Whole-person care in general practice

Factors affecting the provision of whole-person care

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This article is part three in a three-part series on whole-person care in general practice.

Background and objective
Whole-person care (WPC) is a key characteristic of general practice, but it may not be consistently practised. Previous articles in this series suggest a model of WPC that views patients as multidimensional persons; has length, breadth and depth of scope; is founded on a strong doctor–patient relationship and involves a healthcare team. This article reports factors that general practitioners (GPs) believe affect their provision of WPC.

Methods
Semi-structured interviews were conducted with 20 Australian GPs or general practice registrars and analysed using grounded theory methodology.

Results
Participants identified overarching factors (time, perceived value of WPC) and factors related to immediate (interpersonal dynamic), local (practice structure, relationship between care providers) and broader (health system structure) contexts that affect WPC. They volunteered practical suggestions to support WPC.

Discussion
GPs believe that multiple factors acting at micro and macro levels affect WPC provision. These findings provide a basis for strategies to support WPC.

WHOLE-PERSON CARE (WPC) is a defining feature of general practice, and it has received recent attention in response to increasing multimorbidity.[1–3]

The authors of the current study previously reviewed general practice literature to clarify the features of WPC (Supplementary Figure 1, available online only).[4] They subsequently conducted a qualitative study with the aim of determining how Australian general practitioners (GPs) understand WPC and identifying the factors that affect its provision.

Parts one and two of this series suggest a model of WPC developed from participants' responses (Supplementary Figure 2, available online only).[5,6] Participants valued WPC, describing it as an approach that views patients as multidimensional persons; has length, breadth and depth of scope; and is founded on a doctor–patient relationship within the context of a healthcare team.

Practically applying this model of WPC is likely to involve challenges. Previous literature suggests that GPs' rhetorical commitment to WPC may not be translated into practice.[7,8] This article reports factors that Australian GPs believe affect their provision of WPC.

Methods

Detailed study methods and participant characteristics are reported in part one of the series.[5] In brief, GPs or general practice registrars practising in Australia were recruited and completed a semi-structured interview concerning their understanding of WPC, its facilitators and barriers, and how they anticipated Health Care Homes (HCHs) would affect WPC.[9] Transcripts were analysed using grounded theory.[10]

Results

Nineteen GPs and one general practice registrar participated; demographics are reported in part one.[5]

Six themes describe the factors that participants believe affect WPC provision: 1) time investment; 2) perceived value of WPC; 3) interpersonal GP–patient dynamic; 4) relationship between care providers; 5) practice structure and 6) health system structure. These are divided into factors related to immediate, local and broader contexts of care, and overarching factors. Table 1 describes their relationship to WPC. Table 2 lists participants' practical suggestions to support WPC.

Overarching factors

Overarching factors included time available and the perceived value of WPC.

Time available

Participants consistently reported that sufficient time with patients is necessary for WPC.

> *[T]rying to do adequate whole-patient care takes time.* (GP20)

> *Fifteen-minute appointment slots … don't work with … holistic care … [They] work for acute care … and not with chronic care … that is a major barrier to it.* (GP17)

> *[I]f I'm rushed … I know damn well I can't provide holistic care in seven minutes.* (GP04)

The importance of time was two-fold. First, developing the relationship foundational to WPC takes time.

> *[T]ime is probably the single greatest … asset in the doctor–patient relationship.* (GP10)

This often occurred over multiple consultations, 'like a shellacking process' (GP10). Longer consultation times enabled patients to feel 'heard' (GP01), with 'time and space to talk about what's really important to them' (GP14), rather than being 'brushed aside' (GP05). However, some GPs observed that the doctor–patient relationship sometimes developed 'pretty quickly' (GP15) if rapport was present.

Second, time enabled breadth and depth of care. Several GPs identified that 'in general practice, we can really only scratch the surface if you've got a 15-minute appointment' (GP15); and it takes time 'to explore … all the potential underlying issues' (GP08). Time assisted patients to disclose concerns: 'sometimes people need more time to bring out what's important to them' (GP18). It created a context whereby the GP could gently challenge viewpoints that they believed were detrimental to their patients' health, and, 'slowly assist them … to come to a different understanding' (GP16). GPs also used time diagnostically.

> *[T]hings don't often present clearly … they might need a few days … to become a little clearer.* (GP18)

Participants identified several factors contributing to time pressure, including finite appointment availability, multiple competing demands, personal circumstances, patients 'who kind of like [to] talk a lot' (GP11) and proportionally lower government remuneration for longer consultations. Several suggested interventions to reduce this pressure (Table 2).

Perceived value of WPC

The second overarching factor affecting WPC provision was its perceived value for patients, doctors and healthcare policymakers.

GPs observed that some patients were unwilling to engage in WPC. A variety of explanations were postulated, including unawareness of its importance and the GP's role to provide WPC (instead perceiving the GP as an acute care provider or 'referral agent' [GP17]), and patients not prioritising preventive care. Patients often appreciated WPC after experiencing it, so participants suggested education targeting patients' expectations.

Participants suggested that GPs' attitudes toward WPC affected its provision. Participants indicated that they valued WPC, but some implied that other GPs may not. One reflected that 'the attitude of GPs and people in their practices about whether they even want to do [WPC]' (GP13) was important, and that some GPs limit their scope of practice to specific areas (lacking breadth), or to acute care (lacking depth). Another reflected that, 'there are two types of doctors … in this world', contrasting 'recipe "find the item number"' doctors with 'proper [GPs]' (GP02). One participant suggested that selecting medical students on the basis of 'why they think they even want to be doctors' (GP13) would help to address this.

Finally, some participants believed that 'there's no value placed on [WPC] by the policymakers' (GP09). They believed lack of funding to support WPC

Table 1. Factors that affect the provision of whole-person care

Factor		Aspect of WPC affected*
Overarching	Time investment	Breadth and depth of care (enabled) Development of the doctor–patient relationship (enabled)
	Perceived value of WPC	All domains of WPC through patients', general practitioners' and health policymakers' willingness to engage in or support WPC
Immediate context	Interpersonal doctor–patient dynamic	Doctor–patient relationship
Local context	General practice structure	Length (continuity) of care Doctor–patient relationship Team-based care
	Relationship between care providers	Length (continuity) of care Team-based care
Broader context	Health system funding and structure	Indirectly affects other influencing factors, including time availability, general practice structure and relationships between healthcare providers

**Refer to part one of this series[5] and Supplementary Figure 2 (available online only) for a description of the listed aspects and their role in WPC.*
WPC, whole-person care

reflected this, and they related it to devaluation of primary care. Conversely, one GP compared the Australian system favourably to other health systems, believing that it 'generally promoted' WPC (GP18).

Immediate context

Interpersonal doctor–patient dynamic

Within the immediate GP–patient context, participants felt that interpersonal factors influence WPC provision. These included the doctor's commitment and ability to develop the doctor–patient relationship, the patient's openness to the doctor and the intangible 'gel' (GP12) or fit between the personality and backgrounds of the patient and doctor.

Participants indicated that doctors' intentionality developing the doctor–patient relationship, communication skills and emotional state (eg 'relaxed and happy' [GP05], 'tired or stressed' [GP04] or 'cynical and ... burnt out' [GP01]) influenced the doctor–patient relationship and therefore WPC. Patients being 'open to [the GP's] approach ... and ... honest' (GP08) assisted WPC. Some participants suggested that patients' ability to self-select their doctor helped to facilitate the intangible 'gel' between personalities.

Local context

Participants reported that practice structure and the relationship between care providers affect WPC provision.

General practice structure

GPs identified aspects of practice structure that influenced WPC provision, including physical and human resources, doctors' availability and facility for home visits.

Physical resources that facilitated WPC included comfortable, accessible facilities with thoughtful layout, and practice management software with easy access to patient information and relevant prompts. Well-planned staff and resource utilisation also assisted, particularly practice nursing and support staff involvement.

Additionally, rostering and appointment systems that facilitate availability, including out-of-hours, support the longitudinal aspect of WPC. Participants identified mixed effects of large multi-doctor practices in this regard. These could enable continuity within the practice when the regular GP was unavailable, but potentially detract from the quality of the doctor–patient relationship if a patient did not have a regular GP within the practice. Additionally, some participants who worked part time identified that this could make providing continuity challenging. One managed this by being available for some appointments outside of business hours and encouraging their patients to have a relationship with at least two GPs within the practice.

Several participants identified that offering home visits facilitated WPC through providing insight into patients' lives.

Relationship between care providers

Ease and quality of communication with other health professionals affect WPC provision.

GPs identified that timely local access to allied health and specialists facilitates WPC. They observed that this may be challenging in rural locations, such that

Table 2. Practical approaches to support whole-person care at patient, general practitioner, practice and policy levels

Level	Suggested approaches
Patients	Be open to engaging in WPC and preventive care
	Include family involvement in the care team
GPs	Spend extended time in a single practice
	Develop and practise patient-centred communication skills
	Intentionally develop the doctor–patient relationship
	Practise self-awareness
Practices	Enable time investment (eg scheduling longer consultation times, arranging multiple visits over time, using health check and GP Management Plan item numbers to provide chronic disease/preventive care, considering private billing)
	Enable access (eg appointments reserved for 'on the day' bookings, out-of-hours access, home visitation, strategies to optimise continuity where GPs work part time)
	Obtain appropriate physical resources (eg comfortable, accessible physical facilities; practice management software with appropriate prompts)
	Consider co-location of service providers
Health systems	Value WPC at policy level
	Develop funding structures that support WPC (eg appropriate remuneration for longer consultation times, expansion of item numbers that support WPC, additional allied health funding, flexible funding system, measures that support team-based care)
	Avoid introduction of incentives based on biomedical performance targets/pressure to adhere to disease-specific guidelines
	Modify health workforce measures (eg increase GP numbers and engage other practice staff to provide some aspects of care to reduce time pressure, select medical students on the basis of motivation to practise a whole-person approach)
	Support patient ability to self-select their GPs
Populations	Provide education regarding the value of WPC and GPs' role to provide this care
	Encourage engagement in activities that support WPC (eg attendance for health assessments)

GP, general practitioner; WPC, whole-person care

WPC could 'look a bit different' (GP12) depending on geographical context.

Effective communication and good working relationships between care providers were essential for quality WPC. Participants frequently gave examples where the GP, 'the coordinator of everything ... doesn't necessarily ... get kept in the loop of what's going on' (GP17). This could result in unawareness of other providers' management.

> *I wish that we had ... better... communications ... with the hospital system and specialists or ... allied health. We ... can't really ... communicate that well or ... see ... what care the patient's receiving there ... if we could see that, I think that would really help a lot because it would save the consults where you try and guess what has been done.* (GP14)

Participants repeatedly emphasised that poor communication was problematic when patients attended multiple general practices, with some attending their private-billing GP for 'all of their complex needs or their emotional needs' (GP16) and bulk-billing GPs for more routine care. One GP stated:

> *[C]are ... that's delivered by multiple practitioners ... [is] disjointed care ... sometimes you don't realise as a practitioner that someone else has done something, especially if that patient has ventured to a different practice at a different stage ... you've got no idea what they've previously had.* (GP06)

This could affect preventive healthcare when GPs assumed that this was being provided elsewhere.

> *[T]he other doctor ... might just say, 'Oh, well ... this person's only here for ... a script ... or a medical certificate ... and they have their own usual [GP]. So, I'll just do the ... minimum ... and the other doctor can look after preventive health'.* (GP11)

GPs suggested:

> *[A]t the very least ... there should be communication between ... professionals to make sure that ... if they are going somewhere else ... we ... have the appropriate information.* (GP14)

GPs identified several strategies to facilitate interprofessional communication. Some viewed co-location as ideal, as this enabled providers to know each other and facilitated accessibility, ease of communication and good working relationships. A participant who had previously worked in an Aboriginal community controlled health service, in which services were co-located, emphasised the benefits of this approach. Where providers worked in separate locations, timely written communication and telephone availability facilitated WPC. Some believed that shared electronic health records could facilitate communication but that implementation was not feasible in the current context.

Broader context

Participants emphasised that health system funding and structure affects WPC provision.

Health system funding

Participants consistently stressed that funding structures influenced their capacity to provide WPC, affecting both affordability/accessibility of care and the type of care provided. One participant stated:

> *I think funding ... can be a really important ... facilitator for whole patient care and it can be a really big barrier if it's done the wrong way.* (GP14)

Affordability was important to support the longitudinal aspect of WPC. One GP stated that, in contrast to the US system in which they had previously worked, in the Australian system they 'love the fact that people can see doctors when they need to' (GP10). Others believed that the Medicare Benefits Schedule (MBS) rebate freeze challenged accessibility. Some GPs thought that allied health rebates through Team Care Arrangements supported WPC, but that the limitation to five funded visits annually was insufficient for many chronic disease patients.

Participants felt that funding influenced GPs' practice in ways that could support or detract from WPC. They consistently identified proportionally reduced remuneration for longer consultations as a barrier to WPC. One reflected:

> *[I]t would be nice to be remunerated for longer consultation times ... so that we didn't have that financial pressure to push patients out the door quickly.* (GP14)

Several thought that access to GP Management Plan and health assessment item numbers facilitates WPC, though some identified problems with specific aspects of these assessments. Some participants commented that if performance-based funding were introduced, this would encourage 'disease ... focused care' (GP02) on the basis of generic guidelines, rather than an individualised approach. One stated:

> *I'm really concerned ... that we're gonna be chasing targets that don't have anything to do with good, quality whole-person care ... but that we're gonna be ticking boxes that get us funding.* (GP14)

However, one GP intimated that if outcomes-based funding encouraged longer consultations, this would be advantageous.

Health system structure

Participants also identified that health systems structures influenced WPC provision.

Some GPs felt that the division between state and federal health funding, with perceived privileging of hospital care, negatively influenced WPC. Their views on HCHs described how primary health system structures impact WPC provision.[11]

Discussion

Australian GPs believe that multiple factors spanning immediate, local and broader contexts affect WPC provision. These include time availability, the perceived value of WPC, the interpersonal GP–patient dynamic, general practice structures and relationships between care

providers, and health system funding and structure.

Many of these factors have been associated with quality general practice care. Previous research has shown benefits of increased consultation length,[12–16] a strong doctor–patient relationship,[17] patient-centred communication skills[18] and accessibility.[19] Primary care models internationally aim to incorporate some of these features, particularly in response to increasing multimorbidity.[20–22]

The importance of adequate time to provide WPC was one of the strongest themes identified. This is consistent with previous research. Longer consultations improve anticipatory, preventive, chronic and psychosocial aspects of care, relating to the 'depth' dimension of WPC in the model.[12,13,16] They improve patient enablement and reduce doctors' stress.[14,15] Evidence regarding the impact on patient satisfaction and frequency of prescriptions, referrals, investigations and GP consultations is mixed;[14,23–25] some evidence suggests that quality of time is as important as quantity.[26] Nonetheless, the present study's findings suggest that adequate time is a primary facilitator of effective WPC. Initiatives to support adequate time should facilitate WPC.

Another prominent theme was the importance of efficient interprofessional communication. This is not surprising, given the multidimensionality and team-based approach of WPC. Consistent with GPs internationally, the participants in this study identified frequent gaps in interprofessional communication.[27] Previous research supports their perception that knowing other providers improves communication by increasing familiarity and trust.[28] One suggestion to facilitate this was service co-location. Some evidence associates co-location with improved cohesion, communication, patient and provider satisfaction and cost,[29,30] though other studies suggest it may not improve team effectiveness.[31] Exploring and implementing strategies to support inter-professional communication should be a priority to support WPC.

Participants consistently reported that health systems factors significantly affect WPC provision. These included positive factors such as MBS funding for health assessments and allied health consultations; and negative aspects such as proportionally lower remuneration for longer consultations, capped numbers of funded allied health visits and inflexibility of healthcare delivery models. International primary health systems are being restructured to meet the challenge of increasing multimorbidity; these findings provide insights that could support WPC in this setting.[9,20–22] This is topical for Australia with regard to the current HCHs pilot.[9]

The findings identify factors that affect WPC at multiple levels and provide practical suggestions that can be implemented by individual patients, GPs, practices and health policymakers (Table 2). Further work is needed to develop a comprehensive practical framework to apply these findings and evaluate its efficacy. Evaluation of economic viability is also relevant: these findings suggest WPC is time intensive; however, this investment may reduce costs in the longer term.

Strengths and limitations of the study methodology are discussed in part one.[5] The researchers explored GPs' perceptions of which factors affect WPC but did not measure whether these objectively affect care: this could be explored in future quantitative research.

Conclusion

WPC is a multidimensional approach that encapsulates general practice ideals. Multiple factors related to the immediate, local and broader contexts of care, together with overarching factors, influence its provision. These findings provide direction for individuals, practices and health policymakers to explore and implement measures to support quality WPC.

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