- There appear to be major unanswered questions about how best to led models of person-centred care in vulnerable and disadvantaged populations.

Some strategic measurement issues identified by the scan:

- Measurement is widely considered to be vitally important in embedding person-centred care in the mainstream.
- However, a number of practical and ethical concerns arise, including; the limitations of patient satisfaction and patient experience, a lack of validated models for measurement, uncertain psychometric instruments and the absence of the patient involvement in the design and validation of measurement tools.
- Those tools that exist have mostly been designed for research – i.e. to evidence the benefits of an intervention – and may be challenging for mainstream use.
- Setting and monitoring more personalised outcomes is regarded as important by key contributors, but models are largely experimental.
- Linking measurement to financial incentives and performance assessment seems rare, however this will need to navigate the issue of perverse incentives.
- Fears of measurement 'overload' and capacity issues in management and care professionals highlight the need for practical models in the everyday setting.

16:50 Person-centered care: what it is and what it isn´t – building upon the 2014 Reflection

Dr. Stephen Buetow Associate Professor, Department of General Practice and Primary Health Care, University of Auckland, New Zealand, Sabbatical Fellow, King´s College, University of London & Chairman, ESPCH SIG on Research in PCH

Medicine faces a crisis of depersonalization, scientism and unsustainable costs, which cannot be solved by subprime national initiatives to produce, from evidence, medicine centered on patients. One of the most prominent initiatives is taking place in the US, where comprehensive health reforms are integrating patient-centered concepts into standards of clinical care through innovations in service delivery such as patient-centered medical homes. Yet, patient-centered medicine is part of the overall problem. Raising concerns about a patient-centered medical ethics of principle-governed action for patient welfare and population health, I suggest a need instead for person-centered medicine.

Despite having received the imprimatur of international organizations including the World Health Organization, person-centered medicine (or people-centered medicine) has yet to define itself clearly. I will suggest eight defining values of person-centered medicine, which distinguish this medical practice model conceptually from values of patient-centered medicine. I will suggest that the values of person-centered medicine link to virtues that dispose patients and physicians, as moral equals, to balance their welfare, by doing the right things for the right reasons,

and flourish.

17:10 A Brave New World. Big Data and Person-Centered Healthcare: Opportunities and Threats

Dr. Carmel M Martin, Associate Professor of Family Medicine, Northern Ontario School of Medicine, Ontario, Canada & Visiting Academic, Department of Public Health and Primary Care, Trinity College Dublin, Republic of Ireland & Co-Chairman, ESPCH SIG on Complexity and Health

Unquestionably enormous amounts of data on health systems and individuals are being collected that will increase exponentially in the digital age. Looming close on the horizon is the vast patient genomic data and their promise for personalized medicine. In short, there is a potential tsunami of data coming straight at an already overburdened healthcare industry. The 'internet of things' and the 'quantified self' together with health system data collections present a Brave New World of information.

There are opportunities that a combination of data-driven, evidence-based medicine and modern tools to prod patients to lead healthier lives will go a long way to reducing waste in health spending. The judicious application of smartphones and software could save patients, insurers and governments, enormous amounts of money. Data that are routinely collected can be analyzed to improve care delivery without the addition of expensive major research studies and address some of the challenges of randomized controlled trials. Data-centric methods and increasing analytic power to both diagnose, treat and monitor will become increasingly more sophisticated. Patients themselves may be empowered and learn to monitor personal health data themselves. Big Data are manageable, but it is individualized data that are both more likely to have the most effect on our personal health and much more difficult to deliver. It is claimed that IT vendors can deliver processor, networking and database infrastructures that are capable of handling the data volumes and variety of information fast enough for real-time decision-making. Arguably the healthcare industry will enter into a new era of efficiency that still offers far better outcomes for patients.

Certainly, increasing accessibility of evaluation, informatics and big data from health organization systems and individuals has the potential to create major challenges to privacy ethics and person-centredness. Health services draw on predominantly technical and 'objective' rather than subjective approaches. It is very difficult to integrate interpretivist (subjective) and positivist (objectivist) information and knowledge. The increasing reduction of personal experiences to metrics in the positivist paradigm may underplay their meaning and importance. Nevertheless, in the future, the intention is to shift from collective and system perspectives to the perspective of the individual, integrating personalised 'omics' and information at the point of delivery. This flux of knowledge between and within paradigmatic or pragmatic approaches has the potential to expose or obscure the uncertainty and the 'unorder and disorder' in what is known and from whose perspective and what it means. Transdisciplinary, complex adaptive systems theory with multi-ontology sense making are discussed as an overarching framework for the exposition and pragmatic resolution of tensions and contradictions in person-centred care and big data analytics.

A person-centric framework for big data should focus on to the individualizing of care and enhancing experiences of persons in health settings. A transdisciplinary approach within a complexity framework is articulated.

17:30 Does an update of the Biopsychosocial Model improve its applicability for person-centered healthcare?

Dr. Dr. Thomas Frohlich MD PhD (Presenter), Physician, Heidelberg, Germany & ESPCH Vice President (Western Europe) [with Abstract Co-authors Bevier, F. F., Chisholm, H. H., Henningsen, P., Miall, D. S., Sandberg, S., & Schmitt, A.].

To initiate a debate about an advanced biopsychosocial (BPS) model we suggest a formal approach to achieve a better communication of its up to now diverging and mutually isolated constituents. The principal problem that researchers have identified with the current bps model is its complete lack of internal formal homogeneity. Its aims are respected and widely accepted, yet its eclecticism and the loose (if any) formal connection of its divergent

approaches hinder its theoretical basis and clinical application. An advanced BPS model should be easier and more intuitive, enabling a wider application than has proved possible with the previous model. We have applied various tools in a modification of the model which we believe has resulted in a wider applicability and we have enacted some basic initial choices that have enabled us to address entities that are fundamentally different on a structural level.

Our approach has been to apply the well-established concept of sets formed in a dynamic. Members of sets have something in common that makes them belong to something common and, if they are more than one, then they have also something that makes them individual and distinct. A simple distinction, then, is the one of lasting versus changing aspects. The latter can be understood as realized states, whereas the entity hypostasized as being their lasting source is in fact always a hypothesis concerning this supposed basis and sequence of events. Beginning with these assumptions, we continue by suggesting that the following statements should be discussed and, if and in so far as they seem reasonable, accepted as defining an initial working model for further discussion:

1. A formal, not merely descriptive, distinction of a lasting source and its temporal realizations is necessary

2. All realizations that occur only once formally are assumed to be parts of a stochastic process

3. All realizations that occur more than once are assumed to come from a lasting source, with the source prevailing at least as long as the iterations occur

4. Sources may combine to create either a stochastic mess or a formally coherent set.

5. Formally coherent sets of sources, if lasting, can be hypostasized, as long as (seemingly) coherent sets of realizations (as states and corresponding sets of iterated and hence to the degree of iteration supposed as non-stochastic changes of states) are observed

6. To be a source is formally different from observing a source. To be a source does not exclude the potential to observe realized states of a hypostasized source, also if oneself is the observed source

7. Coherent, non-stochastic sets of sources may exert a choice with regard to what they process further and what they do not

8. This choice, if lasting and as long as it is lasting, constitutes the specific perspective of the corresponding source

9. If a coherent, non-stochastic set of sources successfully iterates itself as this coherence, it must be assumed that the choice it made, and the way of further processing chosen input, is supportive with regard to its survival

10. Put in other terms, it may be hypostasized that this specific choice and specific processing of input serves to make the coherence survive, which may be interpreted as fulfilling a task and thus having an aim

The model issues in precise form the pivotal point of any qualified approaches to science and humanities. Thus, in considering the formal differences between stochastic and ordered processing, a more detailed discussion will reveal that it allows the coherent interactions on a physical and, if given biological level as well as the different levels of human activity, to be addressed, including selective reactivity and experience and including experience of oneself as a individual and unique subject. Attributions of meaning, also in an emotional and existential sense, are easily described, as well as realizations in the form of verbal utterances and their mutual understanding. Hence, the model has an improved applicability in a human medicine correctly understood as person-centered.

Session 5, Early Morning Session

PERSON-CENTERED HEALTHCARE – WHAT ARE THE WAYS FORWARD? – II

09:20 The power of 'story', symbolic illness, relationship-based healing and person-centred healthcare.

Professor Brian Broom, Consultant Physician (Clinical Immunology), Department of Immunology, Auckland City Hospital and Adjunct Professor, Department of Psychotherapy, Auckland University of Technology, New Zealand & Chairman, ESPCH SIG on Personhood and the Dynamics of Healing

In New Zealand, over the last 25 years, there has developed a person-centred approach to physical illness underwritten by the following principles and assumptions: (1) Physicality and subjectivity are developmentally co-emergent; (2) Personhood is not a dualistic concept; (3) Mind and body are not separate compartments; (4) All reality is multidimensional and all illness is multi-factorial; (5) There is no disorder in which body or mind can or should be sectored off and neglected; (6) Meaning, symbol, and story are crucial elements in a person-centred approach to healing; (7) Personhood is deeply relational and (8) Healing has a relational dimension. Much of this can be captured by deploying the notion of 'story' alongside conventional health discipline approaches.

What does this look like in the clinic? A patient with a serious and symbolic 'allergic illness' will be presented, demonstrating: the relevance of 'story'; the chronicity arising from failure to attend to story; the practicality of biomedical and story approaches in the same clinical time/space; the common sense questioning, listening and relational skills required to make a difference; and, finally, the difference that this way of working does make.

Amongst the many issues that arise: Illness is meaning-full and can be powerfully symbolic. Patients can sit for years (and die) without these meanings being accessed. The story is often as crucial as the biomedical data. Diagnosing depression and anxiety is not enough. In respect of illness the patient's story may be predisposing, precipitating, and perpetuating. We are not talking merely about post-illness narrative-making. Addressing meaning adds a powerful dimension to therapy.

09:40 A person-centered approach to the understanding and management of multi-morbid, socially complex illness

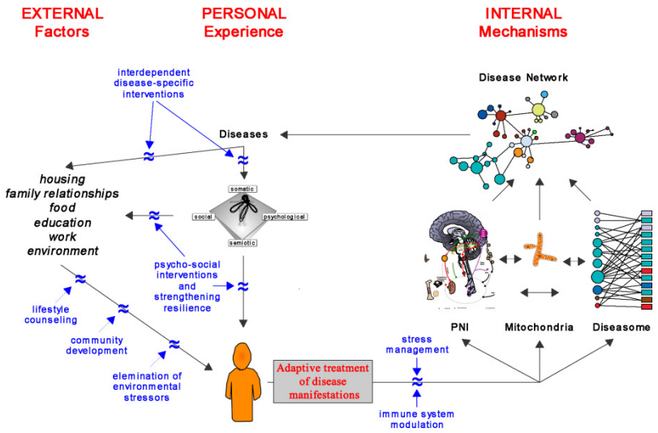
Dr. Joachim Sturmberg, Associate Professor of General Practice, Monash University, Melbourne, Australia and Co-joint Associate Professor of General Practice, University of Newcastle, Newcastle, Australia & Co-Chairman, ESPCH SIG on Complexity and Health

Multi-morbidity remains a poorly defined concept. For some it is a numerical concept, the total number of diseases in the one person (multiple morbidities), for others it is the number of other diseases occurring concurrently in relation to an index disease (co-morbidities) and yet others see it as a persistence of diseases over time (chronic disease). Each of these concepts has significant limitations: they neglect the patient's subjective experience of their illness, they neglect the severity of the disease and its impact on daily functioning and they fail to provide an integrated understanding of the underlying mechanisms resulting in the patient's disease presentations.

Multi-morbidity is the end product of an emergent process resulting from the constant perturbations of our various physiological networks. The main regulators of these interconnected networks are the mediators of the hypothalamic-pituitary-axis and sympathetic nervous system. Their feedback loops control gene, mitochondrial and cell function which can both stabilize or exacerbate disease processes. However, external environmental inputs can modulate the hypothalamic-pituitary-axis and sympathetic nervous system and thus influenced disease progression.

These understandings of multi-morbidity offer new insights into the management of people at risk or already established disease. At an individual level allopathic interventions need to consider potential unintended network perturbation that might result in the exacerbation of other disease processes. Greater emphasis is needed on

managing stress as stress increases the pro-inflammatory load contributing to disease progression.



At the population level greater emphasis is needed to reduce the effects of our ever increasing environmental stressors: pollution, poor housing, job insecurity, family relationships, poor social infrastructure, degrading physical infrastructure, access to healthy fresh food etc.

Person-centered management of multimorbidity does embrace the complexities of the physiological networks operating at the subcellular and cellular levels in the context of the complexities of the person's social and societal environments.

10:00 Better Lives through Personalization – the example of PCH for those with challenging learning difficulties

Professor Roger Ellis OBE, Director, Social and Health Evaluation Unit & Emeritus Professor of Psychology, Universities of Chester and Ulster & Chairman, ESPCH SIG for Learning Difficulties

This paper describes a Personalisation Programme provided by the organization Choice Support for adults with learning difficulties. The programme was provided for seventy adults with learning difficulties, many severe. The programme achieved significant improvements in quality of life for most people and with substantial savings. Personalisation, synonymous with patient -centred care, means thinking about care and support services in an entirely different way. It means starting with the person as an individual with strengths, preferences and aspirations and putting them at the centre of the process of identifying their needs and making choices about how and when they are supported to live their lives. It requires a significant transformation of adult social and health care so that all systems, processes, staff and services are geared up to put people first.

The Choice Support Personalisation Programme had three main features: (1) Person Centred Planning; (2) Individual Service Funds and (3) Better Nights, a new form of night support which encourages greater independence.

Person Centred Planning means exploring in detail what each individual wants and needs and planning support accordingly. Exploring needs and preferences with a group of people many of whom had severe learning difficulties and little or no spoken language required special skills from support staff.

An Individual Service Fund represents a notional allocation of money to each individual for support based on individual need and preference as opposed to a block grant and a standard support for all.

Better Nights was a shift from Waking Nights with support staff available and monitoring individuals throughout

the night to Sleep In where the care staff followed normal waking and sleeping patterns together with the individuals thus encouraging a more normal life style with greater independence.

The Social and Health Evaluation Unit has completed two programme evaluations one of Better Nights and one of Personalisation more broadly. In each case the Unit's Trident method was used focusing evaluation questions on outcomes; process; and stakeholder perspectives. Data from the evaluation were assessed together with the substantial savings achieved.

Specially devised audit tools were devised to assess quality of life and risk management. Overall the results of these audits showed a maintenance or improvement in quality of life for the service users and effective management of risks. These quantitative data were complemented with individual case studies. The process of implementation was described in sufficient detail to allow replication, learning and continuous improvement. Stakeholder perspectives were surveyed from care staff, parents and relatives and social services staff.

The process of implementation required sustained innovative responses at strategic, organisational and clinical levels and these are described and their implications for person- centred healthcare discussed.

Overall the programme had achieved its stated outcomes in person-centred care with substantial savings. For the minority of service users whose quality of life did not appear to improve, further detailed analysis and planning is being undertaken.

10:20 Setting Limits: Can PCH assist clinicians in the allocation of increasingly limited resources?

Dr. Mark Tonelli, Professor of Medicine, Division of Pulmonary and Critical Care Medicine & Adjunct Professor of Bioethics and Humanities, University of Washington, Seattle, United States of America & ESPCH Chairman, Case-based Decision Making

The role of the clinician in person-centered healthcare has not yet been fully elucidated. Clearly, the clinician's role is more active than that espoused in some versions of the patient-centered movement, where the clinician may be viewed only as a purveyor of information. For healthcare to be person-centered, the clinician must recognize the patient as a person and join him in the process of healing. The positive aspects of this active role have been emphasized in the early literature of the person-centered movement.

But the clinician is also a person, embodying personal, professional and societal values. To advocate that she completely subjugate her values to the will of the patient would seem to be asking too much. In the United States of America, there is an ongoing debate regarding whether a clinician's personal religious values allow him to withhold interventions desired by the patient, for instance pregnancy termination or prescriptions for contraception. I will not be addressing this issue directly. Rather, I will propose that a clinician's professional and societal values do allow, and in some cases require, her to set limits with regard to medical treatments available to the patient. This would include saying no to requests for some interventions requested explicitly by a patient who believes he will benefit from that intervention. The grounds for such refusal, which can be considered bedside rationing, may stem from agreed upon professional values regarding the proper role of the clinician and/or from recognition of the clinician's role as a steward of limited resources. Defining inappropriate treatment, interventions that should not be offered or provided even when requested, requires professional consensus and societal acknowledgment, but in a person-centered medicine will usually be made at the level of a particular patient, rather than a system-wide denial. Limit setting should be made explicit and is subject to challenge, but the locus of decision-making in such cases lies solidly with the clinician.

Session 6, Late Morning Session

PERSPECTIVES ON IMPLEMENTATION – I. EVOLVING HEALTH POLICY, RESOURCE ALLOCATION AND DIGITAL AND mHEALTH

11:40 Person-Centered Health Policy: The Case of the Patient-Centered Outcomes Research Institute (PCORI) of the United States of America

Dr. Sandra Tanenbaum, Professor, Health Services Management and Policy, College of Public Health, Ohio State University, Ohio, United States of America & Chairman ESPCH SIG on PCH and Health Policy

One of the many provisions of the Affordable Care Act of 2010, sometimes referred to as ´Obamacare´, is the establishment of the Patient-Centered Outcomes Research Institute (PCORI). PCORI is a public-private agency concerned primarily with funding and guiding comparative effectiveness research. Health policy experts had long recommended that comparative effectiveness research be undertaken along with the more common effectiveness studies of a single health care intervention. Comparative effectiveness research would determine which of multiple interventions is most effective for a specific condition. PCORI was created to accomplish this task, and the politics of health care reform yielded a uniquely American institution. It is not a purely public agency, but has ties to the federal government; its findings may not be used as the sole basis for coverage under government health programs and the comparative research undertaken must be "patient-centered." In a concession to disability activists and political conservatives, PCORI is mandated to answer the question of comparative effectiveness in the context of "patients like me." Patient-centeredness takes a number of forms in both the solicitation of research proposals and the requirements that funded investigators must meet. These will be reviewed in general and for a PCORI-funded study on which this speaker is a co-investigator. The ways in which PCORI's patient-centeredness is and is not person-centered will be considered.

12:00 Implementing Person-Centred journeys through hospital stays and home and community care in 3 European Countries: Conceptual and practical challenges

Dr. Carmel M Martin, Associate Professor of Family Medicine, Northern Ontario School of Medicine, Ontario, Canada & Visiting Academic, Department of Public Health Primary Care, Trinity College Dublin, Republic of Ireland & Co-chairman, ESPCH SIG on Complexity and Health

Person Centred Health Care (PCHC) models aim to transform systems to achieve 'better clinical outcomes, increase patient and clinician satisfaction and decrease or contain healthcare costs' in the current 'epidemic' of chronic and multi-morbid illnesses. PCHC must thus address the needs of the frailer, multi-morbid population with potentially low levels of vision, hearing and computer literacy, vulnerability to social isolation and also care for their caregivers who are often elderly themselves. Patients and caregivers need to drive their own care, education and information generation and use, respecting the older patient's desires and capacity for sharing decision- making and with enablement as a key goal. Developing a PCHC patient journey system through hospital stays, primary care and home care in 3 different European health and social care settings – Cork, Bangor and Lübeck provides many opportunities and challenges.

Complex Adaptive Systems Theory (CAS) Theory provides a framework for personal health journeys. Transforming historically dependent, non-linear dynamic, self-organising health systems through the framework of PCHC need accounts for:

- *Historical influences* – including trajectories of ageing and health, and capacity for self-organisation within different systems at individual, service and societal levels;
- *Current influences* – including family and community relationships, health systems and social services dynamics, culture; and

- *Future opportunities* – understanding and acting on radical innovation products and processes, as well as incremental improvements, while recognising emergence, self-organising systems and adaptation.

The introduction of office-based carers (advocates) supports vulnerable older people and their caregivers using experts systems which aim to ensure that the patient voice is central to and appropriately driving healthcare decisions. This addresses the 'impersonal' nature of big data analytics that are increasingly driving healthcare to work to business models and efficiencies.

A focus on individual journeys within unique health services and systems with different languages and cultures is required for PCHC development in 3 European settings. The challenge is to develop 'generic' linkages among care silos from in-hospital, GP outpatients and home settings. Taking a personal journey approach that connects individuals with their health service event information, rather than trying to link massive record systems with different 'languages' of provider groups that use Big Data analytics. This radical shift prioritizes, rather than overshadows, the patient 'voice' and experience in health system vertical and horizontal information and care integration. Individual experiences and care events can be language and culture agnostic if modelled mathematically using natural language processing. Individual data can provide real time risks and predictive data that is appropriate to feed into all clinical contexts including hospital, GP and homecare. Providers access current, historical and predictive individual information at the point of care across silos with rolling communication and feedback via a dynamic patient journey data service. Care advocates enhance and monitor personal journey care. Care coordination among disciplines and services is not achieved by mere juxtaposition, if it is not supported by human engagement and advocacy when patients are frail and vulnerable.

12:20 Is Digital Health a Viable Pathway to Advance Person-Centered Healthcare?

Dr. Dwight McNeill, Instructor of Health Policy and Population Health, Suffolk University, Boston, Massachusetts, United States of America (Winner of the ESPCH 2015 Book Prize)

The American way of producing health is failing. It continues to rank very low among developed countries on our basic human need: to live a long and healthy life. Abundant research shows that our own behaviors can be far more consequential in determining our healthy longevity than the actions taken by others on our behalf. Indeed, five behaviors of everyday life, including eating poorly, smoking tobacco, drinking alcohol, exercising too little and not taking medications account for the majority of years of healthy life lost, largely due to chronic illnesses. Yet changing and sustaining these behaviors has been seemingly intractable for a sizeable at-risk population. Doctors, governments and a burgeoning self-help industry exhort people to change, but their efforts have not been sufficient. The question posed in this presentation is whether digital health tools can help enable, equip and engage people to be active co-producers of their own health.

Societal trends indicate that people may be poised to act. People are breaking free of medical paternalism that breeds dependence. More information has been liberated for their use and technologies make it more accessible and sharable. With the large increase in out-of-pocket financial exposure due to the new generation of health insurance plans with astonishingly high deductibles, people are more vigilant about the value of healthcare. Additionally, people want convenience, eschew encumbrances and believe in themselves to do many of the tasks previously owned by professionals in many aspects of their lives. And innovative technologies offer a variety of promising, cost-effective tools including self-administered diagnostic tests, self-monitoring devices and coaching software to control glucose and blood pressure, smartphone apps and "adds" to maintain healthy behaviors - and much more.

There are significant barriers to the widespread development and adoption of these digital health tools including physician practice norms, reimbursement policies and cost, proof of cost-effectiveness and substantial privacy concerns. But, perhaps the most important challenge at this stage is to accomplish a basic business function—to please the customer.

Technology innovators produce the apps and adds, the connected devices, social network platforms and comput-

ing capacity to power digital health. But, so far it has not produced the ´killer app´ or even captured much consumer attention. The business model, so successful for other purposes, and mostly for fun, has to change when it comes to behavior change. It needs to change from making us ´click´ for the purpose of generating advertising revenues, to understanding what makes us tick in order to make behavior change stick. For example, technology is very capable of producing wise, insightful information to know the individual better than she knows herself. It can develop "digital hugs" to engage the individual emotionally because that social connection is so important for change. And it can provide dynamic, smart coaching to help people overcome barriers and sustain new behaviors.

The bottom line is that people need to be their own Chief Life Officer and invest the time to reap the full benefit of our substantial birth asset. The surest way to do this is to stay healthy and manage the five behaviors of everyday life. Increasingly, people are grabbing the baton, others are welcoming them as true partners in health, and powerful digital tools are emerging to equip them to be successful.

12:40 Promoting PCH-mediated patient adherence via mHealth

Mr. Kevin Dolgin MBA, President, Observia, Associate Professor at IAE de Paris, Université Paris I (Panthéon-Sorbonne), Paris, France & Chairman, ESPCH SIG in Patient Behavioural Studies

Over recent years, there has been increasing focus on the issue of adherence to treatment in the world of healthcare, whether on the part of patients, payers, prescribers or the pharmaceutical industry. With average adherence rates across chronic illnesses at roughly 50%, all players involved have begun to recognize the need to address this problem and a plethora of programs and aids have been initiated across the world.

Many different types of programs exist and each of them employs some means of communicating with patients. Outside of pure financial/coupon programs (which are primarily American), adherence programs generally aim to motivate patients via both education and behavioral techniques; this requires communication and communication requires channels. These can be broadly categorized into automated and human channels: the first provide either a set message content or personalize content via an automated set of algorithms whereas the latter feature live communication with other people.

For those who would create adherence programs, this raises the question of which channels are most effective. The short answer is that a unique mix of channels will undoubtedly have the greatest impact. However, economic reality dictates that the more ambitious and costly a program is, the less likely it is to see the light of day. Efficiency must be considered and the different channels considered on the basis of their cost-effectiveness. When this is done, mobile communications, primarily through text messaging, often rises to the top as a particularly cost-effective means of building adherence programs.

There are numerous examples of text messaging programs across regions, patient types and pathologies that highlight the effectiveness of this channel, even for populations that may seem on the surface to be counter-intuitive, such as the elderly or for populations in the developing world, ranging from programs like TExT-MED in the United States, which boasts a 100% referral rate to a Kenyan program directed at healthcare workers regarding malaria that was estimated to represent an investment of less than $100,000 to be rolled out nationally with forecasted significant impact on nationwide health.

Text-based programs should not be confused with reminders. Some are indeed limited to simple treatment reminders, but the most effective make use of sophisticated profiling algorithms to provide individualized coaching, based on behavioral theories such as the theory of planned behavior or the transtheoretical model of change. By employing such approaches, the cost effectiveness of mHealth programs focusing on text messaging has been demonstrated to be significantly greater than other remote channels, even those allowing direct contact with healthcare professionals. The reasons behind this are best investigated via frameworks that come not from the world of medicine, but from behavioral science, including consumer behavior.

Session 7, Early Afternoon Session
PERSPECTIVES ON EDUCATION AND TRAINING

14:00 Building a person-centered medical school. Why? How? What remains to be done?

Dr. Fernando Caballero Martinez, Dean of Medicine, Francisco de Vitoria University, Madrid, Spain & Chairman, ESPCH SIG on Undergraduate Medical Education

Francisco de Vitoria University opened a School of Medicine in 2010, following the implementation of the Bologna Process in Europe. The new policy environment created a unique opportunity to consider which innovations in undergraduate medical education would have the potential to provide a superior model of medical education that would, by its nature, satisfy the University's ambitions for the training and formation of future doctors. In summary, the University decided to adopt a person-centered medicine approach that could enhance the person-centeredness of health systems, by inculcating notions of values and other components of the humanistic approach from the very first years of undergraduate training.

All of the individuals involved in the construction of the Medical School (students, university teachers and doctors in practice) were able to agree on the deficiencies inherent within traditional university medical programs and which act to preclude an ability of the doctor to deal with the range of patient needs that extend beyond the purely biological and physical. The Bologna Process recommends a renewed educational model that supports all dimensions of the professional competencies of the student undergoing training: knowledge, skills, professional capabilities and ability to exercise judgement - as opposed to a traditional medical education based on the communication of 'textbook knowledge', followed by clinical training with an impact less than could potentially be achieved via new and more innovative models.

With this considered, Francisco de Vitoria University decided to immerse its medical students in a framework of explicit professional values, inspired by the ethical thinking of Dr Edmund Pellegrino. We understand – and teach – that the relationship between a patient and a doctor is a meeting of two people in a spirit of service, where the doctor gives all he/she has to offer and where he/she places the patient´s welfare before his/her own. For such a relationship to be productive, complete trust between the doctor and patient is a complete prerequisite. Within this relationship, the doctor will attend to the patient's physical needs, to organ dysfunction, organic disease, etc., and will use some principles of evidence-based medicine (EBM) in order to do so. However, the patient is more than a subject or object or complex biological machine and the wise physician will need to consider how to deal with a range of other patient needs, many of them 'subjective' in their character. Indeed, the 'good' doctor will have successfully learned the appropriate relational and professional abilities to guarantee complete respect for the patient´s rights, values and autonomy. These skills include the ability to enter into shared decision-making with the patient and to ensure that objective facts do not enter unnecessary conflict with subjective values.

The University believes that person-centered healthcare is one means of doing this, through its conceptual and practical ability to negotiate between facts and values and because it allows clinical practitioners to draw heavily on medicine's science, but also heavily on all of the other sources of knowledge in medicine that are of additional relevance to the making of good clinical decisions and thus to responding well to the unique clinical circumstances of the individual clinical case. It is for this very reason, that the University strongly encourages person-centered care teaching, in order for our students to learn how to integrate scientific advance with kindness, care, compassion and a deep respect and attention to the patient's personal narratives, values, preferences, his/her cultural, relational and social situation, psychology, emotions and spirituality, their human dignity - in short their biography as a person. This 'holistic approach' is, we believe, directly representative of an authentic account of clinical medicine and the best way forward in our modern times and a highly effective means fo dealing well with the patient's suffering.

The presentation will outline, in an entirely practical manner, the defining characteristics of our new and person-centered School of Medicine. It will detail the content of our specific programmes and explain how these fulfil

the School's strategic objectives and direction. The following key characteristics will be discussed:

- Our system for selecting candidates who wish to join the Medical School. This evaluates academic performance and intellectual level, but also, and critically, seeks to identify specific personality traits that predict the behaviour that we would expect from doctors, in accordance with the School's values as discussed above.

- The teaching programme on clinical communication and relational abilities (supported by a standard patient programme employing patient actors).

- The teaching programme for the intensive clinical training of the students, based on a phase of advanced clinical simulation (robot) before clerkships and an on-line, real time supervision of each student´s performance during hospital experience, by means of an electronic portfolio (supported via a Tablet with its own evaluation software).

- The teaching programme in the medical humanities, which is taught throughout the whole degree, with a progressive training in the history of thinking, anthropology, general ethics and applied bioethics. Social and human science, taught in cross-section, is part of this and aims to provide for students an attractive learning experience, given that it involves practical placements, for example in palliative care environments and in psychiatric environments. Moreover, with bioethics in mind, the University has also organised student visits to locations which commemorate Medicine and the Holocaust. Such innovations highlight the human and social dimensions of medicine, and are introduced in the first year of the degree.

- The teaching programme on clinical research, orientated to person-centeredness, is delivered via small groups working cooperatively, which analyse various aspects of patients´ experience as they enter and experience the health system and with reference to the classical biopsychosocial and indeed a biopsychosociospiritual approach.

The curricular innovations described above are all fully compatible with the essential scientific 'soundness' characteristic of any Faculty of Medicine within Europe and elsewhere. The difference at the University is that we teach all of our students how to contextualise medicine's accumulated and accumulating science – the context being that of the whole person who, ill and suffering, approaches his/her doctor and clinicians for help.

Now is time to rethink achievements and shortcomings. A detailed knowledge of the process of acquisition of a student´s clinical expertise and of the student attitudes leads to the need to guarantee the greatest periods of exposure to clinical practice (real or simulated) and, at the same time, to the most effective ways of gaining extensive medical knowledge. These two goals are in competition in terms of a student´s available time and that is why the Faculty of Medicine is analysing a new teaching model to overcome this limitation.

14:20 Empathy in graduate medical education milestones

Dr. Nathan Schou Bertelsen, Visiting Assistant Professor, Koç University School of Medicine, Istanbul, Turkey, and Assistant Professor of Medicine and Population Health, Bellevue Hospital, New York University School of Medicine, United States of America

Competencies in both empathy and cross-cultural health are considered essential skills for physicians. A bedside learning activity was developed and piloted to define and teach empathy for residents, in order to improve clinical skills in cross-cultural patient care. This activity was done on an inpatient medicine teaching service at Bellevue Hospital Center and New York University School of Medicine in New York City, USA. Twenty-nine residents in internal medicine and thirteen faculty participated in one bedside session each. The objective of this exercise was to help the learner utilize empathy to: 1) gauge a patient's identity and culture; 2) assess health literacy; and 3) change clinical management. Patients with communication barriers were interviewed with the BATHE technique. All participants received anonymous surveys. Seventy six per cent of participating residents agreed that this activity improved their ability to provide cross-cultural care, 87% agreed that it assessed their patient's health literacy and 87% agreed that it changed their clinical management. Empathy offers a promising bedside exercise in which to gauge health literacy and to demonstrate effective cross-cultural patient care. Based on this experience, an instructor's guide was written for faculty, for use in training residents in empathy and cross-cultural patient care.

Practice Points

1. Competencies in empathy and cross-cultural patient care are essential skills for physicians.
2. The BATHE empathy technique improves cross-cultural communication, changes clinical management, and improves patient outcomes.
3. Based on this pilot experience, an instructor's guide was written for faculty to facilitate their own bedside teaching sessions on empathy.

14:40 The challenges of training clinicians towards person-centred care in hospitals, private practice, general practice, allied health disciplines and psychotherapy

Professor Brian Broom, Consultant Physician (Clinical Immunology), Department of Immunology, Auckland City Hospital and Adjunct Professor, Department of Psychotherapy, Auckland University of Technology, New Zealand & Chairman, & Chairman, ESPCH SIG on Personhood and the Dynamics of Healing

A whole person approach to physical illness faces many challenges in Western healthcare contexts that are underwritten by positivism, mind and body dualism, physico-material reductionism, anti-subjectivity, diagnosis-centredness, specialist-based fragmentation of care, the privileging of technological information over other human realities and the consequent economic structuring of healthcare.

The presenter's experience of these challenges arises from: trainings both as a specialist clinical immunologist and as a psychotherapist; instigating a multidisciplinary private health centre aspiring to whole person care; private practice as a consultant immunologist and psychotherapist; instigating a national network of clinicians interested in whole person approaches; instigating and leading a University Master´s training program in whole person approaches with clinicians from a wide variety of disciplines; many years supervising psychotherapists and other clinicians working in a person-centred way with persons with physical illnesses; and, over the last 8 years, working as a senior physician in a conventional tertiary hospital immunology department, promoting whole person approaches. The training philosophy has been to enable clinicians to bring change to their clinical practices in their ordinary disciplinary work-place.

What have we learned about the transformation of practice to person-centredness? I suggest the following:

1. Intellectual and conceptual clarity. Most clinicians find it is impossible to change to a whole person approach unless they have a solid paradigmatic framework that makes sense and can be rigorously defended. A clinician cannot do consistent non-dualist work if strongly residually dualistic.

2. The need for a supportive change environment. Clinicians may listen and get excited but feel confused and powerless when back in the 'real' clinical environment. Change typically occurs in people who enter sustained change programs. Social pressures, the need to belong, feeling incompetent and vested interests are powerful inhibitors, whatever the evidence that change is needed.

3. Person-centred care demands listening and intimacy skills. Some clinicians are 'naturals' and mainly need permission and support. Others need a journey of personal change and some cannot face this.

4. Procedural skills in the consultation. It takes time to learn how to welcome and host both physical and non-physical aspects of persons in the same clinical time/space.

5. While many of the challenges are generic, each health discipline and work context has its own typical and very specific challenges;

6. Resistance to change is mainly a clinician and health system problem, not a patient or client problem. Most patients, especially those with chronic conditions, greatly appreciate a whole person approach. While much good comes from focusing on the supply side (the clinicians) of whole person care, it does mean confronting a very dominant paradigm, powerful vested interests, and enormous structural inertia. Stimulating the demand side (the patients) is a real option.

Session 8, Mid Afternoon Session - A & B
FAMILY CENTERED CARE & PATIENT COMMUNICATION

15.00. Family-centered care: history, application and subversion

Professor Linda Shields (Presenter), Professor of Nursing, Tropical Health Research Unit, James Cook University and Townsville Hospital and Health Service, College of Healthcare Sciences, James Cook University, Townsville, & Honorary Professor, School of Medicine, The University of Queensland, Australia & ESPCH SIG Chairman on Child and Family Centered Care [with Abstract Co-author Benedict, S].

Family-centred care is currently the philosophical cornerstone of paediatric practice. It is to be found in policy documents and guidelines in children's health care across the world, and is becoming widely discussed for care across the lifespan. While it sounds good, it is not supported by rigorous evidence and is under scrutiny as other models emerge and health care changes.

This paper will discuss the historical development of family-centred care, and why it is now being questioned. But then the discussion will turn to how family-centred care can be subverted to meet evil ends. When the Nazis came to power in Germany in 1933, they implemented policies designed to support the family, to encourage families to develop good habits, and good health, and to have many children. There was even a particular programme, Lebensborn, designed to selectively breed "good" Aryan children.

What we would call family-centred care today had a real place in the Nazi world, provided the family was racially "pure", fitted the definitions of a "good racial mix" and its members were not "life unworthy of life". Family-centred care Nazi style led to the so-called "euthanasia" programmes which saw disabled and ill children and adults killed if they were deemed to be "useless feeders" and a drain on the healthy family and healthy state.

This paper concludes by describing this subversion of family-centred care to meet a truly malevolent philosophy.

15:50 Engaging Patients in Communication about their Care Transitions

Professor Wendy Chaboyer, Director, NHMRC Centre of Research Excellence in Nursing Interventions for Hospitalised Patients (NCREN) & Centre for Health Practice Innovation (HPI), Menzies Health Institute Queensland, Griffith University, Queensland, Australia & Professor, Institute of Health and Care Sciences, Gothenburg University, Sweden

Engaging patients in clinical communication is founded on the belief that patients have a legitimate right to be included in their own care and decision making. Yet, this is not a simple thing to enact, with organisations struggling to involve patients in authentic ways. Existing strategies for actively involving patients in clinical communication about their care transitions are poorly understood.

The aim of this study was to explore how health care professionals engaged patients in communication associated with care transitions.

An instrumental case study approach was used. A purposive sample of key stakeholders representing (a) patients and their families; (b) hospital discharge planning team members; and (c) health care professionals was recruited

in five Australian health services. Individual and group semi-structured interviews were conducted to elicit detailed explanations of patient engagement in transition planning. Interviews lasted between 30 to 60 minutes and were digitally recorded and transcribed verbatim. Data collection and analysis were conducted simultaneously and continued until saturation was achieved. First strategies and tools used by participants were extracted and described. Then, thematic analysis was undertaken.

A total of 62 people were interviewed, 27 (44%) individually, and 35 (56%) in groups in a total of 11 groups. Thirty six nurses (58%), 9 allied health professionals (15%), 7 patients (11%), 7 physicians (11%), 2 volunteers or health advocates (3%) and 1 family member (2%) were interviewed. Participants described a number of different strategies used to engage patients and their families in communication about their care transitions, reflecting a multifaceted approach to engaging patients. Examples of these strategies included bedside handover, multidisciplinary rounds, and hourly rounding. When participants described these strategies, they seemed to indicate that they improved communication in general, and as a result, communication about care transitions was also improved. An important characteristic of these strategies was that they were tailored to meet the needs of individual patients. Examples of tools described by participants include patient care boards, protocols and checklists and patient passports. The five themes that emerged are: 1) Organisational commitment to patient engagement; 2) The influence of hierarchical culture and professional norms on patient engagement; 3) Condoning individual health care professionals' orientations and actions; 4) Understanding and negotiating patient preferences; and 5) Enacting information sharing and communication strategies. Most themes illustrated how patient engagement was enabled, however barriers also existed.

Our findings show that strong commitment to patient-centred care throughout the organisation was a consistent feature of health services that actively engaged patients in clinical communication. Understanding patients' needs and preferences and having both formal and informal strategies to engage patients in clinical communication promoted this involvement.

This study is part of a larger project commissioned by the Australian Commission on Safety and Quality in Health Care on engaging patients in communication at transitions of care. The project's research team was co-led by Tracey Bucknall and Wendy Chaboyer. The rest of the team include Anne McMurray, Andrea Marshall, Brigid Gillespie, Shelley Roberts, Alison M Hutchinson, Mari Botti, Lauren McTier and Helen Rawson.

16:40 Patients' and Nurses' Preferences for Patient Participation in Nursing Care

Ms. Georgia Tobiano RN (Presenter), Doctoral Candidate, Centre for Health Practice Innovation, Menzies Health Institute, Griffith University, Queensland, Australia [with Abstract Co-authors; Bucknall, T., Marchsall, A., Guinane, J., & Chaboyer, W].

Patient participation is increasingly recognized as a vital strategy to improve patient safety and is a core concept of person-centred care. Unfortunately, patient participation is not easily achieved with many barriers influencing its success. Nurses may play a key role in facilitating patient participation, yet their behaviors do not always reflect this. The aim of this study was to explore patients' and nurses' preferences for patient participation in nursing care.

This ethnography was conducted in four medical wards, located in one public and one private hospital, in two states. Forty interviews were conducted and fourteen nurses and two of their patients were observed. Patient and nurse interview transcripts were analyzed separately using inductive content analysis. Field notes of observations were organized into 'encounters'. An encounter began when the nurse entered the patient's room and ceased once the nurse left. Encounters were analysed using deductive content analysis, using Eldh et al.'s framework which includes four types of participation; meaningful dialogue, shared knowledge, partaking in planning and managing self-care. Inductive analysis was undertaken on data that did not fit the framework or criteria for an encounter.

Four categories were uncovered in the patient data. The first category, valuing participation, showed patients' willingness for participation. Exchanging intelligence, the second category, was a way of participating where patients' knowledge was built and shared. The next category, being on the lookout, was a type of participation where pa-

tients monitored their care, showing an attentive approach towards their own safety. The final category, balancing power was characterized by patients feeling their opportunities for participation were restricted, due to a sense of unbalanced power.

Five categories emerged from the nurses' views. First, acknowledging patients as partners showed nurses respected patients as legitimate participants. Second, managing risk emphasised nurses need to monitor participation to ensure rules and patient safety was maintained. Third, enabling participation demonstrated nurses' strategies that enhanced patients' participation. Fourth, hindering participation encapsulated nurses' difficulty in engaging patients who had certain characteristics. Finally, nurses realised participation as patients being involved in physical activities or clinical communication.

Deductive analysis of the observational data showed that knowledge sharing (60/116 (52%) encounters) and meaningful dialogue (59/116 (50.8%) encounters) were more commonly practiced. Involving patients in planning (32/116 (28%) encounters) and managing their self-care (18/116 (16%) encounters) was less frequently witnessed. One inductive category, labelled "controlling the environment" emerged, which showed some nurses' behaviours hindered patient participation.

Patients were motivated to and valued participation. Cultivating this motivation may be essential for patient empowerment and patients' practices of safety-monitoring. The nurse's role in enacting participation is complex, having to accommodate each patients' risks and characteristics, highlighting the need for good assessment skills to maintain safety. Patients and nurses recognized the crucial role nurses have in facilitating patient participation, while displaying controlling behaviours may reduce patient participation. Certain types of participation appear more accepted; knowledge-sharing occurs frequently, compared to activities like managing self-care.

17:00 Caring for carers: Spanish perspective in palliative care

Ms. Macarena Quesada Rojas MA, Data Manager, Clinical Trials Department, Health Research Foundation (FFIS), Virgen de la Arrixaca Hospital & Doctoral Candidate, Department of Social Health Sciences, Faculty of Medicine, University of Murcia, Spain.

As the human lifespan increases, the provision of care to the elderly becomes increasingly important. Developed countries have experienced a dramatic rise in life expectancy in the last twenty years. This situation is set to become more with United Nations population projections for 2050 suggesting that up to 30% of the European population will be over 65 by that time. Spain's population will become the third oldest in the world, with 34.1% being aged over 65, behind only Japan and Italy (35.9 and 35.5 respectively). At the same time, because of the aging population, more people die after long illness from heart disease, cerebrovascular disease including stroke, chronic respiratory disease, respiratory infections and cancer. In Spain, the main cause of death among people age 40 to 79 is cancer (314.8 per 100,000). Advanced cancer victims represent a large percentage of palliative care patients.

The World Health Organization defines Quality of Life (QoL) as an individual's perception of their position in life in the context of the culture and value systems in which they live and in relation to their goals, expectations, standards and concerns. Palliative care offers a support system to help patients live as actively as possible until their death. It affirms life and regards dying as a normal process, but intends neither to hasten the former nor prolong the latter. Chronic disease that causes patients and caregivers to lose control over their lives has an adverse effect on their social, work, family/marital life and causes their health and QoL to deteriorate. The decrease in the caregiver's QoL influences the quality of care and thus the QoL of the patient.

The time dedicated to a caregiver's activity is comparable to a standard working day, but the hours tend to increase as the disease worsens. In the worst-case scenario, taking care of the patient becomes a full-time occupation for the family caregiver. Informal caregivers are usually the hidden victim of the disease, and so have been labeled the "hidden patients".

Carer support is based on five specific areas: information about the illness suffered by their family member, training in patient care, how they take care of themselves, the carer's own needs and the amount of help they receive.

The relationship formed with the carer should be based on empathy and active listening. We should allow carers to express their feelings, doubts, frustrations, fears about the future and uncertainty in the face of difficult situations. We should try to assess their attitude and aptitude as a carer, how caring has affected their personal life and that of the patient and if they are showing any signs of excessive strain. We should try to anticipate that strain. Once we have assessed the carer's situation we can move on to support strategies and begin to care for the carer. "Caring for carers" should become a priority in palliative care.

Session 9, Late Afternoon Session

CONTROVERSIES AND HORIZONS

17:50 Assisted Dying or Assisted Living? Can physician assisted suicide form part of the person-centered healthcare framework?

Mr. Harry van Bommel, Founding Member, Canadian Hospice Palliative Care Association and Hospice Palliative Care Association of Ontario, Canada & Executive Director, Resources Supporting Family and Community Legacies Inc., Founder of Canada 150 Project, Co-Founder NavCare Canada.

I will speak from a patient-family perspective and as the author of 50 books (half of which are in the field of family caregiving and healthcare).

In Canada the debate to legalize assisted suicide is over. It has moved from theoretical debating points to practical implementation after a recent Supreme Court judgment of 9-0 declared that physician-assisted suicide must become legal by next year. The Supreme Court decided that "a competent adult person who (1) clearly consents to the termination of life and (2) has a grievous and irremediable medical condition (including an illness, disease or disability) that causes suffering that is intolerable to the individual in the circumstance of his or her condition" has the legal right to physician-assisted suicide. This decision has the broadest parameters yet seen internationally which may allow almost anyone to ask for help to die.

Speaking from a review of historical trends, I will identify specific reasons why assisted suicide and euthanasia have no place in person-centered healthcare, nor for that matter in any model of medical care, especially palliative care. I will identify specific modern trends towards early deaths within healthcare systems of people considered vulnerable by age, ability, education, income level and other social determinants of healthcare. I will outline some recommendations that assisted suicide and euthanasia be taken out of the medical realm altogether and present what I consider to be a relatively more safe alternative for those who have been given the legal right to a state-sanctioned death.

My presentation will not include moral, religious or ethical reasons against assisted suicide and euthanasia as these are, by now, well known. Rather, I will examine the historical consequences that legalization inevitably causes vulnerable people to die sooner and unnaturally as compared to valued people. I will strongly highlight that no system of legalized state-sanctioned death has ever proven to protect vulnerable people.

18:10 Why Traditional, Complementary and Alternative Medicine (CAM) are intrinsic to the person-centered healthcare framework.

Professor Paolo Roberti di Sarsina, Specialist in Psychiatry & President, Charity for Person Centred Medicine (Moral Entity), Bologna, Italy; Member, Observatory and Methods for Health & Coordinator Master´s Course "Health Systems, Traditional and Non-Conventional Medicine", University of Milano-Bicocca, Milano, Italy & Chairman, ESPCH SIG on Traditional, Complementary and Alternative Medicine (with Abstract Co-author Tassinari, M.).*

One of the key facets of the modern debate on person-centered healthcare is how PCH can be implemented in practice. Indeed, there is a real risk, without such implementation, that PCH will be marginalized as a lofty ideal

without practical applicability. Although it may seem obvious to say that the focus of any medical intervention should be the patient, seen as a human being, he/she is still too often considered nothing other than a set of organ systems, diseases and symptoms to be "put right" in a battle between the atavistic doctor and "clumsy" nature. Yet the holistic view of the person as a whole is nothing but the fundamental premise from which one must begin in medical science and not an understanding to be subsequently achieved.

From our point of view, Traditional, Complementary and Alternative Medicine (CAM) must form part of the person-centered healthcare framework. We say this because if, for biomedicine, the important roles of the external environment, social relationships, or the quality of food/nutrition are fairly recent discoveries, for CAM they have always been the foundation of diagnostic and therapeutic intervention. For CAM, the human being becomes a dimension in space, manifest through the integration of a multiplicity of different dimensions. This complexity, referred to as a reflection of Nature and the Cosmos more generally, necessitates by its nature a fully person-centered healthcare.

From the ontological point of view, CAM is an anthropologically-based, humanly founded system which was already being exercised by doctors in the ancient world long before the biomedical paradigm emerged. The need for a person-centered medicine naturally emerges in any course of treatment and is fundamental to therapeutic success. In biomedicine, only informed consent has been typically required. However, in CAM, the participation of the patient in the CAM therapy is an inseparable component of the therapy itself. It is part of the CAM belief system, so to speak, that the expectations that the patient and the doctor hold regarding the therapy significantly influence the outcome. Indeed, if the treatment setting is producing a considerable influence on the emotional state of the patient then that indicates that this is precisely the point from which one needs to begin to understand how important and cost-effective the centrality of the person is, not only in the therapeutic context, but also in the experimental one.

** Due to conflicting professional commitments, Professor Roberti di Sarsina is now unable to present his lecture in person. Professor Andrew Miles has agreed to present Professor Roberti di Sarsina´s PP slides on his behalf, to enable discussion at the Panel.*

18:30 Person-centered Healthcare – Quo Vadis? Opportunities and Horizons.

Professor Andrew Miles Senior Vice President & Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, Journal of Evaluation in Clinical Practice and European Journal for Person Centered Healthcare, Faculty of Medicine, Francisco de Vitoria University, Madrid, Spain and Faculty of Medicine, Imperial College London UK

In this particular presentation I will reflect not on the progress that PCH has made to date, but on what developments I believe are now necessary to secure its ongoing progress. In this context I will discuss the need for:

Ongoing conceptual and epistemological clarification of PCH. It is clear from the literature that PCH means different things to different people, whether clinicians, managers, politicians and policymakers and the general public. More work is therefore needed in order to clarify divergent understandings and agree common definitions.

Education in PCH principles and practice. It is axiomatic that general education in PCH principles and practice is fundamental to efforts to re-humanize clinical services. Education in this context should have as its priority, the education in PCH of: (a) undergraduate medical and non-medical clinical students, beginning with screened entry selection for clinical training & (b) health services managers, health policymakers and politicians & (c) patients and patient advocacy organizations themselves.

Postgraduate training. Continuing professional education and development is a moral duty of all clinicians and it is a responsibility of health systems to ensure that such education is properly in place. While education in PCH theory and practice is likely to permeate undergraduate medical and clinical curricula over time, the majority of clinicians who are currently working in practice will not therefore have received the benefit of such teaching. Given this, it is important that appropriate training be provided to such colleagues. This will require the development and use of educational packages in different forms.

Service re-configuration and re-design. Clinical services have traditionally been designed with the needs of the organization and its staff in mind and not with reference to the needs of patients, so that patients approaching the system are typically fitted into pre-existing organizational structures and processes. For an effective PCH, services must be built around the patient, not patients built around and the health system. To enable the implementation of agreed approaches to PCH, various levels and extents of service re-configuration and design are necessary.

Transformational and Servant Leadership. A conceptual/epistemological clarification of PCH, a PCH-enriched undergraduate and postgraduate education and training and a recognition of the need to re-configure and re-design clinical services are all vital for the advancement of healthcare personalization. But it remains highly unlikely that such developments will have any effect in terms of implementation without the exercise of transformational and servant leadership by those experienced in the exercise of such functions. The creation of transformational and servant leaders of PCH is therefore necessary and methods to form these leaders are thus a priority.

Multidisciplinary Team Working. The implementation of PCH is unlikely to occur, or to be sustainable, without a clear acknowledgement of the need for multidisciplinary team (MDT) working. Medical colleagues alone are not sufficiently equipped to effect a transition away from the current de-personalized models of care to a more person-centered approach. An acknowledgement of the vital place of effective MDT working for PCH implementation and the development of policies and methods to enable it is therefore required.

Patient Education, Advocacy and Empowerment. The place of patients (and their families and friends) themselves in determining PCH plans and implementation strategies remains central. A recently published systematic review of the literature on the methods of patient empowerment reported that significant uncertainty remains about the best way to define and measure it and that a consensus is needed from which to develop a core set of patient empowerment constructs and appropriately validated measurement indices and tools. Increasing the health literacy of patients in understanding, self-managing and working with clinicians to manager their condition(s) is key here as is the urgent need to increase the political power of the patient voice in all matters relating to patient care – both at local and national levels.

Raising Awareness and General Advocacy of PCH. Much work remains to be done in ensuring a continuing - and amplified – advocacy of PCH. The raising of awareness of PCH´s benefits must combat the erroneous idea, prevalent in some medical and management circles, that PCH is in essence a sentimental activity which looks back to medicine´s past, rather than looking forward to healthcare´s future. PCH is, on the contrary, a dynamic activity that brings with it not only increases patient and clinician satisfaction, but superior clinical outcomes when compared to ´care as usual´ and with measurable decreases in health system costs. This message, based on a rapidly growing empirical research base, cannot be over-emphasized or over-communicated. Going forward, more effective external and public relations strategies are required for PCH and better use of social media by PCH leaders should form one plank of such activities. It is suggested that such approaches, in combination with others, will lead to an increased awareness of the importance of PCH approaches in the medical, managerial, policymaker, political and public minds, thus making more likely an acceleration of the operational implementation of PCH into routine health and social care systems.

Research. A rapidly growing empirical research base indicates that PCH approaches to patient care increase patient adherence to both simple and complex medication regimens, that they decrease the frequency of primary and secondary care clinical consultations, that they decrease the frequency of disease and illness exacerbations, that they decrease hospitalization rates, that they decrease length of stay when hospitalization occurs, that they result in increased patient satisfaction rates, that they result in increased clinician satisfaction and reduced clinician burn out rates and that they result in reduced malpractice claim suits. An imperative for PCH, in addition to those suggested above, must therefore be to confirm the result of these initial studies, thus to consolidate the

evidence for PCH, enabling powerful arguments to be made for its adoption and funding in practice. It is here that economic studies are necessary, in order to cost PCH-mediated changes in service utilization and delivery. The result of such research are vital in securing the attention and action of health policymakers and the governments they serve.

Systems for PCH Implementation. The implementation of new systems of working and governance in health services are often described in a binary fashion as ´top down´ (stick) or ´bottom up´ (carrot) – the carrot-stick metaphor being well recognized and much used within management theory. I argue that systems for the implementation of PCH approaches must be ´bottom up´, thereby providing ´carrots´, rather than wielding ´sticks´. The idea (articulated singly elsewhere) that PCH can be implemented by top down, WHO or State Government designed strategies is simplistic and naïve. On the contrary, the implementation of PCH should be progressed via democratic means, involving detailed collegial discussions with the clinical professions and their professional organizations at individual State level in collaboration with well-respected PCH leaders and with implementation planned in a bottom-up, democratic fashion, and being fully sensitive to local and national cultural considerations and resource constraints.

It is argued that each and every one of the above approaches are necessary if we are to move PCH from a simple rhetorical advocacy into operational practice. Such a process is complex and will take time, almost certainly several decades. If successfully achieved, PCH will return to the clinical professions a definitive ambition to treat patients as persons, moving competence or even high competence in the direction of clinical excellence.

ANNOUNCEMENT OF THE WINNERS OF THE ESPCH MEDALS AND PRIZES AND FRANCISCO DE VITORIA UNIVERSITY RECOGNITION

Presidential Medal for Excellence in Person-centered Healthcare

is awarded to

Professor Bernie Carter BSc PhD RSCN SRN FRCN

Professor of Children's Nursing at the University of Central Lancashire UK & Director of the Children's Nursing Research Unit (CNRU) at Alder Hey Children's NHS Foundation Trust UK & Clinical Professor, University of Tasmania & Visiting Professor, Edge Hill University
& Editor-in-Chief, Journal of Child Health Care

Senior Vice Presidential Medal for Excellence in Person-centered Healthcare

is awarded to

Dr. James A Marcum BSEd MS MATS PhD PhD

Professor, Department of Philosophy & Director, Medical Humanities Program, Baylor University, Texas, United States of America

ESPCH Platinum Medal

is awarded to

Mr. Steven Rose RN RMN MSc FRSA FCWR

Chief Executive, Choice Support

ESPCH Gold Medal

is awarded to

Professor Jack Dowie MA PhD

Emeritus Professor of Health Impact Analysis, Department of Social & Environmental Health Research, Faculty of Public Health & Policy, London School of Hygiene and Tropical Medicine, London UK & Chairman, ESPCH SIG on Health Impact Analysis

ESPCH Sliver Medal

is awarded to

Dr. Nathan Schou Bertelsen BA MD

Visiting Assistant Professor, Koç University School of Medicine, Istanbul, Turkey, and Assistant Professor of Medicine and Population Health, Bellevue Hospital, New York University School of Medicine, United States of America

ANNOUNCEMENT OF THE WINNERS OF THE ESPCH MEDALS AND PRIZES AND FRANCISCO DE VITORIA UNIVERSITY RECOGNITION

ESPCH Bronze Medal

is awarded to

Dr. Chiung-Jung (Jo) Wu BN MN DrHlthSc RN FACN

Senior Research Fellow, School of Nursing, Midwifery and Paramedicine, Faculty of Health Sciences, Australian Catholic University, Visiting Fellow, School of Nursing, Queensland University of Technology, Brisbane, Australia, Honorary Research Fellow, Mater Research Institute-University of Queensland, Brisbane, Australia and Honorary Research Fellow, Royal Brisbane and Women's Hospital, Brisbane, Australia

ESPCH Book Prize

is awarded to

Dr. Dwight McNeill MPH PhD

Instructor of Health Policy and Population Health, Suffolk University, Boston, Massachusetts, United States of America

ESPCH Essay Prize

is awarded to

Dr. Sandro Tsang PhD

Senior Postdoctoral Visiting Fellow, University of Nottingham &
Tutor at the Peoples Open Access
Education Initiative, Manchester, UK

ESPCH Inaugural Postgraduate Master´s Degree Studentship

is awarded to

Dr. Derek Mitchell BA (Hons)(Oxon) MA (UKC) PhD (UKC) PGDipHCE (Kings, London) PhD

Winner of the Presidential Medal for Excellence in Person-centered Healthcare

Professor Bernie Carter BSc PhD RSCN SRN FRCN

Professor Bernie Carter has always been a strong and successful advocate for family-centered care. Most importantly, her work has allowed the voices of children to be heard about the care provided to them in health services. While it is known that the implementation of family-centered care can be problematic, Professor Carter has provided an alternative way to focus care on children and their families as is set out within her seminal 2014 textbook ´Child-centered Nursing: Promoting Critical Thinking´. Professor Carter developed the Children´s Nursing Research Unit at the University of Central Lancashire UK, a collaborative initiative between the University, Liverpool John Moore´s University UK, Edge Hill University UK and Alder Hey Children´s NHS Foundation Trust UK. This initiative has brought together nursing scholars, clinicians, children and their families and is strongly focussed on research into the provision of person-centered care for children. Professor Carter is Editor-in-Chief of the Journal of Child Health Care, the official journal of the Association of British Paediatric Nurses and she has steered this journal from its foundation into what it is today – a periodical of high international reputation. Professor Carter is also Chairman of the Royal College of Nursing Pain in Children and Young People Community. Professor Carter´s research has focussed on the lives of children and their families which have become disrupted by pain, illness, disability and disadvantage and in the development of person-centered approaches to their care. She continues to be preoccupied with the development of the knowledge base underpinning person-centered healthcare practice and service delivery. Professor Carter has been awarded a Fellowship of the Royal College of Nursing in recognition of her reputation as one of the world´s most important scholars in the study of how person-centered healthcare can be delivered to children and families. The President of the Society is proud to award the Presidential Medal to Professor Bernie Carter. (For biography view Conference Participants)

Winner of the Senior Vice Presidential Medal for Excellence in Person-centered Healthcare

Dr. James A Marcum BSEd MS MATS PhD PhD

Dr. James Marcum is an internationally distinguished authority in the philosophy of medicine, having studied the philosophy of science with Thomas Kuhn. Dr. Marcum contributed to the philosophy of science and medicine for over a decade at Harvard Medical School before moving to his current Chair at Baylor University. Dr. Marcum has published major works of signal relevance to person-centered healthcare in an extensive range of scholarly journals including Synthese, Perspectives on Science, History and Philosophy of the Life Sciences, Journal of the History of Medicine and Allied Sciences, Perspectives in Biology and Medicine, Theoretical Medicine and Bioethics and the Journal of Evaluation in Clinical Practice. His recent books ´An Introductory Philosophy of Medicine: Humanizing Modern Medicine´ and ´The Virtuous Physician: The Role of Virtue in Medicine´ are major contributions to the global discourse on the philosophy of medicine with direct importance to the development of person-centered healthcare as is his ongoing work on personalist thought in the refinement of the person-centered healthcare thesis. The Senior Vice President of the Society is proud to award the Senior Vice Presidential Medal to Dr. James Marcum. (For biography view Conference Participants)

Winner of the ESPCH Platinum Medal

Mr. Steven Rose RN RMN MSc FRSA FCWR

Mr. Steven Rose has a proven outstanding and long term commitment to the person-centered care of people living with profound learning disabilities, continuously since 1974, and to the measurement of the resulting benefits. He has shown a lifetime of dedication to the person-centered care of people living with challenging learning disabilities and acted indefatigably as the Director of a Charity that has become the largest single supplier of staff to support disabled people in the UK. He has overseen a personalisation programme that has resulted in a significant improvement in the life of adults with learning difficulties via the charity Choice Support. Mr. Rose´ personalization programme has replaced a standard level of support funded through a block grant with person-centered care and support organized through person-centered plans and individual service funds. Formal analysis of this scheme has not only demonstrated that is has resulted in an improvement in the lives of people (and their families) with profound learning disabilities, but that it has achieved significant savings in addition. Mr. Rose´s efforts have resulted in a new model of care for people with learning disabilities in the UK, with lessons cross-applicable in Europe, based on his sustained vision and leadership. The ESPCH is proud to recognise this scale of achievement through its award of the Platinum Medal of the Society.

Biography:

Mr. Steven Rose MSc RN(LD) RMN FRSA FCWR has worked with people with learning disabilities for over forty years. He commenced his career in the NHS and was appointed a director of Nursing at the age of 29. In 1991 after seventeen years in the NHS he was appointed to his current position, Chief Executive of the charity Choice Support. Steven is a Fellow of the Centre for Welfare Reform, vice Chair of the Housing & Support Alliance and a Visiting Senior Research Fellow in Learning Disability Research and Policy Development at Buckingham New University.

As Chief Executive of Choice Support he has overseen its growth and development from an organisation with 10 employees, an annual turnover of £1 million based in a single London borough to become one of the leading disability charities in the England; employing approximately 2000 staff, including over 400 disabled people, with an annual turnover approaching £40 million, providing support to 1450 people.

1991 Steven managed the first large scale externalisation of NHS learning disability services to the voluntary sector from Camberwell and Lewisham Health Authorities and subsequently he led work on the closure of six learning disability hospitals. In 1994 he was appointed by the Chief Nursing Officer for England to co-lead a national project.

Choice Support has a long history of innovation; current examples include its contract with the Care Quality Commission to provide 'Experts by Experience' (currently over 450) to support its registration and inspection processes; and being the first organisation in England to convert a £6.5 million block contract to 83 Individual Service Funds (ISFs). Independent research (Better Lives) established that the ISF personalisation project saved the local authority £1.8 million (29% of budget) and demonstrated significant qualitative improvements in people's lives.

Steven is widely published in professional journals and book chapters.

Profile:
Choice Support

http://www.choicesupport.org.uk/

Choice Support is a pioneering social care charity supporting disabled and disadvantaged people. It was formed in London in 1984 as Southwark Consortium, to support people with learning disabilities to leave long-stay institutions. Now, as well as people with learning disabilities Choice Support provides services for homeless people, and people with autism, mental health needs, physical disabilities and complex health needs.

Choice Support is governed by a voluntary Board of Trustees who bring a wide range of skills and experience to the organisation. The Board includes two members with learning disabilities and a parent carer. Responsibility for the operational management of Choice Support lies with the Senior Management Team, led by Chief Executive Steven Rose MSc, RN(LD), RMN, FRSA, FCWR. When Rose took up his post in 1991 Choice Support employed 10 people, had an annual turnover of £1 million and was based in a single London borough. It is now one of the leading disability charities in the England, employing approximately 2000 staff, including over 400 disabled people. It has an annual turnover approaching £40 million, and provides support to 1450 people.

Writing recently about Choice Support's values, Rose said:
"At Choice Support we believe in a fair society where people with disabilities receive the support that they want, to allow them to live as equal contributing citizens. In our experience this is usually achieved by putting people in control of their lives. This means having self-determination, a clear sense of direction, control of money, a home, the right support and being part of a local community. People must also be safe from abuse and exploitation.
We achieve this through active partnerships with the people we support, their friends and families. We listen closely to what people say they want and respond accordingly, always upholding their rights. We also believe that it is important to be open to new ideas and to have the courage to put them into practice."
Choice Support has been characterised by innovation since its inception. It was the first consortium of its type, and oversaw the first large scale resettlement programme from a mental handicap institution.

In 1991 when Rose came into post Choice Support piloted individual budgets in Southwark, and is now working with local authorities across the country to hand over budgetary control to the people it supports. The same year it opened some of the first supported living services in the country, which gave people more income and security of tenure by separating support and housing provision. The following year it instigated one of the first service brokerage projects in the country.

Since then the values Rose writes about have continued to find expression in many aspects of Choice Support's work, while influencing the wider social care scene. A quality department, which continually monitors services, includes a team of quality checkers - people with support needs trained to check and assess services. This experience of harnessing the power of personal experience in service monitoring led to Choice Support being awarded a contract to employ, train and manage Experts by Experience for the Care Quality Commission (CQC). Experts by Experience are people with experience of receiving health and social care services, who work with CQC inspectors to monitor all health and social care services across England.

Choice Support continues to seek new ways of making its services more responsive, personalised and effective. It looks to a future when anyone needing care and support can, with the help of their families, friends, advocates and professionals, choose, plan, and purchase the services they want and need.

Winner of the ESPCH Gold Medal

Professor Jack Dowie MA PhD

Professor Dowie has made an outstanding contribution to the theory and practice of clinical decision-making and to the advancement of the field of person-centered healthcare. His current work on the development and evaluation of Annalisa, a user-friendly implementation of Multi-Criteria Decision Analysis which he designed in order to facilitate a more equal balancing of intuition and analysis in health decision-making, whether it the community setting of screening, the clinical setting of the doctor-patient consultation or the macropolitical setting of health and non-health sector policies, programmes and projects, has been groundbreaking and is of direct relevance to the advancement of person-centered healthcare. Of equal relevance to person-centered healthcare has been his work in clarifying the ways in which such decision tools should be evaluated and in establishing the principles appropriate for action evaluation (decision-making in medicine or public health), a process very different from those that are appropriate for knowledge evaluation ('science', whether it be biophysical, epidemiological or social). The ESPCH is proud to recognise this scale of achievement through its award of the Gold Medal of the Society. (For biography view Conference Participants)

Winner of the ESPCH Silver Medal

Dr. Nathan Schou Bertelsen BA MD

Dr. Bertelsen has made a signal contribution to the cultivation and maintenance of empathy as part of medical training via his work ´Empathy in Graduate Medical Education Milestones´ and to the person-centered care of people victimized by torture. The ESPCH is proud to recognise Dr. Bertelsen´s achievements through its award of the Silver Medal of the Society. (For biography view Conference Participants)

Winner of the ESPCH Bronze Medal

Dr. Chiung-Jung (Jo) Wu BN MN DrHlthSc RN FACN

Dr. Wu has made major contributions to the field of self-management for patients with coronary heart/cardiovascular disease and diabetes through technological interventions. She has influenced and led novel research (competitively funded as an individual and in participation with medical and nursing teams), nationally and internationally, to study these issues from inpatient status to home. She has pioneered the implementation of her research (telephone, text messaging, internet technology) in order to develop innovative methods to reduce hospital re-admission and to improve health outcomes. She has developed an efficient, effective, safe, patient-centered and equitable care programme dedicated to the improvement of health outcomes. Her work is cross-applicable to European health systems. The ESPCH is proud to recognise this achievement through its award of the Bronze Medal of the Society.

Biography:

Dr. Chiung-Jung (Jo) Wu MSc RN DrHlthSc FACN is a Senior Research Fellow, Faculty of Health Sciences, Australian Catholic University (ACU), and has previously held Research Fellow position, Nursing Academic at the School of Nursing, Queensland University of Technology (QUT). She is also a Fellow of Australian College of Nursing (FACN), Visiting Fellow with QUT, an Honorary Research Fellow with the Royal Brisbane and Women's Hospital (RBWH), and Mater Research Institute-University of Queensland (MRI-UQ). Dr Wu has over 16 years' clinical working experience in intensive care unit/coronary care unit and as a diabetes educator in Australian and in Taiwan.

Her doctoral studies emanated from over 16 years' clinical experience in the Coronary Care Unit (CCU) where she observed differences in the progress of cardiac patients with diabetes. Her post-doctoral studies have continued to advance knowledge in the promotion of self-management for patients with coronary heart disease and diabetes. Dr Wu is currently collaborating with clinicians, national and international researchers towards further studies on promoting self-management incorporating telehealth into the delivery of the program, evaluating different delivery modes and undertaking the intervention in different cultural contexts.

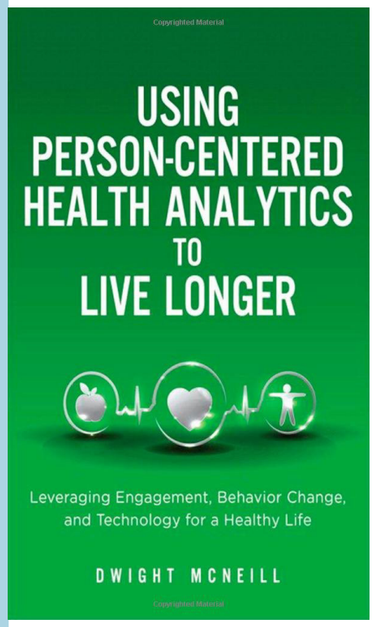
Dr Wu has been awarded a number of competitive research grants with approx. value of AUD$2.1 million, has published papers including systematic reviews (quantitative and qualitative) in refereed journals and has presented at several international and national conferences. Dr Wu is Chair of Expert Reference Group, Cardiovascular Node (Southern Hemisphere), a reviewer of nursing/ behavioural journals, nursing textbook chapters and grant applications, Editorial Board member of International Nursing Review (Official Journal of International Council of Nurses).

Dr Wu has been accredited supervisor since completion of her doctoral qualification. She supervises 6 higher degree research students (2 PhDs, 1 Research Masters and 1 Honours student successfully to completion), as well as providing mentorship to less experienced colleagues and clinical staff in undertaking research.

Winner of the ESPCH Book Prize

Dr. Dwight McNeill MPH PhD

Dr. McNeill´s book is extremely timely. While the United States continues to argue about whether and how to provide all of its citizens with health insurance and how to contain the high costs of healthcare, it has lost sight of the purpose of it all. The purpose of the vast $USD 2.8 trillion health care industry, the most expensive by far of all countries in the world, is to produce better health for all Americans. Dr. McNeill´s book shows that this is failing and is getting worse, with the Nation spending much more time worrying about saving dollars than about saving lives. Dollars, as McNeill´s book points out, are far easier to measure, so that even the value of a life is measured in these terms. At its best, the health system is about getting more value for money spent, but the achievement of better quality and outcomes through known approaches is typically not attempted because either it costs too much, is not rewarded financially, or is hard to accomplish successfully. Dr. McNeill emphasizes that despite the well-intentioned actions of governments, life sciences and technology, the most important resource for achieving our full health potential is ourselves. Dr. McNeill´s book is about how people themselves can achieve better health and how others can help them to do this. Dr. McNeill introduces person-centered health analytics (pchA) and shows how it can be used to master five everyday behaviours that cause and perpetuate most chronic diseases. Dr. McNeill´s book provides a detailed insight into these issues and offers the reader a comprehensive framework and practical tools for living longer and healthier lives. His book provides a clear path forward for both individuals and stakeholders, including providers, payers, health promotion companies, technology innovators, government and analytics practitioners. The ESPCH is proud to recognize Dr. McNeill´s work through the award of the Society´s Essay Prize. (For biography view Conference Participants)



Dr. Dwight McNeill, PhD, MPH:
Using Person-Centered Health Analytics to Live Longer: Leveraging Engagement, Behavior Change, and Technology for a Healthy Life

The American way of producing health is failing. It continues to rank very low among developed countries on our most vital need…to live a long and healthy life. Despite the well-intentioned actions on the part of government, life sciences, and technology, the most important resource for achieving our full health potential is ourselves.

This book is about how you can do so, and how others can help you. Dwight McNeill introduces person-centered health analytics (pchA) and shows how you can use it to master five everyday behaviors that cause and perpetuate most chronic diseases.

Using Person-Centered Health Analytics to Live Longer combines deep insight, a comprehensive framework, and practical tools for living longer and healthier lives. It offers a clear path forward for both individuals and stakeholders, including providers, payers, health promotion companies, technology innovators, government, and analytics practitioners.

(hardcover). New Jersey: Pearson FT Press Analytics; 2015 April

http://www.amazon.com/Using-Person-Centered-Health-Analytics-Longer/dp/0133889971/ref=asap_bc?ie=UTF8

http://www.pearsonhighered.com/educator/product/Using-PersonCentered-Health-Analytics-Live-Longer-Leveraging-Engagement-Behavior-Change-and-Technology-Healthy-Life/9780133889970.page

Make preventive health work—finally
Discover a new vision for people-centric, self-managed, 24/7 behavior change

Support individuals as they systematically improve their health trajectories
Implement a complete framework for engaging individuals in "coproducing" health

Use and share powerful personal health tools that are already here
Help people know themselves, protect their health, mind illnesses, and manage their data

Overcome five key barriers to person-centered health analytics
Address issues related to physicians, payment, proof, pleasing customers, and privacy .

Review (more reviews at www.pearsonhighered.com)
"Dwight McNeill's book marks a new step in our collective understanding of the relationship between health and the vastly complex health care system that consumes so much of our national attention and wealth. Health care purchasers are looking for a way to link together their efforts to promote wellness and personal engagement with their investment in the hugely expensive medical care system. This book shows that we can focus on the emerging ways to manage our personal well-being while leveraging the health care system for its particular strengths. It is valuable to all of us as patients, consumers, and families—and will outline a new direction for purchasers, payers, and policymakers trying to set a fresh course for U.S. health care."
—David Lansky, Chief Executive Officer, Pacific Business Group on Health

Winner of the ESPCH Essay Prize

Dr. Sandro Tsang PhD

Dr. Tsang´s recent Essay, ´Arrow Physicians: are economics and medicine philosophically incompatible?´, [Tsang, S., (2015). Journal of Evaluation in Clinical Practice 21, 419 – 426], directly challenges the claim that economics and medicine are philosophically incompatible disciplines, by drawing on the ideas of economist Kenneth Arrow who considered the relationship between trust, reciprocity and the efficient use of communal resources. Tsang uses the term ´Arrow Physicians´ to characterize "a humanistic carer who has concern for the patient and acts on the best available evidence with health equity in mind". Dr. Tsang´s Essay contributes valuably to person-centered healthcare in arguing for an interdisciplinary approach which strongly contends that the application of economics to medicine can actually help to humanize, rather than de-humanize, the medical encounter. Tsang´s thinking, set out in this Essay, argues that Arrow Physicians are entirely communitarian in approach, but with a thorough and profound concern for the individual in front of the clinician. The ESPCH is proud to recognize the importance of Dr. Tsang´s Essay through the award of the Society´s Essay Prize.

ESSAY:

Arrow physicians: Are economics and medicine philosophically incompatible?

Economics is en route to its further expansion in medicine, but many in the medical community remain unconvinced that its impact will be positive. Thus, a philosophical enquiry into the compatibility of economics and medicine is necessary to resolve the disagreements. The fundamental mission of medicine obliges physicians to practise science and compassion to serve the patient's best interests. Conventional (neoclassical) economics assumes that individuals are self-interested and that competitive markets will emerge optimal states. Economics is seemingly incompatible with the emphasis of putting patients' interests first. This idea is refuted by Professor Kenneth Arrow's health economics seminal paper. Arrow emphasizes that medical practice involves agency, knowledge, trust and professionalism, and physician–patient relation critically affects care quality. The term Arrow Physician is used to mean a humanistic carer who has a concern for the patient and acts on the best available evidence with health equity in mind. To make this practice sustainable, implementing appropriate motivations, constitutions and institutions to enable altruistic agency is critical. There is substantial evidence that polycentric governance can encourage building trust and reciprocity, so as to avoid depletion of communal resources.This paper proposes building trusting institutions through granting altruistic physicians adequate autonomy to direct resources based on patients' technical needs. It also summarizes the philosophy bases of medicine and economics. It, therefore, contributes to developing a shared language to facilitate intellectual dialogues, and will encourage transdisciplinary research into medical practice. This should lead to medicine being reoriented to care for whole persons again.

Reference:

Tsang S. Arrow physicians: Are economics and medicine philosophically incompatible?. Journal of Evaluation in Clinical Practice. 2015 June; 21(3): 419-426

Biography:

Dr. Sandro Tsang PhD has been trained as an Economist. She was awarded a PhD in Empirical Economics (Management) by the University of Granada, Spain, in 2011. She was also awarded an MSc in Economics from the University of Surrey, and a PgDip in Financial Economics and a BSc in Economics from the University of London. Her research focus has been on medical decision-making both in general or specific contexts such as eHealth and antibiotic prescription decisions. In 2011, she was introduced to epistemology research by Professor Michael Loughlin of Manchester Metropolitan University. Since then, she has been conducting research related to the

ethics of medical practice. So far, she has published five sole-author papers, and co-authored two papers with Dr. John Lane, a former academic of London School of Economics. Her publications include mathematical modelling, statistical modelling and applied epistemology. The results have implications for deriving practicable policies. She is a postdoctoral research associate at the Chinese University of Hong Kong, and involved in several government projects. She spends her spare time on volunteer tutoring for the People's Open Access Education Initiative (PU). She delivers health economics and academic writing skills to the master students, and is an examiner and advisor of dissertations for the master degree of public health at PU. She is currently a senior postdoctoral visiting fellow at University of Nottingham. She is working with a trans-disciplinary team to study clinical decision-making for influenza-like illness. She has introduced epistemology elements into the research. She will also be involveed in analysing the qualitative data from individual clinician interviews by applying fuzzy clustering analysis to fully explore the potential of qualitative data. The results will have implications for deriving policies related to influenza pandemic preparedness and response as well as facilitate the understanding of antimicrobial prescribing behaviours.

Winner of the ESPCH Inaugural Postgraduate Master´s Degree Studentship

Dr. Derek Mitchell BA (Hons)(Oxon) MA (UKC) PhD (UKC) PGDipHCE (Kings, London) PhD.

The ESPCH studentship was advertized on-line, with multiple applicants applying for the studentship and six students shortlisted in accordance with the collaborating university´s policies. One student, with an outstanding background in applied philosophy, Dr. Derek Mitchell, was selected as the winner of this Award. The title of the approved thesis is as follows: "Putting Phenomenology into Practice - Towards an Epistemology of Person Centred Healthcare." Dr. Mitchell will use a Heideggerian/Havi Carel phenomenological type of approach, employing some of Gadamer's hermeneutic thinking in order to develop a philosophical ground or justification for person centred healthcare. Due to longstanding charitable commitments, Dr. Mitchell is unable to be present personally in Madrid on 18 & 19 June 2015. His studentship will therefore be confirmed in absentia and the award received on his behalf by the academic superviser of his project, Professor Michael Loughlin, Chairman of the ESPCH SIG on Health Philosophy. The Society is proud to welcome Dr. Mitchell as its first postgraduate student.

Biography:

Dr. Derek Mitchell BA (Hons)(Oxon) MA (UKC) PhD (UKC) PGDipHCE (Kings, London) PhD first studied philosophy at Oxford and subsequently at the University of Kent and Kings College, London. Derek began work in the Health Service in 1986 and combined a successful career as a manager in every aspect of primary care, with a part-time academic career teaching and writing mainly within the Health Service, including workshops covering ethical topics for General Practice postgraduate work and Registrar training. As a manager Derek's undertook groundbreaking work in primary care clinical effectiveness and clinical governance which led to the development of the Quality and Outcomes Framework for United Kingdom General Practice in 2003. Derek retired from the Health Service in 2004 due to a serious chronic illness.Following retirement Derek continued to teach and write philosophy as much as was permitted by his illness, and, after surgery in 2009, now spends his time doing sessional teaching in philosophy and other work in support of the Health Service. Derek teaches philosophy for the Workers Educational Association, Canterbury Christchurch University in Kent, and privately. He also works as a volunteer patient representative for stoma patients with the Health Service in East Kent. Derek was the chairman of the East Kent Hospitals Trust Patient and Public Advisory Forum from October 2012 to March 2014. Derek's first book Heidegger's Philosophy and Theories of the Self was published in 2001 and his second Everyday Phenomenology in 2012. Derek has also had work published on evidence based medicine and person centered healthcare. Apart from philosophy Derek enjoys recreational cycling and growing prize winning flowers, fruit and vegetables.

Professor Sir Jonathan Asbridge DSc(hc) has a long and distinguished record of achievement within the British healthcare system organisation, accreditation, re-configuration and regulation. Gaining appointment to the positions of Chief Nurse of the Oxford University and Cambridge University Teaching Hospitals early in his career, he moved to St. Bartholomew's and The Royal London Foundation NHS Trust as Chief Nurse and Executive Director of Quality, later to lead the Trust, one of the biggest and most complex in the UK, as Chief Executive. He was the Inaugural President of the UK Nursing and Midwifery Council with responsibility for the fitness for practice and regulation of the UK's 700,000 nurses and midwives. He is a previous Deputy Chairman of the UK Council for Healthcare Regulatory Excellence and has acted as a Government 'Tsar' for Patient Experience in Emergency Care and for Patient and Public Involvement in Healthcare. Sir Jonathan has been involved in the development of several major NHS policies and conducted several formal Inquiries both in the UK and overseas. He was appointed Foundation Professor of Nursing at the University of Buckingham, UK in 2010 and was a Founding Board Member of the European Federation of Nursing Regulators and a Member of the International Council of Nurses Global Observatory on Licensure and Registration. Sir Jonathan was awarded the Degree of Doctor of Science honoris causa for services to healthcare by the City of London University in 2004 and was invested with the Honour of Knighthood by Her Majesty Queen Elizabeth II for services to Healthcare on the occasion of The Sovereign's 80th Birthday in 2006. Sir Jonathan is married with four children and is professionally based in Oxford, England.

Dr. Fernando Caballero Martínez is Dean of Medicine at Francisco de Vitoria University, Madrid, Spain. He graduated in Medicine in 1988 at the Complutense University in Madrid and specialized in Family and Community Medicine through the resident training program in Puerta de Hierro University Hospital, Madrid during 1988-1991. He completed a Master's degree in Biomedical Research Methods (DISMIC) at the Centre for Public Health of the Autonomous University of Madrid in 1997 (here he is currently completing a PhD in Medicine) and obtained a Diploma in Advanced Clinical Research Methodology (DAMIC) from the National Public Health School of the Carlos III Health Institute, Spanish Health Ministry in 1999. From 1991 to 1994 he worked as a General Practitioner in a University Primary Care Health Center (Pozuelo de Alarcón, Madrid). In 1994 he was appointed Academic Head of the Family Medicine Postgraduate Program in Puerta de Hierro University Hospital and Director of the Primary Care Research Unit in the 6th Area of the Madrid Health Service. There, he was made Director of Department of Research & Continuing Medical Education in 1998. In 2010 he joined Francisco de Vitoria, Madrid, as Dean of the School of Medicine, where he also works as a teacher, designing and managing a person-centered undergraduate program. He has an extensive experience in clinical and epidemiological research and long experience and a distinguished track record in student teaching. Among his various awards are the National Medical Research Management Prize (1996) and the National Medical Education Management Prize (1999) conferred by the National Public Health School (Spain Health Ministry) & Arthur Andersen Consultants. His current professional interests include clinical effectiveness and clinical outcomes assessment, new methodologies for learning and medical education, professionalism, ethics and person-centered medicine. Dr. Caballero belongs to the Spanish Family and Community Medicine Society (SEMFyC), and to the WONCA International Society. At the ESPCH, Dr. Caballero is Chairman of the SIG on Person-Centered Undergraduate Medical Education and a Member of the Editorial Board of the European Journal for Person Centered Healthcare, the official journal of the Society

Dr. Juan Perez-Miranda is currently Vice-rector for International Relations at Francisco de Vitoria University, Madrid, Spain and was formerly Vice-Dean for Institutional Relations within the university's School of Medicine. He holds a PhD Degree in Medicine and Surgery from the University of Extremadura, Spain and a Master's degree in Business Administration from IESE Business School, Barcelona, Spain. He was previously Dean of the Biomedical Sciences School at the Universidad Europea de Madrid, Spain and Medical Director at the International Health Foundation (IHF) based in Madrid, Spain. IHF's main objectives are the promotion of excellence in the Spanish health care system and international relationships with healthcare institutions and companies. Dr. Perez-Miranda was responsible for scientific programs and international projects. Dr. Perez-Miranda has also worked for two pharmaceutical companies in marketing and medical positions and has been Managing Director of Infanta Cristina University Hospital, Badajoz, Spain as well as Board Member of the University Hospital of the University of Navarra, Spain. He has collaborated regularly as a lecturer and speaker in numerous University health related Academic Programs and as a speaker at international forums and conferences.

Professor Andrew Miles MSc MPhil PhD DSc(hc) is Senior Vice President and Secretary General of the European Society for Person Centered Healthcare (ESPCH). He is Editor-in-Chief of the European Journal for Person Centered Healthcare and Editor-in-Chief of the Journal of Evaluation in Clinical Practice, currently based at the Society´s European Headquarters within the Medical School of Francisco de Vitoria University, Madrid, Spain. Gaining his first Chair at the age of 30, he was formerly Professor of Clinical Epidemiology and Social Medicine & Deputy Vice Chancellor (Deputy Rector) of the University of Buckingham UK, holding previous professorial appointments in the departments of primary care and public health medicine at Guy's, King's College and St. Thomas' Hospitals' Medical School London and at St. Bartholomew's and The Royal London Hospitals´ School of Medicine, London. He is a Visiting Professor at the University of Milan Italy, at the Medical University of Plovdiv and at the National University of Bulgaria in Sofia. He is a Fellow at the WHO Collaborating Centre for Public Health Education and Training within the Faculty of Medicine at Imperial College London UK. He is a Distinguished Academician of the National Academy of Sciences and Arts of Bulgaria and a Fellow of the New York Academy of Medicine USA. He trained at the University of Wales and its Medical School in Cardiff UK and holds four higher degrees: two Master's degrees (prostate pathology, clinical audit/evaluation) and two Doctorates (pineal gland neuroendocrinology, person-centered medicine), one of the two latter being awarded honoris causa for his contribution to the advancement of person-centered healthcare internationally. He has published extensively in the peer reviewed medical and biomedical press, has co-edited 47 medical textbooks in association with an extensive number of Royal Colleges and medical and clinical societies in the UK and has organised and presided over more than 100 clinical conferences and masterclasses in London as part of a major and long term contribution to British national postgraduate medical education. He has lectured widely in person-centered healthcare across Europe. Professor Miles is accredited with having changed the direction of the global EBM debate away from scientistic reductionism based on population-derived aggregate biostatistical data and rigid foundationalism, towards the embrace of the complex and the personal within international medicine and health policymaking. He has a profound interest in the modern management of long term, multi-morbid and socially complex illnesses and the methods through which medicine´s traditional humanism can be re-integrated with continuing scientific and technological advance. Professor Miles co-founded the ESPCH in 2013 with Professor Sir Jonathan Asbridge DSc (hc).

Dr. James A. Marcum BSEd MS MATS PhD is professor of philosophy and director of the Medical Humanities Program at Baylor University in Waco, Texas, USA. He earned doctorates in philosophy from Boston College and in physiology from the University of Cincinnati Medical College. He also holds a Masters degree in theology from Gordon-Conwell Theological Seminary. He was a postdoctoral fellow at Harvard Medical School and Massachusetts Institute of Technology and a faculty member at Harvard Medical School for over a decade before coming to Baylor University. He received grants from several funding agencies, including the National Institutes of Health, the National Science Foundation, and the American Heart Association, as well as having the distinction of being awarded the first Frederik B. Bang Fellowship at the Marine Biological Laboratory in Woods Hole, Massachusetts. He delivers invited lectures frequently at both national and international conferences. His current research interests include the philosophy and history of science and medicine. Examples of his recent publications appear in Annals of Science, International Studies in the Philosophy of Science, Synthese, Perspectives on Science, History and Philosophy of the Life Sciences, Journal of the History of Medicine and Allied Sciences, Medicine, Health Care and Philosophy, Perspectives in Biology and Medicine, and Theoretical Medicine and Bioethics. His research interest in the biomedical sciences was in the regulation of hemostasis. Examples of his science papers appear in American Journal of Physiology, Journal of Biological Chemistry, Journal of Cell Biology, Journal of Clinical Investigations, Biochimica et Biophysica Acta, Biochemistry and Biophysical Research Communications, Experimental Cell Research, and Biochemistry. His most recent books are The Conceptual Foundations of Systems Biology: An Introduction. Systems Biology—Theory, Techniques and Application Series. x + 155 pp. Hauppauge, NY: Nova Science Publishers, 2009, and The Virtuous Physician: The Role of Virtue in Medicine. Philosophy and Medicine Series, volume 114. xiv + 241 pp. New York: Springer, 2012.

Professor Michael Loughlin PhD is a Professor of Applied Philosophy at Manchester Metropolitan University. He has written extensively on the relationship between knowledge, science and value in clinical practice, applying arguments developed in his PhD (on the relationship between epistemology and ethics) and early publications in philosophy to analyses of the nature and role of rationality, evidence, judgement and intuition in medicine and health care. His early work (including a 2002 book, Ethics, Management and Mythology) raised methodological questions about quality measures, bioethics and the use of evidence in health policy, criticised the role of management theory in undermining professional autonomy and defended a conception of professional judgement with reference to a 'virtues' approach to practical wisdom. He has written many articles in academic journals and popular media, and addressed international audiences of practitioners and policy-makers on evidence-based medicine. He has co-authored policy documents and advised professional groups on the philosophical education of practitioners. As Associate Editor of the Journal of Evaluation in Clinical Practice he has edited several special issues on philosophical aspects of health care. He is the editor of Debates in Values-based Practice: Arguments for and Against (Cambridge University Press, 2014). His recent work on medical epistemology has raised questions about scientism and moral realism, defending a humanistic conception of rationality and science in practice. In 2014 he received the Senior Vice President's medal for Excellence, for his foundational work in the Philosophy of Person-Centred Healthcare, and he currently chairs the Special Interest Group in Health Philosophy for the European Society for Person Centered Healthcare.

Dr. Rani Lill Anjum BA MA PhD is a philosopher, working mainly on causation. She got her doctoral degree from University of Tromsø in 2005 within philosophy of logic and language, followed by a 3 year Postdoctoral Fellowship during which she wrote the book Getting Causes from Powers (Oxford University Press 2011) with Stephen Mumford at Nottingham University. After returning from Nottingham, she was Principal Investigator of the research project 'Causation in Science' at Norwegian University of Life Sciences (www.nmbu.no/causci). Her newest research project, 'Causation, Complexity and Evidence in Health Sciences' (CauseHealth), is a 4 year interdisciplinary project that invites philosophers, medical researchers and practitioners to critically examine the ontological and methodological foundation of medicine. All her research since 2001 has been funded by the Research Council of Norway's FRIPRO scheme for Independent Projects.

Dr. Peter Wyer MD is Associate Professor of Medicine at Columbia University Medical Center and is founder and co-chair of the Section on Evidence Based Health Care (SEBHC) of the New York Academy of Medicine. He is an educational innovator in the field of research applied to practice and practice-based learning and improvement. He is a co-author of the User's Guides to the Medical Literature and has initiated innovative educational series in peer reviewed journals, both in his own clinical specialty, emergency medicine, and in general medical journals. He is a member of the editorial board of Journal of Evaluation in Clinical Practice, the European Journal of Person Centered Healthcare and the Annals of Emergency Medicine. Under the auspices of the multidisciplinary SEBHC, Dr. Wyer leads the development of "Teaching Evidence Assimilation for Collaborative Health Care (TEACH)" program which offers a unique integration of multiple interfaces between research and healthcare together with principles of narrative medicine and person-centered care. He has published widely on different aspects pertaining to such integration within the healthcare system. With Dra Suzana Alves Silva, he co-chairs the Special Interest Group on Evidence-based Medicine, Patient-centered Care and Person Centered Medicine of the European Society of Person Centered Healthcare . He is a member of the steering group of Guidelines International Network/North America and has played the lead role in organizing federally funded guideline conferences in the US.

Dr. Mark Tonelli MD MA is Professor of Medicine (Pulmonary and Critical Care Medicine) and Adjunct Professor of Bioethics and Humanities at the University of Washington in Seattle, USA. Primary interest in medical epistemology, particularly the value of varied kinds of medical knowledge for clinical decision making. Has also published extensively on the ethics of care in critical care medicine.

Dr. Benjamin Djulbegovic MD PhD is a Distinguished Professor and Professor of Medicine and Oncology at the University of South Florida and H Lee Moffitt Cancer Center & Research Institute. He also serves as the Associate Dean for Evidence-based Medicine & Comparative Effectiveness Research at the USF. His major academic research interest lies in the field of mathematical modeling in medicine with a focus on evidence-based medicine, decision-analysis, clinical reasoning, systematic reviews /meta-analysis and comparative effectiveness research, ethics and design of clinical trials, practice guidelines, outcomes research, impact of clinical trials and the role of uncertainty in medicine. He is particularly interested in the issues related to development of rational and ethical decision-making to create a framework for action in order to do more good than harm for individuals and societies (and consistent with individual and societal values and preferences). Dr. Djulbegovic has extensively published and taught on these subjects. As of April of 2015, he has published more than 270 papers in peer-review journals, 170 abstracts and two books : "Reasoning and Decision Making in Hematology", which in 1993 was listed as the one of the best books of the year (J Natl Cancer Inst) and "Decision-Making in Oncology. Evidence-based management" and was translated from English in other languages. His work has been published in all major journals including Nature, N Engl J Med, Lancet, JAMA, BMJ, Annals of Internal Medicine etc. Since 2009, he has been consistently selected as 1% of top US doctors by the US News & World Report. Dr. Djulbegovic's research has been funded both by federal and private entities.

Dr. Michael Makhinson MD PhD is an Associate Professor of Psychiatry at the David Geffen School of Medicine in Los Angeles, California and Co-Director of Inpatient Psychiatry at the Harbor-UCLA Medical Center in Torrance, California. He obtained his M.D. and Ph.D. (in Neuroscience) degrees at the UCLA School of Medicine. His graduate research focused on studying the cellular basis of mammalian learning and memory. Since completing residency training in Psychiatry in 2005 and turning toward clinical science, he has served as a Director of Inpatient Psychiatry at Harbor-UCLA Medical Center, which is a public teaching hospital with a catchment area of over four million people. His clinical activities include general inpatient psychiatric practice, teaching house staff and students, and administering the inpatient clinical service. More recently, he has become interested in the cognitive systems that govern decision-making, particularly with respect to medical decisions and evaluation of clinical evidence, and their implication for greater models of health care. These ideas have been published in the Journal of Psychiatric Practice, the Journal of Nervous and Mental Disease, and the Journal of Evaluation in Clinical Practice.

Dr. Shashi Seshia MD(Bombay) FRCP(Canada and Edinburgh) is Clinical Professor of Pediatrics (Division of Pediatric Neurology), University of Saskatchewan, Saskatoon, Canada. He has spent his professional career primarily as a front-line clinician and teacher in Child Neurology. In addition, he has published just over a 100 peer reviewed papers and chapters, and been an invited speaker at national and international conferences; areas of interest have included coma, electroencephalography, headache and inter-observer variability. Recently, he has turned his attention to the Evidence-based Medicine paradigm and the quality of healthcare evidence, and has co-authored two reviews on these issues. His presentation at the 2nd Annual Conference and Awards Ceremony of the European Society for Person Centered Healthcare will be based on the second of these two reviews published in the December 2014, 20th anniversary issue of The Journal of Evaluation in Clinical Practice.

Professor Jack Dowie MA(NZ) PhD(ANU) took up the newly-created chair in Health Impact Analysis at the London School of Hygiene and Tropical Medicine in 2000, leaving the Open University where he had been a member of the Faculty of Social Sciences since 1976. While at the OU he designed and ran the multi-media courses on RISK (from the late seventies) and PROFESSIONAL JUDGMENT AND DECISION MAKING (from the late eighties). His early qualifications were in history and economics at the University of Canterbury, New Zealand and he went on to merge these disciplines in doctoral work (at the Australian National University) and subsequent lecturing in economic development and economic history (at ANU, Kent and Durham). What had been side interests in accidents, gambling and health eventually took over and led to full time involvement with risk and judgment in health decision making and to involvement with both clinical decision analysis and cost-effectiveness analysis in health care. Jack was a founder member of the Health Economists Study Group and the Society for the Study of Gambling. He recently completed ten years' service as a member of the Appraisals Committee of the then National Institute for Clinical Excellence (NICE). He formally retired in 2003 but remain active in the School and University of Sydney School of Public Health, mainly in connection with his software implementation of Multi-Criteria Decision Analysis. Annalisa is designed to facilitate more equal balancing of intuition and analysis in health decision making, whether it be in the person-centred settings of screening or clinical consultation, or the citizen-centred setting of health and non-health sector policies, programmes and projects. Jack Dowie is responsible for the online postgraduate course on Translational Health in Sydney.

Ms. Mette Kjer Kaltoft MPH RN WHO 'Health for All 2000' has been an inspiration since 1984, leading to interest in innovative approaches to health literacy and care as ways of meeting the challenges of working as a health visitor in multi-ethnic communities. A MPH, followed by Middle East studies, Modern Standard Arabic, Health Impact and Decision Analysis, and intercultural communication, eventually led to collaboration with a decision support software developer and health economist applying visual Multi-Criteria Decision Analysis (MCDA) at both clinical and policy levels.

My professional background includes RN, post-graduate courses at Mayo Medical Center and obstetrics at a WHO-accredited Baby-Friendly Birth Center in Rochester, Minnesota, USA, intensive care pediatric and community nursing, outreach projects in sexual- and reproductive health, and cultural mediation. Research positions and working as a R&D nurse at Odense University Hospital Svendborg Sygehus preceded the present PhD study, which is exploring the feasibility and acceptability of offering outpatients personalised decision support via the simplest form of MCDA using Annalisa software to prepare for a forthcoming consultation. Introducing MCDA-based interactive decision support in clinical cross-disciplinary settings is the present challenge, along with developing a dually-personalised instrument to provide a decision specific person-provider measure of concordance, as a generic outcome and Person-Reported Outcome/Experience Measure for decision quality. The future may involve home-based decision support, incorporating the use of social media. The implications of moving towards a prescriptive, rather than descriptive paradigm of decision support, challenges the status quo at all levels, and overall, translation is the outcome I hope for the future, acknowledging words matter while numbers count.

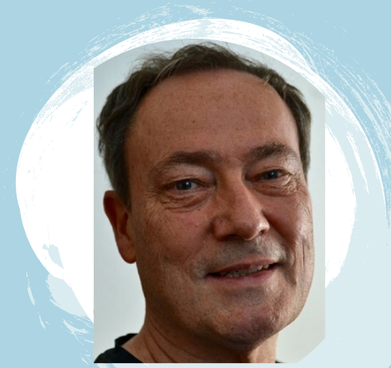
Dr. Suzana Alves da Silva MD PhD is a Senior Researcher at Hospital do Coração/HCor, at the National Institute of Cardiology/INC and at Amil Assistencia Medica Internacional. Dr Silva has years of experience developing and overseeing projects on the area of Outcomes Research, Public Health and Health Technology Assessment in these institutions contributing with expertise on the methodological approach to clinical studies and systematic reviews and for the identification of topics of priority in these areas. She has served as faculty and collaborator of the McMaster University Annual Workshop in evidence-based practice since 2007 and as Faculty and Coordinator of Rio EBCP Annual Workshop since 2006. The latter is recognized in Brazil as one of the main opportunities for EBCP training of health care professionals and health managers from private and public health system organizations. As co-investigator on the New York Academy of Medicine Teaching Evidence Assimilation for Collaborative Healthcare project between 2009 and 2012, funded by the US Agency for Healthcare Research and Quality, she designed and oversaw the development and implementation of the SIMPLE website (www.ebcp.com.br/simple), a blended learning system. She has published a number of articles related to therapeutic interventions on the area of cardiology and intensive care as well as on the history, strengths and limitations of EBCP training and practice, several of which have introduced a new model for integration of clinical evidence into the health care system. With Dr. Wyer, she co-chairs the Special Interest Group on Evidence-based Medicine, Patient-centered Care and Person Centered Medicine of the European Society of Person Centered Healthcare.

Mr. Ed Harding MHA FACHE is Director of The Health Policy Partnership. His expertise is in the development of strategic, multi-agency partnerships for health, and in facilitating the engagement of wider societal leaders in health policy through the provision of accessible, credible, and evidenced-based information on health issues.

Ed has helped lead a number of multi-stakeholder research projects, most recently on diabetes, person-centred care, and stroke prevention. Over the past decade, he has published major policy reports (both UK and international), academic papers, and several national policy implementation toolkits. Ed worked at the UK Department of Health for several years, where he managed national improvement programmes in integrated care and strategic local partnerships for health and wellbeing, and was a consultant to the Personal Health Budgets pilot programme. Before joining the Department of Health, he was Senior Researcher at the International Longevity Centre UK, a registered London-based charity. Prior to working in health policy he was Head of Key Supporters at the 'No.10' campaign group, Britain in Europe. Ed is fluent in French and Spanish, having a degree in Modern Languages from the University of Sheffield.

Ed is currently leading a project, commissioned by the Health Foundation, a UK based charity, to undertake an international environment scan on person-centred care. The report has brought together interviews and written contributions from many of the key individuals and organisations active in person-centred care around the world.

Dr. Stephen Buetow MA(Hons) PhD is an Associate Professor and Deputy Head of the Department of General Practice and Primary Health Care at NZ's University of Auckland. A social scientist by background, he holds a PhD from the Australian National University and worked as a Research Fellow at the UK's National Primary Care Research and Development Centre. He has published two books and over 140 peer-reviewed Journal articles, most recently in the area of social theory and medicine. He is currently writing a book, Person-centred medicine: Balancing the Welfare of Physicians and Patients. Buetow is an Associate Editor of the Journal of Evaluation in Clinical Practice and European Journal for Person-Centered Healthcare. He directs a core, postgraduate research methods course at his University, has supervised 9 PhD students to successful completion and has chaired numerous national funding committees.



Dr. Dr. Thomas Fröhlich MD PhD is a medically qualified psychotherapist working in Heidelberg, Germany. He initially studied biology at Freiburg University and Heidelberg University, Germany, before proceeding to study medicine and to complete theses in biophysics and medicine in 1978 and 1983, respectively, having graduated in medicine at the University of Heidelberg in 1980. From 1980 - 1986, he worked at the Paediatric Hospital, University of Heidelberg. From 1973-1976 and 1986 - 1987, he worked at the Max Planck Institute for Medical Research, Heidelberg, conducting research in biochemistry, biophysics and human physiology. From 1986-1990, he studied the techniques involved with the psychoanalytic psychotherapy of children and adolescents at the Institute for Analytical Psychotherapy for Children, Heidelberg, Germany and has practised privately in paediatrics, allergy and psychotherapy since 1988. From 1997, he has collaborated in research at the Institute of Medical Biometry and Informatics, Heidelberg University, with the Technical University Braunschweig, Institute of Medical Informatics (Reinhold Haux), Hospital of Internal Medicine and Psychosomatics, Heidelberg University (Gerd Rudolf) and Psychosomatic Medicine, Klinikum rechts der Isar, Munich Technical University, with Peter Henningsen. Dr. Fröhlich has been awarded research grants to develop understanding in his field and has published extensively. He has conducted ground breaking research on the mathematical representation of psychosomatic interactions in childhood asthma and on the prevalence, psychosomatics and treatment of childhood and adult asthma. He has lectured at the Institute of Medical Informatics Technical University Braunschweig and since 2001 has been CEO of Heidelberg Metasystems GmbH, a research organization mainly focused on asthma prevalence and treatment issues and on IT-supported early detection of common chronic diseases in a family medicine private practice setting. He has developed a web-based IT tool for the treatment of self-reported stress and symptoms of psychic and organic diseases in paediatric and family medicine private practice contexts, which may be viewed at: www.medkids.de.

Dr. Carmel M. Martin MBBS MSc PhD MRCGP FRACGP FAFPHM is an Australian medical graduate from the University of Queensland. Completed her Masters in Community Medicine at the London School of Hygiene, University of London and a PhD at the Australian National University. Carmel's research in Australia, Canada and Ireland has focused on reforms related to primary health care and chronic care, the nature of health in body, mind, society and the environment and meaning and sense-making about personal health. Her PhD on the care of chronic illness in general practice, explored the nature of the experience of illness and care associated with multi-morbidity from the perspectives of those afflicted and their general practitioner/primary care physician as the key 'users' of care. This PhD led to a wide range of systems based interventions, underpinned by complex adaptive systems theory and social constructionist perspectives in Australia, Canada and Ireland. Dr. Carmel Martin is joint chief editor of the Forum on Systems and Complexity in Medicine and Healthcare in the Journal of Evaluation in Clinical Practice

She has an extensive experience of health service innovation and service development in Primary Care. A particular focus is to improve chronic illness care around trajectories of illness and wellness using complex systems theory and IT systems (http://tcd.academia.edu/CarmelMartin)

Professor Brian Broom MBChB FRACP MSc(Immunology) is a health academic and practitioner in both clinical immunology and psychotherapy, and has pioneered, in New Zealand, a non-dualistic, 'whole person' treatment of people suffering physical disease. The work has been recognized nationally in being a finalist in the 2015 Senior New Zealander of the Year Awards.

From an academic post in Clinical Immunology at the Christchurch School of Medicine, he diverged (1982) into psychiatry and psychotherapy training in pursuit of a 'mind' side to his work. In 1987 he initiated the Arahura Centre, Christchurch, intent on exploring whole person approaches to healing, and there recognised symbolic disorders and somatic metaphors; see Broom, B. C., R. J. Booth, et al. (2012). "Symbolic illness and 'mindbody' co-emergence. A challenge for psychoneuroimmunology." Explore 8 (No 1, January/February): 16-25.

He has developed a radically non-dualistic, conceptual basis for person-centred care, which holds physical and subjective dimensions together in the clinical time/space, and established a post-graduate, multi-disciplinary MindBody Healthcare Masters programme for clinicians at AUT University, Auckland.

He initiated the MindBody Trust (New Zealand) which facilitates whole person practice. He has lectured and led workshops in New Zealand, USA, UK, Germany, Austria, Australia, Finland, Denmark, Sweden, Croatia, and Switzerland.

His three books represent decades of 'whole person' clinical work and training clinicians: Somatic Illness and the patient's other story. A practical integrative approach to disease for doctors and psychotherapists. (Free Association Books, New York/London, 1997); and Meaning-full disease: How personal experience and meanings initiate and maintain physical illness (Karnac Books, London, 2007). His third book, Transforming clinical practice using a mindbody approach. A radical integration (Karnac Books, London, 2013), is a collection of chapters written by him and 17 clinicians ex-students of the University program about this process. He supervises 'whole person' PhD and Masters students.

Dr. Joachim P. Sturmberg MBBS DRACOG MFM FRACGP PhD is Associate Professor of General Practice at the Departments of General Practice The Newcastle University, Newcastle – Australia.

Joachim is a Principle at Wamberal Primary Care, Wamberal – Australia for over 25 yrs. He is actively involved in the Royal Australian College of General Practitioners and the local area primary care organisation. He co-leads the WONCA and ESPCH, and is a participant in the NAPCRG special interest groups on Systems and Complexity in Health. He recently co-organised and chaired the First International Conference on Systems and Complexity for Healthcare.

His research interests relate to the application of systems and complexity principles to health care delivery, health policy and health systems organisation. He has been invited to speak on these topics in Europe and North America, he has published extensively on these topics in peer-reviewed journals and has contributed several book chapters on these topics.

Current research collaboration focuses on the nature of multimorbidity from an interconnected physiological perspective, and the study of aging as reflected in heart rate variability.

Selected Bibliography:
Sturmberg JP and Martin CM (eds), Handbook of Systems and Complexity in Health, Springer 2013.Sturmberg JP (ed), Proceedings of the 1st International Conference on Systems and Complexity for Healthcare, Springer (forthcoming late 2015). Sturmberg JP, Knowing in Medicine. JECP 2010: Martin CM and Sturmberg JP, Chronic care Sturmberg CM, O'Halloran D and Martin CM. MJA

Dr. Sandra J. Tanenbaum PhD MSS was educated at Bryn Mawr College and the Massachusetts Institute of Technology. Trained as a political scientist and social policy analyst, she has taught for twenty-five years at The Ohio State University and spent the five years prior to that as an analyst for the Ohio Medicaid Program, the federal-state health care financing program for low-income Americans. Dr. Tanenbaum is an expert in U.S. health policy and politics and came to person-centered health care through her critique, in the New England Journal of Medicine, of evidence-based medicine as a goal of U.S. health policy. Over the last twenty years, she has written extensively on evidence-based medicine and its alternatives, for example, on evidence-based regulatory standards, the meanings of "patient-centered" care, and particularism in health care.

Dr. Tanenbaum is USA Regional Editor for the Journal of Evaluation in the Clinical Practice, a member of the editorial board of the European Journal of Person-Centered Healthcare and of the Journal of Health Policy, Politics and Law, and SIG chair for health policy and politics of the European Society for Person-Centered Healthcare. She has published in the journals noted and in Health Affairs, Milbank Quarterly, Health Care Analysis, Health Economics, Policy and Law, Boston Review and others.

Professor Roger Ellis OBE received his OBE is 2002 in recognition of a long and highly successful career in Higher Education which included innovative teaching, curriculum development and applied research in education and training for healthcare, social care and education. He was responsible for the first degree courses in the United Kingdom in Occupational Therapy, Physiotherapy, and similar programmes in Nursing and Speech and Language Therapy. He was for ten years the Chairman of the Health and Medical Services Board of the Council for National Academic Awards which validated all the degree programmes in the health area in the then Polytechnics. He is Emeritus Professor in Psychology at both the University of Ulster and the University of Chester. During his career he has established a number of contract research centres including, most recently, the Social and Health Evaluation Unit at the University of Chester which is now based at Buckinghamshire New University. This unit has completed, over twelve years, more than one hundred externally funded programme evaluations in community development, social care, healthcare, education, regional development and community safety. It now has branches in England, Northern Ireland, Canada and Hungary. One significant strand in this work of late has been the evaluation of programmes aimed at improving the life of those with often profound learning difficulties. These have included programmes of resettlement from hospital care to supported housing in the community and, programmes aiming to personalise care and support. He has brought to these evaluations internationally recognised expertise in programme evaluation including the development of innovative and effective methods and a capacity to conclude evaluations with recommendations that have impacted on practice and policy. He is proud to have contributed to evaluations of programmes of support for those with profound learning difficulties, which have produced significant results and impacted on quality of life, independence and person-centred care. He has published more than sixty evaluation reports, ten books and over 200 articles in refereed journals in the broad area of Applied Psychology. Latterly, outcome audit at interpersonal and organisational levels has been a particular interest and he brought these insights to the exploration and analysis of the night support and personalisation programmes of Choice Support.

Mr. Kevin Dolgin BA MBA MRes is and Associate Professor, University of Paris I (Panthéon-Sorbonne), co-founder and President of Observia, former founder and partner of Areks and Senior Principal of IMS Health. Kevin Dolgin has worked with and studied the pharmaceutical industry for over twenty years. Since the creation of Observia in 2011, he has focused his research on patient adherence: the extent of non-adherence, its impact, the reasons behind non-adherence and the most relative effectiveness of different approaches to address adherence issues. He has published in numerous trade journals as well as in the European Journal of Person Centered Healthcare and has spoken at numerous pharmaceutical industry and medical conferences, as well as having co-chaired Eye For Pharma's Patient Summit in 2013.

Kevin's academic background includes a BA from Fordham University, an MBA from INSEAD, and a Master of Research from the University of Paris I. He is currently working on his doctoral thesis at the University of Montpellier, focusing on the patient decision-making process with respect to adherence.

Dr. Dwight McNeill PhD MPH is a teacher, author, and consultant. He is a Lecturer in the Healthcare Administration Program at the Sawyer Business School, Suffolk University, Boston, USA, where he teaches courses in population health and health policy. McNeill, who has a PhD (Brandeis University) in Health and Social Policy, as well as a MPH (Yale University) in Epidemiology and Public Health, specializes in advanced analytics that support population health, person centered health, and healthcare transformation.
Over his 30-year career, he has worked in corporate settings and state levels; analytics companies; and provider settings. McNeill has extensive experience working in corporate settings, most recently as the global leader for business analytics and optimization for the healthcare industry for the IBM Corporation, and previously as director of healthcare information at GTE Corporation (Verizon). As the former assistant commissioner for Health Data and Analytics for the Division of Health Care Finance and Health Policy of the Department of Health and Human Services, McNeill helped bring an analytic focus to healthcare reform in Massachusetts. At the Agency for Healthcare Research and Quality, McNeill helped translate research to action and promoted the importance of performance measurement and national priorities at the National Quality Forum.

McNeill has published numerous articles in Health Affairs and other prestigious journals. He is the author of three book on health analytics. His latest is ¨Using Person-Centered Health Analytics to Live Longer: Leveraging Engagement, Behavior Change, and Technology for a Healthy Life¨. His other books on health and healthcare analytics include: ¨A Framework for Applying Analytics in Healthcare: What Can be Learned from the Best Practices in Retail, Banking, Politics and Sports¨ and ¨Analytics in Healthcare and the Life Sciences: Strategies, Implementation Methods, and Best Practices¨.

Dr. Carlos Martín Saborido PhD MsC PT area of expertise is the Health Economic Modelling. He had been working as a Research Associate at the Spanish Health Technology Assessment Agency, mainly doing HTA reports, and in the Regional HTA Unit in Madrid as a Health Economics Research Fellow. Internationally, Dr. Carlos Martín Saborido has been working in the Liverpool Review and Implementation Group (University of Liverpool) in the UK, assessing economic evaluations on behalf of NICE, and doing HTA reports for the NIHR Health Technology Assessment Programme. He have been a Public Health Economist in the Joint Research Centre (European Commission), developing economic evaluations in the Public Health Frame. In the academic ground, he lectured Statistics, Research Methods and Economic Evaluation of Health Technologies, mentoring and guiding several PhD and MSc thesis.

Currently, Dr. Carlos Martín Saborido is Director of the Health Technology Assessment Unit (Faculty of Medicine) Universidad Francisco de Vitoria, doing Economic Evaluations for Scientific Societies, Government institutions and private institutions. teaching modeling, systematic reviews methods and network meta analysis.

Dr. Nathan Schou Bertelsen MD BA is a clinician educator in internal medicine. He is currently a Visiting Professor at Koç University School of Medicine (KUSOM) in Istanbul, Turkey, and Assistant Professor of Medicine and Population Health at Bellevue Hospital / New York University School of Medicine (NYUSOM) in New York City, USA.

Dr. Bertelsen completed residency training in internal medicine at Cornell University/New York Presbyterian Hospital, received his M.D. from University of Minnesota Medical School, and has a B.A. in government/international relations at Georgetown University. At NYUSOM, he directs the Global Health Selective for medical students and Global Health Elective for residents in internal medicine, and at KUSOM, he organizes curriculum in bedside teaching and cross-cultural communication. In 2011, he was awarded Faculty of the Year in the NYU Division of General Internal Medicine, and in 2014, he completed the Merrin Master Clinician Bedside Teaching Fellowship Program from the NYU Program for Medical Education Innovations and Research, with his focus on teaching empathy in medical training.

Professor Bernie Carter PhD BSc RSCN SRN FRCN is Professor of Children's Nursing at the University of Central Lancashire and Director of the Children's Nursing Research Unit (CNRU), Alder Hey Children's NHS Foundation Trust. She is also Clinical Professor at the University of Tasmania. She is a Fellow of the Royal College of Nursing in recognition of her contribution to children's pain. She is the Editor-In-Chief of the Journal of Child Health Care (Sage Publications).

Bernie's research is narrative, dialogic, appreciative, collaborative, and arts/activity-based in its approach. She works collaboratively with children and their families to ensure that her research resonates with those things that truly matter within their experiences and lives. She finds that framing teaching and research in an appreciative manner can help reveal stories of success and achievement that provide individuals and organizations/ settings the confidence to explore new avenues of learning, growth and development.

Her particular research interests relate to children's pain, chronic illness, disability, care provision for children with complex health care needs and the role that children's nurses play in the lives of children, young people and their families. Using narrative and arts-based approaches means that dissemination can become an active process with participants being able to share their experiences with other people facing similar situations (see for example, the My Child is in Pain web resource which has been developed with parents http://mychildisinpain.org.uk/).

She is firmly committed to working with marginalised children whose voices are rarely heard and to contributing to the debates around children's agency and the ways in which children can be protagonists for change.

Professor Linda Shields MD PhD FACN is Professor of Tropical Health Nursing at James Cook University and Townsville Health District in Queensland, and is an Honorary Professor in the Department of Paediatrics and Child Health at The University of Queensland. Her research interests include the influence of a tropical environment on nursing and health outcomes across the life span; the care of children in health services, in particular family-centred care, and the history of nursing and ethical issues surrounding nursing such as nurses' roles in the euthanasia programmes of the Third Reich.

She holds a Doctor of Medicine from The University of Queensland, the first nurse in Australia to attain a Higher Doctorate. Her previous positions include professorial appointments at the University of Limerick in Ireland, University of Hull in England, and Curtin University in Western Australia.

In 2014, Professor Shields was awarded a Silver Medal by the European Society for Person Centered Health Care for her work in family-centred care research. She is a Life Member of the Australian College of Children and Young People's Nursing, a Fellow of the Australian College of Nursing; Sigma Theta Tau International; and has just been inducted into the Sigma Theta Tau International Nurse Researcher Hall of Fame. She has over 300 publications in nursing, medical and history journals and several books and chapters.

Professor Wendy Chaboyer RN PhD is the Director of the Australian National Health and Medical Research Council (NHMRC) Research Centre of Excellence in Nursing Interventions for Hospitalised Patients; the first NHMRC funded nursing centre of research excellence in Australia (2011 – present). She was also the foundational Director of the Research Centre for Clinical and Community Practice Innovation, which grew significantly in funding, grant successes, membership numbers and discipline representation during her eight tenure (2003 – 2011).

Wendy focused her research interests on acute and critical care nursing practices. Over the past decade, this has led to a number of studies related to patient safety. Some of this work has been in relation to adverse events clinical handover, the ICU discharge process and more recently in the areas of patient participation in patient safety activities, pressure injury prevention and surgical wounds.

Wendy has won over AUD $8 million in competitive research grants. She has over 180 peer reviewed publications, 10 book chapters and one edited book in its second edition. Wendy has supervised 12 PhD students, 1 Master of Philosophy, 18 Masters and 2 Honours students to completion and she is currently supervising 6 PhD students.

Wendy sat on the Australian Commission on Safety and Quality in Health Care's Expert Advisory Committee on Clinical Handover and their Expert Technical Advisory Panel for developing national safety goals in health. Wendy has been very active in the Australian College of Critical Care Nurses (ACCCN), having sat on the National and State Boards of Directors for several terms. Wendy is currently a visiting professor with the Institute of Health and Care Sciences at the Sahlgrenska Academy, Gothenburg University (2013-2015). In 2015 she will be inducted into the Sigma Theta Tau International's (STTI International Nursing Honour Society) International Nurse Researcher Hall of Fame.

Ms. Georgia Tobiano RN BN(Hons) is currently a PhD candidate at Griffith University, Australia, and is due for completion this year. She was awarded the Griffith University Postgraduate Research Scholarship in 2012, for her PhD. Her research focus is patient-centred care, in particular involving patients and their families in their hospital care. Her PhD is an ethnography, which explores patients' and nurses' preferences for patient participation in nursing care. Under the guidance of Professor Wendy Chaboyer, Professor Andrea Marshall and Professor Tracey Bucknall, the team has gained a better understanding of how Australian nurses currently partner with patients and some of the barriers and facilitators to achieving this concept. Georgia has continued to pursue the involvement of consumers in hospital care, currently working as a project manager for a multisite survey which assesses patients' and nurses' preferences for participation in bedside handover. Georgia completed her Honours degree in 2010, with Class 1 Honours, and was awarded a Griffith Award for Academic Excellence. For her honours, she conducted a case study investigating family members' participation in the nursing bedside handover under the supervision of Professor Wendy Chaboyer and Professor Anne McMurray. Her research demonstrated the value family members had for being involved, and the many ways family members actively engaged to improve the quality and safety of bedside handover.During her entire time as a higher degree research student, Georgia has continued to work as a Registered Nurse at Gold Coast University Hospital. This has allowed Georgia to maintain current nursing knowledge and support research within the hospital to promote evidence-based practice.

Ms. Macarena Quesada Rojas MA is a Ph.D. student at the Department of Social Health Sciences, Faculty of Medicine, University of Murcia. Her thesis examines "Factors associated with the quality of life and the needs of informal caregivers of terminal patients". She graduated from the University of Murcia in 2005 with a degree in Psychology before obtaining her M.A. in Social-Gerontology from the University of Granada in 2007. From 2007-2010 she carried out research work for the University of Granada, the Health Research and Training Foundation in Murcia (FFIS) and the University Hospital Virgen de la Arrixaca (HUVA, Murcia). She currently works at the Department of Clinical Research at the FFIS/HUVA in Murcia.

Mr. Harry van Bommel MAdEd CTDP his work in home and hospice care 30 years ago when he cared for his parents and grandfather at home until they died. His writings, speaking and recorded songs all come from a patient-family perspective. He is the author of 50 books and is the co-founder of navCare.org – a collaborative project to help family caregivers navigate healthcare and other systems for their loved ones.

Harry is the Executive Director of the not-for-profit organization, Legacies Inc. (www.legacies.ca). Legacies is determined to provide patients, families and care providers with free and low-cost home and hospice care information so that everyone with a serious or life-threatening illness can live life as fully as possible. Since1999, over 200,000 copies of his books, Caring for Loved Ones at Home and Family Hospice Care have been distributed through more than 500 organizations across Canada for distribution to patients, families, professionals and volunteers and also available for free reading and printing from his web site, www.carelibrary.com (www.carelibrary.com). Harry is opposed to euthanasia and assisted suicide for practical and historical reasons. Harry was born in The Netherlands and now lives and works in Toronto, Canada.

Professor Paolo Roberti di Sarsina MD holds a Degree in Medicine and Surgery, is a specialist in Psychiatry and has directed psychiatry units in various healthcare centres in Italy. He was a Medical Director of Psychiatry in the National Health Service at the AUSL of Bologna, Department of Mental Health, carrying out clinical psychiatry and activities for the integration of MNC in the NHS. Paolo Roberti di Sarsina is also a researcher and a prolific author of many published medical articles and books, as well as a founder of charities, non-profit foundations and initiatives in Italy for non-conventional medicine and Person Centered Healthcare. His work in these two causes extends into various associations and networks internationally, as he holds their membership and acts as a director or a co-ordinator for some of them. Currently, Paolo Roberti di Sarsina plays a fundamental role in Italian non-conventional medicine. He served from 2006 to 2013 as the Expert for Non-Conventional Medicine, High Council of Health, Ministry of Health, Italy.

Paolo Roberti di Sarsina served as referee for documents about TCAM in the World Health Organization. He was the representative of Italy in the NATO Science and Technology Organisation (STO) for Integrative Medicine Interventions for Military Personnel HFM-195 (RTG), 2010-2014. Within the European Union, he has been an Italian member of the EU funded (FP7) "CAMbrella Consortium" 2010-2012, a pan-European research network for Complementary and Alternative Medicine (CAM). He is also involved in the EU funded "China and Europe Taking Care of Healthcare Solutions Consortium", CHETCH, 2014-2017, under the EU 7th Framework Programme (FP7), People Marie Sklodowska-Curie Actions (MSCA), International Research Staff Exchange Scheme (IRSE). He also participated in the European Union Actions COST-action E39 "Forests, Trees and Human Health & Wellbeing" (Domain: Forests, their Products and Services), 2004-2008 Member Working Group 1: Physical and mental health and wellbeing. He is a participant in the International Research Seminar on Ayurveda Network (IRSA) – IRSA Consortium for Horizon 2020. Dr Roberti di Sarsina is the sole Italian researcher whose articles are quoted in the recent WHO Traditional Medicine Strategy 2014-2023.

He is responsible for Complementary and Alternative Medicine and Contacts to Patient Organisations of the European Association for Predictive, Preventive and Personalised Medicine, EPMA. He is founder and president of the Charity for Person Centered Medicine, based in Bologna, Italy, the sole Italian Charity devoted to the mission of Person Centered Medicine. The Charity has been recently raised to the status of a Moral Entity, according to the Italian Law. Paolo Roberti di Sarsina is currently the chairperson for Traditional, Complementary and Alternative Medicine of the Observatory and Methods for Health, University of Milano-Bicocca, Milano, Italy and is the Coordinator of the Master´s Course "Healthcare Systems, Traditional and Non-Conventional Medicine" in the same University. Under PubMed Paolo Roberti di Sarsina has 23 articles indexed both in the field of Traditional, Complementary and Alternative Medicine (TM/CAM) and the epistemology of the Person Centered Medicine paradigm. He was recently appointed (May 2015) to the chairmanship of the ESPCH SIG on Traditional, Complementary and Alternative Medicine.

Ms. Mariateresa Tassinari MPhil obtained a Bachelor's degree in Philosophy at University of Bologna and a Master degree in Philosophy of Science at University of Padova with the thesis " Issues of Non Conventional Medicines: Semantic, Epistemology, Salutogenesis and Person centered Medicine". She also attained a Master at University of Milano-Bicocca in "Health Systems, Traditional and Non Conventional Medicine". At the moment she is Phd candidate at "Institute of Transcultural Heath Studies" Europa-Universität Viadrina Frankfurt Öder under the Supervision of Prof. Dr. Dr. phil. Harald Walach. The current affiliation is "Charity for Person centred Medicine-Moral Entity" located in Bologna (Italy).

Mr. Andrew Williamson is the Senior Production Editor on the European Journal for Person Centered Healthcare and Director of Finance and Operations, Person Centered Healthcare Ltd.

Before joining PCH Ltd three years ago he work for Waterford Wedgwood Royal Doulton for 26 years, holding senior management roles in the Retail Division working on Systems, Operations and Procedures.

Prior to this, he studied Theology at St. John's Seminary, Wonersh and at Heythrop College, University of London, UK.

Mr. Enrique Martín BA MA specializes in Advertising and Public Relations and holds a Master´s degree in Protocol, Communication and Event Management from the University Rey Juan Carlos, Madrid, Spain. He accomplished a year of Erasmus study in Communications at the University of Milano-Bicocca. His primary interest in communication and events management allowed him to work for The Spanish Tourist Office (The Embassy of Spain) in Copenhagen, Denmark, organizing events to promote the image of Spain in the Nordic countries. With his research in communication, he wrote his thesis "The Brand Spain in Denmark: analysis of perception of the Danish society about Spain" based on measuring the perception of a country image by empirical analysis of tourist experiences, media influence and online communication. Currently, Enrique Martin is Project Manager for Events, External Communications and Public Relations at the European Society for Person Centered Healthcare, Madrid, Spain.

Dr. Vivian Mounir MBChB graduated from the Faculty of Medicine at The University of Alexandria, Egypt, with a Bachelor´s Degree of Medicine and Surgery in 1995. She practised medicine as a General Practitioner in a rural Mother & Child Public Healthcare Center, Ministry of Health, Egypt, for two years, after which she conducted four years of residency training to specialize in Internal Medicine at El Mubarrah Hospital of The Health Institute of Alexandria, Egypt. The residency program involved inpatient wards, emergency department, outpatient clinic, hemodialysis, intensive care, coronary care, and hematemesis ward.

However, her urge for a more artistic creativity for a future career compelled her to change from medicine to applied arts. She studied graphic design, concluding a Microsoft-Adobe certified course in graphic applications. Soon afterwards, she started the actual career shift by studying at the Fashion Design Center in Alexandria, from which she graduated with a Master´s degree of Fashion Design and Stylist. This educative center is a collaborative project between the Egyptian Ministry of Industry and the Milan-based Istituto di Moda Burgo. She then worked at Puttmann-Egypt, which is a high-street ready-to-wear fashion brand for children-wear, having its headquarters in Paderborn, Germany. As she worked there for two years, she actively took on many design assignments and ascending job roles; from a Fashion Designer Assistant, to Sample Line Coordinator, then to Special Client Coordinator, and finally to Embroidery Design and Embroidery Quality Supervision. After gaining much experience at Puttmann-Egypt, she freelanced fashion design for some time, when she realized the importance to compliment her experience with the knowledge of fashion marketing, branding, and communications. She followed on to study Fashion Communication in the Istituto Europeo di Design in Madrid, Spain, and graduated with a Diploma of Fashion Communications in 2013. She then spent 8 months in an internship at StyleCode, which is a well noted consultation firm in Fashion Styling and Image Management in Madrid, Spain. In StyleCode, Vivian was involved in fashion styling projects, as well as fashion communication assignments in the form of online fashion journalism, graphic design, fashion video making, and community management.

Vivian´s multiple skills in medicine, design and communications, led to her current work as a Senior Project Manager in the European Society for Person Centered Healthcare, and as an Editorial Office Administrator for the Journal of Evaluation in Clinical Practice, Wiley Publications.



Universidad
Francisco de Vitoria
UFV Madrid






Universidad Francisco de Vitoria (UFV) is a private, non-profit private Catholic University located in metropolitan Madrid, Spain. It was founded in 1993 as an affiliate of "Universidad Complutense" and achieved full accreditation in 2001. Since then it has become a fast-growing, international institution of higher education with 3.500 undergraduate and 1.500 postgraduate students. Today, the Campus houses six major Faculties and one school of culinary arts, collectively covering the full spectrum of research and education.

With a student-centered and comprehensive educational approach, UFV accompanies each of its students from the beginning to the end of their studies, not only providing them with the support that they need to become outstanding professionals in their particular fields, but also to be well-rounded thinkers and leaders able to make important contributions to Society. As part of this approach, the University ensures that students engage fully in numerous social responsibility and volunteering programs, facilitating an outreach to 10.000 individuals in need and therefore providing a great source of enrichment for our students.

In 2010, University Francisco de Vitoria initiated its new 6-year medical degree with a program designed to cover not only the intensive transmission of theoretical knowledge, but also offering students opportunities to develop an integral professional competence, including an emphasis on communication skills, clinical reasoning, the natural integration of social and ethical aspects of the medical profession as well as the recovery of a properly humanistic vision of medicine. Our Curriculum focuses on five main areas to support the development of ethics and professionalism in medical students: student selection, curriculum design, role modeling, new teaching and learning methods as well as assessment method.

Further information on our person-centered medical school and its ongoing development can be obtained by writing to Dr. Juan Perez-Miranda, Vice Rector for International Relations at: j.perezmiranda@ufv.es

Universidad Francisco de Vitoria - Madrid
Carretera Pozuelo a Majadahonda, Km 1.800,
28223 Pozuelo de Alarcón,
Madrid, Spain.
www.ufv.es

ESPCH Announcements

For further information and contacts:

To register interest in the Conference and to receive more detailed information, please e-mail Mr. Enrique Martin at: enrique.martin@pchealthcare.org.uk

For clinical and academic queries and queries related to sponsorship and commercial exhibition, etc., please contact: Professor Andrew Miles DSc (hc) at: andrew.miles@pchealthcare.org.uk

For online registration: http://pchealthcare.org.uk/conferences

ESPCH Online Presence:

ESPCH website: www.pchealthcare.org.uk

YouTube: espchealthcare@gmail.com

Twitter: @ESPCHealthcare

Facebook: https://www.facebook.com/espchealthcare

Universidad Francisco de Vitoria UFV Madrid

EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

FIRST EUROPEAN CONFERENCE ON INCREASING THE PERSON CENTEREDNESS OF THE CARE OF THE FRAIL ELDERLY

22Nd & 23Rd October 2015

Francisco de Vitoria University

Madrid, Spain

The Conference is one of a series of major events organised by the newly founded European Society for Person Centered Healthcare (http://www.pchealthcare.org.uk) – an organisation created to work with clinicians, patients and their families, academics, policymakers and governments, to encourage the return of humanism in healthcare.

The aim of the Conference is to review current European and world guidance for the prevention and management of frailty in the elderly and to place this knowledge within the current clinical and organisational frameworks of person-centered healthcare (PCH). PCH is a new and emerging system of care provision that 'bridges the gap' between EBM and humanism, allowing clinicians and health systems to deliver far more individually tailored services to patients and their families, frequently with increased patient satisfaction and at reduced cost.

The Conference will bring together leading clinicians, academics, health and social care professionals, policymakers and politicians from across Europe, together with key speakers from North America, Oceania, and elsewhere.

An Official Declaration will follow the Conference to which all those participating will be invited to add their names. The Declaration will call upon individual governments and the EU itself to recognise how the person-centeredness of care provision for the frail elderly can be increased and to take policy and operational action accordingly.

All colleagues with an interest in and responsibility for the prevention and management of frailty in the elderly and the organisation and provision of associated services are strongly encouraged to participate in the Conference in order to maximise its subsequent impact on policy formation and health service provision.

EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

FIRST EUROPEAN CONFERENCE ON INCREASING THE PERSON CENTEREDNESS OF CARE FOR PEOPLE LIVING WITH HIV/AIDS

9Th & 10Th November, 2015, Francisco de Vitoria University, Madrid, Spain.

Universidad Francisco de Vitoria UFV Madrid

Recent decades have seen major increases in the scientific understanding and clinical treatment of HIV infection that have radically transformed the morbidity and mortality resulting from disease. The accompanying shift of HIV/AIDS care from acute hospital-based presentations of disease to long term chronic illness management in the community has done much to empower the patient and to encourage self-care and wellbeing. Such monumental progress has nevertheless been accompanied by some less positive results. Of these, a greater distance between the patient and the clinician in terms of the therapeutic relationship has been noted. Intervals between outpatient consultations of 6 months are now less than uncommon and actions during the consultation are often limited to monitoring of adherence to drug regimens, toxicity and symptom control, with a cursory enquiry as to the patient's general health. With such observations in mind, the forthcoming Conference will discuss and debate a variety of key issues and questions, including (among others), those that follow:

•There is a growing global consensus that much greater attention needs to be afforded to the cultivation of humanistic values in healthcare, so that clinicians become better qualified to understand and respond to the subjective experience of illness by the patient, as well as holding an objective account of biological dysfunction and its interventional treatment. Global shifts to person-centered care, as well as the ongoing progress in biomedicine and technology, pose inherent challenges to the philosophy, nature and delivery of 21st Century healthcare. What will this these changes to the political and health policy environment of international medicine mean when considered specifically in the context of HIV Medicine/Care and how should we respond to this new 'environment' in terms of HIV Care policies?

•Person-centered care is a philosophy and a method of 'being and doing' in clinical practice, being constituted by many components and actions that collectively aim to deliver a more effective and complete model of medicine/healthcare than is typically provided currently.. What questions do we need to ask ourselves if we are agreed that we need to respond in some way to the new environment and collaborate in the development of the relevant tools, their validation and their use and evaluation in our work?

•Patient advocacy, education and empowerment are acknowledged in general rhetorical terms to be important for patients and as key general components of patient-centered care. However, they are ill-defined in terms of the academic rigour that as clinicians we require.. How are we to understand these concepts and their lexicons in the context of HIV Medicine/Care in order to address them more coherently in clinic?

•Person-centered care advises and requires clinical practitioners to ask a multiplicity of questions of themselves and of their patients.What are the relevant questions for HIV/Medicine Care? For example, are we now meant to elicit the patient's narrative in our work and, if so, how do we do it and how do we use it to understand the patient's values and preference sensitivities? Are we being sufficiently culturally sensitive in our work? What of the existential and spiritual concerns that the patient may be experiencing? Are we aware of the patient's psychosocial status and of concerns relating to relationship and psychosexual functioning? Are we screening for anxiety, depression and for possible alcohol and substance misuse? Are we employing a shared decision-making approach in our work, so that we are accompanying patients, rather than directly instructing them in one direction or abandoning them to a sea of decision options as an alternative approach?

•Person-centered care argues, even defines, that unless the above questions are posed and adequately considered, clinical practitioners cannot demonstrate that they take seriously the need to assist healthcare's transition from a reductive anatomico-pathological account of disease to a fuller, more humanistic model of serving the sick. sIs it true that without an appropriate consideration of these clinical factors, HIV clinicians cannot but fail to 'know' the patient and run the risk of treating patients more in the manner of a complex biological machines than as unique individuals, which is to say persons? Is it true that in order to move our high technical skills in the direction of high clinical excellence and to further the development of our specialty and HIV Care more broadly, we now need to apply our science within a far more humanistic framework than perhaps we do at the current time?

•Person-centered care insists that, far from being an idealist, outdated Hippocratic account of healthcare, it has a rapidly expanding empirical research base to demonstrate its superiority over 'care as usual'. Is it true that person-centered, relationship-based models of care increase patient adherence to both simple and complex medication regimens, that they maximise desired clinical outcomes, that they decrease the frequency of symptom exacerbations and distress, that they reduce frequency of hospitalization, that they decrease length of hospital stay following admission and reduce the frequency of secondary and primary care consultations? Is it true that these approaches are additionally associated with increased patient and clinician satisfaction with care, that they are negatively correlated with clinician burnout and that they are positively correlated with decreased economic and human resource utilization? Are, then, solid quantitative and thus 'hard' data therefore now being added to the results of so much qualitative and thus 'soft' research conducted over recent years and that these data argue strongly for the clear and direct benefits of this approach: an increased quality of care and clinical professionalism and a cost-reduced or cost-contained care? How and why are these data important for HIV Medicine/Care?

•Person-centered care advises various levels of clinical service reconfigurations and reorganizations to enable us to deliver it more effectively and to remove barriers, including also developments in IT and medical informatics, in order to enable more humanistic care. What does HIV Medicine/Care need to do in this context and who should do it and how?

•Person-centered care is focussed in considerable measure on the achievement of healthcare outcomes defined by the patient and clinician together. How can we recognise when these have been accomplished in the context of HIV Care and how can we demonstrate them using quantitative and qualitative measurement tools?

•Person-centered care, via its empirical research base, promises major benefits to patients, clinicians and health systems as well as a contribution to medicine's philosophy. When these have been realized, what then remains to be done? How do we go further from there? What will be necessary next as part of service development?

Additional et pro nota bene

•The conference will bring together leading European and non-European experts across a wide variety of medical and healthcare specialties, principally HIV Medicine and Nursing, but also and equally, clinicians and academics drawn from all of the disciplines relevant to the provision of effective, humanistic HIV services. In this way, the broadest account of what constitutes optimal care of the patient with HIV/AIDS will become possible to define.

•All delegates to the Conferences are invited to the launch of the International Journal for Person-Centered HIV/AIDS Care, which will take place immediately before the Conference Dinner at the conclusion of Day One.

•The Conference will issue a Declaration on the next steps necessary for the development of Person-centered HIV Care in Europe, to which all those delegates in agreement may add their signature in support, prior to discussions on the Declaration with relevant European clinical societies and governments.

European Society For Person Centered Healthcare

Causation, Complexity and Evidence in Health Sciences (CauseHealth)

4th December 2015
Francisco de Vitoria University, Madrid, Spain

Universidad Francisco de Vitoria UFV Madrid

One Day Symposium in collaboration with The CauseHealth Project, addressing multi-morbid, socially complex long-term illness through person-centered healthcare.

This one day symposium is being organized as a collaborative project between the European Society for Person Centered Healthcare and the CauseHealth Project, a four year research project funded by the Research Council of Norway and conducted from the Norwegian University of Life Sciences (NMBU).

The CauseHealth Project is set to study the increasing incidence of so-called medically unexplained symptoms (MUS) and conditions such as chronic fatigue syndrome, irritable bowel syndrome, low back pain, multiple chemical sensitivity and fibromyalgia. These conditions, and others like them, are reported to constitute 30 percent of the symptoms currently reported to doctors, with each presenting patient demonstrating a largely unique combination of symptoms and illness profile. Typically, these chronic conditions are often depicted as outliers: atypical illnesses where standard causal explanation fails, and not as opportunities to study causation more effectively in order to better comprehend the causes of health and illness more generally. As such they represent a real methodological challenge for medical and health services research.

Given the nature of MUS and of co- and multi-morbid, socially complex chronic illnesses more generally, EBM-type clinical thinking has only partial value and it is increasingly recognized that far more complex approaches to the investigation and management of these conditions are urgently required. Indeed, complex disorders are difficult to study and treat because they have multiple causes: genetic, environmental and lifestyle factors (many not yet elucidated) and because each patient presents with a unique combination of biological, psychological, spiritual and social characteristics. It is here that person-centered healthcare approaches, in both theory and practice, retain a vital place in assisting both clinicians and patients to better understand and deal with their illness experiences.

In order to debate these issues and to generate further in-depth insights into the problem of MUS and chronic illness management more generally, the symposium will bring together a wide range of distinguished clinicians from primary and secondary care responsible for the investigation and care of such symptoms and conditions, together with senior academics from the philosophy of science and medicine, clinical psychology, medical sociology of key relevance to this area of clinical practice, health services provision and basic and applied research.

Conference places are limited to a total of 130 and early registration is therefore encouraged.

SOCIETY ANNOUNCEMENT

ESPCH HIGHER DEGREE FEE SPONSORSHIPS - 2016: Invitation To Submit An Expression Of Interest

The President, Senior VP and Officers of the Society are pleased to invite registrations of interest in the Society's higher degree fee sponsorship grants for 2016.

The Society selected its first postgraduate Master´s Degree student in May 2015 with the award to be formally conferred during the 2015 Awards Ceremony at the Second Annual Conference of the Society in Madrid on 18 & 19 June 2015.

The Society now invites registrations of interest from professionally qualified doctors, nurses and other health service professionals, including health policy and management colleagues, for a range of 2-year part-time Master's degree fee studentships to be offered by the Society with the Society's collaborating European university partners.

Interested colleagues, both students and potential supervisors, are invited to write to the Society (via the contact details below) with specific areas of research interest and outline proposals. Expressions of Interest should consist of an introductory letter to the Senior VP & Secretary General (for contact details, see below) attaching a circa 1,000 word outline of the project proposal, the student's Curriculum Vitae and the Curriculum Vitae of the proposed first and second supervisors. Letters should be signed by the prospective student and supervisors. A clear statement of how the proposed research is likely to contribute to the literature on humanistic healthcare is essential.

In addition to primary research as the basis of the higher degree, the Society is equally prepared to consider applications for secondary research, for example, structured and systematic reviews of the literature.

On receipt of an Expression of Interest, the Society will provide further information to guide formal applications.

Contact details:
Professor Andrew Miles MSc MPhil PhD DSc (hc): andrew.miles@pchealthcare.org.uk

SOCIETY ANNOUNCEMENT

ESPCH INTENSIVE 7-DAY RESIDENTIAL TRAINING COURSES IN PERSON-CENTERED HEALTHCARE (PCH) - 2016: Invitation to Submit an Expression of Interest

The President, Senior VP and Officers of the ESPCH are pleased to announce the availability in 2016 of the Society´s intensive residential training courses in PCH. In what follows we provide an overview of the aims, content, structure and costs of the courses. Further information may be obtained by using the contact information provided at the bottom of this announcement.

About the Courses

Course types
(1) Course A (Basic). For clinical practitioners working in everyday practice and service institutions
(2) Course B (Advanced). For advanced practitioners/service directors wishing to become mentors, teachers and leaders in PCH

Aim
To equip course participants with a through working knowledge of the principles and practice of person-centered healthcare through expert teaching and interaction with internationally distinguished clinicians and academics working in the field of PCH.

Content
Modern understandings of the nature of clinical knowledge. The lexicon and vocabulary of PCH. The differences between person and patient-centered care. A review of the global literature on PCH. The multiple components of the PCH approach – what are they and how do they piece together? What is the relationship between PCH and EBM/P? How to implement relationship-centered care. The evidence for PCH – qualitative and empirical. Costing and measuring PCH. Communication skills, active listening and non-directive counselling. Teaching self-help and management to patients and their families. Empowering the patient. The methods and processes of making shared clinical decisions with the patient. Methods for accompanying the patient along the trajectory of illness. Methods to increase adherence to therapy. Developing and using person-centered health records Transformational and servant leadership in PCH. Clinical services re-configuration and re-design to facilitate the implementation of PCH and provide value-added services. Increasing the person-centeredness of the clinical team. Regional and global health policymaking and policy developments in PCH. The politics of PCH. Using PCH to manage co- and multi-morbid long term, socially complex illness. Research in PCH – who is doing what and where to start yourself. Building person-centricity into scientific studies and clinical trials. (etc).

Who should attend?
Consultant Physicians and Trainees in primary and secondary care across all medical specialties. Clinical Nurse Specialist and Nurse Consultants. Colleagues working within the Professions allied to Medicine. Directors and Managers of Patient Advocacy Groups and Organizations. Directors and Associate/Assistant Directors of healthcare services delivery across primary, secondary and tertiary care. Health services managers and health academics. Healthcare services commissioners. Healthcare policy-makers Members of the Pharmaceutical Industry with special responsibilities for patient education, empowerment and advocacy.

Which course will suit me?
If you fit one of the professional categories immediately above, but have a limited knowledge of the principles and practical techniques of person-centered care, then you are advised to apply for Course A. If you already have a good working knowledge of the principles and practical techniques of patient-centered care, then you are advised to apply for Course B.

Structural and related aspects
Each week long training course (whether Course A or B) commences on a Saturday and ends on a Sunday. Participants will arrive between 15.00 - 18.00 hours on the commencing Saturday (Day 1), in time for check-in, registration, group and faculty introductions (19.00 hours) and a communal supper (20.00 - 22.00 hours). Study begins on Sunday morning (Day 2) at 08.00 hours [breakfast at 07.00 hours, lunch at 13.00 - 14.00 hours + working tea/coffee breaks] and concludes each weekday at 18.00 hours [supper at 19.00 hours]. Each study day consists of formal lectures and also tutorial-style small groupwork and a case-based interactive Masterclass with videos. Written materials and books will be provided. Relaxation and meditation time is incorporated within the training days, along with time for personal study and group interaction. Visits to notable local monuments and attractions are included in the overall programme. Participants may also take advantage of a 1-2-1 meeting with a member of faculty of their choice (by arrangement outside of the formal study periods). Participants will check-out following breakfast and a farewell session [09.00 hours] on the following Sunday. The courses have been designed to achieve maximum education and training (54 hours) within a minimum annual leave/study leave period away from the workplace (5 working days). Places are limited to a maximum of 25 participants per course, dividing into five, 5-participant member groups for tutorials/groupwork.

CPD and Certification
The courses will be CPD accredited and formal Certificates of Attendance will be issued.

Locations and Dates of the Courses
Rome or Madrid or Sofia - 2016. Dates and locations to be announced in late September 2015.

Costs
£1,250.00 per participant. The fee includes single accommodation, all meals and refreshments, all educational materials and a free copy of the major 55-chapter volume 'Person-centered Healthcare. How to Practise and Teach PCH'. Participants are eligible for a 50% discount on first year membership of the European Society for Person Centered Healthcare and with it free access to the European Journal for Person Centered Healthcare and discounts on all of the Society's conference initiatives.

Further information
For further information and to register preliminary interest in these courses, contact:
Professor Andrew Miles MSc MPhil PhD DSc (hc): andrew.miles@pchealthcare.org.uk

SOCIETY ANNOUNCEMENT

Joining the European Society for Person Centered Healthcare

The President, Senior VP and Officers of the Society cordially invite interested colleagues to membership of the Society. Interested colleagues should consult the Notes for Guidance and then complete the Membership Application Form:

MEMBERSHIP APPLICATION FORM

(Please see the 'Notes for Guidance' below before completing this form)
(Please send your CV or any supporting documents to Professor Andrew Miles at: andrew.miles@pchealthcare.org.uk)
(Application to Society Membership is available at http://pchealthcare.org.uk/conferences/joining-european-society-person-centered-healthcare)

I would like to be considered for membership of the Society at the following level (tick as appropriate):

- ◯ a. Distinguished Fellow (Clinical Professional and/or Academic)
- ◯ b. Fellow (Clinical Professional and/or Academic)
- ◯ c. Member (Clinical Professional and/or Academic)
- ◯ d. Member (Patient)
- ◯ e. Member (Industry)
- ◯ f. Associate (Clinical Professional and/or Academic)
- ◯ g. Student
- ◯ h. Chairmanship/Deputy of an SIG. Name of SIG: _____

I would like my Institution to become a Corporate Member or Corporate Sponsor (select below) of the Society and request relevant details and fees.

- ◯ Corporate Member
- ◯ Corporate Sponsor

Name of Institution: _____

Address of Institution: _____
Address 1: _____
Address 2: _____
Town: _____
County: _____
Postal Code: _____
Country: _____
Contact e-mail: _____

Your details
Title (Prof/Dr/Mr/Ms, etc.): _____
Name: _____
Occupation: _____
Address 1: _____
Address 2: _____
Town: _____
County: _____
Postal Code: _____
Country: _____
Contact e-mail: _____

Notes for Guidance

A. Membership of the Society is open to all healthcare workers (including retired), healthcare managers, health academics, healthcare policymakers and government advisers, patients, patient advocacy groups (as corporate members) and members of the pharmaceutical and healthcare technology industries. The costs of membership are as detail below and the benefits of membership are set out below (see 'D'). Applications received will be considered by the Society's Membership Committee. Membership fees become payable on election and are annually renewable.

B. All applications should be accompanied by full and up-to-date Curriculum Vitae and a covering letter outlining the applicant's achievements (and/or plans) in the field of person-centered care. The covering letter should document the achievement with reference to the membership criteria set out below (see 'C') and should indicate which Special Interest Group (SIG) or SIGs the applicant would like to join (no limit) The Application Form with the covering letter and CV should be sent to Professor Andrew Miles using the 'SEND' function at the end of the Application Form below. If preferred, the Application Form and supporting materials can be sent by post to: European Society for Person Centered Healthcare, c/o 77 Victoria Street, Westminster, London SW1H OHW, UK.

C. The Society has various categories of membership and these are as follows:

(a) **Distinguished Fellow** (Clinical Professional and/or Academic)
[Criterion and fee: outstanding contribution to the field of person-centered clinical practice: €150]

(b) **Fellow** (Clinical Professional and/or Academic)
[Criterion and fee: major contribution to the field of person-centered clinical practice: €100]

(c) **Member** (Clinical Professional and/or Academic)
[Criterion and fee: significant contribution to the field of person-centered clinical practice. Membership fee: €75]

(d) **Member** (Patient)
[Criterion and fee: currently a patient or a patient's carer: €75]

(e) **Member** (Industry)
[Criterion and fee: an active member of the healthcare industry: €250]

(f) **Associate** (Clinical Professional and/or Academic)
[Criterion and fee: a promising ongoing contribution to the field of person-centered clinical practice: €50]

(g) **Student** (Clinical or health-related studies)
[Criteria: detectable commitment to the principles of person-centered clinical practice: €25]

D. There are 10 principal benefits to membership of the Society. These are as follows:

(1) Free on-line access to the European Journal of Person Centered Healthcare (Priced for non-members at €270, for print and online and €195, for online only and for non-member institutions €345, for print and online and €250, for online only).

(2) Bi-monthly Bulletin of the ESPCH by e-mail direct from the President, detailing new bibliography of relevance to the field, forthcoming European and other conferences and all details relating to the Society's activities, including updates on the work of the Special Interest Groups.

(3) A Directory of Members documenting their areas of interest, current research activities and contact details, to enable cross-institutional collaboration and networking.

(4) Eligibility for consideration of award of the Society's Platinum, Gold, Silver and Bronze Medal and Book and Essay Prize in recognition of individual contribution to the development of excellence in person-centered clinical care

(5) 25% discount of the Annual Conference and Awards Ceremony delegate fee for the 1st Annual Conference

in Madrid on 3 & 4 July 2014 and a 25% discount on the delegate fees for other events within the European Conference Series on Person Centered Healthcare.

(6) 20% discount on the published price of the Society's publications. (e.g., the price of €60, versus €75, for the forthcoming major textbook: Person-Centered Healthcare. How to Practise and Teach PCM. The same 20% discount applies to the forthcoming textbook Person-centered Healthcare Education: A Vision for the 21st Century. Similar preferential prices are also available to Society members for each publication within the Society's forthcoming 'Clinical Practitioner Handbooks on Person Centered Healthcare' Series, which will generate diagnoses-specific guides for immediate use within routine clinical practice in the management of a wide range of chronic illnesses and to assist study of a wide variety of non-clinical areas of relevance to PCH.

(7) Eligibility for invitation to lecturing positions on the intensive educational courses to be organised by the Society (Fellows and Members only) in various European countries and also within the USA.

(8) Eligibility to apply to the Society for research grants and Higher Degree Studentship fee grants.

(9) Automatic 10% discount on registration for the Society's 7-day residential intensive study courses on person-centered healthcare, whether at practitioner-learner level or practitioner-teacher/mentor/leader level.

(10) A 15% discount on the subscription costs to any of the Society's clinical condition-specific quarterly journals and an automatic invitation to apply for membership of their Editorial Boards, Peer Review Colleague Directories.

E. Corporate Membership and also Corporate Sponsorship of the Society (Platinum, Gold, Silver, Bronze) is invited and available at a negotiable cost based on the size of the organisation and the World Bank status of its geographical location. The benefits of Corporate Membership and Corporate Sponsorship are highly substantial and include:

(1) High visibility of the Institution's Logo and Statement of Commitment to Person-Centered Healthcare

(2) Free advertising opportunities in the Society's Monthly Bulletin

(3) A gratis Advertising/Marketing Stall at the Society's Annual Conference & Annual Academic Awards Ceremony

(4) Personal Introductions to Distinguished Clinicians of the Society by the President/Senior VP

(5) Generous reductions on block purchases of delegate places at the Society's Annual Conference and Academic Awards Ceremony

(6) Preferred Sponsor Status of the Society's publications and also of its Intensive Training Courses for practising clinicians wishing to:

(a) become PCH trained practitioners

(b) those practitioners who seek to become PCH Mentors and Leaders in their field of practice

Further information

For further information, teleconference or face-to-face meetings and indicative cost estimates, please contact in the first instance: Professor Andrew Miles at: andrew.miles@pchealthcare.org.uk

EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

Madrid, June 2015