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Research

How younger adults with psychosocial problems experienced person-centered health consultations

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Abstract
Much attention is focused on the social determinants of health. Family medicine is challenged with a growing number of vulnerable persons with psychosocial or lifestyle related problems. The objective of this work was to explore how vulnerable younger adults experience person-centered preventive health consultations with their general practitioner. The design and setting for this work were a secondary qualitative analysis of a randomized controlled trial (RCT) in Danish general practices. Younger adults (20-45) were consecutively invited to answer a screening questionnaire about psychosocial and lifestyle-related problems when visiting general practice (28 general practitioners (GPs)) for ordinary consultations. The 30% most vulnerable persons were invited to participate in a randomized controlled study. Intervention participants (n = 209) received a structured 1- hour 'health consultation' with their general practitioner focusing on resources and self-chosen goals and a 20-min follow-up after 3 months; control participants (n = 255) received usual care. At 1 year, 180 participants answered a follow-up postal questionnaire, of whom 135 answered the open-ended question: "Do you think the health consultation was worthwhile?". This question was analyzed using qualitative content analysis. Six themes were prevalent: 'Meeting the doctor in a different way', 'Supporting dialogue', 'Food for thought', 'Feeling better', 'Opportunity for change', and the health consultations were 'Not worthwhile'. Offering vulnerable younger adults a structured, person-centered preventive health consultation strengthened the doctor-patient relationship, allowed patients to reflect on their life situation, enhanced their perceived ability to cope with their problems and their belief in and ability to initiate wanted changes, thereby enhancing self-efficacy

Keywords
Patient experience, vulnerable populations, general practice, patient-centered care, self-efficacy, physician-patient relations

Introduction

Inequality in health is growing, and socioeconomically disadvantaged people live significantly shorter and have considerable disparities compared with the rest of the population.[1] Vulnerable groups have difficulties utilizing available healthcare services.[2] Moreover, their health needs are often complex, intersecting with social, psychological and economic domains.[3]

Policymakers, administrators and healthcare professionals all agree to promote health equity and take action against health inequities. However, traditional screening and lifestyle counselling built into general health checks seem not to work,[4]and new approaches to the encounter with vulnerable and socially highly exposed persons are needed.[5] Practices to improve health equity and outcomes for socially at-risk populations are emerging;[6] and preliminary experience suggests that interdisciplinary community-based interventions combined with a person-centered approach may have some effect.[7] Still, there is a demand for new models to manage disease and health-related conditions empowering people to gain greater control of their life and health.[8]

Evidence-based guidelines and the individual desires, preferences and priorities often conflict. Medical solutions and life style advice may fall far down the list of what to do, when it comes to everyday living in socially deprived and vulnerable populations.[9]

Pragmatic solutions combining evidence-based approaches with person-centered medicine require a trustful relationship, and general practice with its possibility for trustful continuity is well situated to reach vulnerable and at-risk individuals.[10] However, for patients in general practice to duly benefit from this position, we must have a better understanding of the associations between social

risk factors at the population level and their clinical expressions in individuals, in terms of illness, sick role behaviour, manifest disease and individuals' potential for constructive coping.[11]

Research on the general practitioner's (GP's) role in addressing health problems in younger vulnerable adults is scarce. However, in a Danish randomized controlled study from 1998-1999, general practice-based 'preventive health consultations' focusing on well-being, health- and illness-behaviour, resources and self-chosen wishes for change reduced the number of psychosocial and/or lifestyle-related problems and enhanced mental wellbeing.[12]

We do not know why these consultations reduced the number of problems, nor how the services available for problem solving were experienced. In the search for how to best engage in these processes, we decided to explore why the 'preventive health consultations' in the Danish study were associated with beneficial effects.

Intervention participants were asked about their experiences in a postal questionnaire one year after the consultation.[12] Their answers to an open-ended question are the basis of this study, the aim of which is *to explore how vulnerable younger adults experience person-centered health consultations with their general practitioner.*

Method and Material

Subjects

Participants were recruited by the secretary when attending the GPs' surgery for an ordinary consultation. Inclusion criteria were age between 20–45 years, ability to read and understand Danish and having no severe acute illness or severe psychiatric problem. A total of 2,056 accepted the invitation and provided written consent to the study objective:" To support your resources in order to prevent larger problems or illness". Participants were screened by completing a "problem questionnaire" with 33 items about self-rated health, personal network and resources, lifestyle and social situation.

Participants reporting 7 or more out of the 33 problems (30%, n = 625) were defined as 'vulnerable' and were invited to participate in the randomized trial. Those who accepted the invitation completed a more comprehensive questionnaire at home, including global questions about their psychosocial and lifestyle-related situation. The questionnaire also invited the participants to write down their own suggestions for desired changes and their goals in this respect. Upon returning the filled-in questionnaire, 495 were randomized for intervention (n =240) or control (n=255).

The intervention consisted of a 1-hour 'health consultation' and a 20-min follow-up within 3 months with their own GP. Control participants received usual care.[12] Both groups received a 1-year postal follow-up.

Prior to the intervention, GPs attended educational courses focusing on social psychology, abuse and skills in lifestyle motivational interviewing.[13-14] The take-home messages of these courses were meant to further a structured person-centered approach,[15-16] emphasising the recognition of 'being the expert of your own life', the importance of 'setting his or her own agenda'[17] and supporting a salutogenic approach trying to avoid medical risk discourse domination.[18]

Throughout the 18-month study period (1998-2000), the GPs received continuing training from competent behavioural science teachers. In total, 40 hours of educational training were provided. During the first consultation, one or two goals for lifestyle or living conditions were selected, incorporating a realistic self-chosen time frame for milestone evaluation. Resources and barriers to fulfil the specific goal were verbalised and written down.

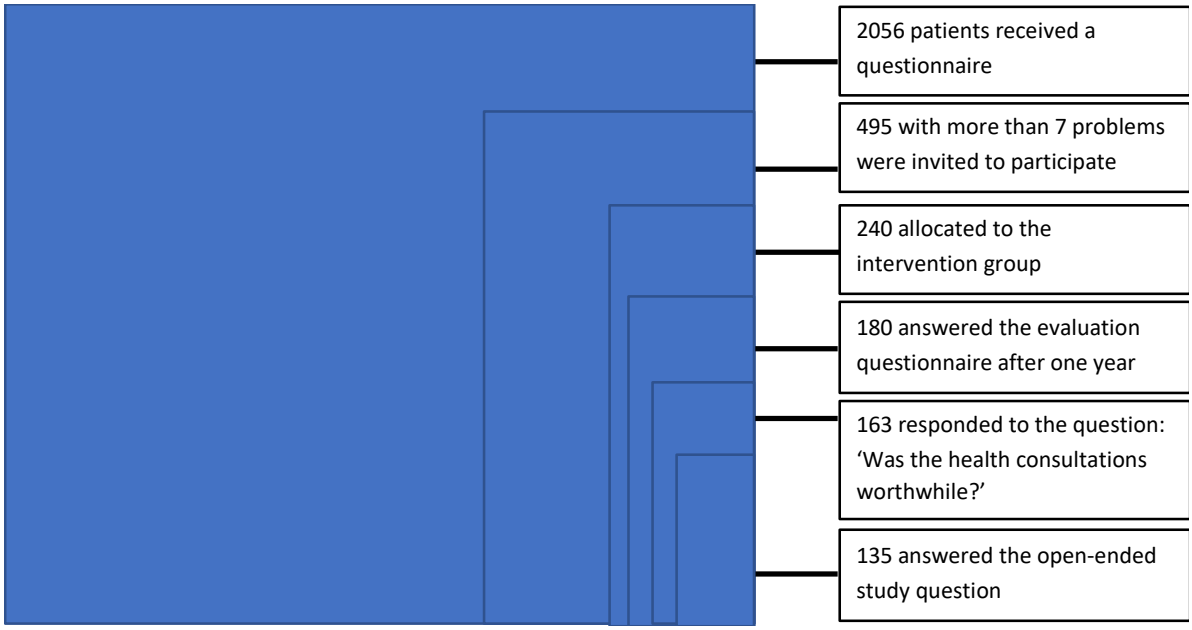
Of 240 intervention participants, 209 received the first health consultation and 151 also the follow-up. A total of 180 participants answered the evaluation questionnaire after 1 year, and 163 responded to the final question 'Do you think the preventive consultation was worthwhile?', with 75 (42%) answering "Yes, very much" to this question, 67 (37%) answering "Yes, to some extent" and 21 (12%) answering "No". Seventeen (9%) participants did not answer this question.

Finally, the participants were invited in an open-ended manner to explain *why* they found the health consultations worthwhile. A total of 135 participants made short statements, which formed the basis for this qualitative analysis. Although there was only little space to answer the question, respondents did state a few keywords and typically wrote one or two sentences which were analyzed as described below. (Figure 1)

Analysis

The answers to the open question were analyzed using systematic text condensation inspired by Malterud.[19] The answers were reviewed and analyzed jointly by LS and LH. This was followed by discussion of the formation of recurrent themes with a view to including as many aspects as possible. Next, meaning units were identified, separated from the material and reassessed. This produced six code groups, which were then re-evaluated by comparing the code groups with the original themes. One person could express more than one theme in his or her answers.

Figure 1. Derivation of the study population



Results

Six themes were prevalent: 1) 'Meeting the doctor in a different way', 2) 'supportive dialogue', 3) 'food for thought', 4) 'feeling better', 5) the 'opportunity for change', and 6) the health consultations were 'not worthwhile'. (Figure 2)

'Meeting the doctor in a different way'

'Meeting the doctor in a different way' is a structural theme, where the possibility for the encounter, and the time available frames another dimension to the doctor patient relationship.

These participants commented on the basic experiences of being offered a different kind of encounter; the undisturbed time available and the possibilities arising from the person-centered and structured way of discussing their self-perceived problems.

Thirty-one participants (23%) mentioned different aspects of the encounter. Several explicitly underlined the time available:

"The doctor had time to talk with me".

The participant's and the doctor's mutual understanding was clearly emphasised. One mentioned both aspects:

"I got to know my doctor better and vice versa".

Some specifically mentioned the relationship with the doctor becoming stronger:

"Have got a closer relationship with my doctor".

'Supportive dialogue'

'Supportive dialogue' is reflecting the process: the professionality, motivational person-centered interviewing, and posing the right questions.

The positive aspects of being able to verbalise their difficulties was highlighted by 41 participants (30 %). Some focused on the concrete benefits of discussing a problem, while others emphasised the doctor's contribution.

"It was good to be able to discuss personal problems thoroughly".

Confidential professionality with trustful recognition and careful support was expressed as:

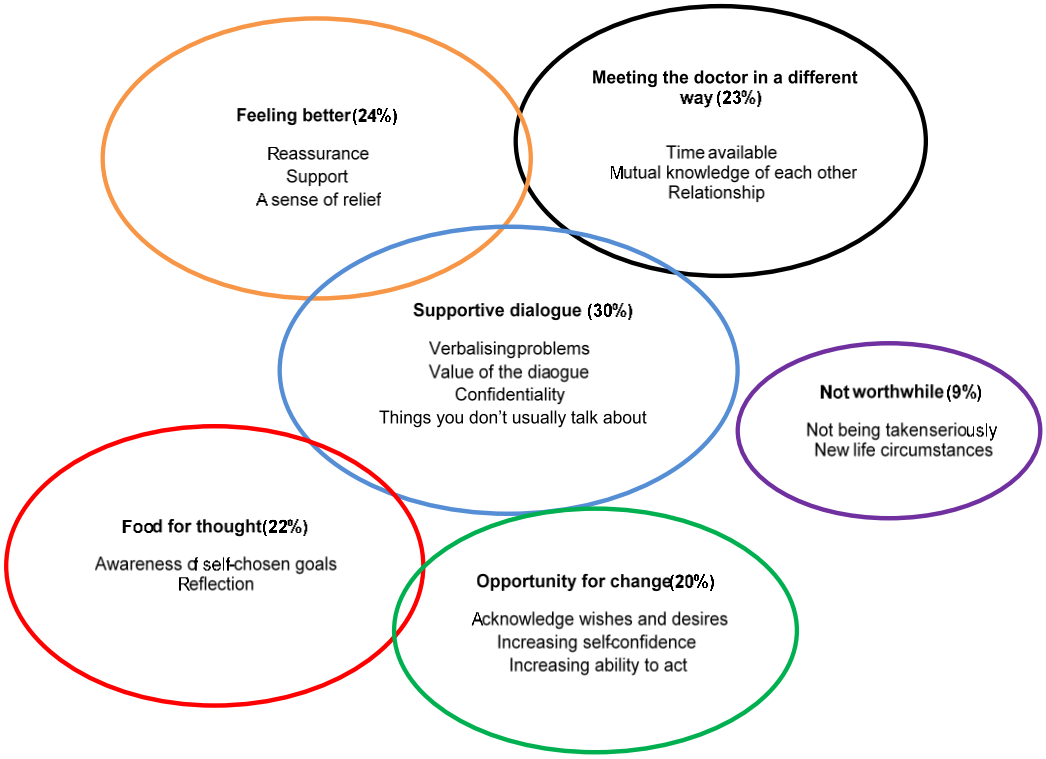
"He's a good person to discuss your problems with".

Indication of missing someone to talk to about difficult life aspects was expressed as:

"There was the opportunity to talk about some things in life that I don't talk with anyone else about".

The advantage of having a professional interlocutor who was not personally involved was also mentioned:

Figure 2. Health consultation themes



"It was good to talk with an anonymous person".

'Food for thought'
Thirty participants (22%) focused on increased awareness of difficult life circumstances, and that they had started to reflect more on these circumstances.

"It opened my eyes to many things" and "some things were brought into focus".

"I am thinking more about what I want".

Three participants in this group felt that they benefited; still, they also mentioned that the consultations had made them focus on something negative of which they had not previously been aware:

"It turned out that I was actually very sad".

'Feeling better'
Thirty-three participants (24%) felt that the consultations contributed to improving their condition and wellbeing.

"It gave me renewed courage" and "I felt better mentally".

Some felt better because the consultations offered a sense of relief:

"Because telling someone about your problems makes you feel relieved".

"Felt more comfortable and had closer contact".

'Opportunity for change'
Twenty-seven participants (20%) found that the consultations provided them with an opportunity to change difficult life circumstances.

"The consultations put spotlight on a decision I actually had taken but lacked the energy to execute".

Descriptions reflect several steps in the process of change from 'finding out what they wanted', to 'experiencing an increasing belief in what was possible' with concrete and detailed descriptions of the changes that were actually

beginning to happen, e.g., cutting back on smoking, weight loss or starting relevant treatment.

"I could see ways for changing myself".

'*Not worthwhile*'
Twelve participants (9%) did not find the consultations worthwhile. 'Not meeting consultation expectations' was the main reason for finding the health consultation not worthwhile:

"Because the doctor didn't take my problems seriously".
And life conditions had changed, solving the current problems:

"Pregnant at the time, now with three children and a job to attend to".

Discussion

Summary
This study explored how younger adults with many bio-psychosocial or lifestyle-related problems experienced participating in 'preventive health consultations' with their GP. The dialogue focused on verbalizing and prioritizing potential problems endeavouring self-assessed resources and own suggestions for desired changes and goals [20]. Most participants found the consultations worthwhile. They emphasized the allocation of ample time with the doctor strengthening the doctor-patient relationship. The consultations allowed them to reflect on their life situation, enhanced their perceived ability to cope with their problems and strengthened their belief in and ability to initiate the changes they wanted.

Strengths and weaknesses
A postal 1-year follow-up was completed in 1999-2001. Even though several years have passed since the original study was conducted, personal wellbeing, coping strategies and professional interviewing techniques have not changed dramatically. In-depth qualitative interviews with a strategic sample of participants might have been a better method but was not part of the original study design.

The qualitatively analyzed study question was part of a larger evaluation questionnaire primarily consisting of quantitative yes/no questions. Our analysis is based on a single open-ended question where the space allowed for comments were limited. Having had a more comprehensive text material would have been advantageous, but the information obtained identifies essential, basic elements in the doctor-patient encounter that deserve attention.

We obtained information only on issues raised by the participants themselves and therefore discuss these issues only. We assume that participants gave priority to what first came to mind, or what was most essential to them. It cannot be precluded that the answers were positively biased. Participants may hence have tailored their responses to what they thought the GP wanted to hear; still, we do not expect this bias to be prominent as participants were told that GPs would not have access to their answers. The most positive and articulated participants are presumably over-represented.[21] However, 12 participants (9%) did in fact *not* find the consultations worthwhile.

Even though the group of participating GPs was selected and highly motivated, these 'negative' evaluations, underlining 'not being taken seriously', suggest that some GPs may not have been able to have a sufficiently person-centered focus. Despite their motivation and 40 hours of training, it might be very difficult to focus on the patients' perspectives.

Comparison with existing literature
In this study we used a structured person-centered framework intervention approach to improve health outcomes for younger vulnerable adults. Many studies concentrate on measurable biomedical risk factors, meeting guidelines, and failure to fulfil quality indicators.[2-4] We found no comparable studies discussing younger vulnerable patients' view on this kind of intervention.

Although it is likely that the most significant contributions to reducing health inequalities are based on economic and social conditions, health service interventions should also be considered.[6] A systematic review of 17 interventions to improve diabetes care in socially disadvantaged populations found positive outcomes associated with cultural tailoring of the intervention, community educators or lay people leading the intervention, one-on-one interventions with individualized assessment and reassessment, incorporating treatment algorithms, focusing on behaviour-related tasks, providing feedback and high-intensity interventions delivered over a long period of time.[22]

Overall, the best way forward seems to include continuity, person-centeredness, and interdisciplinary community-based interventions.[7] General practice is well situated to maintain continuity and to build on-going relationships and is easily accessible.[23-25]

Implications for research and/or practice
GPs have a unique possibility to offer a person-centred approach to vulnerable patients, which may enhance their self-efficacy and ability for problem solving. Furthermore, GPs may contribute significantly to collaborative strategies, bringing together representatives from different primary care disciplines and the sharing of values and visions which is a prerequisite for delivering the best

possible support to vulnerable groups. GPs have a positive effect on patient care, especially for the underprivileged population segments.[26]

We therefore found it relevant to explore central qualitative aspects of offering health consultations to vulnerable patient groups proven to be effective.[12,27] The analysis included elements of therapeutic discourse such as receptiveness, active listening, a relation based on trust and empathy developed over time and patient life story knowledge.[20] Making themselves available more as an interlocutor than as a physician, GPs may boost patients' ability to reflect on and articulate perceived problems, eventually promoting self-efficacy.[13]

Patient self-care and the ability to profit from public healthcare services and treatment offers depend on the balance between barriers and resources. Vulnerable patients tend to experience more barriers than resources, which leads to low self-efficacy.[13]

The current understanding that more knowledge changes an individual's attitudes and thus leads to behavioural improvements must be adjusted in relation to vulnerable groups. Rather than more knowledge to initiate behavioural changes, vulnerable individuals need increased belief in their own ability to take care of their health.[9]

Disadvantaged people need different and more individualized healthcare services with a higher degree of personal support. Vulnerable patients' resources and self-efficacy may improve by using a truly person-centered approach. This study shows how GPs may contribute in this respect. 'Personal doctoring' is a well-known approach in general practice.[26,28] It has been shown to provide higher patient satisfaction, less subjectively perceived illness and fewer hospital referrals.[23] If GPs want to engage in health promotion models, targeting vulnerable groups could therefore be an effective option. However, this person-to-person clinical approach with psychosocial understanding of illness and shared decision making can be time consuming and will therefore likely challenge modern medicine. Supporting vulnerable patient groups requires interdisciplinary person-centered services prioritising education of health professionals in attitudes and communicative competences, and allowing for structural frames and opportunities.[29]

In conclusion, well-prepared person-centered and structured preventive health consultations offered to vulnerable younger adults in general practice had a positive impact on their ability to reflect on and articulate problems and to initiate actual changes by enhancing their self-efficacy.

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