Person Centered Medicine

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Editors

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Chapter 1
Introduction to Person Centered Medicine

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1.1 Introduction

Person Centered Medicine (PCM), as a basic concept, recognizes the whole person as the center of medicine and health and as the objective and protagonist of health actions. This compact notion will be unpacked and explained through complementary delineations, both informal ones and those resulting from systematic conceptualizations studies presented in the course of this introductory chapter.

To understand further PCM as a concept and as a programmatic movement, a number of angles are to be engaged in this chapter. These include historical unfolding, philosophical bases, maturation processes, inter-institutional collaboration, organizational development, and scholarly activities such as research projects, educational programs, and publications.

Then, the present Person Centered Medicine book will be outlined and analyzed in terms of their objectives, authorship, structure and content. Major substantive topics as well as issues for the implementation of person-centered care will be touched on. The chapter will end with concluding words on the book's thrust and horizons.

1.2 Historical Development of Person Centered Medicine

An overview of the historical development of medicine in general reveals the special place of the person throughout such development. The pre-historic Neanderthal era strongly suggests the crucial role of social mutual care for the protection and promotion of life and health among our remote ancestors.

It appears that care for illness and injury became widespread and depended on the close social bonds developed within groups and the concern for each other's well-being [1]. This resonates with the contemporary understanding of universal health as both a right and a responsibility.

An appraisal of Early History documents the personalized concept of health throughout both Eastern and Western ancient civilizations. In the Far East, the first significant records of formal medicine were in China, where the sense of complementarity (the *ying* and *yang*) was a fundamental symbol of health [2]. From 1700 BC, the Vedic and

Sanskrit books in India detailed medical practices some of which, such as Ayurveda holistic medicine and massage, may have been established as early as 3000 BC [3].

Highly relevant to Person Centered Medicine and contemporary ecological concerns is the encompassing concept of health in the Andean cosmovision as harmonic equilibrium among the internal, social and natural worlds, which appear to resonate in several other ancient civilizations [4]. Also interesting and relevant are the discernible coincidences on the concept of life well lived, *eudaimonia* in Aristotelian ethics [5, 6] and *allyn kawsay* in the Andean worldview [7]. The intrinsic value of an encounter between persons highlighted in Ubuntu humanism in Africa [8] resonates with the previously mentioned mutuality of social support for health among Neanderthals.

In the Middle Age, the Golden Era of Islamic Medicine revealed the attentive and considerate attention dispensed to ill persons to promote their well-being, as epitomized by the architecture and landscape of some of the world's earliest hospitals built in that era [9, 10].

During the Modern Age, first, the rediscovered interest on the person in the arts, and then the cultivation of the humanities through the *illustration* and *rationalism*, as eponymized by Spinoza [11], demonstrated high concern for the flourishment of human beings.

The first phase of the Contemporary Age, from the late eighteenth century to the end of the nineteenth century, has as highlights, first, the French Revolution and its Declaration of Human Rights, and second, German Philosophy on ethics, particularly through Immanuel Kant's [12] categorical imperative affirming the person as always a goal, not a means.

A second Contemporary phase, covering the twentieth century, exhibits early person-centered formulations, highlighted by Jose Ortega y Gasset's [13] dictum *I am I and my circumstance, and if I do not save it, I do not save myself*, by the books of Tournier [14], starting with *Médecine de la Personne*, and by Rogers [15] and Rogers and Rosemberg [16] person-centered approaches to education and psychotherapy, especially *Becoming a Person* and *The Person as Center*. There were also proposals for a patient- or person-centered medicine connected with highly relevant medical fields such as dementia [17] and family medicine [18] and within specific countries such as Italy, with proposals related to alternative medicine [19] and medical epistemology [20]. All this took place at the same time as the massive development of scientific medicine, with its hyperbolic interest on organs and diseases, led to striking advances in diagnosis and treatment, but also to neglect of the doctor-patient relationship, dehumanization of medicine and commercialization of health care [21].

1.3 Collaborative and Institutional Development of Person Centered Medicine

Building on twentieth century person-centered care proposals and responding to its noted challenges, a collaborative, institutional and programmatic movement for person centered medicine emerged in the twenty-first century. It involved two phases. The first one from 2005 to 2008 took place in the form of an Institutional Program

on Psychiatry for the Person within the World Psychiatric Association (WPA). The second one, since 2008 to date, evolved from the first one by extending its scope from psychiatry to medicine at large and progressing institutionally through collaboration with a large number of top global institutions in medicine and health.

The Institutional Program on Psychiatry for the Person, established by the 2005 General Assembly of the World Psychiatric Association (WPA), involved an organization-wide initiative (engaging its 130 national psychiatric societies and 65 scientific sections) and affirming the whole and contextualized person of the patient as the center and goal of clinical care and health promotion, at both individual and community levels. This was set to involve the articulation of science and humanism to optimize attention to the ill and positive health aspects of the person. As care is basically a partnership experience, the program involved the integration of all relevant health and social services. Furthermore, the program also involved advancing public health policies.

Historians Garrabe and Hoff [22] have noted that the core principles behind psychiatry for the person could be already detected at the very beginning of the WPA in 1950 and appeared to be the critical factors underlying its emergence. As a conceptual and programmatic introduction, two editorials were published in *World Psychiatry*, one on articulating medicine's science and humanism as a basic tenet [23] and another on the dialogic basis of the profession [24]. A monographic set on the conceptual bases of psychiatry for the person was prepared and eventually published [25, 26].

A key area of work was person-centered diagnosis, building on an earlier consultation with a large number of WPA national psychiatric societies and the resulting development of the *International Guidelines for Diagnostic Assessment (IGDA)* combining standardized multiaxial and personalized idiographic formulations [27] as well as on close collaboration with the World Health Organization for the planning of ICD-11 [28, 29]. This eventually led to the construction of the Person-centered Integrative Diagnostic Model [30].

The second phase of the institutional development of Person Centered Medicine started around 2008, through contacts between the leaders of WPA and those of other important global organizations such as the World Medical Association, the World Health Organization, the World Federation of Neurology, the World Organization of Family Doctors (Wonca), the International Council of Nurses, and the international Alliance of Patients' Organizations, among others. These interactions revealed wide interest in a perspective that placed the person at the center of general medicine and health care.

This led to the collaborative organization of the first Geneva Conference on Person Centered Medicine at Geneva University Hospital in April 2008. This started a process of annual Geneva Conferences, from which emerged the International Network, now International College, of Person Centered Medicine [26, 31].

Collaboration has been particularly strong with the World Medical Association (WMA) and the World Health Organization (WHO). Relevant to cooperation with the WMA is its long standing commitment to medical ethics as manifested by its *Geneva Declaration* as an updated *Physician's Oath* [32], and its *Declaration of Helsinki* as Guideline for Ethical Medical Research [33, 34]. In line with this, the WMA, which

is headquartered just outside Geneva, has provided logistic support for the ICPCM's annual Geneva Conferences since its first edition in 2008 to date, and has facilitated the prominent participation of WMA presidents at many of these Conferences.

World Health Organization [35] World Health Report identified *People-centered Health Services* as one of its pivots and made this perspective a fundamental element of its Program of Work, which has been the basis for much of its collaboration with the ICPCM along the years. WHO also provided funding for the ICPCM's seminal study on the Systematic Conceptualization of Person Centered Medicine and the Development and Validation of a Measurement Index [36]. WHO also hosted many of the ICPCM Geneva Conferences at its headquarters in Geneva. Furthermore, WHO's Regional Office for the Americas is collaborating closely with the ICPCM's Latin American Network in the exploration and delineation of innovative persons-centered health strategies.

The Geneva Conferences on Person Centered Medicine were conceived since its first edition in 2008 as the stable matrix for the conceptual and procedural maturation of a perspective that could evolve into a programmatic movement for a whole-person medicine. The selection of Geneva for this purpose was predicated in its being known as the *city of encounters* and its hosting within its boundaries and surrounding area the most important global institutions for medicine and health such as the World Medical Association, the World Health Organization, as well as the World Health Alliance that encompasses the International Council of Nurses, International Pharmaceutical Federation, the World Dental Association, and the Council of International Organizations of Medical Science, among others.

As the chronological list of Geneva Conferences show on Table 1.1, there have been 14 such events between 2008 and 2022, one every year except in 2020 due to the Covid19 pandemic. The Conferences in 2021 and 2022 were held on line only.

Table 1.1 ICPCM Geneva conferences on person centered medicine

No.	Year	Main theme
1	2008	Conceptual explorations on person-centered medicine
2	2009	From concepts to practice
3	2010	Collaboration across disciplines, specialties and programs
4	2011	Articulating person-centered clinical medicine and people-centered public health
5	2012	Chronic diseases: person- and people-centered perspectives
6	2013	Person-centered health research
7	2014	Person- and people-centered care for all
8	2015	Person-centered primary health care
9	2016	Person-centered integrated care through the life course
10	2017	Celebrating 10 years of promoting healthy lives and well-being for all
11	2018	Person centered women's health 40 years after alma ata
12	2019	Promoting well-being and overcoming burn-out
13	2021	Self-care and well-being in the times of Covid-19
14	2022	Optimizing clinical care through person centered medicine

Their main themes, as a group, covered general conceptual and strategic issues, examined core principles of PCM, and dealt with major challenges such as the burnout of health professionals and the Covid19 pandemic. Since the 5th Geneva Conference, their impact was extended through a Declaration that was disseminated widely.

The International Congresses of Person Centered Medicine were organized by the ICPCM and a host institution annually since 2013 as attempts to extend the PCM perspective world-wide and to learn how PCM may be practiced in different latitudes and meridians. The first one in Zagreb recognized the pioneer PCM achievements of our colleagues in Croatia, and honored Andrija Stampar, the founder of the Zagreb University School of Public Health and early person-centered care proponent who chaired the First World Health Assembly and coined the still currently official definition of health focused on the promotion of well-being. As shown in the list of these nine Congresses on Table 1.2, they have been held annually in four different world regions. Their main themes decided jointly by the ICPCM Board and the host organization have covered topics that are of both broad international significance and pointed interest locally. Every International Congress has been generating a Declaration to extend its impact, accompanied by an academic paper to support it.

The Paul Tournier Prize constitutes an annual event to promote Person Centered Medicine by honoring the legacy of Paul Tournier, the Geneva family doctor regarded as one of the fathers of Person Centered Medicine. It is awarded annually since 2017 by the International College of Person Centered Medicine in cooperation with the Paul Tournier Association and the Paul Tournier Family, to scholars who have made highly distinguished international contributions to this programmatic perspective. The Prize winners, who are listed on Table 1.3, have come so far from North America, Latin America and Europe, which are the world regions, along with Oceania, currently most active in the cultivation of Person Centered Medicine.

Table 1.2 ICPCM International Congresses of Person Centered Medicine

No.	Year	City	Main Theme
1	2013	Zagreb	Whole person in health education and training
2	2014	Buenos Aires	Advancing humanistic and interdisciplinary health care
3	2015	Londres	Celebrating primary care achievements: seeing the person behind the patient and a life course approach
4	2016	Madrid	Person centered medical education and the goals of health care
5	2017	Zagreb	Person-centered cancer care
6	2018	Nueva Delhi	Person-centered care for non-communicable diseases
7	2019	Tokyo	Work-life balance: challenges and solutions
8	2020	Montevideo	Responding to the pandemic with persons-centered comprehensive care, human rights and sustainable development goals
9	2021	Kuwait	Culture and person centered clinical care and public health in the eastern Mediterranean region

Table 1.3 Winners of the Paul Tournier Prize

Prize year	Winner's name	City and country
2017	Wim Van Lerberghe	Geneva, Switzerland
2018	C Robert Cloninger	St. Louis, USA
2019	Alberto Perales	Lima, Perú
2020	George Christodoulou	Athens, Greece
	John Cox	Cheltenham, United Kingdom
2021	W James Appleyard	Canterbury, United Kingdom
2022	Sandra Van Dulmen	Nijmegen, The Netherlands

1.4 Conceptual Development of Person Centered Medicine

In its most basic form, it may be said that Person Centered Medicine (PCM) is a perspective that places the whole person as the center of an encompassing concept of health and as the target and protagonist of health actions. Analyzing this formulation, the term *perspective* could be seen just as a generic concept or, taking into account various important considerations discussed throughout this book, it could be said that it is a historically- and philosophically-grounded collaborative programmatic movement. For a further ontological interpretation, it could be said in the words of the eminent Latin American internists Calderon and Vildózola [37], that this perspective constitutes both a fundamental *principle* and a crucial *strategy* in medicine.

A key term in the definition of PCM is the *person*, which appears more valuable than alternatives such as "individual" or "self" on two important grounds. One is its strong connection to ethics, a concern of the highest order in medicine as evidenced by the commitment of the World Medical Association [34] to its Helsinki Declaration, and by the close relationship between person and ethics, i.e., WHO ethics specialist Bouësseau [38] asserted at a Geneva Conference on Person Centered Medicine that if a research project is ethical it has to be person-centered and if it is person-centered, it would be ethical. Furthermore, Ierodiakonou [6] has argued that Aristotle's ethics work is based on person-centered considerations, and Kant's [12] categorical imperative states that the person is always a goal not a means. Consideration of ethics, ensures respect for the dignity of persons and for their autonomy (which is essential for coupling promotion of human rights with promotion of human responsibilities).

A second ground for preferring the term person to various alternatives is the richness of its descriptive and scientific meaning, as follows, (1) *Person* is quite proteic and comprehensive with biological, psychological, social, ecological and spiritual dimensions, (2) It promotes a concept of whole health, encompassing ill health (diseases, disabilities, health problems) and positive health (functioning, resilience, well-being), (3) It represents an organizing pivot for understanding the increasingly prevalent multimorbidity and the corresponding need for the coordination of health services, (4) It highlights the persons that are behind the roles of patients, health professionals, and family members. The last point also explains why person-centered is preferable to patient-centered, i.e., "patient" is just a role, while "person" stimulates broadness and creativity in care.

Further substantiating and delineating the conceptual value of the *person*, is that this is ontologically a central, basic, irreducible element; and epistemologically, it can be stated that person-level knowledge is both important and possible [39]. Concerning the centrality of the person for understanding health, this has been pointedly argued by Cassell [40] and Cassell and Stoyanov [41] ("the person as center of health") and by Tempier [42] ("what is good for the person, is good for his/her health"). In regard to the view of the person as target and protagonist of health actions, this is widely acknowledged as Cassell [43] does in his *Nature of Healing*.

To complement the presentation and analyses above of a central formulation of PCM, some other helpful formulations are presented next. Well received in the clinical arena is the assertion that PCM involves a medicine *of the person* (of the totality of the person's health, including its ill and positive aspects), *for the person* (promoting the fulfillment of the person's life project), *by the person* (with clinicians extending themselves as full human beings with high ethical aspirations, and *with the person* (working respectfully, in collaboration and in an empowering manner with the person presenting for care) [31].

Also important, as proposed by then WHO Assistant Director General and now PAHO Director General Carissa Etienne, is the articulation of person-centered clinical medicine and people-centered public health and to involve a wide range of professional and patient organizations to implement and promote such perspectives [44]. As *person* and *people* are seen as the two sides of the same coin, the term *persons* is often used.

Furthermore, as a theory of medicine, PCM is seen as *informed* by evidence, experience, and values, and aimed at restoring and promoting the health and well-being of whole persons. Finally, the following two research models on conceptualization and measurement and on a person-centered integrative diagnosis are denotative of the conceptual development of Person Centered Medicine.

1.4.1 Systematic Conceptualization and Measurement of Person-centered Medicine and Care

In response to the growing interest and variable understanding of person-centered medicine and care, the need for efforts on their systematic conceptualization and measurement became apparent. With financial support from the World Health Organization, the International College of Person Centered Medicine undertook this task [36]. The objectives included the elucidation of the core concepts of person centered medicine and healthcare, the design of a prototype measuring instrument, and the study of its metric structure, further development, acceptability, reliability and validity. The methods employed were the following: A systematic review of the literature, consultation exercises with broad international panels composed of health professionals and representatives of patient and family organizations, and quantitative and qualitative data analyses.

The following key concepts underlying person centered medicine were elucidated: (1) Ethical Commitment, (2) Cultural Awareness and Responsiveness, (3) Holistic scope, (4) Relational Focus, (5) Individualized Care, (6) Common Ground for Collaborative Diagnosis and Care, (7) People-centered Systems of Care, and (8) Person-centered Health Education and Research. On this basis, a Person-centered Care Index was developed composed of 8 broad items and 33 sub-items, each measured on a 4-point scale. The PCI is displayed in Table 1.4.

Table 1.4 The person-centered care index (PCI)

No.	Indicators	Never	Occasionally	Frequently	Always
1.	Ethical commitment				
1.1	The dignity of every person involved is honored	1	2	3	4
1.2	The patient's rights are respected	1	2	3	4
1.3	The patient's autonomy is supported	1	2	3	4
1.4	The patient's empowerment is advanced	1	2	3	4
1.5	The patient's personal values and needs are understood and respected	1	2	3	4
1.6	The fulfillment of the patient's life project is enabled and encouraged	1	2	3	4
2.	Cultural sensitivity				
2.1	The patient's ethnic identity and cultural values are recognized	1	2	3	4
2.2	The patient's language and communication preferences are considered	1	2	3	4
2.3	The patient's gender and sexual preferences are respected	1	2	3	4
2.4	The patient's spiritual needs are pointedly considered	1	2	3	4
3.	Holistic scope				
3.1	The biological, psychological, social, cultural and spiritual factors of health inform understanding and care	1	2	3	4
3.2	Both health problems/disabilities and positive health are attended	1	2	3	4
4.	Relational focus				
4.1	Clinicians, patients and families work in partnership	1	2	3	4
4.2	Empathy in clinical communication is emphasized	1	2	3	4
4.3	Inter-personal trust is fostered throughout the care process	1	2	3	4
5.	Individualized care				
5.1	The patient's individuality and unique qualities inform care	1	2	3	4

(continued)

Table 1.4 (continued)

No.	Indicators	Never	Occasionally	Frequently	Always
5.2	The patient's historical and social context are factored in process of care	1	2	3	4
5.3	The patient's personal growth and development are promoted	1	2	3	4
6.	Common ground for diagnosis and care				
6.1	Diagnosis of health status involve patient/ clinician joint understanding	1	2	3	4
6.2	Diagnosis is cooperatively worked out for whole person and whole health	1	2	3	4
6.3	Care plan decisions are made collaboratively	1	2	3	4
7.	People-centered systems of care				
7.1	The health and rights of all people in the community are attended	1	2	3	4
7.2	The community participates in the planning of health services	1	2	3	4
7.3	Collaboration across disciplines and service programs is promoted	1	2	3	4
7.4	Personalized services are aimed at attaining high quality and excellence	1	2	3	4
7.5	Health services are responsive to specific community needs	1	2	3	4
7.6	Health services are integrated and coordinated around patients' needs	1	2	3	4
7.7	Services emphasize people-centered primary care	1	2	3	4
7.8	Services ensure continuity of care	1	2	3	4
7.9	Services are informed by wide person-centered perspectives	1	2	3	4
8.	Person-centered education, training and research				
8.1	The health system promotes person-centered public health education	1	2	3	4
8.2	The health system promotes person-centered health professional training	1	2	3	4
8.3	The health system promotes person-centered health research	1	2	3	4
Global average score					
Additional evaluative comments					

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Please rate the following person-centered care indicators in terms of their level of presence in a given health service. The term "patient" here refers to a person who experiences health problems and/or uses health services. To obtain a global average PCI score, please add the partial scores and divide this by the number of items actually rated.

The study of its metric structure revealed high Cronbach internal consistency (0.95), scale unidimensionality through factor analysis (69% of the variance accounted for by the first factor), and interesting inter-correlations such as the sub-item attaining the highest correlation with the global average score being "fulfillment of the person's life project" (0.88). Validation studies in California, London and Lucknow (India) showed quite high levels of inter-rater reliability (above 0.80 intra-class correlations for most items) and substantial content validity.

The elucidated core concepts of person centered medicine appear to be consistent with those of international studies on the bases of person- and people-centeredness in primary care and on research and implementation of person centered care. The concepts are also consistent with the key domains of person-centered diagnostic approaches. Further validation studies with larger samples in diverse settings and cultures seem to be warranted. In conclusion, the emerging core concepts of person centered medicine appear to be robust. The Person-centered Care Index based on such concepts appears to have suitable metrics and promising acceptability, reliability and content validity.

1.4.2 The Person-Centered Integrative Diagnosis Model

Also of substantial conceptual value for Person Centered Medicine is the Person-centered Integrative Diagnostic (PID) model aimed at evaluating the person's whole health through key informational domains, upon establishing a common ground among involved professionals, patient and family, and employing categories, dimensions and narratives as descriptive tools [30]. The specific objectives of the pertinent research program were to review the conceptual bases of person-centered integrative diagnosis as a component and contributor to person-centered psychiatry and medicine and to outline its design and development. To this effect, an analysis was conducted of the historical roots of person-centered psychiatry and medicine and of emerging efforts to reprioritize medicine from disease to patient to person in collaboration with global health professional associations and with the coordinating support of the International Network and the subsequent International College of Person Centered Medicine.

The emerging Person-centered Integrative Diagnosis (PID) model articulates science and humanism to obtain a diagnosis *of the person* (of the totality of the person's health, both ill and positive aspects), *by the person* (with clinicians extending themselves as full human beings), *for the person* (assisting the fulfillment of the person's health aspirations and life project), and *with the person* (in respectful and empowering relationship with the evaluated person). This broader and deeper notion of diagnosis goes beyond the more restricted concepts of nosological and differential diagnoses [45]. More specifically, the proposed Person-centered Integrative

Diagnostic model, is defined by three keys: (a) broad informational domains, covering both ill health and positive health along three levels: health status, experience of health, and contributors to health, (b) pluralistic descriptive procedures (categories, dimensions and narratives), and (c) evaluative partnerships among clinicians, patients and families.

An unfolding research program is focused on the construction of practical guides and their evaluation, followed by efforts to facilitate clinical implementation and training. In summary, Person-centered Integrative Diagnosis is aimed at appraising the total health of the total person through plural descriptions and evaluative partnerships in order to establish the bases for integrative and effective care of the total person.

1.5 Scholarly Development of Person Centered Medicine

Research, educational and publication activities are milestones of PCM scholarly development. They are outlined below.

1.5.1 Research on Person-Centered Diagnosis

The diagnostic instrument investigated involved the practical application of the Person-centered Integrative Diagnosis (PID) model in terms of the (Latin American Guide for Psychiatric Diagnosis) (GLADP-VR) published by the Asociación Psiquiátrica de América Latina, Sección de Diagnóstico y Clasificación [46]. This guide represents an adaptation of the ICD-10 that seeks through a biopsychosocial approach to better reflect the holistic framework and culture of Latin American countries. This revision of the original GLADP included updated Latin American annotations and the new integrated diagnostic model centered on the person.

The aim of this study was to evaluate among Latin American psychiatrists the levels of applicability and usefulness of the GLADP-VR in comparison with major international diagnostic classification systems [47]. The survey evaluation instrument included questions about fundamental characteristics of a useful diagnostic guide and comparative questions about the acceptability and usefulness of the GLADP-VR, the original ICD-10, DSM-IV and DSM-5, and suggestions to improve the guide. The sample included 127 Latin American psychiatrists with an interest on diagnosis and classification and membership in one of the 17 national psychiatric societies affiliated with Latin American Psychiatric Association (APAL). They were sent the evaluation instrument by e-mail. Thirty-seven (29.1%) responses were obtained. There were no indications of demographic bias between respondents and no-respondents. The vast majority of respondents answered the questionnaire completely. Ninety-two percent reported knowing the GLADP-VR before the survey and 65.6% had actually used it before.

Concerning results, the most commonly used diagnostic system was the original ICD-10 (86.5%), followed by the GLADP-VR (56.8%). Regarding applicability, the diagnostic system recognized as the most user-friendly was the ICD-10 followed by the GLADP-VR, with the most difficult being the DSM-5. Concerning diagnostic accuracy, the GLADP-VR was found most useful; and the DSM-5 was least useful. Regarding usefulness for clinical care and professional practice, the ICD-10 was rated highest, followed by the GLADP-VR, and lowest was DSM-5. Regarding usefulness for yielding a complete view of the clinical situation, the GLADP-VR was best (83.3%), and DSM-5 was the lowest. Concerning cultural and psychosocial contextualization, the GLADP-VR was considered most useful, well above the original ICD-10 and the DSMs. Furthermore, the GLADP-VR was considered more useful for teaching and research by about 80% of psychiatrists, superior to the other diagnostic systems.

The findings of this study on the most prevalent use of ICD-10 are consistent with the results of a survey conducted earlier by the World Psychiatric Association across the world [48]. In addition, in the present study less than half of the respondents used regularly the DSMs. The findings of the present study concerning the GLADP-VR were quite consistent with the corresponding findings of an earlier preliminary evaluation of the GLADP-VR. This seems to be related to the GLADP-VR comprehensive personalized diagnostic formulation with various components, including narratives. In conclusion, there were indications that the GLADP-VR is seen in Latin America as having higher diagnostic accuracy, yielding a comprehensive view of the clinical situation and its context, and more suitable for teaching, research, and work in community mental health.

1.5.2 Research on Person-Centered Care

This research line is illustrated by a Comparative Study of Prototype Hospitals in Lima with the Person-centered Care Index Rated by Health Professionals conducted by Perales et al. [49]. The development of generic instruments with substantial metric features to appraise progress towards person-centered care is quite encouraging. The aim of the present study was to initiate a person-centered care research program in Latin America through the comparative evaluation of prototype hospitals in Lima, Peru with the use of the generic Person-centered Care Index rated by health professionals.

The study design involved the comparative appraisal of person-centered care in four prototype hospitals through the engagement of health professionals using the generic Person-centered Care Index (PCI) [36]. A Spanish version of the PCI was prepared for the present study in Lima, Peru. For this, groups of physicians and nurses working in clinical medicine and surgery services were engaged from four prototype hospitals, i.e., a public general hospital, a public specialized hospital, a social security hospital, and a private hospital.