

# Person-centred medicine and mental health

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This paper discusses an integrated approach to person-centred medicine and its role in the future of mental health care. The origins and current status of this emerging field are revised with special attention to the contributions made from psychiatry and to the implications for psychiatric diagnosis and evaluation of the three pillars of the Person-centred Integrative Diagnosis (PID) model: its conceptual domains (health status, experiences and contributors to ill and good health), the related evaluative procedures, the partnerships needed and the existing links and differences with people-centred care and personalised medicine. In spite of their striking complementarities person-centred medicine and personalised medicine do not yet have substantial bridges built between them. Knowledge transfer and coordination should be established between these two models which will cast medical evaluation and care in the upcoming future.

**Key words:** People-centred care, Personalised medicine, Person-centred integrative Diagnosis, Person-centred medicine.

## Background

During the second half of the 20th Century medical diagnosis was progressively simplified by identification of a reduced set of symptoms and signs for every disease which was consequently incorporated to operational diagnostic systems and clinical guidelines. These systems increasingly relied on laboratory testing, biomarkers, imaging techniques and support decision systems. However, this approach is also related to extreme specialisation and uncontrolled commoditisation of the health care field, resulting in neglect of patients' personal needs and concerns, and weakening of the doctor–patient relationship (Heath, 2005). Person-centred medicine proposes the whole person and his/her context as the centre and goal of clinical care and public health (Salloum & Mezzich, 2011) taking into account the patients' values and health experiences, as well as to their resilience, environmental and personal resources, quality of life, and other aspects of positive health (Mezzich *et al.* 2010a).

In a landmark report, the Institute of Medicine concluded that the U.S. health system was seriously flawed and requires a new framework with a new set of aims and rules, a key principle being person-centredness (Institute of Medicine, 2001). Along the same lines, the U.S. Presidential Commission on Mental Health (2003) found the national mental health care system is in a state of disarray and proposed a

thorough transformation of the system to be driven by the patient and the community. The World Health Organization European Office (2005) proposed an Action Plan to reorganise mental health care around the needs of patients and carers. A similar approach has been adopted in the UK (Department of Health, 2009).

## A short history of person-centred medicine

The personalised approach is a distinctive pattern of many ancient medical systems, for example Chinese and Ayurvedic, where practitioners follow the bodily state and the experience of the patient from visit to visit and adjust treatment accordingly (Kirmayer, 2004). Ancient Greek philosophers and physicians also advocated for a holistic approach and such encompassing Eastern and Western views are consistent with the World Health Organization's broad definition of health as a complete state of physical, emotional and social well-being, and not merely the absence of disease (Mezzich *et al.* 2010a).

The development of the person-centred approach is closely linked to a restricted number of medical disciplines, as family medicine, psychiatry, paediatrics, geriatrics and general internal medicine. Paul Tournier, a Swiss general practitioner, made a seminal contribution to the renaissance of person-centred medicine in the 1940s (Pfeifer, 2010). A patient-centred 'medical home' model, which aims to provide comprehensive primary care and facilitate partnerships between individual patients and their physicians and, when appropriate, the patient's family, was developed in 1967 by

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the American Academy of Paediatrics and endorsed later by the American Academy of Family Physicians and a growing number of national health professional associations (Rosenthal, 2008). Family physicians have adopted a holistic and contextualised patient-centred approach (McWhinney, 1989). The American physician Eric Cassell highlighted the importance of suffering as an experience of the whole person, and introduced the concept of personhood in general medicine (Cassell, 1982; Cassell, 2010).

Mental health has also played a decisive role in shaping the person-centred model. In the 1940s Carl R. Rogers in the U.S. argued for a *Client-Centered Therapy* and for the value of open communication and empowering individuals to achieve their full potential (Rogers, 1951, 1961). The beginnings of the World Psychiatric Association (WPA) in 1950 already revealed interest on the concept of the person as central to the field (Garrabe, 2008). W.A. Anthony incorporated the concept of personhood and recovery to the psycho-social rehabilitation field (Anthony, 1993, 2004). This approach goes beyond the focus on symptom management and functional improvement to promote wellness and quality of life, in a process that involves shared decision-making, and where the needs of the patients always come first.

The Finnish psychiatrists Y.O. Alanen developed the *Need-adaptive Assessment and Treatment* approach, which encourages attention to the meaning of patients' experiences and to the nature of their needs (Alanen, 1997). The interest on person-centredness has kept pace with a renaissance of philosophical analysis in psychiatry aimed at addressing the complexity of illness experience and engaging the patient as a person. *Values-based practice* (Fulford *et al.* 2002) and the multi-level explanatory schemas (Schaffner, 2009) are key contributions to this movement.

Psychiatry has also played major role in developing a common framework by encouraging networking and bridging in this area. During the past decade the Section on Classification, Diagnostic Assessment and Nomenclature of the WPA promoted and extended the person-centred approach to diagnosis and intervention based on the person-centred model (Mezzich & Ustun, 2002; Banzato *et al.* 2005; Salloum & Mezzich, 2009). This group developed the International Guidelines for Diagnostic Assessment (IGDA), a comprehensive diagnostic schema that integrates a standardised multi-axial formulation, employing scales and official typologies yielding information comparable across the world on illnesses, disabilities, contextual factors and quality of life, and an idiographic, personalised statement allowing clinicians, patients and families to indicate what is unique and most meaningful in the contextualised clinical

situation, including positive factors, as well as joint plans for restoration and promotion of health.

Members of the Classification Section and several other WPA scientific sections actively cooperated in the organisation of the Geneva conferences on person-centred medicine (Mezzich, 2011b), from which aroused the International Network for Person-centred Medicine (INPCM) (Mezzich, 2011a), now the International College of Person-centred Medicine (ICPCM) and the International Journal of Person-Centred Medicine (Miles & Mezzich, 2011). These initiatives have been landmarks in a process of building a movement of medicine for the person through the collaboration of major global medical and health organizations and a growing group of committed individuals.

The institutions formally involved in the Geneva Conferences have included the World Medical Association (WMA), the World Organization of Family Doctors (Wonca), the International Network for Person-centred Medicine, and other organisations such as the Council for International Organizations of Medical Sciences (CIOMS), the World Federation for Mental Health (WFMH), the World Federation of Neurology (WFN), the World Association for Sexual Health (WAS), the International Association of Medical Colleges (IAOMC), the World Federation for Medical Education (WFME), the International Federation of Social Workers (IFSW), the International Council of Nurses (ICN), the European Federation of Associations of Families of People with Mental Illness (EUFAMI), the International Alliance of Patients' Organizations (IAPO), the University of Geneva School of Medicine and the Paul Tournier Association. Since 2010, the Geneva conferences have been organised together with WHO (Health Systems and other Departments).

### The Person-centred Integrative Diagnosis (PID)

The PID is a person-centred approach to diagnosis that continues and expands the previous work made at IGDA. Psychiatric diagnosis is here regarded as an assessment process not only for nosological or differential diagnosis but also for the understanding of the person experience and its contextual instances. The development of PID included three focus or discussion groups with psychiatrists, health professionals and other health stakeholders (patients, families and advocates), and a survey of a global network of national classification and diagnosis groups. The main findings from these consultations include the perception that planning of treatment and care (rather than illness identification or inter-clinician communication) is the

main purpose of diagnosis; the desirability of simplifying standard psychopathological classifications through clusters and prototypes; and that diagnosis should cover not only disorders but also disabilities, positive aspects of health, risk and protective factors, and the patient’s values and experience on illness and health. These consultations also supported the use of dimensions and narratives in addition to categories as descriptive tools; and the importance of basing the diagnostic process on an active partnership among clinicians, patients and families. These consistently expressed perspectives seem to strongly support a person-centred diagnostic approach in contrast to the conventional disease-centred diagnosis (Mezzich *et al.* 2010a).

The PID conceptual framework covers domains of both *ill health* and *positive health* along three complementary levels: Health Status, Experience of Health and Contributors to Health (Fig. 1) (Mezzich *et al.* 2010a).

The domain level on *Health Status*, includes first illnesses or disorders of both mental and physical forms which should be assessed according to the international standards (mainly WHO’s International Classification of Diseases and related diagnostic tools). Disabilities would be assessed through procedures such as those based on the International Classification of Functioning and Health (ICF) (WHO, 2001). The assessment of the well-being aspect of Health Status should be developed through scales appraising quality of life and related constructs (Cloninger & Cloninger, 2011). The domain level on

*Experience of Health* appraises the patient’s illness- and health-related values and cultural experiences, which should take into account guided narrative procedure built on world-wide experience with the Cultural Formulation (Mezzich *et al.* 2009). The third domain level on *Contributors to Health* covers the intrinsic and extrinsic biological, psychological and social factors of both risk and protective types. Their assessment should involve a combination of procedures aimed at assessing healthy and unhealthy life-style factors and related health contributors (Alonso *et al.* 2010; Cloninger & Cloninger, 2011).

The PID conceptual model is also linked to a novel evaluation system and new cooperation needs. The *Pluralistic Descriptive Procedures* system (Mezzich *et al.* 2010a) follows an open building-blocks approach to generate an evaluation system usable within the PID framework. For example, the diagnostic evaluation process should be broadened to incorporate probabilistic and prototypical categories (Westen, 2012), clinimetrics (Feinstein, 1987) and categorical–dimensional hybrid models (Muthén, 2006). It should also incorporate narratives as a critical component of the evaluation process, given its importance of understanding patients’ illness experience in the context of their life stories and current illness narratives. The person’s illness narrative and account of health and resilience offer the clinician a clear picture of issues and priorities that can organise and guide clinical intervention (Kirmayer, 2000).

Psychiatric research has already incorporated many of the components of PID in transcultural studies

ILL HEALTH	POSITIVE HEALTH
<b>I. HEALTH STATUS</b>	
<b>Illness &amp; its Burden</b> a. Disorders b. Disabilities	<b>Well Being</b> Recovery/Wellness Functioning
<b>II. EXPERIENCE OF HEALTH</b>	
<b>Experience of Illness</b> ( <i>e.g. suffering, values, understanding and meaning of illness</i> )	<b>Experience of Health</b> ( <i>e.g. self-awareness, resilience, fulfillment</i> )
<b>III. CONTRIBUTORS TO HEALTH</b>	
<b>Contributors to Illness</b> ( <i>intrinsic/extrinsic; biological, psychological, social</i> )	<b>Contributors to Health</b> ( <i>intrinsic/extrinsic; biological, psychological, social</i> )

Fig. 1. PID domains.

(Mezzich *et al.* 2009), managerial epidemiology (Krumholz *et al.* 2006) and translational research (Wang *et al.* 2009; Ruggeri, 2011). However, the practical implementation of *Pluralistic Descriptive Procedures* implies a full change of mental health evaluation, particularly as regards to the incorporation of narratives, personal experiences and positive health components such as resilience or flourishing. Narratives have been used extensively in qualitative research and are a valuable source of information (Charon, 2006), but the development of a set of metaphors for quantitative analysis, and its use in routine practice or to generate evidence-informed care poses many challenges to psychiatric evaluation. The use of Semantic Web Knowledge techniques (Tao *et al.* 2010) in the analysis of narratives may allow for extensive review of the personal experiences of patients with severe mental disorders including positive accounts of recovery (Roberts, 2000). The development of *narrative banks* of health experiences may contribute to a better understanding of positive and negative aspects of ill health and may also contribute to improve diagnosis and treatment planning based on personal preferences and experiences. This approach has been suggested to improve knowledge on medication intake, attitudes and adherence in mental disorders (Tibaldi *et al.* 2011). PID has been adopted by the Revision of the Latin American Guide for Psychiatric Diagnosis (GLADP) produced by the Latin American Psychiatric Association (Saavedra *et al.* 2011a). It is important to note that the scientific application of the PID principles should not be limited to high income countries, as they are particularly important in low- and middle-income countries.

The World Health Organisation has recently produced Community-Based Rehabilitation (CBR) guidelines (WHO, 2010a) within its CBR programmes currently applied in over 90 countries. In order to provide a common framework for the CBR programmes a CBR matrix was developed in 2004 which consists of five key components: health (including promotion and prevention), education, livelihood, social and empowerment. The later includes advocacy and communication, community mobilisation, political participation, self-help groups and disabled peoples organisations. Recent psychiatric epidemiological studies in Peru covered ill- and positive-health, and employed narratives in addition to categories and dimensions (Instituto Nacional de Salud Mental, 2002; Saavedra *et al.* 2011b).

In order to put the PID model into practice the development of cooperation is essential. Therefore, *Partnership for Evaluation* is a fundamental element of person-centred care, and involves the pursuit of engagement, empathy and empowerment as well as respect for the autonomy and dignity of the consulting person. In fact, it is crucial for achieving shared

understanding for diagnosis and shared decision making for treatment planning with the patient and his/her family (Mezzich *et al.* 2010a).

### **Bridging and knowledge transfer in person-centred medicine**

Being a multidisciplinary and relational field (Mezzich, 2011a), person-centred medicine is closely linked to the new science of bridging, knowledge management and knowledge transfer.

Bridging encompasses a broad range of concepts, tasks, technologies and practices aimed at improving knowledge sharing and cooperation in care and support for persons with health problems. Bridging concepts should be based in health ontology and develop a common terminology knowledge base (Salvador-Carulla, 2009). Once a PID model has been agreed, it may be helpful to agree to the development of a conceptual map of related concepts, as well as a link with the ontology health databases such as SNOMED-CT (Rosenbloom *et al.* 2009). For example, it is necessary to clarify the existing difference between the concepts of well-being, quality of life, health experiences and values and contributors to health. The ontology and the semantic interoperability of the information systems developed in areas related to person-centred care has to be established. Bridging tasks may include all activities of dissemination, coordination, assessment, empowerment, delivery, management, financing and policy within the field of person-centred medicine. Bridging technologies include mainly information technologies, and the evaluation system that may eventually provide a usable battery of assessment instruments, analysis techniques and evaluation guidelines. Bridging practices in the field of person-centred medicine should also be registered and incorporated to practice banks.

Knowledge transfer is not a linear one-time event; it requires ongoing active dialogue and exchanges between researchers, policy makers, practitioners and client groups, in order to develop and to implement a holistic integrative care and support; or to effectively exchange the procedures and experiences in translational research, transdisciplinarity, and in the development of multidisciplinary groups in research, education, provision, management and policy (McDaid *et al.* 2009). The role of networks, knowledge brokering and partnerships deserve special attention. The coordination and partnership may include all stakeholders from health researchers to policy decision makers and society. In 2009, the Barcelona declaration on bridging and knowledge transfer opened the road for a formal development of this field (Salvador-Carulla *et al.*



2009). Several members of the International Network of Person-Centred Medicine participated in the related international conference and contributed to define this new field of expertise.

### Setting links with people-centred care and personalised medicine

Health-related person-centredness and PID encompasses all health sciences and person-centred medicine should be defined within the broader context of person-centred care. However, the relationship, boundaries and hierarchy of person-centred medicine should be established with the areas of *people-centred care* and *personalised medicine* to enable a more effective model of integrated care.

According to WHO, people-centred care covers person-centred care as it is an umbrella term that better encapsulates the foremost consideration of the patient across all levels of health systems (WHO, 2010a). The WHO vision for people-centred health care 'is one in which individuals, families and communities are served by and are able to participate in trusted health systems that respond to their needs in humane and holistic ways. The health system is designed around stakeholder needs and enables individuals, families and communities to collaborate with health practitioners and health care organizations in the public, private and not-for-profit health and related sectors in driving improvements in the quality and responsiveness of health care' (WHO, 2007). Providing equitable access to people-centred care has been described as one of the key components of an effective health system by WHO (WHO, 2010b).

However, differences exist between the individual care approach and the population policy approach that go beyond this perspective. The WHO proposal of a hierarchical relationship of these terms into one parent category (people-centred care) and a child category (person-centred care) should be revised. Recent developments in people-centred care and person-centred care are closely coordinated particularly through the partnership developed at the Geneva conference series since 2010 (Mezzich, 2011b).

The advances in new diagnostic and treatment technologies have coalesced in the model of personalised medicine (Abrahams *et al.* 2005) aimed at tailoring diagnosis and treatment to every individual's genomic profile and biomedical characteristics. As person-centred medicine has produced an integrative model of diagnosis, a similar process has occurred in the field of individualised medicine. 'Theranostics' (a term formed by the combination of 'Therapeutics' and 'Diagnostics') describes the process of diagnostic

therapy for individual patients using biomarkers to test possible reaction to taking a new medication and to predict the most suitable drug for a patient along with assessing the efficacy of the drug and other care interventions (e.g. changes in health-related habits) based on the test results. Theranostics is broadly used in functional imaging and nanomedicine. Both personalised medicine and theranostics are highly commoditised and have raised an increasing interest by health companies and governments in contrast with the limited commercial support provided to implement person-centred medicine into actual practice. A 'Genomics and Personalized Medicine Act' was introduced to the US Congress in 2006, 2007 and 2010 to address scientific barriers, adverse market pressures and regulatory obstacles even though the reliability, the health economic aspects and usability of personalised medicine is still in its infancy (Ng *et al.* 2009).

In spite of their evident complementarities, personalised medicine and person-centred medicine are currently at odds. These two approaches will certainly have a major impact in mental health care, training and policy. It may be path-opening that high-tech personalised medicine and person-centred medicine that articulates science and humanism build bridges to develop an integrative medical practice that finally encompasses high technology with high human contact. Current models of integrative care do provide a framework for supporting this common perspective on behavioural sciences and mental health (Singer & Ryff, 2001).

### Declaration of interest

None.

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