

## EDITORIAL INTRODUCTION

# Clarifying the concepts, epistemology and lexicon of person-centeredness: an essential pre-requisite for the effective operationalization of PCH within modern healthcare systems

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Conceptual clarification, contextualisation, definitions of person-centered care, disease-centered medicine, empirical research base, evidence-based medicine, excellence in clinical practice, humanism, leadership, lexicon, methodology, operational implementation, person-centered healthcare, person-centered medicine, philosophy of medicine, reductionism

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## Introduction

In a previous Editorial [1], we referred to person-centered healthcare (PCH) as a new way of ‘thinking and doing’ in clinical practice, one that had become necessitated by medicine’s relentless empiricism, its positivistic reductionism and its failure to care for patients as individuals, which is to say as *persons*. In this, we found ourselves able to agree with Charon [2], but needing to distance ourselves from an over-arching description, by Weatherall, of modern medicine as a “failure” [3]. Indeed, modern advances in medicine may accurately be described as a triumph - but a triumph of scientific and technological advance only, not a triumph represented by an increased excellence in clinical practice *per se*, if excellence (*versus* competence) is to be defined as the successful translation of such advances to patients within an overtly humanistic framework of care - the process which represents and causes contextualisation [4]. If we add the statistics which demonstrate high rates of medical error and iatrogenic injury within health services and also the increasingly frequent institutional failings of major hospitals and the Care Home scandals of recent times to medicine’s tendency to view patients as subjects or objects or complex biological machines requiring some sort of ‘fixing’, then it is clear that modern healthcare systems are experiencing little short of an existential crisis. Such a crisis - and the high burn out rates of clinicians which also contribute to it,

can no longer be ignored or ‘whitewashed’ over. Indeed, health systems themselves need to be ‘fixed’ if they are to become more ‘fit for purpose’. How, then, are such individual failings to be prevented from causing *outright* institutional failure? We contend that an urgent move to a more person-centered way of ‘thinking and doing’ may well represent a credible answer to such a question. But other questions must, still, legitimately, be asked: ‘What *is* person-centered healthcare?’ ‘*How* are we to understand it?’ ‘*What* is its essential meaning?’

## Person-centered healthcare

Miles has previously described person-centered care as a philosophy and method which enables “affordable biomedical and technological advance to be delivered to patients within a humanistic framework of care that recognises the importance of applying science in a manner which respects the patient as a whole person and takes full account of his values, preferences, aspirations, stories, cultural context, fears, worries and hopes and thus which recognises and responds to his emotional, social and spiritual necessities in addition to his physical needs” [5]. At the time of its publication, the purpose of advancing such an assertion was hardly to declare an *ex cathedra* level of definitional clarity, but rather to stimulate the generation of scholarly debate and to invite methodologists

and health services researchers and those involved in service re-configuration - as well as economists - to begin to consider how such a vision could translate into new models of clinical and social care for operational implementation within modern health and care services.

As part of this exercise, Miles invited twenty commentators from a variety of academic and clinical backgrounds, specialties and disciplines, to analyse - indeed critique - the assertions advanced in a Discussion Paper which Miles had previously published and from which the above 'definition' derived [5]. Of the twenty colleagues invited, a gratifying eighteen agreed to examine the paper from their individual positions of understanding and expertise with, in some cases, the insights of co-authors. We publish the collected responses within the current issue of the *European Journal for Person Centered Healthcare* [6-23]. We express our deep appreciation to the commentators for the time and effort that they have invested over an extended period of time in this task - a task which we are fully confident will bring forth considerable fruit in terms of advancing the concepts, epistemology and lexicon of person-centered healthcare. It has not been our intention to respond to these individual papers here, but rather to afford the reader sufficient time to assimilate the content of these collected works in advance of our publication (within 2 (3) of the EJPCH) of a detailed *second* Discussion Paper [24]. That particular article will, over approximately 20,000 words and 300 references, respond fully and in detail, to the multiple points raised by the commentators, discussing, in addition, the central importance of personalism and non-foundationalism as two schools of philosophical thought which we believe to be of radical importance in advancing the person-centered healthcare (PCH) thesis. Such efforts, we contend, represent essential pre-requisites for the development of models of care that are directly informed by core PCH principles, but which *must* be sufficiently flexible to enable their operational implementation within the economic and manpower constraints of routine clinical practice and modern healthcare systems.

A clarification of the conceptual and epistemological basis of person-centered healthcare will form the opening session of the First Annual Conference and Awards Ceremony of the European Society for Person Centered Healthcare (see Appendix 2, p. 8: Madrid 3 & 4 July 2014). That clarification will draw upon the commentaries published here, before the Conference moves to consider the growing empirical research base which increasingly indicates a superior effectiveness of PCH-type approaches to care over and above 'care as usual' (certainly in terms of quality, but *also* cost). Indeed, as we have already stated and re-iterate directly here, person-centered healthcare, while retaining a broad appeal to those healthcare practitioners and healthcare systems concerned to deliver more humanistic models of care above those which are currently available, continues to be characterized by an incomplete theoretical and empirical research base which could provide an epistemological and broader justification of its own claims that it represents a superior model of care over and above those models of care that currently exist. Given the epistemological and methodological weaknesses

of the current PCH approach and a need not to commit the now well acknowledged epistemic errors of EBM [24-39], a further theoretical strengthening and conceptual underpinning of person-centered healthcare is therefore urgently indicated. It is this need, then, that the first part of the Conference will directly address. Appendix 1 to this Editorial Introduction (p.6) documents recent appointments to and news from the European Society for Person Centered Healthcare. Appendix 2 (p.8) publishes and details the Second Announcement of the First Annual Conference and Awards Ceremony of the ESPCH, with Appendix 3 (p.10) inviting applications for Society Membership. Appendix 4 (p.12) provides details of the First European Conference on Increasing the Person Centeredness of Care for People Living with HIV/AIDS, with Appendix 5 (p.14) announcing the First European Conference on Person-centered Medical Education.

## What other form of medicine could there possibly be?

We fully expect that some clinical colleagues will assert that our contention that healthcare should return to its humanistic basis - and urgently so - advances nothing *new* or is even *unnecessary*. They will claim that their practice is already "fully person-centered" ("What other kind of care can there possibly be?") and that novel approaches to care such as person-centered healthcare, aimed at addressing the failures of clinical practice (which have been and are increasingly well documented), offer limited benefits to the clinical professions and their ethical, moral and technical advancement.

If that proves to be the case, then that is precisely what many clinicians said when confronted by the (more tenable) claims of the Evidence-Based Medicine (EBM) Movement: that clinical practice was culpably slow in introducing new innovations recommended by well conducted clinical trials, when their findings were accepted by the consensus of clinical societies, into routine clinical care for the direct benefit of patients. We knew then that the rejection by clinical practitioners of that *central* claim of EBM was irrational - given documented observation - and we assert that attempted refutations of the person-centered healthcare thesis are likely to prove similarly so. Whereas EBM proceeded to develop methods (ill-conceived in general philosophical and methodological terms) to accelerate the transfer of research into practice without an adequate epistemological basis, person-centered healthcare must at all costs - and as we have emphasised in this article - avoid the same destiny as EBM within the History of Medicine [25-39]. Indeed, it is for this reason that the European Society for Person Centered Healthcare [40] has been created: to help safeguard medical theory in terms of how it understands the person of the patient and thus to return to medicine and healthcare more broadly a more accurate understanding of what constitutes optimal clinical practice, correcting the erroneous thesis advanced by EBM: that medicine can rely, essentially, on science alone in its management of suffering. For this reason - and

with far more detailed general justification to appear in 2 (3) of EJPCH - we reject in substantial measure, the entirely predictable arguments of Post and Gordon Guyatt [17] within the current issue, though we acknowledge and greatly welcome their new engagement in academic debate.

## Competence *versus* excellence in clinical care

We re-iterate here our strongly held view that excellence in clinical practice will remain out of reach until clinicians apply advances in biomedicine and technology within a humanistic framework of care. By this we mean that modern clinicians must re-learn the methods of contextualisation. High technical skill remains high technical skill only and we view as a truism the claim that clinicians cannot, *ipso facto*, achieve *excellence* in their profession until they learn how properly to use these advances in the context of the human person who has become ill and who suffers. A fervent desire to achieve such high professionalism, surely the duty of any vocation, demands the admission of concepts of excellence and full considerations of how to achieve it. In terms of clinical practice, this will necessarily involve the cultivation, through undergraduate and postgraduate and continuing education and other means, of a definitive *ambition* to treat patients as *persons* and a willingness to attend to the subjective experience of illness by the patient as fully as is done when measuring the objective parameters of disease in order to understand and treat dysfunction in purely biological terms.

To those colleagues who claim, then, that person-centered healthcare offers nothing *new* or is *unnecessary*, we say this: medicine and healthcare has always aimed to be entirely humanistic, whenever and wherever possible and for much of its long history this is precisely what medicine has 'known' and done. However, while medicine's historic ideals and practice in this context remain deeply relevant to the exercise of clinical care and to the development of new models of caring, the last century of positivistic empiricism has gravely distorted such former ideals and the capacity of physicians to build upon them. We contend, with considerable emphasis, that the older notions of *caring* need to be re-discovered - and urgently so, thus enabling modern medicine to understand that its function involves not only efforts to ameliorate, attenuate and cure, but also and vitally so, efforts to care, comfort and console [4,38]. The challenge is, then, perhaps, this: to take the humanistic endeavour of former and historical years and to attempt to *revive* it within the utterly different and hugely more complex health system environments of our current Age. It is a *sine qua non* that such a proposed process will require extremely careful conceptual enquiry and methodological development and it is precisely this that the new European Society for Person Centered Healthcare is determined to achieve.

## Medicine and its ongoing professionalism

What role will medicine play in this overall process? Sadly, we must admit (with some reticence and a degree of inescapable pessimism) that we hold that modern medicine, as a profession, may simply not have the ability (or enthusiasm) to recover the humanism of its previous, long and distinguished history. We remain deeply concerned about this, because we believe it eminently observable that the relentless reductionism of the profession, particularly among its academic ranks and their over-reliance on science for the care of patients [41], together with relentless superspecialisation and increasing service fragmentation, has disturbed the essential equality of relevance of the subjective and objective in the making of appropriate clinical decisions in the context of the individual patient. This, we believe, may have irreversibly altered the outlook and consciousness of the Profession of Medicine - and not for the better. Whether this is our own wrongly held perception or does in fact prove to be a reality, will become clearer with the elapse of time, now that we are in the Century of the Patient [42]. Current insight suggests - and it is our prediction - that the major driving forces of person-centered change are likely to be represented by multi-disciplinary clinical teams led by specialist senior nurses and strategically influenced by patient advocacy organisations, most especially in the context of the growing epidemic of long term chronic illness [40]. Under no plausible or possible circumstances could or should the profession of medicine be excluded from such efforts, but we think it likely, on the balance of probabilities, that medicine's contribution to the development of more person-centered healthcare services is likely to be represented and guaranteed by a small number of enthusiastically person-centered physicians, medical leaders and medical champions, who will add to and complete the work of the multidisciplinary clinical teams to which we have already referred. We intend the Special Interest Group (SIG) network of the European Society for Person Centered Healthcare [40] to be an important means of identifying, 'harvesting' and bringing into direct contact such particular colleagues.

## Conclusion

It is our definitive view that a move to far more person-centered clinical practices and healthcare systems which increase clinical excellence and decrease healthcare costs, is the only way through which patients can be given a better 'deal' and where clinical professionalism can be fostered and advanced. Indeed, if care is to move away from a purely reductive anatomico-pathological focus in the direction of a more authentically anthropocentric model of clinical care that aims to take as full an account of the subjective experience of illness by the patient as it does of the objective measurement and monitoring of disease [43], then it would appear that professionals should be given the

greatest of encouragement by Government Regulators, the Public, Healthcare Charities and Foundations, as well as Industry, to engage with this new system of ideas and its trial methods. Person-centered approaches to care are not, after all, in any way, *options*. They are in no way idiosyncratic methods to be employed by a minority of empathetic healthcare workers. On the contrary, they are *imperatives* if medicine and the clinical professions are to remain *vocations* and not 'service industries', processing patients in the manner of statistics as part of some wider industrial, State-funded or privately delivered 'method' of 'dealing' with the illness and suffering of its many citizens.

## Conflicts of Interest

The authors of this Editorial Introduction declare no conflicts of interest.

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# SOCIETY ANNOUNCEMENT



**The President and Senior Vice President are delighted to announce the following further appointments to the Special Interest Groups of the Society:**

**Special Interest Group – Shared Decision-Making**

Professor Alan Cribb BA PhD, Centre for Public Policy Research, Department of Education and Professional Studies, King's College London, UK

**Special Interest Group – Patient Behavioural Studies**

Mr. Kevin Dolgin BA (Econ) MBA MRes, Associate Professor, University of Paris, France & President, 'Observia' (An e-Health Information and Support Service for Patients)

The newly appointed SIG chairmen increase the number of appointed SIG chairmanships from 24 to 26. The President and Senior VP congratulate the new chairmen and continue to welcome applications for the decreasing number of SIG chairmanships that currently lie vacant. Applications for other SIG chairmanship positions currently under consideration will, if successful, be announced in Volume 2, Number 2 of the EJPCH.

**The following announcements are also made:**

1. Professor Joaquin Casariego Garcia-Luben, Director of International Affairs in Medicine, Universidad Francisco de Vitoria, Madrid, Spain, has been appointed Vice President for International Relations of the Society.
2. The Society has appointed Professor Brian Gazzard MD FRCP as a Principal Advisor to the Expert Planning Committee (EPC) for the 'Increasing the Person-centeredness of Care for People Living with HIV/AIDS' European Conference of the Society. Professor Gazzard remains one of the most influential and highly distinguished members of the international HIV/AIDS Community. He is the Founding Chair of St Stephen's AIDS Trust and also the Director of HIV Clinical Research at the Chelsea and Westminster Hospital, London, UK. The St Stephen's Centre remains one of the largest clinical units in Europe. Professor Gazzard is also the Founding Chair of the British HIV Association (BHIVA) and chaired the BHIVA Executive from 1995-2004. He was awarded the UK Department of Health Prize for Distinguished Achievement in 2002 and received a CBE for services to healthcare in 2011 from Her Majesty Queen Elizabeth II.
3. The ESPCH has appointed Dr. Anton Pozniak PhD FRCP as Editor-in-Chief of the new *European Journal for Person-centered HIV/AIDS Care*. Dr. Pozniak started caring for patients with HIV in 1983 at the Middlesex Hospital, London, UK. He worked as a Consultant Physician in Zimbabwe where he researched for his doctorate in TB/HIV and moved back to the UK in 1991. He directed the HIV Research Unit at King's College, London, before moving to his current position as Consultant Physician

## Appendix 1

at the Chelsea and Westminster Hospital in 1998. Dr. Pozniak is a Life Member of the British HIV Association (BHIVA) and was involved in the writing of the BHIVA anti-viral HIV guidelines. Dr. Pozniak chairs the BHIVA TB/HIV Guidelines Committee. He has been an adviser on HIV and AIDS to the UK Government Health Select Committee and is a member of the Expert Advisory Group on AIDS for the UK Department of Health. He is a member of the European AIDS Clinical Society and is a member of the Governing Council of the International AIDS Society. Dr. Pozniak is Vice Chair of the European AIDS trial network NEAT and is a member of the Scientific Advisory Board and Executive Committee of the Charity LEpra.

### **SOCIETY NEWS**

#### **1. The European Headquarters of the Society**

The Society has moved into its *interim* European Headquarters in the historic City of London and has become fully operationally functional from 1 January 2014. The Society can be contacted by e-mail (and post, if preferred) as follows:

- (i). General Enquiries: [info@phealthcare.org.uk](mailto:info@phealthcare.org.uk)
- (ii). Executive Enquiries: President: [president@phealthcare.org.uk](mailto:president@phealthcare.org.uk) / Senior VP and Secretary General: [andrew.miles@phealthcare.org.uk](mailto:andrew.miles@phealthcare.org.uk)
- (iii). Administrative and Membership Enquiries: [rudolf.raducan@phealthcare.org.uk](mailto:rudolf.raducan@phealthcare.org.uk)
- (iv). Post: European Society for Person Centered Healthcare, c/o 77 Victoria Street, Westminster, London, UK.
- (v). Telephone: E-mail correspondence is preferred for reasons of efficiency and cost, but telephone communication can be arranged and scheduled by request to Mr Rudolf Raducan ([rudolf.raducan@phealthcare.org.uk](mailto:rudolf.raducan@phealthcare.org.uk))

#### **2. The Society Website**

The Official Website of the Society has now been launched and may be viewed and navigated at: [www.phealthcare.org.uk](http://www.phealthcare.org.uk). The recently appointed full time Administrator to the Society, Mr. Rudolf Raducan ([rudolf.raducan@phealthcare.org.uk](mailto:rudolf.raducan@phealthcare.org.uk)), will be pleased to provide any assistance necessary.

#### **3. Bi-monthly Bulletin from the President of the Society**

The bi-monthly Presidential e-Bulletin of the Society (entitled 'Progress') will commence publication on 30 April 2014. It is available *free* to Society Members (at all grades) and at a monthly 'one off' cost of €5 (individual) or €50 as an annual (institutional) subscription. For further details please contact Mr. Rudolf Raducan at: [rudolf.raducan@phealthcare.org.uk](mailto:rudolf.raducan@phealthcare.org.uk)

# SECOND ANNOUNCEMENT



## FIRST ANNUAL CONFERENCE AND AWARDS CEREMONY / (& Dinner) OF THE EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

**3 & 4 July 2014: Aula Magna, Universidad Francisco de Vitoria,  
Pozuelo, Madrid, Spain**

### About the 1st Annual Conference and Awards Ceremony

The President, Senior VP and the Officers of the Society are pleased to announce the dates of the First Annual Meeting of the ESPCH, which will take place over two intensive study days, punctuated by the Annual Awards Ceremony and Conference Dinner. The Conference itself will address key issues and questions of direct relevance to the advancement of person-centered healthcare including (among others), those that follow:

### The Conference

Person-centered healthcare (PCH), while retaining a broad appeal to those healthcare practitioners and healthcare systems which seek to deliver more humanistic models of care above those that are currently available, continues to hold an incomplete theoretical and empirical research base in terms of an epistemological justification of its own claims that it represents a superior model of care over and above those models of care that currently exist. Given the epistemological and methodological weakness of the current PCH approach and a need not to commit the epistemic errors of EBM, a further theoretical strengthening and conceptual underpinning of person-centered healthcare (PCH) is therefore urgently indicated. *The Conference will discuss and debate the current status of PCH in terms of its epistemology and empirical research base and will delineate the way forward in relation to how the necessary conceptual clarifications can be achieved and in terms of how the empirical research base can be strengthened.*

PCH is a philosophy of care, but it is also a method. *The Conference, with reference to the current conceptual base of PCH, will review, debate and discuss the development of a wide range of 'hands on' clinical tools and audit criteria currently being developed by various multi-disciplinary SIGs of the Society, with the aim of identifying strengths and weaknesses and generating a series of recommendations to guide and inform ongoing methodological developments.*

PCH, even when theoretically justified and with the necessary methodologies developed and validated, is unlikely to achieve operational implementation without the generation of additional justificatory data. *The Conference, acknowledging the same, will discuss and debate how developments in the health policy and political dimensions of PCH must be analyzed as they relate to PCH in health services generally and within the European Union in particular in order to guarantee progress. Methods of political advocacy in this context will additionally feature as part of this necessary debate.*

PCH has economic implications, but the empirical research base accumulated to date suggests that the practice can cost-contain if not cost-reduce healthcare expenditure, while simultaneously increasing the quality and patient focus of care. *The Conference will debate and discuss currently available health economic analyses of PCH and re-imburement perspectives, aiming to guide and inform further analyses and research activity in this context.*

PCH must be *taught*, not 'caught'. Strategies for the incorporation of PCH into undergraduate and postgraduate clinical curricula are therefore of vital necessity in order to move the re-humanization of healthcare services forward, especially



## Appendix 2

given data demonstrating reductions in student humanism and empathy during the middle years of undergraduate training. *The Conference will therefore discuss and debate the elements of PCH teaching that would valuably be introduced into undergraduate clinical curricula, in advance of the Society's major conference on this specific matter to be held in Madrid on 24 & 25 October 2014*

PCH is not easily delivered within the constraints of current health services infrastructure and management. *The Conference will therefore debate and discuss the necessary clinical service reconfigurations and new information technologies that will be necessary to deliver more adequate PCH models of clinical practice that are fit for purpose for 21st Century healthcare.*

### **The Awards Ceremony**

At the formal and academically robed Awards Ceremony, the President will confer the annual *Platinum, Gold, Silver and Bronze* medals of the Society together with their accompanying certificates for distinguished achievement in PCH, followed by the annual *Book Prize* and the annual *Essay Prize*. The winner of the Platinum Medal of the Society will then deliver a *Lectio Magistralis* on Day 2 and will be joined in the ensuing Panel Discussion by the winners of the Gold, Silver and Bronze medals in their respective roles as panel discussants. The *Lectio Magistralis* will be published in unabridged form within the *European Journal for Person Centered Healthcare*, accompanied by an over-arching Editorial Accolade by the EJPCH Editor-in-Chief.

### **The Book 'Person-centered Healthcare. How to Practise and Teach PCH'.**

The Conference will present details of the forthcoming 55 chapter seminal volume *Person-centered Healthcare. How to Practise and Teach PCH*. The volume, a seminal text for the teaching and practice of PCH, is available to Society members and to non-members attending the conference at a significant discount. The volume is advanced as essential reading for all medical and healthcare students, clinical postgraduates and to established professionals in practice.

### **The Declaration**

The Conference will conclude with the publication of a *Declaration* on the next steps necessary for the effective development of PCH in Europe, to which all those delegates in agreement may add their signature in support, prior to direct discussions on the *Declaration* with European governmental powers. The *Declaration* will represent a principal means of opening conversations with EU governments on how to reform services in accordance with the PCH model of care.

### **Full Conference Programme**

The full programme of the Conference and a listing of the educational institutions and specialist European and global clinical societies and other sponsors who are supporting the Conference is available on the ESPCH Website: [www.pchealthcare.org.uk](http://www.pchealthcare.org.uk) With places limited, colleagues are encouraged to register their interest in securing a delegate place as soon as possible *via* the contact details provided within this Second Announcement.

### **Costs:**

Conference: Day 1 or Day 2: €150 (medical), €95 (non-medical), €75 (patients, clinical students), €300 (Industry)

Conference: Day 1 and Day 2: €275 (medical), €175 (non-medical and non-medical academic), €100 (patients, clinical students), €500 (Industry)

Awards Ceremony and Dinner: €65 (Places are limited to 250 delegates and will be awarded on a 'first come, first served' basis.)

### **For further information and to register interest, contact the Society Administrator:**

Mr. Rudolf Raducan at: [rudolf.raducan@pchealthcare.org.uk](mailto:rudolf.raducan@pchealthcare.org.uk)

### **Additional *et pro nota bene*:**

The Conference and Awards Ceremony/Dinner is open to non-members of the Society as well as to enrolled members of the Society. Non-members of the Society attending the Conference will be invited to join the Society during the course of the Conference. Colleagues joining the Society in this way will be eligible for a 10% reduction on membership fee at the appropriate grade.

## Appendix 3

### INVITATION TO JOIN THE EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

The President, Senior VP and Officers of the Society cordially invite the reader to apply for membership of the Society

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
- g. Student

h. Chairmanship of an SIG  Name of SIG \_\_\_\_\_

Name: (Prof/Dr/Mr/Ms): \_\_\_\_\_

Occupation: \_\_\_\_\_

Address \_\_\_\_\_

E-mail: \_\_\_\_\_

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

Name of Institution: \_\_\_\_\_

Address of Institution: \_\_\_\_\_

Contact e-mail: \_\_\_\_\_

#### Notes for Guidance

1. 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 fees for membership are as detailed below and the benefits of membership are set out overleaf. Applications received will be considered by the Society's Membership Committee and the applicant will be advised of the outcome accordingly. Membership fees become payable on election and are annually renewable.

2. 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 and should indicate which SIGs the applicant would like to join (no limit) The

## Appendix 3

Application Form with the covering letter and CV should be sent to Professor Andrew Miles: [andrew.miles@phealthcare.org.uk](mailto:andrew.miles@phealthcare.org.uk)  
Or by post to: European Society for Person Centered Healthcare, c/o 77 Victoria Street, Westminster, London SW1H 0HW, UK.

3. The Society has criteria for membership and these should be examined when completing this Application Form. The criteria are as follows: (a). *Distinguished Fellow* [Criterion and fee: outstanding contribution to the field of person-centered clinical practice: €150]; (b). *Fellow* [Criterion and fee: major contribution to the field of person-centered clinical practice: €100] (c). *Member (Professional)*. [Criterion and fee: substantial 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* [Criterion and fee: significant and promising contribution to the field of person-centered clinical practice: €50] & (g). *Student* [Criteria: Detectable commitment to the principles of person-centered clinical practice: €25].

#### 4. 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. 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 and Peer Review Colleague Directories.

5. 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 and (b) those practitioners who seek to become PCH Mentors and Leaders in their field of practice. 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@phealthcare.org.uk](mailto:andrew.miles@phealthcare.org.uk)

#### NOTE

Please send this completed Application Form with supporting papers, to: Professor Andrew Miles MSc MPhil PhD DSc (hc): [andrew.miles@phealthcare.org.uk](mailto:andrew.miles@phealthcare.org.uk)

# SECOND ANNOUNCEMENT



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

**18 & 19 September 2014: Aula Magna, Universidad Francisco de Vitoria, Pozuelo, Madrid, Spain**

### About the First Annual Conference

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 of direct relevance to increasing the person-centeredness of care for people living with HIV/Aids, 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. The global shift to patient-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 change in 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 and academics 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?*
- Patient-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*

## Appendix 4

*our work, so that we are accompanying patients, rather than directly instructing or even abandoning them to a sea of decision options?*

- Patient-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. *Is 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 have at the current time?*
- Patient-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?*
- Patient-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?*
- Patient-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?*
- Patient-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 easier to define.
- All delegates to the Conferences are invited to the launch of the *European Journal for Person-Centered HIV/AIDS Care*, which will take place immediately before the Presidential Address and 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 direct discussions on the *Declaration* with relevant European clinical societies and governments.

The full programme of the Conference and a listing of the educational institutions and specialist European and global clinical societies and other sponsors who are supporting the Conference will be available very shortly. Places are limited and colleagues are therefore encouraged to register their interest in securing a delegate place as soon as possible via the contact details provided within this First Announcement (see 'Contact Us', below).

### **Contact us:**

- **For further information, registration details and costs, contact: Mr. Marcos Maseda, HIV/AIDS PCH Project manager at: [marcos.maseda@phealthcare.org.uk](mailto:marcos.maseda@phealthcare.org.uk)**
- **For sponsorship & exhibition enquiries and to pose any clinical or academic questions, contact Prof. Andrew Miles at: [andrew.miles@phealthcare.org.uk](mailto:andrew.miles@phealthcare.org.uk)**

### **Acknowledgement:**

The Society is most grateful to ViiV Healthcare for a generous grant of unrestricted educational sponsorship.

# SECOND ANNOUNCEMENT



## FIRST ANNUAL EUROPEAN CONFERENCE ON PERSON-CENTERED UNDERGRADUATE CLINICAL EDUCATION

**23 & 24 OCTOBER 2014**

**Aula Magna, Universidad Francisco de Vitoria University, Madrid, Spain**

### **About the First Annual Conference:**

The President, Senior VP and the Officers of the Society are pleased to announce the dates of the First Annual International Conference of the ESPCH on Person-centered Undergraduate Clinical Education, which will take place over two intensive study days punctuated by the Presidential Address and Conference Dinner and will address key issues and questions of direct relevance to increasing the person-centeredness of undergraduate clinical education, including (among others), those that follow:

- There is a growing international 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. The global shift to patient-centered care as well as the ongoing progress in translational medicine, pose inherent challenges to the philosophy, nature and delivery of 21st Century healthcare and thus to clinical teaching and training, observations which argue for an urgent re-appraisal of traditional medical and healthcare education. *How should Academic Medicine and the healthcare professions respond to this new 'environment' in terms of policies?*
- The enormously competitive admissions process for medicine in particular and the healthcare professions in general allows the opportunity, if it is used, to select students disposed to healthcare's inherent humanism, as well as to its scientific advances, so that, as Cohen has said, candidates can be selected not only in accordance with what is in their heads, but also in terms of what is in their hearts. *How do we best select medical students and students in nursing and the other healthcare professions with such imperatives in mind?*
- The Conference will debate the contention that high technical skill in the application of biomedical knowledge and technology is high technological skill *only* and that for the achievement of *excellence* in clinical practice, the science of medicine must be fused with humanism, without

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which functional integration clinical excellence remains *ipso facto* out of reach. *What do we need to teach and 'do' within undergraduate medical and clinical curricula in order to inculcate a growing humanism in students selected for study and to ensure that they maintain it throughout their entire period of undergraduate training?*

- A person-centered, humanistic undergraduate education requires person-centered and humanistic teachers. *How do we teach the teachers and train the trainers?*
- The Conference will debate and formulate a *Declaration* on the next steps necessary for the development of person-centered clinical education in Europe as one tool aimed at causing an accelerated shift of clinical education away from a reductive anatomico-pathological focus, towards one that is more authentically anthropocentric in its nature. *What should be included in and excluded from the Declaration and how should it be used and with which colleagues, agencies and governments should it be discussed across Europe?* (all those delegates in agreement with the final Draft may add their signature in its support)

### **Additional *et pro nota bene***

- The Conference is the first of an annually recurring series in undergraduate and postgraduate education, devised and organised by the European Society for Person Centered Healthcare (ESPCH).
- The full programme of the Conference and a listing of the educational institutions and specialist European and global clinical societies and other sponsors who are supporting the Conference will be made available in due course. Places are limited and colleagues are therefore encouraged to register their interest in securing a delegate place as soon as possible *via* the contact details provided (see 'Contact Us', below).

Delegates at the Conference will be offered a substantial (20%) discount on the price (€75) of the major textbook *Person-centered Healthcare Education: a Vision for the 21st Century* to be generated by the Conference and made available in December 2014 and a substantial (20%) discount on the costs of membership (*via* Society membership of the appropriate grade) of the Special Interest Group (SIG 78) on Person-centered Undergraduate Medical and Clinical Education, thereby affording them access to and involvement in the work of the SIG and receipt of its communications, publications and news bulletins.

### **Contact us:**

- **For further information, registration details and costs, contact Mr. Marcos Maseda at: [marcos.maseda@pchealthcare.org.uk](mailto:marcos.maseda@pchealthcare.org.uk)**
- **For sponsorship & exhibition enquiries and to pose any clinical or academic questions, contact Professor Andrew Miles MSc MPhil PhD DSc (*hc*) at: [andrew.miles@pchealthcare.org.uk](mailto:andrew.miles@pchealthcare.org.uk)**