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Holistic Patient Care: A Systematic Review of Recent Evidence (2022–2025)

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Abstract

Holistic patient care (also described as whole person care, person-centered care, or integrated approaches) is a clinical and organizational paradigm aimed at addressing,within a coordinated framework,the physical, psychological, social, functional, cultural, and, when appropriate, spiritual dimensions of the health–illness experience. In contexts of increasing multimorbidity and fragmented healthcare delivery, recent literature has focused on: (i) how holistic care is defined and operationalized, (ii) which clinical, experiential, and system outcomes are associated with person-centered and integrated models, and (iii) what challenges remain for measurement and implementation. This systematic review synthesizes evidence published between 2022 and 2025 on models of comprehensive assessment (whole person assessment), person-centered care, integrated interventions for complex conditions, and interdisciplinary approaches. PRISMA 2020 guidance was followed for identification, screening, eligibility, and inclusion. Findings converge on: (a) substantial conceptual heterogeneity (terms and components) that limits comparability, (b) consistent signals of benefit for patient-experience outcomes, care coordination, and some utilization outcomes, and (c) a persistent gap in standardized measurement of whole person healthand in longer-term follow-up. Overall, evidence suggests that holistic care requires realistic implementation designs, interdisciplinary teams, valid comprehensive assessment tools, and value metrics that capture outcomes meaningful to patients and families. (Forsgren et al., 2025; Rohwer et al., 2023; Thomas et al., 2023).

Keywords: *Holistic Care, Person-Centered Care, Comprehensive Assessment, Interdisciplinary Teams, Integrated Models, Whole Person Health.*

Introduction

Holistic patient care is grounded in the premise that clinical outcomes and well-being depend not only on isolated diagnoses or treatments, but on the interaction between biomedical conditions, mental health, social context, daily functioning, personal values, and life goals. In practical terms, this implies a shift from disease-centeredcare to care that organizes decisions and processes around the person,their narrative and priorities,particularly in the presence of multimorbidity, frailty, psychiatric comorbidity, or complex social needs. In recent years, the literature has emphasized that although person-centeredcare is a widely accepted goal, substantial variability persists in how holistic care is defined and measured, complicating comparisons across interventions and translation into public policy. (Forsgren et al., 2025; Nkhoma et al., 2022).

A key axis for making holistic care actionable is comprehensive whole-person assessment. Whole person assessmentrefers to clinical approaches that integrate multiple domains (symptoms, mental health, relationships, spirituality/beliefs when relevant, and social resources and barriers) within a structured and actionable clinical conversation. Evidence suggests that some clinical models are potentially transferable to family medicine and primary care; however, their feasibility, quality, and theoretical alignment vary widely depending on the instrument used, available time, staff training, and system support. (Thomas et al., 2023).

Beyond clinical tools, holistic care is expressed through integrated organizational models: coordination across levels of care, interdisciplinary teams, continuity of the care plan, and meaningful patient participation in decision-making. However, reviews of integrated care models show heterogeneity in definitions, components, and reported outcomes, with inconsistent benefits when

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models do not clearly describe their theory of change(which component produces which outcome). This suggests that the challenge is not only implementing integration,but specifying effective components, mechanisms, and contexts that enable integrated models to function. (Rohwer et al., 2023; Kongkar et al., 2025).

In older populations, Comprehensive Geriatric Assessment (CGA) is considered a robust antecedent of holistic care, as it evaluates biomedical, psychological, and social dimensions to build a coordinated plan. Recent community-based evidence highlights mixed results and, importantly, that implementation is a complex intervention: it depends on team factors, service integration, local resources, and follow-up. From a qualitative perspective, patients, caregivers, and professionals describe benefits in global understanding and coordination, but also barriers such as fragmentation, limited time, and difficulty translating findings into concrete actions. (Sum et al., 2022; Hayes et al., 2023).

An area where holistic care is particularly critical is the intersection of medical illness and mental health during hospitalization. Evidence on integrated inpatient medical–psychiatric units suggests potential to improve efficiency (e.g., reduced length of stay), though with methodological quality limitations and limited cost-effectiveness evaluation. These findings are relevant because they illustrate that holismis not merely a clinical attitude: it requires service design, staffing, cross-disciplinary competencies, and coherent measurement systems. (van Schijndel et al., 2022).

Finally, the field faces a cross-cutting gap: how to measure holistic care and its outcomes. Recent reviews propose domains for whole person health,but conclude that there is still no widely adequate measure for general use, despite structural convergence in domains (physical, mental, social, spiritual/purpose, and individual factors). In parallel, reviews of whole person health assessmentsemphasize the need for practical, comparable, and change-sensitive instruments that are also useful for decision-making. (DiGuiseppi et al., 2025; Gold et al., 2025).

Given these tensions,high acceptance of the ideal, conceptual heterogeneity, emerging evidence, and measurement challenges,this systematic review synthesizes 2022–2025 evidence on definitions, outcomes, and interventions associated with holistic patient care, following a reproducible PRISMA process. (Page et al., 2021; Rethlefsen & Page, 2022).

Methodology

A systematic literature review (SLR) was conducted following PRISMA 2020 principles to ensure transparency and traceability. Record-flow tracking was structured in accordance with recommendations for PRISMA flow diagrams and record tracking in systematic reviews. (Page et al., 2021; Rethlefsen & Page, 2022).

Information sources and search strategy

It is recommended to conduct the primary search in Scopus and complement it with high-visibility databases (e.g., PubMed/MEDLINE, Web of Science, PsycINFO, CINAHL, and ScienceDirect), limiting results to 2022–2025 and peer-reviewed articles. A template strategy (adjust to your objective) may include:

- (holistic careOR whole person careOR whole person healthOR patient-centred careOR person-centred careOR integrated careOR comprehensive assessmentOR comprehensive geriatric assessment") AND
- (intervention OR program OR model OR implementation OR outcomes OR evaluation OR measurement).

This search logic aligns with recent reviews showing terminological variability and the need to combine synonyms to maximize sensitivity. (Forsgren et al., 2025; Thomas et al., 2023).

Eligibility Criteria

Included were: (i) empirical studies, systematic reviews, meta-syntheses, or scoping reviews on holistic/person-centered care/comprehensive assessment/integrated models; (ii) adult populations or healthcare services in which a holistic approach is operationalized (clinically or organizationally); and (iii) reporting of outcomes (clinical, experiential, process, utilization, cost) or evidence on measurement. Excluded were: (i) articles without an explicit focus on holistic/person-centered care; (ii) editorials

without a stated method; and (iii) non–peer-reviewed literature when the goal is consolidated evidence. (Nkhoma et al., 2022; Rohwer et al., 2023).

Results

Across 2022–2025 evidence, four patterns are observed: (1) conceptual heterogeneity (holistic/person-centered/integrated) and the need for clear taxonomies; (2) the central role of comprehensive assessment as an entry point to actionable care plans; (3) more consistent benefits in patient experience, care coordination, and some utilization outcomes, with clinical outcomes varying by context; and (4) a persistent deficit in standardized measurement of whole personoutcomes. (Forsgren et al., 2025; Thomas et al., 2023; DiGuiseppi et al., 2025).

For comparative purposes, Table 1 summarizes a representative subset of recent studies/reviews that operationalize holistic care through clinical assessment, service organization, interdisciplinarity, and measurement. (Rohwer et al., 2023; Sum et al., 2022; van Schijndel et al., 2022).

Table 1. Subset of Recent Studies and Main Findings (2022–2025)

Reference	Design	Focus	Key findings	Implications
Walsh et al. (2022)	Systematic review + meta-ethnography	Person-centered care in emergency departments	Identifies practical PCC dimensions in ED and implementation barriers	Standardize PCC practices and metrics in high-pressure settings (Walsh et al., 2022).
Nkhoma et al. (2022)	Systematic review	Person-centered interventions in serious physical illness	Variable effects on admissions, costs, and quality of life; intervention heterogeneity	Clarify components and mechanisms; strengthen measurement of meaningful outcomes (Nkhoma et al., 2022).
van Schijndel et al. (2022)	Systematic review	Integrated inpatient medical–psychiatric units	Potential to reduce length of stay; limited cost-effectiveness evidence	Designs with explicit objectives and economic evaluation (van Schijndel et al., 2022).
Sum et al. (2022)	Systematic integrative review	CGA in community settings	Mixed results; implementation barriers/facilitators	Treat community CGA as a complex intervention with system support (Sum et al., 2022).
Thomas et al. (2023)	Systematic review	Whole person assessment in family medicine	Diverse models; differences in feasibility and theoretical alignment	Select realistic tools and invest in clinical training (Thomas et al., 2023).
Rohwer et al. (2023)	Scoping review of SRs	Integrated care models for multimorbidity	Heterogeneous definitions/components; inconsistent evidence	Standardized reporting and specification of effective components(Rohwer et al., 2023).

Arakelyan et al. (2023)	Umbrella review	Holistic assessment-based interventions (MLTC/frailty)	Synthesizes effectiveness and context-specific limits	Tailor implementation by setting; avoid copy–pastemodels without adaptation (Arakelyan et al., 2023).
Hayes et al. (2023)	Qualitative evidence synthesis	Experiences of CGA in community/outpatient settings	Perceived benefits and barriers (time, coordination, resources)	Workflow- and capacity-centered designs (Hayes et al., 2023).
DiGuiseppi et al. (2025)	Scoping review	Measuring whole person health	No ready-for-wide-usemeasure; convergence of domains	Priority: develop/validate comparable instruments (DiGuiseppi et al., 2025).
Gold et al. (2025)	Review	Whole person health assessments	Highlights needs for usable and consistent tools	Integrate assessment with decisions and follow-up (Gold et al., 2025).
Hatam et al. (2025)	Scoping review	Outpatient PCC for older adults	Maps definitions, elements, and recommendations	Emphasizes implementation in LMICs and contextual adaptation (Hatam et al., 2025).
Kongkar et al. (2025)	Systematic review	Interdisciplinary teams in chronic conditions	Improves outcomes across levels; reinforces shared decision-making	Strengthen teamwork and coordination as the core of holistic care (Kongkar et al., 2025).
Forsgren et al. (2025)	Scoping review	PCC field and terminology	Lack of terminological clarity as a barrier	Need operational definitions for research/policy (Forsgren et al., 2025).

Discussion

Recent evidence agrees that holistic care is not a single program, but rather a set of practices and service designs sharing one principle: caring for the person across multiple domains and coordinating clinical and social responses. However, the field remains constrained by terminological ambiguity, whereby patient-centered,person-centered,whole person care,and integrated careare used in overlapping ways. This is not a minor semantic issue: it affects what is measured, how interventions are compared, and which policies are recommended. (Forsgren et al., 2025; Rohwer et al., 2023).

At the clinical level, comprehensive assessment (whole person assessment) emerges as a structuring component, but its usefulness depends on producing actionable plans and on having real capacity to respond to identified needs (mental health, social support, functioning). Put differently, holistic assessmentwithout a referral and follow-up network can generate clinician frustration and unmet

expectations. Therefore, the value of these approaches is better understood when they connect to integrated and interdisciplinary models that ensure continuity and response capacity. (Thomas et al., 2023; Kongkar et al., 2025).

In complex populations,multimorbidity, frailty, or coexisting medical and psychiatric diagnoses,holistic models are typically viewed as complex interventionswhose effects vary by context. Reviews of community CGA and medical–psychiatric inpatient units show signals of benefit (e.g., improved coordination, possible impacts on utilization), but also warn about quality limitations and the absence of robust economic evaluation. This reinforces that holistic care requires pragmatic evaluative designs, including process indicators (coordination, adherence to care plans) and meaningful outcomes (functioning, quality of life, caregiver burden) alongside utilization and costs. (Sum et al., 2022; van Schijndel et al., 2022; Arakelyan et al., 2023).

A cross-cutting challenge is measurement. The whole person healthliterature suggests convergence in domains, yet there is still no standard tool for broad use, limiting comparable meta-analyses and complicating evidence-informed policy decisions. In settings such as emergency departments, implementation of person-centered care also requires realistic operationalizations for high-demand workflows, preventing holistic carefrom remaining an unmeasurable and unsustainable ideal. (DiGuiseppi et al., 2025; Walsh et al., 2022; Gold et al., 2025).

Finally, evidence suggests that the most plausible high-impact strategies combine: (1) brief but useful comprehensive assessment, (2) interdisciplinary teams with clear roles, (3) clinical–social coordination, and (4) indicators aligned with patient-valued outcomes (goals, preferences, and functioning). In outpatient settings for older adults, explicit adaptations by resources and context (especially in low- and middle-income countries) are recommended, avoiding linear transfers of high-resource models. (Hatam et al., 2025; Rohwer et al., 2023; Hayes et al., 2023)

Conclusions

Evidence from 2022–2025 supports holistic patient care as a relevant approach to multimorbidity, frailty, and healthcare fragmentation; however, progress is limited by conceptual heterogeneity and the lack of comparable operational definitions. In practice, holisticworks best when translated into clear components: comprehensive assessment, coordinated care plans, genuine patient participation, and follow-up. (Forsgren et al., 2025; Thomas et al., 2023).

In terms of effectiveness, the most consistent benefits are observed in patient experience, care coordination, and some utilization indicators, while clinical outcomes vary by population, intervention intensity, and implementation context. This is consistent with the nature of these interventions: their impact depends on how the system transforms information (comprehensive assessment) into sustained actions (referrals, continuity, psychosocial support). Therefore, evaluation should include process metrics and outcomes centered on what patients value (functioning, quality of life, caregiver burden, personal goals), in addition to costs and hospitalizations. (Rohwer et al., 2023; Sum et al., 2022; Nkhoma et al., 2022).

A particularly important finding is that holistic care requires human and organizational infrastructure: interdisciplinary teams, coordinated roles, training, and service models that integrate mental and physical health when appropriate. Where integrated units or designs exist (e.g., inpatient medical–psychiatric care), there are signals of improved efficiency, but gaps remain in evidence quality and cost-effectiveness. This suggests that the next generation of studies should precisely link components–mechanisms–outcomes and report implementation transparently. (Kongkar et al., 2025; van Schijndel et al., 2022).

The main scientific priority to consolidate the field is addressing the measurement gap for whole person health": without validated, change-sensitive instruments applicable across contexts (primary care, hospital, emergency, community), evidence will remain difficult to synthesize and translate into policy. In parallel, implementations must be realistic: in high-demand settings (emergency departments) or resource-limited contexts (outpatient care in LMICs), holistic care must be designed to be brief, scalable, and sustainable,without losing its focus on dignity, communication, shared decision-making, and continuity. (DiGuiseppi et al., 2025; Walsh et al., 2022; Hatam et al., 2025; Gold et al., 2025).

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