

JEA



ESPCH-4

The Fourth Annual Conference and Awards Ceremony

THE EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE

26 & 27 October 2017

Westminster Cathedral Hall London, UK

Programme Brochure

13.10	LUNCHEON
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	Session 7. Early Afternoon Session
	FOCUS ON HEALTH POLICY, VALUE AND COMMUNITY-BASED PROVISION OF PERSON-CENTERED MODELS OF HEALTHCARE
	Early Afternoon Chairman Colonel (Rtd) Professor Emerita Marilyn Ray, Christine E. Lynn College of Nursing, Florida Atlantic University, Boca Raton, Florida, USA
13.50	Current U.S. Health Policy and the Future of Person-Centered Care Dr Sandra Tanenbaum, Professor, Health Services Management and Policy, College of Public Health, Ohio State University, Ohio, USA
14.10	The problem of assessment of value of relationship in Patient Centered Healthcare Organizations Professor Didier Vinot, Co-Director, Chair 'Values of Patient-Centered Care' and Vice President for Economic and Social Affairs and Heritage, University of Lyon 3, France
14.30	Homecare: the person-centred approach Ms. Wendy Gee, Director of Nursing, Healthcare at Home Ltd, Newcastle-upon-Tyne, UK
14.50	"The Meaning of Me ®" a Canadian blue print for addressing the complex whole that is the person at the centre of the community based homecare services model Ms. Jane Teasdale, Director, Business Development & Community Relations and Principal Owner Mosaic Home Care Services Inc. and Community Resource Centres, Toronto, Ontario, Canada
15.10	PANEL DISCUSSION WITH DELEGATE PARTICIPATION (with invited Panel Discussant Dr. Elisa Chelle, France)

15.30	BREAK AND REFRESHMENTS
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	Session 8. Late Afternoon Session
	FOCUS ON CONCEPTS OF PERSONHOOD, PATIENT SAFETY AND COMPLEX CLINICAL SCENARIOS
	Late Afternoon Chairman Professor Andrew Miles MSc MPhil PhD DSc (hc), Senior Vice President and Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, <i>European Journal for Person Centered Healthcare</i> / Editor-in-Chief, <i>Journal of Evaluation in Clinical Practice</i>
16.00	A centered concept of personhood Dr. Thomas Fröhlich, Physician, Heidelberg, Germany & Vice President (Western Europe), European Society for Person Centered Healthcare
16.20	Gating the holes in the Swiss cheese: expanding Professor Reason's model for Person-Centered Healthcare Dr. Shashi S. Seshia, Clinical Professor, Department of Paediatrics, Division of Paediatric Neurology, University of Saskatchewan, Saskatoon, Saskatchewan, Canada
16.45	The care and costs of ME/CFS: the EUROMENE initiative Dr. Lorenzo Lorusso, Consultant Neurologist, Pavia, Italy; Dr. Derek Pheby, Visiting Professor of Epidemiology, Buckinghamshire New University, High Wycombe, England, UK; Dr. Lara Gitto, Health Economist & Researcher, CEIS EEHTA (Economic Evaluation and Health Technology Assessment), Univeristy di Roma "Tor Vergata", Rome, Italy & Dr. John Cullinan, JE Cairnes School of Business & Economics, National University of Ireland (NUI), Galway, Republic of Ireland
17.20	PANEL DISCUSSION WITH DELEGATE PARTICIPATION (with invited Panel Discussant Dr. Hilary Burton, Cambridge, UK)
17.40	Closing Remarks Professor Sir Jonathan Asbridge DSc (hc), DHSc (hc), President and Chairman of Council, European Society for Person Centered Healthcare
17.50	CLOSE OF THE FOURTH ANNUAL CONFERENCE OF THE ESPCH Professor Andrew Miles MSc MPhil PhD DSc (hc), Senior Vice President and Secretary General, European Society for Person Centered Healthcare & Editor-in-Chief, <i>European Journal for Person Centered Healthcare</i> / Editor-in-Chief, <i>Journal of Evaluation in Clinical Practice</i>
18.30	MEETING OF COUNCIL OF THE EUROPEAN SOCIETY FOR PERSON CENTERED HEALTHCARE (Members of Council and invited observers only)

material, we also exist as physically based features with a both temporal and spatial rootedness. Being rooted, in turn, implies a corresponding centeredness, establishing and maintaining a unique perspective emerging from the point of view of this material.

As characteristic for all living beings, we also are equipped with a device that by enclosing, filtering, attributing, anticipating and intermediating guarantees our operational, synchronic and sequential consistency and coherence, with the timing produced by our 'inner clock' and the functional positioning enacted in encounters with our 'Umwelt' (Uexküll).

The filtering done by putting an intermediating net over non-self items is based on a transient composition of agents that need not be spatially positioned as a net. They emerge from sets of functions, with underlying agents being elements of sets that need not be disjunct from each other. In formal terms, the envelopes wrapped around focused sets of incoming processes perform an anticipatory *focusing* 'vectorial indexing procedure', or *VIP*, with each vector pointing from inside to outside, or vice versa, and from present to an anticipated next present. They do so in functional analogy to the work of the skin as our physical border. Such functional analogies are common in Biology, like a fly's eye as a functional analogue of a human eye, both realising the potential (*dynamis*) 'ability to see'. Consequently, the centered concept of personhood must be derived from an identification of underlying potentials, their inherent timing and positioning and the inter- mediating function of an anticipating *focusing VIP*, realised as stable or transiently produced enveloping, mutually embodying networks.

16.20 Gating the holes in the Swiss cheese: expanding Professor Reason's model for Person-Centered Healthcare

Dr. Shashi S. Seshia, Clinical Professor, Department of Paediatrics, Division of Paediatric Neurology, University of Saskatchewan, Saskatoon, Saskatchewan, Canada

Introduction: The principles of person-centered healthcare (PCHC) have been discussed in several international forums. Patient safety can be defined as "prevention of (healthcare-associated) harm caused by errors of commission or omission," and implicitly incorporates the goal of ensuring the best possible outcome for every individual: patient safety is person-centered. Although patient safety has improved steadily, harm remains a major global healthcare challenge. To date, efforts to improve patient safety have focused on hospital settings rather than across the continuum of care. Better understanding of the complex covert cognitive factors influencing healthcare-related decisions and organizational cultures could lead to more rational approaches, and thereby to further improvements in PCHC not only in hospitals but throughout the spectrum of care.

Hypothesis: A model integrating the concepts underlying Reason's Swiss cheese theory and the cognitive-affective biases plus cascade has the potential to advance the understanding of cognitive-affective processes that underlie decisions and organizational cultures.

Methods: Thematic analysis and overview, qualitative information from several sources and disciplines being used to support argumentation.

Results-Discussion: In the integrated model, the Swiss cheese slices represent dynamic cognitive-affective gates: Reason's successive layers of defence. Like firewalls and antivirus programs, cognitive-affective gates allow the passage of rational decisions.

Erroneous decisions are blocked and consequences minimized by being constantly mindful, and activating additional cognitive defenses when necessary i.e., through dynamic cognitive-affective gating. Conversely, gates can be breached (i.e., 'holes' created) by one or more elements of cognitive-affective biases plus and other error-catalyzing factors at one or more levels of organizations, teams and professionals. There are far reaching downstream consequences when error catalyzing factors such as unsound decisions or erroneous information are made or circulated by those with authority or influence. Informed shared decision making is an often overlooked yet crucial dynamic cognitive-affective gate (layer of defence) in the care of each individual.

The integrated model addresses the complex covert cognitive phenomena that underlie decisions influencing patient safety. The model can also provide an evidence-informed framework for developing and evaluating strategies to optimize organizational, team and individual cultures and decisions.

Limitations: The concept is abstract, the model 'virtual,' and the best supportive evidence qualitative and indirect.

Conclusions: The integrated cognitive-affective-gated Swiss cheese model may help enhance rational decision making across the continuum of healthcare, thereby enhancing PCHC globally.

16.45 The care and costs of ME/CFS

Dr. Lorenzo Lorusso, Consultant Neurologist, Pavia, Italy and Dr. Derek Pheby, Visiting Professor of Epidemiology, Buckinghamshire New University, High Wycombe, [England, UK](#)

ME/CFS is a seriously disabling condition that may affect two million people in Europe, as well as family members and others. The European ME/CFS Research Network (EUROMENE), a research collaboration involving research institutions in 18 European countries, is endeavouring to enhance research capability in this area, in order to ameliorate the lives of sufferers and those around them. EUROMENE has six working groups, four for research groups (epidemiology, biomarkers, socio-economics, clinical research/diagnostic criteria), and two administrative (short-term scientific missions, workshops and conferences; dissemination).

Working Group 3 (socio-economics), with 10 participants from 6 European countries, has a series of tasks entirely within the field of health economics, and an overall objective to estimate the burden of ME/CFS to society and provide long-term trend estimates for societal impact. As a start, a literature review was undertaken, to review the current state-of-the-art. Initial literature searches were undertaken by Derek Pheby and Xia Wang, and a report prepared by Lara Gitto and Elenka Brenna. The review summarised ME/CFS as a condition of chronic weakness, of sufficient duration and severity to impair functioning, not alleviated by rest, and associated with lower quality of life, higher health care utilisation, and considerable cost implications. Most common in women, the peak age of onset is 20-40. Prevalence is between 0.2% - 2.6%, depending on which of many case definitions has been employed.

The literature review focused on publications applying economic evaluation techniques. A chronological approach was used, to identify possible evolution in research studies, and both direct (i.e. healthcare) and indirect (loss of productivity) costs were