

# Indicators of the quality of general practice care of patients with chronic illness: a step towards the real involvement of patients in the assessment of the quality of care

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## Abstract

**Objective**—To develop a list of indicators of the general practice care of people with chronic illnesses considered important by both patients and practitioners and to identify the indicators that are considered relevant for patient assessment of health-care quality.

**Design**—Qualitative study with focus group interviews and a written consensus procedure.

**Setting**—General practice in the Netherlands in 1993.

**Subjects**—34 patients with chronic illness, mostly members of patient organisations, and 19 general practitioners with expertise in either chronic disease management or experience with patient surveys.

**Main measures**—Aspects of general practice care considered important for the delivery of good quality care that emerged from focus group interviews; the relevance of evaluations of 41 aspects of care for patients explored through the written consensus procedure. Those aspects of general practice care agreed to be both important and relevant by patients and general practitioners were considered to be suitable indicators for patient assessment of the quality of care.

**Results**—Patients and general practitioners differed to some extent in their assessment of the aspects of care that they considered important for quality. They agreed that most indicators of care that related to the “doctor-patient relation” and to “information and support” were relevant and therefore suitable as indicators for patient assessment of health-care quality. There was less agreement about the relevance of indicators of “medical and technical care,” “availability and accessibility,” and “organisation of services.”

**Conclusions**—Several indicators of the quality of general practice care of patients with chronic illness were thought to be suitable for the patient assessment of healthcare quality, but other indicators were not, mainly because of reservations by general practitioners.

**Implications**—Qualitative methods can contribute to the selection of indicators for assessment of the quality of health care in

areas where scientific evidence is limited or where patients’ and providers’ preferences are particularly important.

(Quality in Health Care 1996;5:73-80)

Keywords: general practice, chronic illness, quality.

## Introduction

Quality improvement is most effective if it is focused on issues relevant for both patients and practitioners. But difficulties arise when considering which areas of care could potentially be improved. The delivery of good quality health care depends on many many factors, which range from the comfort of chairs in a waiting room to a doctor’s skill in breaking bad news. Increasingly health care is moving towards evidence based practice,<sup>1-3</sup> and where possible indicators of good quality of care should be based on scientific knowledge. However, in many areas of care scientific evidence is limited and, even where good evidence exists, the quality of care depends on much more than just the good technical delivery of the correct intervention. For example, the views of both patients and providers of care may be crucial – even when scientific knowledge is available.<sup>1-4</sup> Other examples of such areas are doctor-patient communication and the continuity and organisation of delivery of care. Although such aspects of care are subjective, rigorous methods should be applied to the process of selecting indicators suitable for the assessment of quality in these areas. Ideally, problems assessed by quality improvement initiatives should be considered relevant to both healthcare providers and patients. However, patients and practitioners may have different priorities. For example, professionals have been shown to value the continuity of care of people with diabetes more highly than patients do. People with non-insulin dependent diabetes particularly value information, whereas people with insulin dependent diabetes value professional and individualised care.<sup>5</sup>

Patient evaluation of the quality of care is a legitimate target for quality improvement initiatives. It is probably most effective if both patients and practitioners agree about the focus of such evaluation as this will increase the likelihood that such assessments will result in real improvements in either professional performance or the organisation of services.

This paper reports on a study that has considered both doctors’ and patients’ views on

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those aspects of care that are important for the care of people with chronic illness and the selection of those aspects of care suitable for patient assessment of the quality of care. There is little published information about the selection of such indicators.<sup>6</sup> We consulted a panel of patients with chronic illness and a group of general practitioners in focus group interviews followed by a written consensus procedure.

### Methods

#### PANEL

We established a panel of general practitioners and a panel of patients with chronic illness that reflected a broad range of experiences and expertise so that the full range of aspects would be referred to in the focus group. The figure shows the number of participants in each phase of the study. Thirty four patients and 19 general practitioners were involved in the first survey and 31 patients and 20 general practitioners in the second.

The study focused on patients with one of five chronic conditions: diabetes mellitus, asthma and chronic obstructive pulmonary disease (COPD), chronic disease of the locomotor system, cardiovascular diseases, and migraine. It should be noted that the study was not looking for indicators of care specific to particular illnesses but for those aspects of care pertinent to the care of all people with chronic illness. Patients were recruited through patient organisations and a general practice. Both

active and passive members of the patient organisations were recruited.

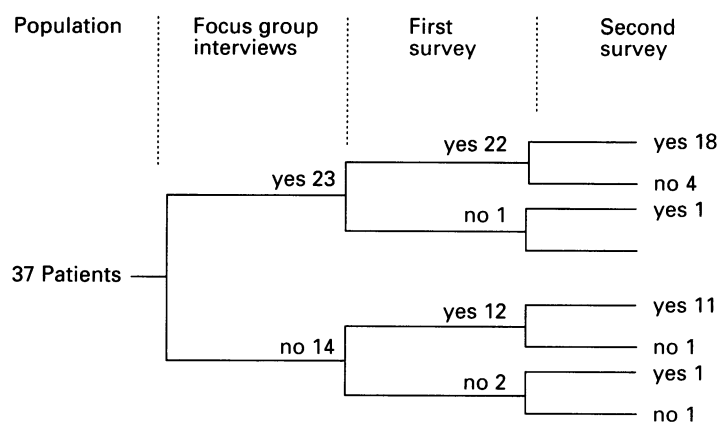
The general practitioners, who were approached individually, were invited to participate either because of specific expertise in the field of one of the chronic diseases or because they had experience with patient surveys. They were recruited from both rural areas and large cities.

#### FOCUS GROUP INTERVIEWS

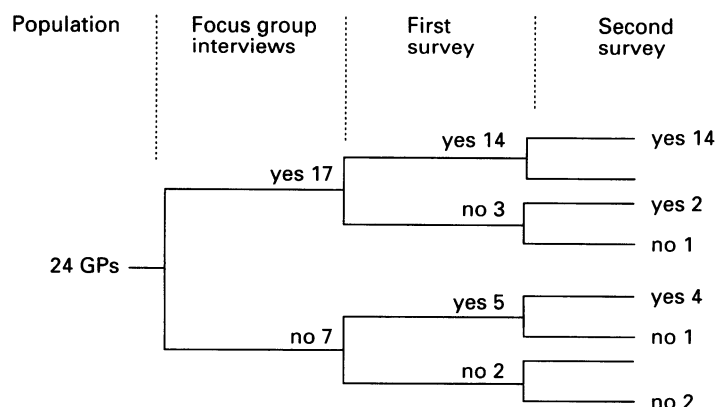
Focus groups were set up to explore those aspects of general practice care considered to be important for the care of patients with chronic illness (box 1). Separate meetings were set up for general practitioners and patients because of their likely different perspectives on care as focus groups should, as far as possible, be homogeneous.<sup>7-9</sup> The patients were not organised in groups specific for illness but were mixed because we were not looking for the perspectives specific to particular conditions but for general issues pertinent to the care of all people with chronic illness. However, active and passive members of patients' organisations were placed in separate groups as we thought that active members might have a different perspective from those who participated less.

Four group interviews with general practitioners (three to seven participants) and five group interviews with chronically ill patients (three to six participants) were organised. The number of interviews per group conformed to the guidelines in the methodological literature – that is, about five for each subcategory within

A



B



The panel in the different phases of the study

### Theory

Focus group interviews are loosely structured group interviews in which four to 12 participants discussed two to four topics, moderated by a facilitator.<sup>7</sup> The focus group technique is particularly useful to explore different views on a topic. The most important principle is that the temporary social structure stimulates and facilitates the provision of information<sup>8</sup> to identify a broad range of information as well as the key issues.<sup>9</sup> This explicit application of group dynamics distinguishes this method from both individual in depth interviews and more structured group techniques – for example, brainstorming and the nominal group technique. A disadvantage is that the perception and judgement by participants may be biased by group dynamics or the influence of the facilitator.<sup>20</sup>

### Our experience

Every patient and general practitioner who agreed to participate in a focus group interview turned up. All groups needed some minutes to understand the tasks and to think about the questions that we asked. Most groups provided a continuous flow of ideas and suggestions. Some groups were very active in providing suggestions, which made it difficult for the facilitator to structure the discussions without being too directive. Several times a theme was discussed in too much detail and the facilitator intervened to focus the group on the broader questions again. The meetings took about one and half hours.

Box 1 Theory and practice of the focus group interviews

the population.<sup>7 8</sup> However, the number of participants per group was smaller than suggested (eight to 10 persons) because smaller groups seemed to generate more ideas and were easier to organise.

In the group interviews important aspects of care were explored by asking about characteristics of good general practice care in three cases of chronically ill patients (box 2). These areas provided a starting point and were not used to restrict the number or range of suggestions. The focus group interviews were led by a facilitator, who stimulated participants to provide ideas and structured the discussion without being too directive (box 1). The interviews were audiotaped and summarised point by point afterwards.

#### ANALYSIS OF THE FOCUS GROUP INTERVIEWS

We categorised the summary points from the focus group interviews with the list of 25 aspects of the quality of health care, developed by the Health Research Council, which is generally accepted in the Netherlands.<sup>6 11</sup> In this way we tried to guarantee that the full range of aspects was covered by our list. In an interactive process of interpreting the points that emerged through the focus groups and discussing the list of the aspects with researchers in the field we developed a revised list that fitted optimally with the data. In this revised list the aspects were organised into five broad clusters.

#### WRITTEN CONSENSUS PROCEDURE

A written consensus procedure was conducted to explore which aspects of general practice care of people with chronic illness were considered by patients (for whatever reason) to be relevant for evaluation of care. The procedure consisted of two anonymous surveys, the first one month and the second three months after the last focus group interview.

For the first survey 36 aspects were chosen that covered all the areas of general practice care distinguished in the revised list, reflecting the priorities of chronically ill patients as much as possible. If an aspect from the Health Research Council was not uncovered by the chronically ill patients in the focus group interviews, other studies on patients' priorities were consulted,<sup>11 12</sup> or aspects of care suggested by general practitioners were used.

In the first survey each member of the panel was sent a list of the 36 aspects of general practice care that had been derived from the focus group and the relevant publications. The panel was asked – for each aspect of care – whether a judgement about the quality of care by patients with chronic illness would be relevant for the improvement of quality of health care. Participants answered using the following categories: extremely relevant, very relevant, moderately relevant, doubtful, and not relevant.

In the second survey a list of nine further aspects of general practice care was sent to each participant, consisting of four aspects that proved to be controversial in the first survey (see later), and five new aspects that had been

### Case 1 Diagnostics

**FOR GENERAL PRACTITIONERS** – A patient consults you because of certain symptoms, for example shortness of breath. In a series of consultations you deepen the anamnesis and you carry out physical examinations. You may also refer this patient to a medical specialist to establish a diagnosis. In the course of time you manage to find an effective treatment. Finally you make the diagnosis of a chronic disease (for example asthma or COPD).

**FOR PATIENTS** – Suppose you go to the general practitioner because recently you have been out of breath very quickly. Your general practitioner asks you several questions and he carries out physical examinations. He asks you to come back several times for further examinations. He sends you to a medical specialist for one consultation. After some months he tells you that you have asthma, a chronic disease of the bronchial tubes. In this period it slowly becomes clear that you have a chronic disease. This case could also concern a different disease – for example, migraine or diabetes.

### Case 2 Rehabilitation

**FOR GENERAL PRACTITIONERS** – You have referred a patient for diagnosis and treatment – for example because of a stroke or vascular surgery. Subsequently you have an important role in the rehabilitation of this patient.

**FOR PATIENTS** – Suppose that you stay in hospital because of a stroke. After a while you are allowed to go home and you are helped by your general practitioner. In this period you have to recover and try to resume your old activities. The same situation could also concern a different disease – for example, a heart disease.

### Case 3 Check ups

**FOR GENERAL PRACTITIONERS** – Mrs De Vries is a well known diabetes patient (non-insulin dependent) who regularly visits you for a health check up. She always makes the appointment herself.

**FOR PATIENTS** – Suppose you have diabetes and you have to visit your general practitioner for a health check up. Among other things your blood sugar concentration and blood pressure are measured. You always make the appointment yourself. In this example a chronic patient regularly visits the general practitioner for health check ups.

### Questions used in the focus group interviews

**FOR GENERAL PRACTITIONERS** – What, in your opinion, is most important for the quality of care for this patient? Please consider the medical care, the relation and communication with the patient, the organisation of care in your practice, and the cooperation with other care providers.

**FOR PATIENTS** – What, in your opinion, is a good general practitioner? Please consider the medical care, the attitude of the doctor to the patient, the organisation of the practice, and the cooperation with other care providers.

#### Box 2 Cases in the focus group interviews

subsequently found in the other studies on patient priorities by the research team.

Thus a total of 41 different aspects of care were included in the written consensus procedure. The numbers reported are based on the first or the second survey, except for the

four controversial aspects and the five new aspects for which only the numbers in the second survey are reported.

#### ASSESSMENT OF SUITABILITY FOR PATIENT ASSESSMENT OF THE QUALITY OF CARE

We thought that an aspect of care was potentially suitable for patient evaluation of the quality of general practice care of people with chronic illness if 50% or more of both patients and general practitioners considered that patient evaluation would be either extremely or very relevant. Those aspects of care that scored between 40% and 50% in one group, and 50% or higher in the other group raised doubts about their suitability. They were classed as controversial and were used in the second written consensus procedure. In our view any aspect for which less than 40% of at least one group indicated that it was neither extremely or very relevant was probably not suitable as an indicator of the quality of care by patients.

### Results

#### ASPECTS AND TYPOLOGY

The revised list includes 20 aspects of general practice care that can be distinguished in five broad clusters (table).

- *Medicotechnical care* – Effectiveness of intervention, the accuracy of care delivery, the competence of the general practitioner, and the burden on the patient by the medical care
- *Doctor-patient relation* – The exploration of patients' needs, the respect for and interest in the patient (humaneness), patients' involvement in treatment decisions, and patients' privacy
- *Provision of information and support* – The quality of information, the support of patients' compliance, the empathy (emotion-

al support), and the support of the patients' social network

- *Availability and accessibility of care* – Waiting times, the time available for patient care, the flexibility of practice organisation, the accessibility by telephone, and the physical accessibility
- *Organisation of services* – The efficiency, the accommodation, the continuity of care within the practice, and the integration of care provided by several care providers

The results of the study are described in five sections that reflect these five clusters.

#### *Medicotechnical aspects of care*

Box 3 shows a summary of the medicotechnical aspects of care that the focus group panels indicated as important for the quality of care. Both patients and general practitioners considered it important that doctors are competent. Patients particularly stressed "knowing most recent developments in medicine" whereas practitioners stressed "working according to protocol." A second difference in perspective was that patients valued "consultation of other care providers in time," whereas for practitioners "knowing if a referral to a specialist is necessary" was important.

The table shows all aspects of care within this cluster. Three of the four indicators of the effectiveness of care and the burden of care on the patient were considered suitable for patient evaluation of general practice care. Those aspects of care that reflected competence and accuracy were less acceptable to general practitioners as indicators that patients could use to assess the quality of care.

#### *Doctor-patient relation*

Box 4 shows the aspects of the doctor-patient relation considered by patients and

#### Views of chronically ill patients (n = 23)

- GP solves acute symptoms of the patient quickly
- GP makes the diagnosis quickly
- GP involves medical specialists or other care providers in time
- GP refers accurately to a medical specialist
- GP has means for performing diagnostic procedures
- GP reacts immediately on complications or alarming test results
- GP does not send the patient to a medical specialist too quickly
- GP has good knowledge of diseases and treatments and knows recent developments
- GP knows his own limits
- GP regularly re-evaluates the needs of the patients
- GP regularly checks and considers the treatment
- Assistant is well informed and competent
- GP takes an active role in risk groups
- GP intervenes if a medical specialist makes mistakes

#### Views of general practitioners (GPs) (n = 17)

- GP provides a good treatment for the patient
- GP prevents complications as much as possible
- GP looks for complications and treats them accurately
- GP takes an accurate history
- GP makes the diagnosis early
- GP does not use "heavy" diagnostic procedures in case of minor symptoms
- GP uses the label "chronically ill" carefully: a patient should not be made more ill than necessary
- GP knows if a referral to specialist care is necessary
- GP has good means for diagnostics: a registration system, instruments, a competent assistant
- GP is physician: competence is the foundation
- GP uses protocols based on the "state of the art" (for example a guideline of the Dutch College of General Practitioners)
- GP foresees possible complications and checks the course of the disease
- GP has good agreement with assistant

Box 3 Summary of important aspects of medicotechnical care

What aspects of care are relevant for patients ( $n = 34$  and  $n = 31^*$ ) and general practitioners (GPs) ( $n = 19$  and  $n = 20^*$ ) ( $n(\%)$  were very or extremely relevant)

Cluster	Aspect of care	Indicator (= specific aspect to measure the quality)	Patients	GPs	Suitable	
Medico-technical care	Effectiveness	Is the GP able to relieve acute symptoms?	33(97)	10(53)	Yes	
		Does patients' health improve or stabilise?	23(68)	13(68)	Yes	
	Accuracy and competence	How quickly and accurately is the patient referred to a medical specialist?	33(97)	9(47)	Doubt	
		How quickly has the diagnosis been made?	30(88)	3(16)	No	
	Burden on the patient	Does the GP act according to current medical knowledge?	23(68)	4(21)	No	
What is the burden caused by the treatment (time, treatment, life rules)?†		23(74)	9(45)	Doubt		
Doctor-patient relation	Exploring patients' wishes and needs	Does the GP pay attention to the burden caused by the treatment in relation to its benefits?	28(82)	13(68)	Yes	
		Does the GP pay attention to patients' needs?	29(85)	18(95)	Yes	
	Humaneness (respect, interest)	To what extent patients' needs are met?	31(91)	18(95)	Yes	
		Does the GP take the patient seriously?	31(91)	16(84)	Yes	
	Patients' involvement in decisions	How do assistants treat the patient?	27(79)	17(90)	Yes	
		Does the GP show personal interest in the patient?	30(88)	14(74)	Yes	
	Patients' privacy	Has the patient been involved in treatment decisions?	30(88)	18(95)	Yes	
		Does the GP show limits in medical matters?	23(68)	13(68)	Yes	
	Information and support	Informativeness	Does the GP guarantee the privacy of the patient?	28(82)	8(42)	Doubt
			Have the disease and treatment been explained?	31(91)	18(95)	Yes
Supporting patients' compliance		How clear are practice organisation rules?	28(82)	18(95)	Yes	
		Does the GP provide information or a referral for public services, etc?†	31(100)	11(55)	Yes	
Empathy (attention for psychosocial problems)		Does the GP tell the patient the preliminary diagnosis?	12(35)	2(11)	No	
		Does the GP stimulate patients' responsibility for life style and taking medication?	28(82)	16(84)	Yes	
Supporting patients' social network		Does the GP guide the patient in accepting the disease?	29(85)	14(74)	Yes	
		Does the GP make social home visits for guidance?	27(79)	6(33)	No	
Availability and accessibility		Does the GP offer support to patients' relatives?	26(76)	11(58)	Yes	
		Waiting times	How quickly is the GP available in case of acute symptoms?	32(94)	16(84)	Yes
Organisation of services	Time for patient care	How long are waiting times (for an appointment, in the waiting room, etc)?	20(59)	13(68)	Yes	
		How much time is available for a consultation?	23(68)	8(42)	Doubt	
	Flexibility	Is it possible for the patient to choose the moment and GP for a consultation himself?†	26(84)	9(45)	Doubt	
		Is the practice accessible by telephone?	31(91)	16(84)	Yes	
	Physical accessibility	Is the practice accessible by car, public transport, etc?†	21(68)	6(30)	No	
Information and support	Efficiency	Is the practice accessible for people with reduced mobility?	29(85)	13(68)	Yes	
		Has the practice assistant been involved in medical check-ups?	14(41)	13(68)	Doubt	
	Accommodation	What about the decoration of the waiting room?†	10(32)	7(35)	No	
		Does the GP actively follow the course of the disease?	30(88)	12(63)	Yes	
	Continuity (general practitioner)	Does the GP keep in contact if the patient is in hospital?	28(82)	7(37)	No	
		Does the GP develop a continuous personal relation with the patient?†	22(71)	13(65)	Yes	
	Integrated care	Do locum GPs know about medical information concerning the patient?†	23(74)	8(40)	Doubt	
		Has home care provided by different care providers been coordinated?	31(91)	9(47)	Doubt	
		Does the GP contribute to the cooperation between home care and informal care?	29(85)	8(42)	Doubt	
		Does home care meet patients' needs?†	26(84)	15(75)	Yes	
Does the GP show an active attitude towards medical specialists and other care providers?		27(79)	7(37)	No		
Do the GP and the medical specialist coordinate activities – for example, concerning information?†	26(84)	13(65)	Yes			

\*Referring to the first and the second survey respectively.

†Numbers based on second survey; all other indicators are based on first survey.

practitioners to be important. The general practitioners stressed the importance of answering patients' needs, whereas the patients wanted to be listened to and taken seriously. Furthermore, patients valued involvement in decisions, whereas general practitioners thought that patients' capacities should not be overestimated.

Most indicators of the doctor-patient relation were considered to be suitable by both panels in the consensus procedure, although

the issue of guaranteeing the privacy of patients was a clear exception (table).

#### Information and support

Both patients and general practitioners valued good information about diseases and treatment as well as psychosocial support of the patient and relatives (box 5). Most aspects of care included in this cluster were considered to be relevant by both patients and general practitioners for patient assessment of quality of

#### Views of chronically ill patients (n = 23)

- Patient can always ask questions
- GP is able to listen to the patient and asks for his own ideas
- GP takes every patient seriously
- GP has a permanent interest in and knowledge of the person and family and life situation
- GP takes enough time to talk with the patient
- GP listens very well
- Assistant is friendly
- GP gives important messages himself
- GP confers with the patient about treatment options, taking his wishes into account
- GP asks patients' permission for a treatment
- GP treats the patient as an equal
- GP is not irritated if the patient asks for a second opinion

#### Views of general practitioners (GPs) (n = 17)

- GP answers patients' needs
- GP acts personally (not according to protocol)
- GP has a good relation with patient: a precondition for being able to support and rehabilitate
- GP sticks to agreements
- GP involves assistants, who are closer to the patient
- GP does not overestimate the capacities of the patient
- GP presents the patient with the choice of treatment or referral, whenever these are medically equal

<b>Views of chronically ill patients (n = 23)</b>	<b>Views of general practitioners (GPs) (n = 17)</b>
<ul style="list-style-type: none"> <li>● GP tells from the start what he suspects</li> <li>● GP explains clearly what the patients' disease is</li> <li>● GP gives information about the treatment – for example, taking medication or being examined</li> <li>● GP points out the consequences of a disease in daily life – for example, acute symptoms</li> <li>● GP explains clearly when the patient can get help</li> <li>● GP gives information or makes a referral for practical aids, patient organisations, and public services</li> <li>● GP offers psychosocial guidance and good rehabilitation</li> <li>● GP stimulates the patient to take his or her own responsibilities</li> <li>● GP pays attention to the patient and his or her relatives</li> <li>● GP makes home visits for consultations</li> <li>● GP instructs patients' relatives accurately</li> <li>● GP also provides rehabilitation information and guidance to patients' relatives</li> </ul>	<ul style="list-style-type: none"> <li>● GP motivates the patient for a treatment and stimulates his own responsibility</li> <li>● GP clearly expresses what can be expected from him and what not</li> <li>● GP explains the essentials of the disease and the treatment, gradually, orally, and in written form</li> <li>● GP answers (non-medical) questions about the disease – for example, concerning public services and organisations</li> <li>● GP provides good information about the practice organisation</li> <li>● GP adapts the communication to patients' level of knowledge</li> <li>● GP sometimes provides long term guidance</li> <li>● GP helps the patient to accept the disease and help</li> <li>● GP gives the patient the feeling that he is present, as often not so much can be done</li> <li>● GP pays attention to patients' social experiences and context (work, family)</li> <li>● GP may do social home visits</li> </ul>

Box 5 Summary of important aspects of medicotechnical care

health care (table). Exceptions were “telling the preliminary diagnosis” and “making social home visits for guidance.”

#### *Availability and accessibility*

Strikingly, in the focus groups patients mentioned many more aspects that related to the accessibility and availability of care than did general practitioners (box 6). Patients valued good accessibility and short waiting times, but also consultation hours for specific chronic diseases and flexible appointment systems. Nevertheless, general practitioners agreed about the relevance of several aspects of accessibility and availability for patient assessment of health care quality but had doubts about others (table).

#### *Organisation of services*

Both patients and general practitioners valued continuity of care and good communication and cooperation between different care providers (box 7). Also both groups valued involvement of an assistant in several ways – for

example, in the measurement of blood pressure. Patients also valued pleasant rooms within the practice. General practitioners also mentioned the importance of good appointment and registration systems. Not all aspects of the organisation of services were considered by the written consensus panels to be relevant for patient assessment of the quality of care. Patients expressed doubts about the relevance of “the involvement of the assistant” and “the decoration of the waiting room” for quality assessment by patients. General practitioners particularly expressed doubts about several indicators that related to the continuity and integration of care.

#### SUMMARY OF THE RELEVANCE OF ASPECTS OF CARE AS INDICATORS OF HEALTH CARE QUALITY THAT CAN BE ASSESSED BY PATIENTS

From the results in the table most aspects of the doctor-patient relation, of information and support, of effectiveness, and of burden for the patient seem to be suitable for patient evaluation of the quality of care. Problems arose in

<b>Views of chronically ill patients (n = 23)</b>	<b>Views of general practitioners (GPs) (n = 17)</b>
<ul style="list-style-type: none"> <li>● Patient is helped immediately if test results are deviant</li> <li>● Practice has an appointment system</li> <li>● Consultations with different care providers can be combined</li> <li>● Practice has consultation hours for specific chronic diseases</li> <li>● During a consultation enough time is available</li> <li>● Waiting times are short</li> <li>● In case of acute symptoms the patient gets help quickly</li> <li>● Practice is accessible – for example, for people with limited mobility</li> <li>● Patient can choose the time for an appointment during working hours</li> <li>● Practice has consultation hours outside normal working hours</li> <li>● Practice can be easily reached by telephone</li> </ul>	<ul style="list-style-type: none"> <li>● Appointment system is efficient and quick</li> </ul>

Box 6 Summary of important aspects of availability and accessibility

Views of chronically ill patients (n = 23)	Views of general practitioners (GPs) (n = 17)
<ul style="list-style-type: none"> <li>● Assistant is involved in several functions</li> <li>● Practice rooms are not noisy</li> <li>● Waiting room is large and well decorated</li> <li>● GP follows the course of a disease and the treatment compliance</li> <li>● GP keeps in contact with the patient when he is in hospital</li> <li>● GP himself takes the initiative for contact or a visit – for example, after the patient leaves the hospital</li> <li>● Assistants do not change all the time</li> <li>● GP, medical specialist, and hospital communicate well</li> <li>● GP and home care providers communicate well</li> <li>● GP mediates actively on the patient's behalf with other care providers</li> <li>● Between the GP and replacing GPs a good transfer of information exists</li> <li>● Rehabilitation is well organised</li> </ul>	<ul style="list-style-type: none"> <li>● GP involves the assistant to save time for other activities</li> <li>● GP plans consultations, examinations, and test results accurately</li> <li>● Good registration system exists</li> <li>● GP takes care that regular health checks and the care in case of emergencies have been organised</li> <li>● GP follows up the patient also if he is in hospital</li> <li>● GP knows that other care providers are able to refer accurately</li> <li>● GP provides an accurate account in cases of consultation with other care providers and he gets an accurate answer</li> <li>● Care providers know who does what, which requires good coordination and communication</li> <li>● GP has a key role in care delivery</li> <li>● Medical specialist is "GP friendly": he does not change the medication immediately and he sends the patient back when possible</li> <li>● A good information transfer exists between hospital and GP</li> <li>● Patient knows that the cooperation is well organised</li> <li>● GP stimulates a good organisation of informal care</li> </ul>

Box 7 Summary of important aspects of organisation of services

the assessment of other categories, with the emergence of clear differences of opinion between patients and general practitioners when considering the suitability of aspects of care that reflect accuracy and competence and to some extent those that describe availability, accessibility, and organisation of services.

### Discussion

In this study we have explored those aspects of general practice care of patients with chronic illness that were considered important both by patients and by general practitioners. Both patients' and doctors' views were used to select aspects of care that are potential candidates as indicators for patient assessment of the quality of care. Of course, before any of these are used in practice as indicators of the quality of care they will need to be thoroughly evaluated. But the indicators derived from this study do reflect patients' perspectives and, as they were chosen only if thought to be relevant by both doctors and patients, there is perhaps an increased chance that using them for quality assessment by patients will result in real improvements in care. The list of indicators need not be fixed but can be adapted to specific aims and change from year to year or from practice to practice.

The study shows that qualitative research methods, in this case focus group interviews combined with a written consensus procedure, offer an approach to the selection of indicators for the evaluation of health care that make sense for all the parties involved. A study that combines assessment of the importance of specific aspects of general practice care with their relevance for patient evaluation of quality of health care seems to be particularly pertinent for quality assurance. As both patients' and

doctors' views were taken into account, the list of indicators is relevant to both groups.

The presence of the same kind of people (colleagues or other patients) in the focus groups seems to have stimulated participants to express their views. Of course, the facilitators' role and group dynamics may have biased the results, but the role of the facilitator is crucial to focus group interviews.<sup>7 8</sup> The non-directive but still task oriented style that was applied seems to have worked well. We found that it was the smaller groups (four to six people) that seemed to be the most productive and feasible, which contradicts published methodological advice. This may be explained by the high degree of commitment of most participants.

In other studies that prioritise patients' views on aspects of care the top priorities include "general practitioner is easy to talk to,"<sup>11</sup> "explaining diabetes and its complications on diagnosis" and "treating each patient as an individual,"<sup>5</sup> and "doctor sorts out problems."<sup>12</sup> Similar aspects of care were mentioned in our focus group interviews as well. Our interviews also showed aspects of care not often included in other studies on patients' priorities. Examples include enough time for each consultation, quick help for acute symptoms, the involvement of a general practitioners' assistant, and cooperation with other care providers.

By including parallel focus group interviews with general practitioners as well as patients we were able to compare the perspectives of both groups. They agreed about the importance of many aspects of general practice care, but there were important differences. For example, patients want doctors who know the most recent developments in medicine and who do

not hesitate to refer to specialists if necessary. General practitioners stress the importance of working to professional protocols and critically evaluating the necessity of referrals.

General practitioners and patients also disagreed about the inclusion of some indicators in patient evaluations of the quality of care. The evaluation of health care from the patients' perspectives must reflect their views, so indicators that do not make sense for patients should be excluded from such studies. A more difficult issue is how to deal with indicators that are relevant for patients with chronic illness but not for their general practitioners. To use such indicators as part of quality improvement initiatives might therefore cause resistance among general practitioners and reduce the likelihood of achieving improvement. On the other hand, as many indicators as possible that patients consider relevant should be included to get a full picture of patients' views. Clearly, a balance has to be found.

A solution may be found through critical evaluation of the indicators.<sup>14</sup> For some aspects of care special knowledge is needed for the formulation of norms, and where people lack this knowledge quality assessment seems to be less valuable. Examples are the "speed of making a diagnosis" and "the extent to which the general practitioner works according to current medical knowledge." Furthermore, people usually need to have experience with aspects of care included in an evaluation of quality of health care to be able to have an adequate perception of its delivery. In some cases, patients do not have this experience. An example is the contribution of the general practitioners to the cooperation between home

care and informal care. Some indicators may be excluded on these grounds.

Quality assessment should lead to improvements in health care delivery, so similar emphasis should be placed on selecting indicators that reflect patients' perspectives and on the implementation and the effectiveness of patient evaluation instruments. Further research is required to show whether and how a balance between both aims can be found.

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