Outcomes from GPs’ Consultations

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ABSTRACT

Background and aims. Patients’ consultations with GPs can deal with a wide range of conditions and problems. Generally, consultation outcomes have been considered in evaluations but outcome has a meaning for elaboration of care beyond the graduating role of quality and other evaluation instruments. Knowledge about outcomes is needed for understanding and development. The aim of this thesis was to investigate outcomes of GPs’ consultations as directly experienced by patients and GPs and to investigate connections between clinical strategies and presumed patient outcomes.

Methods. First, concepts describing outcomes from patients’ and GPs’ viewpoints were developed from interviews in groups and individually. Secondly, based on this, questionnaires about the consultation outcomes were formulated. Then, patients and GPs answered questionnaires regarding the same recent consultation. The numbers of the different outcomes were counted and the experiences of outcomes from the same consultations were compared. Finally, another questionnaire including both the GP outcome questions and questions about the clinical situation and decisions made was answered by GPs.

Results. Concepts describing consultation outcomes were brought forward. Cure/symptom relief, reassurance, patient understanding and satisfaction were used by both patients and GPs to describe outcome of consultations. Only patients described as outcomes a confirmation of their ideas and a change in self-perception. GPs, but not patients, described the patient outcomes in terms of check-up and coping. Besides this, GPs also described other outcomes that concerned relationship-building, a change of surgery routines and self-evaluation. Self-evaluation was related to a perceived collegial consensus about right and wrong.

The concordance between GPs and patients assessing the same consultations was high for satisfaction, intermediate for patient understanding and low for belief in cure/symptom relief.

Clinical strategies were linked to outcomes. Immediate problem solving was registered in about half the consultations. When immediate problem solving was registered the patients were supposed to be more reassured, satisfied and coped better than after gradual problem solving. With increasing psychosocial
Abstract

content of the consultation the GPs registered more dissatisfaction both for themselves and their patients.

Conclusions. Change in self-perception was a prominent patient outcome.

GPs’ self-evaluations ought to have the inherent possibility to serve as a basis for development of general practice.

The entire map of the encountered outcome concepts can serve as a basis for further research and development. The mapping of concepts can be of help when prioritising. Knowledge about the total picture of consultation outcomes can help the GP to understand the patients’ worlds better. It can also contribute to a realistic picture of possible consultation outcomes.

The GPs seemed to adjust their problem solving (immediate or gradual) to the registered problem and furthermore adjust the immediate problem solving, focusing either on the problem or on the patient as a person.
LIST OF PAPERS

This thesis is based on the following papers which will be referred to in the text by their Roman numerals.

I. Andén A, Andersson SO, Rudebeck CE.
Satisfaction is not all – patients’ perceptions of outcome in General Practice Consultations, a qualitative study.
BMC Fam Pract 2005 6:43

II. Andén A, Andersson SO, Rudebeck CE.
To make a difference – how GPs conceive consultation outcomes. A phenomenographic study.
BMC Fam Pract 2009 10:4

III. Andén A, André M, Rudebeck CE. What happened?
GPs’ perceptions of consultation outcomes and a comparison with the experiences of their patients.
Manuscript submitted in December 2008.

IV. André M, Andén A, Rudebeck CE, Borgquist, L.
Clinical Strategies in General Practice.
ABBREVIATIONS AND DEFINITIONS

GP  General Practitioner
CME group  Peer group for continuing medical education
RCT  Randomized clinical trial
WONCA  World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians.
SFAM  Swedish Association for General Practice

General Practice  Here used synonymously with Family Medicine, Family Practice

Common evaluation instruments
Here follows a list of common evaluation instruments that will be commented on or mentioned in the text. To make them accessible to an interested reader there are references to where they are described

<table>
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<tr>
<th>Instrument</th>
<th>Description</th>
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<td>MOS</td>
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<td>HRQoL</td>
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<td>VAS-scale</td>
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<td>Ten point scale marking grade of an experience</td>
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PROLOGUE

My curiosity on outcome has come from many years in practice.

One day when we were about to finish a consultation the patient looked very contented and said with a smile – “Now I have been able to say what I wanted to.” Was that the outcome of her consultation? I was confused. Surely the pronouncement was my task? I realized that for her, one outcome was that she had told me something.

There have been discussions that GPs are not efficient enough at reporting patients with dementia who should get withdrawal of their driving licence to public authorities, that GPs prescribe too much antibiotics and sick-list patients that should not be sick-listed. At the same time the patients get their yearly survey form where satisfaction seems to be the only outcome of the consultation. There is a contradiction here. Should all patients be satisfied? What about those who lost their driving licence or their sick certificate?

I finished my medical studies filled with knowledge and the best of intentions, burning for general practice. I was thrown out into a reality so full of real life and unexpected facts that it has taken half a lifetime to recover and find pathways to work along. With the confusion left from that period a question that has followed me is “What do I actually achieve with my work as a GP?”

I tried to answer the question in different ways. Many years of counting patients, diagnoses and measures gave knowledge about who came and partly why, but not what the consultations actually led to. Rather it increased my curiosity about outcomes.

It was obvious that diagnosis-bound outcomes from specialist care were not enough.

Research in a field as broad as general practice, would necessarily need a great variety of methods and angles of approach. There will always be tensions between breadth and depth – probably more pronounced in general practice than in other fields of medical research. As a GP I have lived with the struggle of trying not to feel inferior because my knowledge has another character than that of the specialists. Specialist knowledge is what counts in medical society- and can be counted on. Generalist knowledge, with its holistic approach, has had more difficulty in showing its indispensability as against traditional research, and thus to get the status it should deserve in medical society in
Sweden. When working in general practice, meeting patients in real life, there are many difficulties in applying a strict evidence-based medicine or simply following the textbook.

During my first years as a GP I worked with a strong feeling that something was very wrong. I felt guilty about this until I realized that as doctors we always work on the minus side of life, at best we can help patients back to their original state but often not even so. It seldom deals with ill patients becoming well. When I realized that most patients know this, but they need to share their burden with someone and to get confirmation from their doctor that they do not miss an important treatment from time to time, I could relax about the guilt. But how are such outcomes illuminated?

Other questions about consultation outcomes arose:

Non-compliant patients with diabetes and hypertension for example, are not unable to be compliant because of their lack of knowledge, there are other hindrances that have to do with the patients’ lives. How far is it my duty as a GP to get them to live in another way? There are simply conflicts between the patients’ agenda and the agenda of the medical society. What outcomes can we expect? What outcomes can we count on?

Thus, after many years of experience my curiosity finally was converted to the subject of this thesis— the outcome of the consultations. In this thesis I have concentrated on outcomes from GPs’ consultations. I will not deal with outcomes from consultations of other professionals in primary care or colleagues from specialist care.
INTRODUCTION

General practice is an arena for a great variety of illnesses, diseases, worries, needs, expectations and demands. Patients consult for anything between birth and death. The possible mission is unbounded. Many patients have symptoms or concerns that are not possible to classify in medical terms while others have a mixture of diseases and illnesses, the whole of which is as difficult to grasp as it is difficult to perceive in detail. Furthermore, some diseases or illnesses are not curable – they get worse or get better whatever the doctors’ actions.

Therefore, during his or her career, a GP may repeatedly ask: What do I actually achieve? What are the consequences of my consultations?

During the 20th century the world has seen a rise in life expectancy and a consequent increase of chronic disease. Where previously mortality and morbidity rates were collected and informative about the burden of illness, this is now extended to include other factors (16, 18). Particularly for chronic disease there has been a change in the way in which health and health care is defined, measured and evaluated, with more patient-based measures of health and illness (19).

Another change is a gradual alteration in what is regarded as illness. Fatigue, restless legs or a blood pressure of 145/90 can be accompanied by many states that were regarded as normal not long ago, but have became matters for health care.

As the view of illness and what health care should actually care for has changed, possible outcome and outcome measures must change as well.

Knowledge about outcomes will be necessary in several ways. It must be of importance for GPs both to realize how outcomes can be seen from other viewpoints and also have knowledge about how their own views of outcomes can be. An appropriate and functional health care needs to be related not only to its aims but also to its outcomes. To set goals for this health care, knowledge about possible outcomes is necessary.
Outcome

Outcome in health care can be seen as something that happens after a series of activities, or outcome can be seen after a separate activity. In this thesis the choice was to find out what happened after a separate activity – the consultation.

With the purpose of finding out what might happen after the consultation and as a consequence of it, the intention was to find and explore as many consultation outcomes as possible. Not to prove anything, but to understand and to find a basis for further development.

The life-world and understanding of illness can differ between patients and GPs (20), but they also communicate and are highly dependent on each other. Therefore the intention was to find consultation outcomes from the patients’ point of view, as experienced by GPs and as described in literature.

Different perspectives on consultation outcomes

Outcome has been regarded in different ways depending on whose viewpoint it is. The saying “The surgical operation was successful, but the patient died” could be an ironical illustration to this.

In general practice there are some clearly discernable different viewpoints concerning the outcome, namely the patient’s, the GP’s, the politician’s and that of managers of care. Originally, the intention of this thesis was to study politicians and managers also, but this appeared to be too complicated. In this thesis, being the most important, only the first two are considered.

The patients

Following the introduction of the concept of patient-centredness there has been a growing interest in the views of patients. Patients’ evaluations are essential parts of evaluations of health care since the eighties. (21) (22, 23) (24, 25). In our literature searches no studies were found however, that addressed outcome as a whole with the full range of possible variations (26).
Patients interviewed about elements of their recent consultation declared that the outcome was together with the relation to the doctor the most important (27).

**The GPs**

Dimensions of outcome of care that patients do not know and cannot know anything about have been described; for example, the impact of the GP’s technical skill or how adequate an action is in a given situation. This has been explored further by Ben-Sira (28).

If GPs were to surrender only to the idea of “patients as customers” their professional virtues could be undermined.

GPs may feel that their experiences from practice are not elucidated in outcome research unless this also adopts a practitioner’s perspective (Hasegawa as cited by Mercer) (29).

The GPs’ views of outcomes are important not only for academic reasons. A GP in a consultation will consider possible and realistic outcomes, and these will serve as goals to aim for during the consultation. The goals can change during the course of the problem-solving as new facts appear. This has been described as reflection in action (30).

It has been shown that patients and GPs perceive consultations differently (31). Is this the case also with consultation outcomes?

**The consultation in General Practice and its outcomes**

Some core aspects of the consultation are briefly discussed below together with outcomes derived from the different aspects. These outcomes are symptom relief, disease control, enablement, general health, satisfaction, compliance and efficiency.
The consultation is the central act of medicine (32). The consultation is the meeting between patient and GP when they together deal with an illness, disease, preventive procedure or other concern of the patient (18). It often includes a physical examination and sometimes laboratory tests or other investigations and often ends up with treatment, advice or information.

A few patients will meet also other members of the team at the general practice office but a majority will see only a GP.

**Symptoms**

We have constant sensations from the body, signs from the inside. Your stomach is growling, there is a little ache in your elbow, there is a tingle in your foot. Sometimes such sensations increase to more evident symptoms, such as dyspepsia, headache or lumbago. If these sensations are considered normal you do not consult a doctor. The symptoms can be accepted if you are in a situation where they might be expected as for example stomachache before an exam. If you are very concentrated on accomplishing a task, you might neglect the sensations. Persons with a chronic disease or a natural decline of functions caused by ageing or pregnancy will adapt to their impairment and avoid situations that they cannot manage. Thus, the degree to which symptoms are tolerable depends both on the individual and on the circumstances. When someone gets new symptoms the question of what is happening in the body will arise. Strong symptoms will be perceived as alarming independent of the situation (33, 34).

The symptom is the experience of the patient. The task of the GP is to grasp and to recognize the patients’ presentation of the symptom (35).

A common lay belief is that a symptom is an expression of a disease, which is far from being always the case.

**Symptom relief**

Relief from the discomfort, or concern caused by the symptom, can be one consultation outcome.

The effect of the consultation on certain symptoms is usually investigated by open questions, with inquiries or with scales. Outcome of consultations for conditions such as back pain (36, 37), neck pain (38), chest pain, fatigue,
headache and abdominal symptoms has been evaluated in this way (39) among many others.

When studying the resolution of symptom concern a VAS scale can be used (40).

**Illness/disease**

One after the other, the GP welcomes mostly well-known patients into the consulting room. They come on their own initiative, having decided to consult about their illness or disease to get an assessment by a GP. For the most part they have their own ideas about what is wrong, which is as important for the GP to respond to as giving biological explanations (31).

Since the sixties General Practice has been struggling with the biomedical paradigm as being the dominating opinion about illness (18, 41). In the tracks of the discovery of bacteria and the successful defeat of the big infectious diseases, diseases with clear biological causes have been considered as more legitimate than states with less evident causes.

Thomasine Kushner criticized the dominance of what she called the “clinical model”. Others have called it the bio-medical model (42) or the conventional method (18). In the “clinical model” the patient is seen as someone who has a disease produced by either an external factor or a malfunctioning structure. Recognition and treatment of this source of pain and unhappiness would, if successful, restore the patient’s wellbeing. However, a majority of a GP’s patients were shown to have illnesses or diseases that lack either objective evidence of physiological pathology and/or are not amenable to cure, in the sense that they are either self-healing or inevitably progressive. Still they will need a GP’s services (43).

**Disease control**

Disease control is thus one possible outcome. It relates to the disease as such, rather than to the way it affects the patient as a person. Biochemical markers and physiological functions are the parameters measured. Laboratory parameters such as glucose, Hba1c and blood pressure can be followed and monitored with great exactness, but still their impact on the individual patient
can be very different. In literature they have been regarded both as intermediate outcomes as in the UKDPS studies (44, 45) and as outcomes in themselves (46-50).

Deaths or major events such as myocardial infarction are so called hard endpoints. An example were these have been used as outcome measures are the Swedish STOP hypertension study (51) and other cardiovascular intervention studies.

When symptoms are clear expressions of a disease symptom relief has been measured to follow the course of the disease or the effect of an intervention. The decrease of tonsillitis symptoms (52) or symptoms from urinary tract infection (53), for example, have been measured to judge the efficacy of different treatments.

**Diagnosis**

The diagnosis aims at helping to understand and explain the development and also the treatment of a disease (54). The classification of diagnoses mirrors current values and beliefs about illness. It varies over time, depending both on new knowledge and on the contemporary view of the interplay between individuals and their surroundings (55, 56).

The relation between symptom and diagnosis is sometimes problematic. Many symptoms that will bring a patient to a doctor cannot be satisfactorily explained by biological models or contained within a diagnosis (34, 57). This is the case for example with fibromyalgia and chronic fatigue (55).

**The patient-centred consultation**

There has been an increasing interest in doctor-patient communication and relations. The importance of doctors’ understanding of how people’s life conditions and circumstances affected illness was described by the psychiatrist Michael Balint (41)

Interviews with patients before and after consultations, and with GPs after consultations, have revealed that patients and doctors live in different conceptual worlds without knowing the extent to which their perceptions
were different and why. Patients’ ideas are extremely important factors in illnesses and in the medical therapeutic process (31).

The meeting between the “voice of medicine” and “the voice of the life-world” can be complicated (20, 58).

Patient-centred care claims to be a complementary extension of the strictly biological view of illness and disease. The patient-centred consultation also aims at considering psychological and social circumstances.

Patient-centred medicine is an approach where the health-care provider uses the patient’s knowledge and experience to guide the interaction within the consultation according to Byrne and Long (59).

Mead described the patient-centred model in five dimensions; the bio-psycho-social perspective, the patient as a person, sharing power and responsibility, the therapeutic alliance and the doctor as a person (60).

Pendleton underlined that the social-psychological approach enables us to see that it is possible for the doctor to develop the patient’s understanding of his health in the consultation and that in so doing he will influence the patient’s health behaviour (32).

Both Mc Whinney and Moira Stewart have described the patient-centred clinical model (18) (61). The model is a method with 6 integrated components:

- Exploring and interpreting both the disease and the illness experience.
- Understanding the whole person.
- Finding common ground with the patient about the problem and its management
- Incorporating prevention and health promotion.
- Enhancing the doctor-patient relationship
- Being realistic about time and resources

Patient-centred care is increasingly advocated, even if there have been different opinions on which components of patient-centred care are most important (62). The patient-centred consultation is the foundation of GPs’ work today, taught at medical schools in Sweden and described in textbooks of family medicine (54) (18). Patient-centred medicine is so well established, that it must be presumed to be more or less practiced by all GPs.

Theories of patient-centred care describe what should happen within the consultation, but what will follow afterwards?
Outcomes that are not related to a specific disease, but rather to the consultation as such are enablement, general health, satisfaction, compliance and efficiency.

**Enablement**

Traditional disease-oriented outcome measures and symptom-monitoring are of very limited relevance when patients come for an assessment or with self-limiting conditions. The Patient Enablement Instrument, PEI, asks about the patient’s ability to understand the illness and to cope with the symptom as well as with life as a whole after the consultation. As a concept, patient enablement emanates directly from general practice. It concentrates on patient outcome irrespective of cause (14). PEI has been used for example in studies of patient-centredness (63) (64). The questionnaire was to be filled in immediately after the consultation and little is known about enablement in the long run.

**General health**

To measure general health, and sometimes a change in general health, is another way to assess outcome in general practice.

Instruments for monitoring general health are well established and applied in several outcome studies in general practice. Medical Outcome Study short form – MOS-sf (11) with the instrument SF-36 (65) (66, Bertakis, 1998 #9, 67, 68) and also in a shorter form SF-12 (69), EuroQol with EQ-5D (5), COOP-Wonca (2, 70), Measure Yourself Medical Outcome (MYMOP) (12, 71) and Nottingham Health Profile, NHP (13, 72) (73) are such instruments.

For example, general health, measured by SF-36, has been related to the GP’s consultation style (65) and the MYMOP scale has been used when studying the effect of patient-centredness on patient outcome (63).

These instruments can be used at different intervals after the consultation and thus a change in general health can be observed over time.

Another outcome measure related to general health was when patients were asked to grade their health before and after the consultation as percentages of their normal, perceived health (74). The effects of physician-patient interaction on the outcome of chronic disease were also measured with four levels of health; excellent – good – fair – poor (48).
Satisfaction

Satisfaction is the dominating concept in outcome research in general practice, either alone or in combination with other outcomes. It is very unspecific however, referring to different aspects of the consultation, such as satisfaction with the doctor, communication, the staff, the accessibility, or fulfilment of expectations. In a review only 4% of 221 studies related satisfaction to the outcome (75). Patient satisfaction with the consultation has been regarded as an important measure of the outcome of the consultation per se, and has also proved to be significant for the healing process, and for compliance with the given prescriptions or advice (74), but it does not necessarily have any bearing on the illness/disease.

Questions on satisfaction are often posed immediately after the consultation. When patients report satisfaction immediately, they refer to the doctor’s behaviour and communication, but later on, after two weeks and three months, they refer satisfaction to the outcome of the consultation (76).

Satisfaction has often been measured with different scales.

Hall’s review found that 75% of the 221 questionnaires were home-made or only used once (75). In the home-made inquiries, the patients expressed 10% higher satisfaction than in the validated inquiries. The number of questions is of importance; the more questions, the less satisfaction. Nowadays validated scales are more commonly used.

Consultation Satisfaction Questionnaire (CSQ) and Medical Interview Satisfaction Scale (MISS) are validated questionnaires to measure patient satisfaction with different aspects of doctors’ performance (21, 77). MISS was originally elaborated in USA as MISS-29 but there is also a version adapted to an English standard, MISS-21 (10).

Patient Compliance

Compliance or adherence, the extent to which the patients follow instructions, advice about lifestyle, or prescriptions given, is another estimated outcome of consultations. It reflects the rapport between doctor and patient.

In a study on the effects of patient-centredness, pills were counted (78). The patients’ self-reported adherence to medication has also been used, although
this method is considered to be less reliable (78). Measuring compliance in a valid way can have methodological difficulties (79). Compliance/adherence has also been used concerning advice given during the consultation. Patients have been asked if they had followed the GP’s recommendations regarding lifestyle changes or fulfilling planned actions (74) or if they had attempted to modify their behaviour with regard to smoking, alcohol consumption, the use of a safety belt, diet, exercise, stress and safe sex in a questionnaire after the consultation (80).

Another way of tracing compliance has been to ask patients about their intention to follow the advice; either immediately (81) or after some weeks (82).

**Efficiency**

The overall efficiency of general practice and primary care, measured through the spill over from a single consultation into tests, revisits, referrals or episodes of hospital care, is a relevant outcome, not least from the perspective of the health-care organisation. Efficiency must also be highly desirable to the individual patient, getting things sorted out straight away. The frequency of revisits and referrals in relation to patient centredness have been studied (40), the frequency of revisits among frequent attenders after an intervention was the subject for another study (83), and fewer revisits were made by irritable bowel syndrome patients if the doctor had been patient-centred (84).

**Summary of concepts describing outcome in studies of consultations in general practice**

Concepts to describe outcomes of general practice consultations found in literature were thus:

- disease control
- symptom relief
- enablement
- general health
- satisfaction
• patient compliance
• efficiency

The concepts could be sorted according to two principles: subjective-objective and being related to illness/disease or not, figure 1.

*Figure 1. Outcomes from consultations in literature.*

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**Evaluation and quality**

Evaluation is performed either to demonstrate accountability, to improve interventions or to obtain progress of basic knowledge (85). Evaluation departs from the insight that honorable intentions are not enough, but good practice and solid results are what really count (85).

Measurements of quality have been mixed up with outcome. Evaluations can be made both regarding quality and regarding outcome. Outcome has a value in itself as being what an action ends up in.

Quality thinking in its present form has its origin in the manufacturing industry in US in the first half of the twentieth century and since then it has spread to service and public sectors. The core is customer-orientation, which means that production development and quality work have the satisfied customer in focus with the aim of increasing demand and thereby incomes (86). Quality advocates often depart from an economical-rational perspective.
There has been hope that quality improvement might be a solution to the economical and dimensional problems that health care is facing.

Quality is the dominating means of evaluating care from the health-care-system level.

There is a large bulk of literature on quality in health care. Quality has been inconsistently and inadequately defined in the empirical literature (88). There are several definitions for example: Quality bears upon all qualities that together give the potential to an object or a phenomenon, to satisfy expressed or understood needs (SS-ISO 8402, 1994). The National Swedish Board of Health and Welfare defined quality as: quality is the degree to which an action fulfils specific demands (SOSFS 2005:12).

In the sixties Donobedian did pioneer work when describing ways to assess quality in medical care. He stated that outcome is the ultimate measure of quality of medical care. But there are difficulties both regarding definitions and ways of measurement of consultation outcomes. Because of these difficulties in finding appropriate measures of outcome in medical care he pleaded for measuring whether medicine was properly practised: the process of care or the structure of care. The structure bears upon the attributes of the settings in which care occurs. If the process and structure are good it should follow that care will be so as well. The structure and the process are easier to define and to measure than the outcome (89). Outcome, he reasoned, was of limited use for several reasons;

- An outcome might be irrelevant to the actual situation, for example survival from a state that is not fatal.
- Sometimes long periods of time must elapse before relevant outcomes are manifest, so the recovery could be caused by sources other than medical care.

Quality has been measured by quality indicators regarding outcome, process and structure.

Outcome measures have a value in themselves but process measures have a value only if they are proven to have a link to outcome (90). In order for a process indicator to be valid it must previously have been demonstrated to produce a better outcome. Similarly, using structural indicators for quality assessment is possible only if structural components have been shown to increase the likelihood of a good outcome or a process that has previously shown to yield better outcomes (91).
Howie stated that assessing quality in general practice is handicapped by the absence of an adequate range of outcome measures. Guidelines for the care of specific diseases often recommend biomedical data for evaluation of treatment effects. For self-limiting conditions, multidimensional problems, or for health promotion, such measures are not sufficient. His group developed the Patient Enablement Instrument, PEI (23).

Quality discussions in health care started as a means for evaluation. Since then there has been a division between quality control performed by the managers of health care and quality development which should be the responsibility of every GP (92). Quality assurance is in-between (86).

**Quality instruments**

Quality measures have come to serve as outcome evaluation. Quality measures can be composed of parts from structure, process and outcome. Three quality instruments are Europep, IPQ and GPAQ.

The Europep instrument (4, 25, 93) has been used for evaluation of care (93), for evaluating GPs (94), for comparison between health care in different countries (93) and for comparison between health-care systems in different countries (95) (96) and other studies.

IPQ, Improving Practice Questionnaire (9) and GPAQ, General Practice Assessment Questionnaire (7) are the measures of patients’ opinions about their GP service as used in the UK.

In the quality instruments questions about outcome have not been clearly separated from questions on structure and process. This makes outcome items difficult to discern and probably also contributes to a diminution of the importance of outcomes.

**To start with the end**

This thesis is as an attempt to find and explore possible outcomes of GPs’ consultations.

In order not to get stuck in previous knowledge about what could be implied, expected, desired or hoped for in different situations, diseases, illnesses,
diagnoses, patients’- and GPs’ characteristics were put aside in the search for outcomes, and outcomes themselves were in focus.

There were several reasons for such a procedure. In general practice there are so many possible problems and diagnoses, so many different sorts of patients to meet many different sorts of GPs, that it was not meaningful to divide them into subgroups. A specific diagnosis rarely entails a certain outcome. Rather, many different states might produce similar outcomes.

Also taken into consideration were my observations that consultations starting with one problem could shift to quite another problem during the course of the consultation. This unpredictability of practice and the certain kind of reflection it entails has been described by Schön (30). Another such possible confounder when outcome is related to “the beginning”, is that persons who are very ill can consider themselves as healthy while persons without either diagnoses or obvious signs of disease might perceive themselves as very ill (97).

Outcome concepts that were found were used to elucidate the clinical process, namely identification of the problem and decision making.

**Decision making**

GPs have to use a variety of clinical strategies to be able to manage the diversity of problems encountered. Decisions have to be made even though uncertainty to some degree will always be present in any medical work, both regarding the nature of the problem and actions to be taken (98). The limited time for each consultation requires rapid actions. General practice is very decision-intensive. In clinical reasoning two major ways of decision making have been described. One is immediate inductive recognition, which is primed, heuristic and largely experience driven. In contrast the other model is slower deductive, deliberate and analytical (99). The immediate intuitive response to a specific situation characterizes the expert. This expertise is context-based. GPs in Sweden describe heuristics or rules of thumb as useful necessary tools in everyday work. Rules of thumb with two different purposes have been identified: to simplify the categorization of the problem to a disease and to make the consultation patient-centred (100).

Can the way of making a decision have bearing on the outcome?
AIMS

General aim

The aim of this thesis was to investigate outcomes of GPs’ consultations in General Practice from patients’ and GPs’ perspectives.

Specific aims

To draw up a systematic outline of how patients experience consultation outcomes.
To explore how GPs conceive the outcomes of their consultations.
To investigate the occurrence of consultation outcomes as experienced by GPs.
To compare GPs’ experiences of consultation outcomes with their patients’ perceptions of outcomes from the same consultations.
To analyse the clinical strategies of GPs with regard to the whole range of problems encountered in everyday work and presumed patient outcomes.
MATERIAL AND METHODS

An overview of material and methods are seen in Table 1.

Table 1. Material and methods.

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Material

**Paper I.** Twenty-eight patients were interviewed, twenty in five groups and eight in individual interviews. Their medium age was 48 years (1-74).

The selection was gradual and purposeful to get patients of different age, sex, and with different sorts of illness/disease. After a pilot group interview with both men and women, that appeared to be dominated by the men in the group, group interviews were made with only men or only women. The receptionist asked patients to join for three groups. Patients for two groups and five individual interviews were recruited by AA in the waiting room.
Three patients, finally, were asked by their doctors. None of the patients was my own patient. Individual interviews were offered to patients who, owing to the point in time, or timidity, were reluctant to come for focus-groups. Taking into consideration patients’ preferences, four patients were interviewed at their homes and four at their health centre. The patients came from four health centers and an after-hours general practice centre in Luleå and Piteå, two medium-sized towns in northern Sweden.

The interviews took place within a week after the latest consultations with their GPs. The questions asked were “What did you get out of your latest consultation? What was the outcome of it?” The interviews were semi-structured and carried out by AA. In the groups a male GP assisted. His task was to watch what happened in the groups, to supplement the questioning and to handle the tape recorder. Careful notes were taken during the interviews and the group interviews were discussed afterwards by the two interviewers. The interviews were audio-taped and transcribed verbatim by AA. The names of the patients were changed already during the transcription.

**Paper II.** Seventeen GPs from northern Sweden were interviewed, twelve in three groups and five individually. The selection was gradual and purposeful to get a variation as to age, gender, ethnicity and years as a GP. The GPs were chosen to give a broad representation. The medium age was 51 years (38-64). They had been working as GPs between half a year and 28 years, nine were women and three had another mother tongue. They worked as public employees in group practices, which is the dominating type of employment for GPs in Northern Sweden. Most of the GPs were known to the interviewers beforehand. By describing their latest consultations, their consultations were unselected.

The interviews were semi-structured. The group interviews were carried out by AA and an assisting male GP, and lasted an hour and a half. The individual interviews were conducted by AA and took about half an hour. Apart from a broader selection of GPs, the intention with the individual interviews was to give possibilities to see aspects that would eventually not come to light in group interviews.

The GPs provided 1-4 cases each, starting with their latest consultation and going backwards. By this procedure the consultations were both unselected and still fresh in the GPs’ memories. In all, outcomes from 43 consultations were described. The cases represented a broad range of conditions that are common in general practice.
The interviews with twelve of the GPs were audio-taped and transcribed verbatim by AA. The tape recorder did not work in one group and one individual interview, but careful notes were taken. The group interviews were discussed immediately afterwards by the two interviewers. The five non audio-recorded interviews, concerning thirteen cases, were transcribed from the notes.

**Paper III.** Twenty-five GPs were randomly selected from all 104 publicly employed GPs in “fyrkanten” and Kalix – the most populated area in Norrbotten in northern Sweden, using the random number table in Excel. There were only 5 private GPs in the region at the period, four of whom were also working in another speciality. They were not in the random list because of feared difficulties of differentiating what they did as specialists and as generalists. Seven GPs were unable to participate and were replaced by the next seven on the list. The 25 GPs worked at 16 group practices in towns and in the countryside. They were asked to invite and inform ten consecutive patients each about participation in the study. All GPs in this area have both pre-booked and emergency patients and by asking for consecutive patients we were sure to get a representative material.

The GPs were given oral and written information by the researcher (AA) and the patients were given oral and written information by the GP, formulated by AA. Both the GPs and the patients were informed that they would be anonymous and that participation in the study was voluntary. Children and other non-autonomous patients were to be represented by their companion. Patients who did not understand the Swedish language were excluded. Patients unwilling to participate were asked to leave an empty questionnaire. The GPs could choose when they wanted to participate during a two month-period in February and March 2007.

The patients left their questionnaires in a closed box at the reception desk, having been ensured that the GP would never see their answers. The questionnaires were coded so that the researcher could connect the GPs’ answers with those of the patients’.

The questionnaires were answered by the GPs and their patients regarding the same consultations. The questions were formulated from the patients’ and the GP’ wordings in the qualitative studies (I, II). The patients’ questionnaires formulated from the patient concepts were thus different from the GPs’ questionnaires that were formulated from GP concepts. The statements were to be answered with yes/no/ I don’t know. The “don’t know” alternative was
necessary so that the informants should not feel forced to choose an alternative when uncertain.

A pilot study was made by AA and another GP with 10 patients each. Afterwards the questions, the answers and the procedure were discussed. We found that the procedure and the questionnaires worked. From other studies we assumed that being dissatisfied was a much stronger statement than not being satisfied (101). Therefore we had statements on both satisfaction and dissatisfaction.

**Paper IV.** GPs interested in research and development in general practice were contacted through an informal network and asked to participate. For the study eight men and eight women, working in health centres all over Sweden were recruited. They filled in questionnaires on 15-30 consecutive consultations each, in all 366 consultations with 378 problems. The questionnaire was presented as an Excel file mailed to the GPs. It concerned the characteristics of the patient and the problem presented, the process of the consultation, the problem solving of the GP and presumed patient outcome.

The questionnaires were piloted and changed several times for clarity and simplicity.

## Methods

### Phenomenography (I, II)

Phenomenography is the empirical study of the limited number of qualitatively different ways in which people experience phenomena in the world (102).

Phenomenography is a research approach originally developed in educational research (103) (104) (105). It originates from the observation that whatever phenomenon or situation people encounter, they will experience it in qualitatively different ways, but in a limited number of different ways. It is described as a qualitative, non-dualistic research approach that identifies and retains the discourse of the research participants. As in other qualitative
research the aim is to describe the world as it is understood or experienced. This is called a second order perspective in contrast to a first order perspective, describing the world “as it is” (103). The aim of phenomenography is to discern and describe the different ways of experiencing a phenomenon in a systematic way (106).

What is experienced is most often described in statements, but it could also be for example drawings or video-recordings. The statements (or other descriptive units) are sorted and grouped together in description categories (107). Through examination, description and comparison of the different conceptions the phenomenon can be understood. The description categories together and the logical relationships between them form the outcome space, which is a picture of the phenomenon under investigation (107, 108).

In phenomenography terms such as conception/conceive, ways of understanding or perceiving something are used synonymously to “ways of experiencing” (107).

A phenomenon is discernible through its different aspects. Referential aspects refer to how the phenomenon relates to its surroundings, its global meaning. Structural aspects refer to the structure of the phenomenon, its characteristics. (109).

The object of research was consultation outcomes seen through the eyes of patients and GPs. The outcome of a consultation is different from the settings or the process of it. The settings are the circumstances surrounding the consultation e.g. accessibility, and the process is what happens during the consultation e.g. whether the doctor had been pleasant. The outcome is the change that happens after the consultation and owing to it. This is the referential aspect of the consultation outcome. The outcome was also defined by belonging to this very specific consultation- we were not talking about the idea of consultation outcomes.

As long as the statements belonged to their context it was possible to discern that one concept could have different meanings. In the study of the GPs for example it was obvious that the GPs when discussing satisfaction referred this both to expected patient satisfaction and to quite another experience, namely if they were satisfied with their own achievement when referring to the collective norm. Thus the statements on GPs’ satisfaction was sorted into two description categories depending on the context in which they appeared; patient outcomes or GPs’ self-evaluation. As the analysis continued the specific consultations were however not in the focus of interest. The outcomes were disconnected from the consultations that had produced them. There
were experiences of outcomes that were similar, and the outcomes were grouped together after similarity.

The way in which a person experiences, and in the interview situation conceives, a phenomenon does not alone constitute a socially or culturally relevant phenomenon; it is a facet of the collectively experienced phenomenon (109). The researcher reconstructs the phenomenon putting together parts of the reports of the different subjects. This becomes the researcher’s description, or version, of the phenomenon and it is called the outcome space.

However, no conceptual distinction is made between the act of originally experiencing the phenomenon and the act of giving words to the conceptions in the interviews. Also, we believe that the phenomenographic horizons vary in their implications, dependent on the relation between the experiencing person and the phenomenon and also on the character of the phenomenon itself. From the beginning we were not fully aware of this difficulty, but along the progress of the study we have tried to choose the most suitable concept for the experiencing and the wording respectively.

Essential to improving health care and developing any discipline is identifying the ways in which phenomena are understood and experienced by practitioners, patients, institutions and society (109).

Recognition of the ways different individuals have of experiencing illness, the body and what happens in and after the consultation can have an important impact on health care, health maintenance, clinical practice, theory and understanding. In accordance with the patient-centred model it is important to get as close as possible to the patients’ perceptions and beliefs. With the aim of understanding a broader picture of outcome, there is an interest also in understanding GPs’ experiences and conceptions of outcomes although in many cases they cannot know for certain. Knowledge about different ways of experiencing, in this case outcomes, is a prerequisite for this understanding.

Since outcome as a phenomenon has not been studied in this way before, established concepts were out of focus in the interviews. Therefore we consider the horizons of the outcome space to relate to the experiences and conceptions of the informants, rather than to their preconceived ideas. This means that when well-known concepts are found within the outcome space, they are products of fresh conceptualizations rather than duplicates of old ones.

Interviews for a phenomenographic research study can be open or semi-structured (107) (106). We chose open-ended questions in order to let the subject choose the dimension of the question they wanted to describe.
Group interviews/Individual interviews (I, II)

The interviews for studies I and II were made in groups and individually. Focus-groups were considered to be a suitable interview form as not only the individuals but also the group-processes would help to provide the material (110) (111) (112). The interviewing for Paper I started with the pattern from focus-group interviews. When it came to the analyses however, the material was not handled as a unit but as separate statements. Therefore in Paper II we did not call it focus groups, even though the interviews were performed in a similar way. The idea when interviewing was that when people can talk uninterruptedly they will tell you what is on their minds and what they find most important. During the interviews the patients and the GPs respectively were brought back to that question at times. The other members of the groups and we, the interviewers, came up with questions and asked for elucidations when something was unclear.

With patient-group interviews we wanted to obtain accounts different from those of a regular doctor-patient interaction. Patients being in the majority and interacting in the groups would provide accounts more like those that patients tell on getting home after the consultation.

With the same purpose in mind we were restrictive in intervening, apart from helping the patients to keep to the question “What did you get from your latest consultation- what was the outcome of it?” We trusted the group mechanisms.

On finding out that some patients felt uncomfortable about group interviews, we also made individual interviews, so as not to exclude possibly important informants due to the method of interviewing. In these interviews we followed the same procedure as in the focus-groups except that AA was the only interviewer.

After the experiences from the patient study we decided to make some individual interviews with the GPs as well.

The phenomenographic analysis (I, II)

The transcribed interviews from studies I and II were analysed in accordance with the phenomenographic analyses as described by Sjostrom (113) with the seven steps;

- familiarization, where the transcripts were read thoroughly many times,
• compilation where relevant parts in the transcripts were chosen,
• condensation where the central parts of the descriptions were identified,
• grouping and classification, where similar descriptions were put together
• comparison and revision where the borders between the description categories were established
• naming of description categories
• contrastive comparison of the description categories which contains a description of every category and a comparison of categories (113).

To become familiar with the material AA transcribed the interviews and thereafter the transcripts were read several times. The parts that were about outcomes from the latest consultations were picked out, and parts from other consultations and ideas about outcomes on the whole were declined.

Those outcomes were literally sorted by hand into different heaps with similar outcomes. The different collections of outcomes were characterized as to their inherent character. In the GP study there was for example one heap with statements where the GPs discussed giving support to their patients. This heap contained descriptions about support, but when the accounts dealt with outcome, the support turned into “coping”. So in the next step when creating a category its name became coping. The category of cure/symptom relief was more obvious from the very beginning, both as to its character and to its name. The description categories were then compared according to similarities and differences, both within the category itself and along internal horizons to the other categories. Some categories were often seen together as understanding and satisfaction in the patient study.

For Paper I an external researcher also did the sorting into categories and after discussion about the few cases with different assessments, agreement was reached. For Paper II this procedure was executed by the authors who first did the sorting one by one, and then after discussion reached agreement.

**Questionnaires (III, IV)**

Questionnaires on patients’ and GPs’ outcome concepts (III) were formulated from expressions in the qualitative studies (I, II). The concept “coping” was, however, initially conceptualized by the GPs as “support”. The questions were
formulated as statements to be answered by yes/no/ I don’t know. The “I don’t know” alternative was necessary so that the patients and the GPs should not feel forced to choose an alternative when uncertain.

Questionnaires for paper IV, clinical strategies, concerned the characteristics of the patient and the problems presented, the process of the consultation, the problem solving and finally the GP questions about outcome from paper III were used to investigate presumed outcome. All questions had closed answers except the diagnosis and rules of thumb which were given in free wording. The definition of a rule of thumb was “a mental pattern used during the consultation, action oriented and that comes to the mind automatically.”

**Statistics (III, IV)**

The answers from the questionnaires for Papers III and IV were entered into Microsoft Excel 2003 SP3. Descriptive analyses were made in this Excel programme. A Chi-square test was used and Fishers’ exact test when appropriate. A p-value below 0.05 was considered significant. The analyses for differences and the significance testing were made in Minitab 14.20 for Paper III and in SPSS 15.0 for Paper IV.

When comparing similar questions for the GP and the patient (III) only the answers from consultations where both had answered were analysed. Index of validity, Index of validity, Iv, a measure to compare an assessment of a phenomenon, with another assessment of the same phenomenon—was also counted for these questions. It is a calculation based on concordant answers divided by total answers. Iv was used to compare similar outcomes from different perspectives for article III (114).

When different questions were compared the "don’t know"-answers were removed as they could mean different things for different questions. In some cases it may reflect the lack of a definite opinion, in others that the question was not understood, and in still other cases that the real outcome was still to occur.

In paper IV relative risk was calculated for immediate decision and known problem with the category “somatic problem where emphasis was given to the symptom” as the reference, with 95% confidence interval (CI). For GP satisfaction and patient outcomes trend analyses Mantel-Haenzel test of trend were used.
Ethics

Study I was approved by the Ethics committee Umeå Universitet, Umeå, Sweden; (Um dnr 03-074) and study III by the Regional Ethical Review Board in Umeå (EPN dnr 06-165M).

The identity of the patients was removed as soon as the processing of the material began. All patients were thus anonymous. The GPs were known to the interviewers but their identity was removed as soon as the processing of the material started. The director for Primary Health Care in Norrbotten County Council gave his approval of studies I-III.

Both patients and GPs were informed in writing and orally about the studies and that it was voluntary and that they could withdraw whenever they wanted.
RESULTS

Patients’ perceptions of outcome in General Practice Consultations (Paper I)

From the patient’s perspective the outcome of a consultation is about

- cure or symptom relief
- reassurance
- confirmation
- understanding
- change in self-perception
- satisfaction

Each category contains what patients refer to as being important to their way of experiencing the outcome of their latest consultation.

Except for change in self-perception, the categories represent the evident needs and requests patients have when consulting. As far as the outcomes are “about” evident needs, the specific outcomes may be presented either positively or negatively; positively when the need in question is met, and negatively when not.

The concepts can be seen on their own or in different combinations.

Cure or symptom relief

This category includes statements where the outcome was cure or symptom relief; either as experienced or as expected but without being obtained. This is a desired outcome but often not possible as many patients have symptoms or diseases that cannot be cured. The patients presenting this outcome often had acute or semi-acute symptoms and/or disease.
The patients who had been cured did not express a change in self-perception.

Citation Nike (woman, aged 55): "I had a pain in the elbow for several months. I work with a physiotherapist and I had been asking over and over again if she could do something. -No she said. I went to a doctor and actually he gave me a diagnosis immediately. I got treatment and I was cured. So I was very satisfied."

Reassurance

Some patients, who had been worried before the consultation, perceived reassurance as an outcome. Their fears were not confirmed. Once the cause of worry had been refuted the worry itself was much diminished and almost forgotten.

A reassurance could be both explicit and implicit. An assessment saying that there is nothing dangerous going on is an explicit outcome.

Citation Nils (man, 73): "I had felt extra beats from my heart and that made my pulse jump. I thought I probably needed a pacemaker but my Doctor said I did not. It will probably disappear by itself. It was a good thing that I don’t need a pacemaker."

A reassurance could also be implicit. Getting a diagnosis or an explanation of symptoms implies that it is not another dangerous disease. The fear did not have to be mentioned. The fear of cancer was seldom openly expressed but often between the lines.

Citation Johnny (man, 62): "Now I had good tests for everything... That was the good experience of my visit. I was not worried. But people around, they die. You are at the age for prostatic cancer".

Often reassurance was seen together with confirmation, especially when a worry had been confuted. But they could also be separate. Patients who had changed their image of themselves expressed confirmation but did not mention reassurance.

Confirmation

The patients had often had thoughts about their symptoms/disease before the consultation, and maybe also fantasies of how it could develop. The GP had observed and listened, added some tests in a few cases, but had then not taken any action beyond confirmation. An outcome for some patients was that their fears or ideas were confirmed or unconfirmed.
Citation Anette (woman 33): "So I asked that doctor -Do I have fibromyalgia? Because I had been thinking and wondering. – Yes she said that has been established. – Yes thank you, then I know, I said. I had had this pain for four and a half years but I had never got round to asking before."

A confirmation of a disease, even when serious, is at the same time a confirmation of an experience, and therefore not only negative. The prevailing uncertainty when the doctor does not know, or does not respond to the worrying experience, may in itself be a torment. Outcomes of this nature presented by patients who were thrown into uncertainty were also placed in this category. They had been referred and were waiting for further treatment or assessments. They did not know what they could expect and were left in a state of confusion. They did not express satisfaction, dissatisfaction or any other feelings with regard to the consultation. The uncertainty of the situation dominated.

Nils (man, 73): "You will see then, you know, if it is the kidneys that are.... The function of the kidneys has been a little poor.... I get so tired all of a sudden and that’s not good...I am not exactly ready to die yet...But you won’t know from one day to another. I have to find out the reason for my being so tired. I mostly want to lie down, but you can’t lie down all the time. You have to keep moving”.

For others confirmation dealt with the fact that they were doing the right thing. Their assessment was recognized by the doctor.

Citation Gudrun (woman 49): "She (the GP) examined me very well. I said I had been seeing a physiotherapist, and she told me to go on with the exercise that I had been taught. I told her I had been taking painkillers, aspirin and paracetamol, and she told me to go on with that, and to take it easy."

For some patients an assessment or information about their condition was the only outcome of the consultation. They had diseases that did not make them disabled but were rather to be considered as risk factors. Without having been worried they had got it confirmed that everything was well.

Some patients perceived lack of confirmation although they had expected it.

Citation Cecilia (woman, 36): "I came to this doctor and told him about all the strange allergies I had had this last week, and showed him my wrist that had become so swollen all of a sudden. So, he said you must have a sprain, and he gave me naproxen. I felt so misunderstood and I was so angry, that I went home and took the cortisone I had got the other day."
Understanding

This category was relevant in all the statements about consultation outcomes. Understanding may be increased or may be a matter of frustration. All patients expressed that they wanted to "know what they had"; some wanted to know more even though they "knew what they had". The patients considered knowledge about their state to be the main outcome of the consultation. They requested knowledge of "what they had" based on their own condition, in their own circumstances and with their own understanding. An understanding might imply quite different things for different patients with a similar medical condition but might also vary over a period of time for the same patient. The name of the disease or a diagnosis was not always what they needed. Neither was the cause always a prerequisite for understanding, although the doctor may have found the explanation of the cause so obvious that there should be nothing left to wonder about.

Understanding is necessary to manage to live on with health problems and the concern caused by them.

Citation Mari (woman, 46): "A diagnosis for me is completely inessential. What I want is that they realize why I have pain. So I can get rid of it."

Patients, who felt that they had not acquired an understanding of their condition, were dissatisfied with the outcome even if they had been cured.

Lejla (woman, 39): "But I mean, just relieving the pain does not help, you also have to know why you have it. It doesn’t help just to be relieved you must know in some way how to handle it to be able to prevent more pain."

Understanding must not be mixed up with explanation because an explanation in the abstract that does not respond to one’s experienced needs is of no benefit.

Citation: Siri (woman, 18): "They never explained why I got this skin-infection, they just said it is some staphylo- or strepto-something."

In other situations, however, information about the condition and nothing more, may lead to a new understanding, which was then the outcome of the consultation.

Citation Erik (man, 63): "I have some stuff that goes from my kidneys into the blood, I don’t know the name of it, I don’t have to because I am not the doctor, but it could get worse if I stopped taking my antihypertensive, it could be dangerous for me and it would really be rotten to get kidney problems."
**Change in self-perception**

In this category we find statements from patients who had had the symptoms or the disease for a long time and now had reached the understanding that it would persist. The consultation had been the last in a row where previous consultations had gradually prepared for a more definite change in self-perception. In this very consultation knowledge had turned into acceptance of the reality of the body and now they were ready to face their future searching for strategies to handle their situation and their lives. The illness/disease did not change but they were satisfied with the outcome.

This outcome was seen in some form in a fourth of the patients’ descriptions.

Citation Hedvig (woman, 59): "It’s something neurological...it’s something in the brain you know...you can’t know for sure what is actually the cause of it...How do you get on with your life after this? The consultation before last was about the whole of me and everything that concerns me... The last time I came here there were three ready suggestions for me; thus the sadness, but also relief. I’m not at all disappointed with that doctor or so, the sadness is about other things – about life.”

Citation Jeanette (woman 31): "I was thrown into a situation when the health insurance office called and wanted to get me on a sickness pension. I got into a state of panic, a sort of is-life-over-now? But after careful consideration I realized that they are right. I cannot go back to my ordinary job, I have too many aches and pains to manage it. So my visit to the doctor today was about how to get on. I had thought out a plan, which we discussed and he printed it out. This implies that I will work half-time in quite another job than my ordinary one. It will give me the possibility to stay at home when I have to stay in bed because my pain is overwhelming or when my handicapped son freaks out.”

**Satisfaction**

A manifestation of satisfaction or dissatisfaction was to be found in many of the patients’ statements. Statements of satisfaction or dissatisfaction often functioned as a summing up or conclusion of the patient’s evaluation of the outcome. Satisfaction was never the main outcome.

The patients were satisfied when they had acquired an understanding of their condition. Patients who "knew what they had" expressed that they were satisfied even though they were not relieved or cured.
Citation Curt (man, 74): "Now the last time my blood pressure had gone down so it was just 170 over 70 and that was good in my case, it had gone down”.

Patients who did not know what they had were dissatisfied even if they had been cured.

Citation Mia (woman, 36): "after having been cured by a penicillin cure:"I didn’t even get to know what I had. I was so angry with myself- why had I not asked? I had to call back to the nurse and ask and she said you have tonsillitis.”

Maja (woman, 20): "I went to the doctor and he bent my knees back and forth and pressed them a little, and then he gave me a prescription for painkillers. But I wanted to know what it might be. He could not answer, because he did not know. I was very dissatisfied with going there. I had realized that myself, that I had pain and needed painkillers but I wanted to know what it was. If he couldn’t help me, I think it was his duty to send me to a specialist.”

All the patients who had acquired an understanding expressed satisfaction
Some were satisfied if they had received confirmation but not an understanding.

Patients who had not acquired an understanding or received confirmation expressed dissatisfaction. They were dissatisfied even if they had been cured. They did not feel reassured.

Patients who were dissatisfied felt that they had not been seen or heard during the consultation. They were mostly women whose mother tongue was different from the doctor’s.

GPs’ conceptions of consultation outcomes
(Paper II)

The GPs described outcomes in four ways: patient outcomes, GPs’ self-evaluation, relationship-building and change of surgery routines.
Patient outcomes are a goal for the consultation. GPs self-evaluation is a reaction to the consultation. Relationship-building is a basis for future consultations and change of surgery routines is a change of the structure
encompassing the consultation. These are all different ways to relate to the consultation outcome.

**The goal for the consultation – patient outcomes**
- cure or symptom relief
- disease control
- reassurance
- understanding
- check-up
- support/coping
- patient satisfaction

**A reaction to the consultation–GPs’ self-evaluation**
- GP satisfaction
- failure

**A basis for future consultations –relationship-building**

**A change of the structure embracing the consultation– change of surgery routines**

The GPs started with a description of the patient outcomes and after a little pause they began to discuss other outcomes. Often this second part was opened with an evaluation of their own achievement.

**Patient outcomes – the goal for the consultation**

**Cure or symptom relief**

The GP expected the outcome to be cure or symptom relief, by treatment or advice. In some cases a treatment or an action was necessary for cure. In others, a treatment would make the cure quicker and safer although recovery could be expected to be spontaneous.
Citation Dr M: “A woman in her fifties had a red swelling on her hand. I think she had erysipelas. I gave her penicillin. I think I will make her better faster this way.”

The GPs often expressed satisfaction in these interviews.

Reassurance

The GP experienced that the patient’s worry about the symptom or condition had been reduced. The GP had reassured the patient by rejecting a specific disease or by explaining what caused the symptoms or by confirming that everything was dealt with in the right way.

Citation Dr M: “So I told him that nothing in the examination pointed at a haemorrhage or brain tumour. So I believe he left reassured.”

Increased understanding

The patient had received an explanation. The GP experienced that this lead to an increased understanding of what was happening in the patient’s body or what to do to feel better. The patient had got increased knowledge.

Citation Dr Z: “So I tried to give a reasonable explanation for her discomfort from the throat. You can have tensions there as well as in other muscles.”

Citation Dr T: “He came with a locking in his thoracic. He had been seeing a chiropractor without results. He got better only when his new girlfriend gave him massage. So I asked him about the relationship and it turned out that the guy could not really decide if he wanted to continue or quit. This was an important outcome—that the ambivalence turned up.”

Check-up

A check-up of a disease, or of risk factors, such as HbA1c or cholesterol gave information as to whether changes in the therapy or follow-up were recommendable. The GPs regarded it as his/her duty to see to it that the risk factors were under control. Sometimes he/she doubted that the patients could take their share of the responsibility. The tests and the disease were in focus even though the patient was well known to the GP. The GP said that he/she
had done what should be done but did not express any further thoughts about possible consequences for the patient.

Citation Dr I: “I met this woman of 56. It was only one of those control visits. I follow her diabetes, I follow all her risk factors, and they have to be under control.”

Citation Dr Y: “Actually it is I who find it necessary to check up her diabetes, because she didn’t have it under control.”

Support

The GP described that he/she had given support so the patient could cope with illness or life. The support could be the GP just being there, without taking any action. The relationship itself was thought to be the main support. It could also be a support to the patient to do something himself. In those cases it came close to understanding. Besides this, support could be substantial, as when sick-listing.

The patients who were perceived to have received support had long-lasting relations with their GPs. Mostly they had psychiatric and/or musculoskeletal problems.

Citation Dr Y: “I tell the patient that you are not alone. I will be beside you and if you need me you can just contact me.”

Citation Dr D: “I help this unemployed man to stay on half-time sick-leave for a pain that is eternal, and thus I contribute to his daily living. Besides this, the only thing I can do for him is just being there.”

Patient satisfaction

Sometimes the GP noticed that the patient seemed satisfied and sometimes the patient had expressed satisfaction. The comments on patient satisfaction could be seen in connection with any of the other patient outcomes except check-up.

Citation Dr V: “He seemed glad and satisfied, he shook my hand and thanked me.”

In its negative form there was only one statement saying that the visit was perceived as meaningless for the patient.
A reaction to the consultation – GPs’ self-evaluation

It became clear that it was important for the GPs not only to see to the patients’ point of view, but also to perform well enough from the professional point of view. They had quite a determined interpretation of the professional perspective as to how to act as a GP in different situations. They presumed that these norms were shared by colleagues both inside and outside general practice. We found a picture of perceived professional norms regarding knowledge and values according to which they decided rightly and wrongly when evaluating their own achievements.

GP satisfaction

The GPs often stated that they were satisfied which was expressed with words such as satisfied, nice, easy. Sometimes a comment followed on what they were satisfied with, e.g. that they had succeeded or that they had inspired someone with confidence. They related their satisfaction to having done what they should; they had fulfilled their own expectations and were satisfied accordingly. When they expected cure/symptom relief they often expressed that they were satisfied themselves.

Citation Dr M: “It is nice to be a doctor when you feel you can make a difference”.
Citation Dr C: “It was a good gut feeling”.

Failure

When the GPs felt that they had not succeeded with the consultation they had an unpleasant feeling of failure. They were worried that they had not lived up to adopted professional norms. They blamed themselves. The colleagues in the group were however eager to support in these situations.

The statements could deal with lack of rapport with the patient, when the GP felt persuaded to take an unnecessary action, or when the GP felt that the patient would not follow the recommendations given. These were situations where the GP simply could not do the right thing.

Citation Dr A: “I have a bad feeling knowing that she doesn’t look after her diabetes. Even though her glucose levels and HbA1c were high I didn’t dare to increase her insulin as she doesn’t manage her diet.”
Citation Dr J: "Big sister had got erythromycin for a mycoplasma infection and now this little sister had the same sort of symptoms but milder. The mother was determined to get a treatment for her. So I gave her antibiotics even though I did not find it necessary, and I feel like shit. Dare I not stand up for anything?"

Some accounts dealt with the fact that the GP had performed an action that was necessary in the short perspective but maybe destructive in the long run.

Citation Dr T: “An unemployed dyslectic man of 24 with headaches after whiplash traumas came for sick-listing and got it. But it is a bad feeling to see him go towards a future with long sick-listing periods already from such a young age.”

There were also examples of the GPs’ worry about being despised by colleagues.

Citation Dr K: “There was this four-year-old girl from a refugee family with haematuria. I sent her as an emergency to the paediatric clinic at four pm, mostly because of language difficulties. It was a really bad feeling. Of course it was best for the patient but not for the receiving clinic. During duty on the paediatric clinic they were always joking about the GPs and their stupid referrals.”

**A basis for future consultations – relationship-building**

The GPs described how they built up a relationship with the patient in different ways. They perceived relationship-building as an important outcome. In some cases the relationship was so important that their own ideas of the best treatment alternatives were pushed into the background, especially when the patient had a very decided idea that was not particularly counterproductive. The relationship with the patient was of great importance for future consultations, but also in the current situation.

Citation Dr O: “He didn’t get any medicines. We began by getting to know each other. We laid a basis for future consultations.”

Citation Dr V: “She wanted physiotherapy for acne. I promised her to make inquiries if there are any such treatments. You can try to meet her expectations even if it isn’t what you would have suggested yourself if it isn’t too bad of course. It can be worth it for future contacts with her.”
A change of the structure embracing the consultation – change of surgery routines

In some cases the GP discovered a need to change surgery routines, which was also conceived as an outcome of the consultation

Citation Dr R: “I discovered that it was impossible to have a HIV-test anonymously in this place. We’ll have to change that.”

A comparison of GPs’ and patients’ perceptions of consultation outcomes (Paper III)

Out of 250, a total of 249 questionnaires were received from the GPs and 245 – one of which was blank – from the patients. Both GPs and patients had answered most of the questions, the maximal internal dropout was 5.7%.

Table 2. GPs’ perceptions of consultation outcomes.

<table>
<thead>
<tr>
<th>GP questions</th>
<th>Yes %</th>
<th>No %</th>
<th>I don’t know %</th>
</tr>
</thead>
<tbody>
<tr>
<td>I believe the patient will get cured or relieved.</td>
<td>51.9</td>
<td>26.3</td>
<td>21.8</td>
</tr>
<tr>
<td>n=243</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe the patient was reassured.</td>
<td>74.2</td>
<td>8.5</td>
<td>17.3</td>
</tr>
<tr>
<td>n=248</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe the patient understands more about his illness/ situation.</td>
<td>69.4</td>
<td>15.7</td>
<td>14.9</td>
</tr>
<tr>
<td>n=248</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe the patient will be able to cope better with his illness or situation.</td>
<td>74.7</td>
<td>7.6</td>
<td>17.7</td>
</tr>
<tr>
<td>n=249</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient got a check-up.</td>
<td>71.9</td>
<td>24.8</td>
<td>3.3</td>
</tr>
<tr>
<td>n=242</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I believe the patient was satisfied.</td>
<td>90.4</td>
<td>2.0</td>
<td>7.6</td>
</tr>
<tr>
<td>n=249</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The patient-doctor relation was strengthened.</td>
<td>69.5</td>
<td>8.8</td>
<td>21.7</td>
</tr>
<tr>
<td>n=249</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I discovered a need to change routines at the surgery.</td>
<td>1.6</td>
<td>93.5</td>
<td>4.8</td>
</tr>
<tr>
<td>n=248</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was satisfied with the consultation.</td>
<td>96.0</td>
<td>2.4</td>
<td>1.6</td>
</tr>
<tr>
<td>n=249</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I was dissatisfied with the consultation.</td>
<td>2.5</td>
<td>92.9</td>
<td>4.6</td>
</tr>
<tr>
<td>n=248</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 2 presents the GPs’ perceptions of consultation outcomes and Table 3 the patients’ perceptions of consultation outcomes.

Table 3. Patients’ perceptions of consultation outcomes.

<table>
<thead>
<tr>
<th>PATIENT QUESTIONS</th>
<th>Yes %</th>
<th>No %</th>
<th>don’t know %</th>
</tr>
</thead>
<tbody>
<tr>
<td>My disease/illness will get cured or better due to the consultation. n=242</td>
<td>60.7</td>
<td>4.6</td>
<td>34.7</td>
</tr>
<tr>
<td>I feel reassured due to the consultation. n=237</td>
<td>88.2</td>
<td>5.9</td>
<td>5.9</td>
</tr>
<tr>
<td>I feel confirmed due to the consultation. n=241</td>
<td>94.2</td>
<td>2.1</td>
<td>3.7</td>
</tr>
<tr>
<td>I have understood more about my disease/illness due to the consultation. n=239</td>
<td>74.5</td>
<td>12.6</td>
<td>13</td>
</tr>
<tr>
<td>I have changed my view of myself and my way of functioning due to the consultation. n=238</td>
<td>48.7</td>
<td>29.8</td>
<td>21.4</td>
</tr>
<tr>
<td>I am satisfied with the outcome of the consultation. n=243</td>
<td>91.4</td>
<td>3.3</td>
<td>5.3</td>
</tr>
<tr>
<td>I am dissatisfied with the outcome of the consultation. n=230</td>
<td>3.9</td>
<td>90.9</td>
<td>5.2</td>
</tr>
</tbody>
</table>

Different degrees of concordance were found between the GPs and their patients on comparing their answers from the same consultations, see Table 4. The GPs’ perception of patient satisfaction was in agreement with the patients’ satisfaction to the rate of 84 %, and GP and patient satisfaction corresponded to 89%. In 69% of the consultations the GP and the patient assessed patient reassurance similarly and the same went for increased patient understanding in 62 % of the consultations. But the belief in patient cure/symptom-relief was shared in only 51 % of the consultations, and furthermore the patients believed in cure/symptom relief when the GP did not, or was uncertain, in 24% of all consultations.
Table 4. Concordant and discordant answers when GP and patient answered similar questions after the same consultation.

<table>
<thead>
<tr>
<th>Concordant answers</th>
<th>Discordant answers</th>
<th>IV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both yes n (%)</td>
<td>Both no n (%)</td>
<td>Both uncertain Dr yes n (%)</td>
</tr>
<tr>
<td>Patient satisfaction n=242</td>
<td>201(83)</td>
<td>17(7)</td>
</tr>
<tr>
<td>Satisfaction n=242</td>
<td>213(88)</td>
<td>19(8)</td>
</tr>
<tr>
<td>Reassurance n=235</td>
<td>155(66)</td>
<td>18(8)</td>
</tr>
<tr>
<td>Understanding n=237</td>
<td>131(55)</td>
<td>34(14)</td>
</tr>
<tr>
<td>Cure/symptom relief n=236</td>
<td>89(38)</td>
<td>34(14)</td>
</tr>
</tbody>
</table>

When comparing the yes/no answers for the questions that were different for GPs and patients, we found a positive association between the GPs’ perceptions of the outcomes cure/symptom relief, reassurance, understanding and satisfaction and the patient’s perception of increased understanding (p <0.02). When we redid the calculations putting ‘yes against the combination of ‘no’ and ‘I don’t know’ the same pattern of associations was seen with one exception – an association between the GPs’ relationship-building and change in the patients’ self-perception (p<0.012) was also found.
Clinical strategies in General Practice (Paper IV)

The GPs registered 378 problems: in 94.2% a somatic problem and in 31.7% psychosocial problems. Hence, there was some overlap, and 25.9% of the problems were registered as both somatic and psychosocial. In exclusively somatic problems emphasis was most often given only to the symptoms (94.6%) and in exclusively psychosocial problems most often emphasis was given to the patient as a person (86.4%), Table 5.

Table 5. Percentage of registered items in relation to problem characteristics in 366 consultations /378 problems.

<table>
<thead>
<tr>
<th></th>
<th>Somatic problem only</th>
<th>Somatic and psychosocial problem</th>
<th>Psychosocial problem only</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>n</td>
<td>258</td>
<td>98</td>
<td>22</td>
<td>378</td>
</tr>
<tr>
<td>%</td>
<td>68.3</td>
<td>25.9</td>
<td>5.8</td>
<td>100</td>
</tr>
<tr>
<td>Female patient</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known problem</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultation process</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Main emphasis on symptom</td>
<td>52.6</td>
<td>59.2</td>
<td>68.2</td>
<td>55.6</td>
</tr>
<tr>
<td>Main emphasis on person</td>
<td>32.5</td>
<td>65.2</td>
<td>70.0</td>
<td>43.2</td>
</tr>
<tr>
<td>Problem identified by patient him or herself</td>
<td>94.6</td>
<td>74.2</td>
<td>38.1</td>
<td>86.5</td>
</tr>
<tr>
<td>Problem solving of the GP</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Immediate</td>
<td>59.1</td>
<td>36.8</td>
<td>55.0</td>
<td>54.7</td>
</tr>
<tr>
<td>Certain</td>
<td>77.8</td>
<td>71.4</td>
<td>77.3</td>
<td>76.6</td>
</tr>
<tr>
<td>Rule-of-thumb used</td>
<td>35.9</td>
<td>24.4</td>
<td>29.4</td>
<td>32.7</td>
</tr>
<tr>
<td>GP satisfied</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presumed patient outcome</td>
<td>93.7</td>
<td>82.7</td>
<td>72.7</td>
<td>89.8</td>
</tr>
<tr>
<td>Patient reassured</td>
<td>72.9</td>
<td>61.2</td>
<td>57.1</td>
<td>69.9</td>
</tr>
<tr>
<td>Patient coping</td>
<td>40.6</td>
<td>30.0</td>
<td>22.2</td>
<td>36.6</td>
</tr>
<tr>
<td>Patient satisfied</td>
<td>80.8</td>
<td>57.1</td>
<td>50.0</td>
<td>73.1</td>
</tr>
</tbody>
</table>
Immediate decisions were registered in 54.7% of the consultations. When immediate problem solving was used instead of gradual problem solving the GPs more often felt certain about their identification of the problem (p<0.001). When the GP had noted that the patient himself/herself had identified the problem immediate problem solving was also registered more often than gradual (p<0.001).

The consultations were classified according to the identified problem and whether emphasis was given to the symptom and/or the person. The categories identified in this way were used for further analyses if they contained more than 10 cases. In the cases with the emphasis on symptoms only, the patient had consulted previously for the same problem to a low degree. The higher the share of psychosocial element in the consultation the more likely it was that the GP had seen the patient previously for that very problem. In immediate decisions the GPs were more often satisfied with the consultation (p=0.012) and presumed that the patients were more often reassured (p=0.006), would cope better (p=0.008) and were more often satisfied (p=0.001) than when decisions were gradual. With increasing psychosocial content of the consultation the GPs assumed fewer patients to be reassured after the consultation (p=0.001) but there was no difference regarding presumed patient coping. For satisfaction, the GPs registered decreasing shares of satisfaction for both themselves and the patients with increasing psychosocial content of the consultations (p=0.001 for GPs and p<0.001 for patients).
DISCUSSION

This thesis started with an exploration of outcomes of GPs’ consultations with a literature study and with interviews about real life experiences. Questions in questionnaires were formulated from the concepts found in the interviews, and a questionnaire study with patients and GPs was performed. Finally the materials were compared.

A number of concepts, valid for describing consultation outcomes, were brought forward. Some of them were new in the outcome context, but most of them were already well known.

Taken together, the studies laid out outcome concepts in four different dimensions. There were outcome concepts concerning patients’ experiences and patients’ capabilities and there were outcome concepts concerning the conquering of a disease in its biological sense. Other concepts put the work of the GP in focus.

The new concepts add as such to our knowledge about outcome in general practice.

All seen together they constitute a map of possible outcomes which can serve as a basis both for professional understanding of the individual consultation and for further research.

When clinical strategies in general practice were studied the GP questionnaire showed that satisfaction decreased with an increasing psychosocial content of the consultation. Immediate decisions were accompanied with more satisfaction, presumed patient reassurance and coping.

Discussion of the method

Advocates for quantitative and qualitative research have claimed that they need different methods for assessments. In both, however, there is a need to show that the research is valid and that it is possible to make generalizing conclusions from it. In this thesis we used both qualitative and quantitative
methods and therefore we try to discuss the methods with this double approach in mind.

Research methods are assessed regarding validity, reliability and generalizability (115). Malterud discussed validity and reliability in qualitative research but also emphasized critical reflection (116, 117). Crabtree and Miller asked for relevance and validity in qualitative research (118).

**Validity**

Internal validity has to do with the research investigating what it is meant to, that it is truthful and trustworthy (117). This applies to the collection of data and to the analyses.

For the interview studies a qualitative method was the evident choice (I, II). The intention was to explore the experiences of outcome as close to the experiencers’ own conceptions as possible. With the phenomenographic approach it was possible to give the concepts the original meaning in their own context as well as bringing the concepts to a more generalizable level. Phenomenography with its focus on differences of conceptions was suited to the study aims, but other qualitative methods would have been possible. The phenomenographic analyses and the interviews revealed concepts that previously had not been clearly formulated from a personal, experiential point of view.

The questions in the outcome questionnaires (III) were derived from the concepts found in the qualitative studies and were thus grounded on the patients’ and the GPs’ own wordings.

**Selection of informants** for the interviews was made gradually and purposefully to get a variety (I, II). There is no ground to believe that these patients and GPs should differ from other patients and GPs. By describing their latest consultation we got unselected cases from both GPs and patients. Patients and GPs described a wide range of patient problems and as experienced GPs we could see that their accounts were representative for general practice patients’ problems in Sweden.

The GPs for the outcome questionnaire study (III) were selected at random and their patients were an unselected material of consecutive patients which should vouch for representativeness. The random selection of GPs by
definition makes it possible to extend the conclusions so as to be valid for a wider circle of GPs.

The GPs answering the clinical strategies questionnaires (IV) were experienced GPs, interested in research and development. They were not selected at random and their judgments would need to be complemented with a broader sample of GPs in an extended study to strengthen the findings. Their cases, by being included consecutively, represented the diversity of different problems, illnesses and ages in general practice, which was also analysed.

**Group and individual interviews**

In the interviews the patients and the GPs were open-minded and keen on discussing even problematic matters.

The group interviews seemed to give a richer material than the individual interviews. In the patient interviews a change in self-perception was only described in the groups. In the group interviews with the GPs it became clear that they related their self-evaluations to internalized norms, perceived as a consensus between colleagues. This was not seen in the individual interviews where there were no colleagues to relate to. The individual interviews were initially undertaken to capture other possible points of view produced by persons who did not want to join a group, but such aspects were not found. Instead the individual interviews produced material that was also found in the groups. However, there was one obvious advantage in also having individual interviews. With these as a background, the collegial consensus among GPs stood out more clearly.

Difficulties about interviewing one’s peers have been described. There might be a hesitation to disclose shortcomings (119). However, in the interviews a desire to share experiences was seen, especially those concerning uncertainty. In interviews, access to a GP by an interviewing GP was easier when the GP researcher was known to the respondent (120). The interviewer was known to the interviewees in our study. Thus self-censorship was believed to be fairly limited.

A weakness of the study that makes comparisons between the studies somewhat unequal is that patients were interviewed within a week (I), but GPs interviewed (II) as well as patients and GPs answering the outcome questionnaire (III) were asked immediately after the consultation. The GPs’ accounts, contradictory to those of the patients, were not thought to develop in time, but rather to disappear from their memory. The questionnaires were handed out immediately after the consultation to get as little dropout as
possible. Thus the patients in paper I and the patients in paper III were not answering the questions with exactly the same premises. It is difficult to voice an opinion on the importance of this difference.

External validity asks in what contexts the findings can be applied. This is dealt with below.

**Reliability**

Reliability means that you should be able to trust the knowledge. This has often been shown by the fact that it is possible to do the same study and get the same result again (115, 116). Reliability in the sense of repeatability is not suited for qualitative research (116). The GP outcome questionnaire has given similar results when answered by randomly selected GPs in northern Sweden (III) and by experienced GPs from all over Sweden (IV).

**Generalizability**

Of the patient outcomes all but one –“change in self-perception” – are found in current evaluation instruments. “Change in self-perception” however is researched in other contexts, namely patients’ adaptation to chronic illness. That the concepts found have been taken up in other settings and circumstances strengthens their generalizability.

The patient outcomes have not been measured together before, although with the addition of a “change in self-perception”, they seem to make up consultation outcomes as a whole as experienced by patients. The patient questionnaire (III) has provided a measure of this whole. However the patient questionnaire should not be regarded as a scoring instrument. Except for confirmation, it is not possible to decide the ideal levels of the outcomes.

Both the patient and the GP outcome questionnaires add to the results from the interviews by giving numbers to the concepts. Knowledge about the occurrence of the experienced and expected outcomes can give information usable in a clinical situation. As a GP you work with the most likely events to the fore and the very rare in the background.

As the very experience of a factual consultation was the focus of the studies the choice was to ask for the outcome of the latest consultation, even though the latest one would probably have been influenced by earlier consultations.
Generalizability from the clinical strategy questionnaire (IV) should be made with more caution due to the selection of the participating GPs commented on. Extending the study to involve a representative sample could throw light on this.

**Language**
In addition there is an overall language problem in presenting the studies in English. However careful you are about meanings, there is the risk of losing shades of meaning through translation, both in the accounts from the interviews and in the questionnaires. The perfectly true story would have to be formulated in Swedish. The concepts have however been used in other countries and cultures and transferability therefore is considered to be sufficient.

**Statistical considerations**
Paper III. A more sensitive leveling of the responses might have been obtained if the response alternatives in the outcome questionnaires had been graded. However, we were primarily interested in the main patterns, which in this context concerns whether the patients and the GPs had experienced a certain outcome or not. Since the answers were so skewed, it made statistical comparisons more limited.

Patients and GPs were in the affirmative, especially about satisfaction. Since so few were negative, it was not possible to draw conclusions about the negative answers.

The kappa coefficient could not be used as the answers were so skewed. If the answers had been dichotomized this could have been avoided by using ppos and pneq, but this was precluded as there was also the “I don’t know” alternative (121, 122). The skewedness also made regression counting meaningless as the correlation coefficients were very low. To decide the size of the study population for the questionnaires a calculation of power should have been tried beforehand. As there was no questionnaire putting the questions in the way we did, it was believed that there was nothing to calculate power against. We were aware that GPs are different and it was important to have many GPs with few patients each rather than the other way round. The numbers had however been discussed with another researcher who had examined the patient-GP agreement with regard to the content of the consultation in a similar way and with a similar number of
doctors and patients. GPs, when asked, had set a convenience limit of eight patients each (123).

When evaluation instruments have been constructed questions that do not discriminate have been excluded, (22). This implies that such instruments alone cannot be trusted for describing the real outcomes. Instead, it strengthens the importance of our attempts to make up a picture of all possible outcomes.

The GPs for the clinical strategy questionnaire (IV) were not selected at random which makes the statistical considerations weaker.

Discussion of the result

What is new?

The map of outcome concepts

Concepts describing outcomes from GPs’ consultations have been mapped together. This has not been done earlier. It provides the possibility to consider both different viewpoints and different possible outcomes.

Confirmation of outcome concepts

Patients’ and GPs’ outcome concepts have been taken from the situation in which they were experienced. Regarding established outcome concepts, these findings confirm their relevance as outcomes in practice.

New outcomes

Patients’ change in self-perception

As has been discussed above a change in self-perception has been well researched and discussed in connection with chronic disease. It became
obvious that the patients could consider such changes as a consultation outcome.

GPs’ self-evaluation
GPs’ self-evaluation has not hitherto been considered as an outcome, and from the patients’ point of view it is not. However the GPs kept on making these evaluations with different degrees of awareness about it, which became evident when they discussed consultation outcomes.

GPs’ relationship-building
Relationship-building was a common outcome experience. This was surprising in the light of what one GP expressed in a comment, “I already have a relationship with my patients so I need not to build it.” Enhancing the relationship between the GP and the patient is one of the core components in the patient-centred method (18).

The GPs obviously take responsibility for relationship-building. The patients do not notice the efforts explicitly, but there are reasons to believe that they would express this specific result otherwise. The patients felt confirmed to a very high degree, which could be a result of the GPs’ efforts. How relationship-building is striven for deserves further attention.

GPs’ change of surgery routines
The discovery of a need to change surgery routines was another outcome concept not hitherto considered as an outcome. It did not occur often, but was another part of GPs’ endeavors to improve their work.

Outcome concepts
Firstly a brief comment on studies I and II is presented which is then followed by a more thorough survey of the different concepts.

Patients’ outcome concepts
The analysis revealed six concepts that were experienced as outcomes by patients in general practice. Cure/symptom relief, satisfaction, reassurance and understanding are well researched, while confirmation has not been
recognized as to its possible importance and a change in self-perception has not hitherto been considered as a consultation outcome.

Outcome from the patients’ point of view is a change within a context, that embraces the person, the body, and/or the person’s understanding of what is going on in his/her own physical body. The predicament of the patient has a major impact on what turns out to be the outcome. Outcomes of consultations, from the patients’ point of view, to a great extent concern how to deal with life changes caused by ill health. In the first place this may be accomplished through increased knowledge and understanding, in the second through cure or relief, and in the third through the acceptance of change and finding coping strategies. One finding was that patients did not assess outcome predominately as a change of symptoms. Neither did they regard prescriptions or sick-listing as outcomes.

The results imply that general practice consultations are often more important for patients than generally supposed. Seemingly small contributions from the doctor, like a pure confirmation of the state of matters, may become great as to their effects.

Also, some outcomes have not been requested by the patient, but still occur.

**GPs’ outcome concepts**

The GPs had both the patient outcomes, as well as self-evaluation, relationship-building and organisational aspects in mind when thinking of outcomes.

The GPs’ conceptions of patient outcomes were largely congruent with described and used indicators and measures as described in literature.

**Discussion of the concepts**

When put together the picture of the outcome concepts with the different approaches looks like this, see Table 6.
Table 6. Outcome concepts seen from different perspectives.

<table>
<thead>
<tr>
<th>Patients</th>
<th>GPs</th>
<th>Literature</th>
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<tbody>
<tr>
<td>Cure/symptom relief</td>
<td>Cure/symptom relief</td>
<td>Symptom relief</td>
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<tr>
<td>Check-up</td>
<td>Disease control</td>
<td>Health</td>
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<td>Confirmation</td>
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<td>Reassurance</td>
<td>Reassurance</td>
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<td>Increased understanding</td>
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<td>Coping</td>
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<td>Change in self-perception</td>
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<td>Patient satisfaction</td>
<td>GP/Patient satisfaction</td>
<td>GP/ patient satisfaction</td>
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<td>Self-evaluation</td>
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<tr>
<td>Relationship-building</td>
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<tr>
<td>Change of routines</td>
<td>Compliance</td>
<td>Efficiency</td>
</tr>
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Here follows a discussion of the different concepts:

- this starts with concepts described by patients and GPs,
- followed by patients’ own outcome concepts,
- then those described by GPs and in literature,
- GPs’ own outcome concepts,
- and outcome concepts described only in literature
- finally a comparison between GPs and patients
Outcome concept described by patients and GPs

Cure or symptom relief

Up to 60.7% of the patients expected cure or symptom relief, and 34.7% were uncertain. Only 11 patients, 4.6%, did not expect cure or symptom relief (III). However when a GP and a patient assessed the same consultation they were both affirmative about expectations of cure/symptom relief only up to 38%, the GPs being less optimistic than the patients (III).

In a study with patients with unselected problems, improvement or resolution of their problem at follow-up was reported up to 55% (124). In the Europep evaluation comparing quality in 16 different countries and described in “The task force on patient evaluation in general practice care”, up to 79% of the 1652 Swedish patients expected quick symptom relief immediately after the consultation (4). Thus the numbers in the study (III) are in-between. It is impossible to ascertain an ideal level.

Cure or symptom relief is what medicine traditionally is about, but in a substantial proportion of the consultations this is not what could be expected realistically.

Reassurance

The outcome patient reassurance showed high numbers, experienced by patients to 88% and expected by GPs to 74% (III). Reassurance was asked for in the quality instrument IPQ where 53000 patients gave it a mean of 84.5% on a scale from 20-100% (9).

Reassurance is a transient state, once it was reached worry was diminished and reassurance had lost its importance. Reassurance could not either be expected after all consultations. An alarming finding during the consultation could cause increased worry.

Understanding

The patients interviewed (I) almost unanimously claimed that they “want to understand what they have.” They discussed and exemplified their need to understand what was happening in their bodies in a way that was valid in their own circumstances and with their own preconceptions.

In 25.6% of the consultations increased understanding was not reported, or was uncertain (III), which, although understanding could not be expected in all cases, indicates a possible area for improvement.
The patients’ need to understand is a central request in the consultation (125) (126-128). It is also an important ingredient of patient-centred care, but while understanding is there, above all an aspect of “finding common ground”, our patients described understanding as enhanced knowledge.

In the Europep evaluation (4) the 1652 Swedish patients, by answering the questions positively -“did the doctor tell you what you wanted to know about your symptoms and/or illness?”, reported what can be considered as increased understanding up to 81% (4).

Satisfaction

In this study, as in many others, the satisfaction scores were overwhelming. Some circumstances might have added to this great satisfaction. Firstly, patients were more satisfied with home-made questions and when the questionnaire contained only a few questions (75) as was the case in the study (III). Secondly, the patients in our study answered immediately after the consultation. Immediate patient satisfaction reflects aspects of doctor-patient communication, but after two weeks and three months satisfaction reflects symptom relief or other outcomes of the consultation (76).

The results suggest a complicated relationship between satisfaction and dissatisfaction. Only half of the non-satisfied patients answered that they were dissatisfied (III). Logically the non-satisfied patients should all have answered that they were dissatisfied.

Many researchers have tried to unravel the parts of the concept satisfaction and have concluded that it is multifaceted and difficult to define (75) (64, 129) (22).

In a meta-analysis of 221 studies satisfaction was 81% (75). More recent studies show similar high figures, Jackson 82% (76). Winefield measured satisfaction with CSQ and found satisfaction 39 on a scale from 4-42 (74).

When one instrument, developed within one set of aims, is used in quite another setting there can be conceptual confusion. For example in the satisfaction instruments CSQ and MISS, the items address aspects of communication, the relationship, the rapport and the intent to comply. In fact, most of them are aspects of patient-centredness. Thus satisfaction as accounted for in MISS and CSQ is about the patient’s assessment of process elements, rather than the experience of satisfaction as a consultation outcome.
Outcome concepts experienced only by patients

Confirmation

The patients described confirmation both as having been seen and listened to and that their ideas had been confirmed, either approved of or rejected. Up to 94% of the patients reported confirmation (III).

Confirmation has been asked for both in quality instruments such as Europep but also in satisfaction instruments such as MISS and CSQ. The word confirmation was not used however. CSQ and MISS asked if the doctor showed an interest in the patient as a person. This can be compared to three questions in the Europep evaluation that can be considered as mirroring different parts of the concept confirmation. The 1652 Swedish patients who answered questions referring to the GPs’ manners were affirmative to –“Was the GP listening to you?” up to 85%, –“Did the GP show an interest in your personal situation?” up to 77% and –“Did the GP make it easy for you to tell him or her about your problem?” up to 75% (4).

Confirmation has been considered in terms of the GP’s role to be a witness of the human condition (130). Confirmation is actually the only outcome that ideally should be obtained in all consultations, meaning that the patient should feel that he/she had been seen and listened to.

Change in self-perception

The most radical patient outcome was a change in self-perception. The patients said they had experienced a change in self-perception in half the consultations (III).

Change in self-perception has not earlier been described as an outcome of GP consultations. The phenomenon “change in self-perception” has been described in studies on how people face the changes of chronic disease or impairment. People with chronic illness, besides working with their illness and their everyday life, also work with their biography, which implies that they change their view of themselves (131). They experience personal and social losses that will influence their concept of self, sometimes for the worse but sometimes even for the better thanks to re-orientation and an acceptance of a new self. This is a process within a context and in interplay with the persons that are close (132) (133). A similar process occurs with the change in women in the menopause, described as “keeping my ways of being” through the terms preserving, limiting change and eventually reappraisal (134).
A definition of health which is relevant in this context is “a home-like being in the world” (135). The patients who had experienced a change in their self-perception caused by disease had lost that feeling, but after this latest consultation they were on their way home again. It is logical that the consultation is a situation where such a change can be facilitated, as it is an occasion where the illness and current function are being discussed and possible ways of handling them are being considered.

A change in self-perception is useful for patients when handling both ageing and impairment and other functional changes that life can bring besides chronic illness. A change in self-perception can possibly have negative consequences also, as when a person gets his/her identity changed by a long term sick-listing making it difficult or impossible to return to work when a disease or impairment has been relieved.

**Outcome concepts described by GPs and in literature**

**Check-up**

The GPs discussed having made a check-up, but did not relate this further to what effect it could have for the particular patient. They never discussed laboratory parameters as outcomes.

It is often impossible to know what impact the diverging laboratory test will have on the particular patient, as knowledge is grounded on groups of patients. This is actually a paradox – parameters that can be measured with great exactness are often of uncertain significance for the particular patient. In larger studies, however, individual differences are evened out, making it plausible that the responses as a whole really have to do with disease.

The patients did not perceive the measures or the check-up as an outcome but could describe that they had felt reassured or confirmed by the information about a good laboratory test.

**Coping/support**

The concept support from the qualitative study (II) was described with the intention of getting the patient to cope. Thus coping was asked for in the questionnaire (III). Coping is being asked for in the PEI, Patient Enablement Instrument (14).

The GPs’ described a support that was not expected to enhance either patient autonomy or coping. In some cases the GPs even experienced that the support
could be a hindrance for the patient to handle his real problems, which was exemplified in some sick-listing situations (II). To strike the balance between positive support and support that is in fact holding the patient back is not easy. Support that does not lead to a more autonomous or capable patient is neither taken up by PEI nor described in other ways. The patients did not mention coping or support as an outcome. They probably do not experience the situation in that way. The questionnaire was hoped to give an answer to what patients experienced when the GPs thought they would cope better, but this did not show up with any clear correlation.

Outcome concepts perceived only by GPs

Self-evaluation

GPs made a complementary addition to the descriptions of patient outcomes by making a self-evaluation, where they used what they perceived as collegial consensus as criterion for their assessment.

It was surprising how strongly the norms from this perceived collegial consensus affected the GPs. The GPs have a body of knowledge, values and norms in common with other specialties, but they also have their own. Their self-evaluation must be regarded within this perspective. This common body seems to develop from education and training, from reflection together with peers, from recent research and debate, as well as guiding principles about right and wrong. The GPs tried to act within professional consensus as far as possible. Most of the time they succeeded and declared themselves satisfied but when on rare occasions they had to diverge from consensus for some reason, it was with a feeling of failure.

It would be of interest to explore this further. Eliot Freidson has been into this subject when he studied how GPs evaluate mistakes in relation to “good clinical practice” – informal rules about what doctors should discover, understand and know (136).

Especially interesting, but also a complicated and delicate matter was self-evaluation when the will to follow the norm was in conflict with other perceived outcomes, as in the cases were the GPs directly contrary to their own conviction did something the patient had requested. Such conflicts can be harmful to both patients and GPs, and would thus be an important subject for further studies.
Winefield has noted that GPs and patients are not satisfied with the same consultations (74). Such differences can arise when the GP, as opposed to the above situation in case of disagreement, does not submit to the patient, but sticks to what is perceived as professional consensus. Thus the patient and the GP do not assess the consultation after the same template. Accordingly the patients’ evaluations cannot be regarded as being the only truth in consultation evaluations. It was found that doctors who had encountered somatising patients with psychosocial problems were more satisfied when they had helped the patient with what they perceived was the problem than when they had fulfilled the patient’s own wishes (137).

The outcome status of this self-evaluation is reinforced by the fact that it will be at the back of the GPs’ mind and influence future consultations. Not only will they strive to act in accordance with the professional consensus as discussed above. Most likely the GPs will also try to avoid situations where they feel that they are not good enough, neither when confronted with the patient, nor with their own professional norms.

If the according conflicts could be openly discussed it would avoid the risk of giving either the patient or the GP a role as a scapegoat and the GPs could develop ways to handle such difficult situations.

**Relationship-building**

The GPs perceived that the relation-ship was strengthened in up to 70% of their consultations (III).

The GPs attach importance to building a relationship with the patient, even if this could result in them acting in a way that they did not really approve of. The emphasis on being an expert not only on the disease but also on the patient is more important in general practice than in other specialties. The relationship is the base for being able to understand the patient as a person. The relationship is built up gradually and is an important part of the Patient Centred Clinical Method (18). Patients have described the importance they attach to their relationship with their doctor (138) (27) (139) (140).

Thus both GPs and patients perceive that the relationship is important.

However the building of the relationship has not been given much consideration in evaluation.
Change of surgery routines

The discovery of a need to change surgery routines was an obvious outcome (II) though it occurred only in a small percent of the consultations (III). This reflects that the GP has not only the current consultation but also future consultations in mind when thinking of consultation outcomes. Besides, this category expresses a readiness to take on responsibility for her/his own organization. This responsibility can get lost in a large organization where the GP will be nothing but a little cog measured with a few indicators.

Outcome concepts described only in literature

Health
The measurement of health is applicable to groups of patients with specific diseases rather than as outcome of GPs’ consultations. Health scales are common in research studies even though the relation between general health and the effects of disease treatment is less clear the closer you get to the individual patient.

Enablement
Enablement is a word constructed to use if the patient was enabled, better able to cope. Prerequisites for enablement are an increased understanding and coping both with illness and life – which together with questions of the patient’s ability to stay healthy, confidence in his/her own health and ability to help himself/herself are what is being asked for in the patient enablement instrument – PEI (14).

This is an outcome that is interesting for general practice but not applicable to many consultations. The PEI instrument has been translated into Swedish and piloted in a study with 14 GPs and 194 consultations but the conclusion was that it was only of limited value in Sweden (141).

Compliance
Compliance with advice or prescriptions has been regarded as an outcome. The concept is not uncontroversial, since it implies the unilateral distribution of knowledge and responsibility on the part of the doctor. Concordance, which recognises the two subjects within the consultation, has been suggested as an alternative term. However, in outcome studies in general practice, compliance/adherence is what has been looked at (79, 142). Compliance is
regarded as an outcome, but has in fact the character of an intermediate outcome, something that can be an aid to reaching an outcome.

**Efficiency**

A few studies tried to evaluate the consultation outcome by measuring revisits or referrals after the consultation.

Now we will leave the survey of outcome concepts and discuss what consequences this insight might have.

**Differences between GPs’ and patients’ outcome thinking**

For the GPs it would be useful to know what differences there might be between their own and the patients’ conceptions and experiences of outcomes. Three types of differences were found.

– They described their consultation outcomes with mostly the same concepts but also some that were different.

– Some concepts were given a different meaning by patients and GPs.

– The same consultation could also be experienced differently by the patient and the GP.

**Different concepts used to describe consultation outcomes**

Patients and GPs both perceived that a consultation could lead to cure/symptom relief, reassurance, increased patient understanding and patient satisfaction. The patients also described confirmation as an outcome. Besides this the patients described a hitherto non-described outcome concept, change in self-perception.

The GPs found that they could support their patients so that they could cope. They also experienced the check-up of a disease or a risk-factor as an outcome.

The GPs, when considering consultation outcomes, also saw to other aspects than patient outcomes. They made up their minds as to whether they themselves were satisfied or not. When doing this they related to what they experienced as a collegial professional consensus about right and wrong. They
also described relationship-building and the discovery of a need to change surgery routines.

**Concepts with a different meaning**

Patients and GPs could mean different things by the same concept. Satisfaction for the patients was a feeling assigned to what had happened to them, while the GPs referred satisfaction mainly to their success of achievement, according to the professional norm. Winefield has also shown that patients and GPs give a different meaning to the concept satisfaction (74). The patients were most satisfied if they had been seen and the GPs if the consultation was quick and had a clear diagnosis.

Understanding was another concept given a somewhat different meaning. The patients by understanding meant that they had increased their knowledge with what they needed to know. But for the GPs patient understanding was believed to have increased if they had been given a piece of information, if the patient had understood the doctor’s words. In literature understanding has also been used to describe mutual understanding; that GP and patient have understood each other (61).

**Different experiences of the same consultation**

Patients and GPs could also experience outcomes from the same consultation differently even when using the same concept. As was described in paper III the concordance about expectation of cure/symptom relief was only seen in 38% of the consultations, the patients being much more optimistic than the GPs. If the patients expect cure or symptom relief to a substantially higher degree than the GPs this could be a source of disappointment to both parties.

Increased patient understanding was another source of discrepancy. The GP and the patient were in agreement on enhanced patient understanding in only about half of the consultations. Correlations between understanding and patient satisfaction were shown in the preparatory work for the PEI instrument. Patients own explanatory models are seldom revealed to the doctor. As these can be very different from the professional perspective of the doctor there is a great risk that the doctor will be unable to understand what the patient is really wondering about (143). The low concordance for understanding suggests that the GP should not trust his/her own perception of patient understanding but rather ask actively about it.
Concordance between GPs’ and patients’ assessments was highest regarding satisfaction, 85% both regarding patient satisfaction and their own satisfaction. Concordance both between GPs’ and patients’ own satisfaction and their respective assessment of patient satisfaction was higher than in other studies (74, 144, 145).

The unmentioned/invisible outcomes

During this work it has been obvious that there are outcomes that are not openly discussed, but still of importance.

There are problems not mentioned. In the interviews we sometimes got a glimpse of the fear of cancer, but it was seldom mentioned openly. It was obvious that when a symptom got an explanation, a fear of something dangerous did not even have to be mentioned. To dismiss such worries, often without even mentioning them, is an important and underestimated part of a GPs’ job.

There will also be actions not undertaken. One man believed he would need a pacemaker and another that he needed an acetabuloplasty, and both were relieved by the information that they did not (I). Many consultations end up with the conclusion that a prescription of antibiotics would be of no use. Those actions not undertaken will seldom be mentioned or assessed, but can still be of utmost importance.

Finally this thesis has pointed out that unmentioned outcomes also can have consequences, in that no importance is attached to them. When a GP has helped a patient to a change in self-perception he might not realize that an important outcome has taken place, and even less will he be able to show both to himself and to his organisation that he has achieved something. This can leave him with an uneasy feeling of not having done anything. GPs have described that lack of recognition for good work is an important source of work dissatisfaction (146).

Today’s quality questionnaires answered by patients cannot be regarded as the only truth about consultation outcomes. Patients have for example been poor at evaluating GPs’ technical skills (28), and they have reported satisfaction even though measures of good clinical practice were not fulfilled (147).
If that which is technical and measurable will define how GPs should practice there will be a risk that doctors do not recognize their work (137) and that outcomes genuinely significant for patients because they reduce or delay suffering, are being ignored (148).

The outcomes as a whole

The overall, systematic picture of perceived outcomes has relevance in itself. It can give a background against which connections can be found and cause and effect possibly understood. It can serve as a ground for prioritising, as a help to bring appropriate matters into the foreground.

Being aware of the possible range of outcomes, in the consultation and in the longer term, the GP may trace the effects of his/her own actions in a more sensitive way. It is not necessary that everything should become matters for open discussion. Some of the outcome concepts, like confirmation or change in self-perception, may not even be a possible request for the patient. Still they should be parts of a valid doctor-patient relation. In recognizing the implicit, that which cannot be verbalized, our findings may be a valuable addition.

Decision making and outcomes from the GPs’ perspective

When the GP’s identification of the problem and mode of decision making were compared with the outcome, outcomes were shown to correlate to the GPs’ clinical strategies in practice. Immediate decisions were accompanied by a more positive view of the consultation outcomes. This could give support to a belief that immediate decisions and heuristics besides being ways to simplify and make efficient decision making (99) also might have a positive impact on the outcomes.

It was shown that GPs adjust their problem-solving, whether immediate or deliberate, to the type of problem. When immediate problem solving was used they also chose to focus either on the problem or on the patient as a person. This can be understood as an expert skill of the GP, developed through experience and an example of successful integration of the biomedical and the humanistic perspectives.
Immediate problem solving was used more frequently when the problem was considered to be purely somatic or purely psycho-social. Still both GPs’ satisfaction and the assessment of the patients’ reassurance and satisfaction were lower when there was more psychosocial content in the consultation, but there was no difference regarding assessment of patient coping. This evokes interesting thoughts if GPs are to be evaluated by patient satisfaction. Should they avoid psycho-social problems to get high scores?

**Future implications**

The concepts that are new in an outcome context open up new questions. The patient concept change in self-perception deserves further studies, both as to when it occurs, and how it can be facilitated when of benefit for the patient as well as how it can be avoided when not.

If GPs’ self-evaluations could be less private and brought up for discussion, for example in CME groups, this could be an important source for awareness and knowledge and possibly be a means of strengthening the GPs. Especially when their obligations towards the patients conflict with the perceived professional consensus, they would be helped by research data that tell how their peers actually deal with similar situations. The GPs’ self-evaluation would make a good basis for such research.

Relationship-building also deserves further studies, both as to how it is strived for and as to how the possible effects of relationship-building might be useful for the patients whether they perceive it or not.

The GPs and their profession will need to formulate their aims and guard their achievements independent of the prevailing system of quality evaluation.

Understanding the patients’ world can help the GP to help his patients. He needs to know that patients often believe in cure/symptom relief where he himself holds this to be out of reach. An understanding grounded on the patient’s own premises is highly valued by patients, and a GP should be aware that he might not realize what the patient needs to understand. A GP also needs to know that a consultation can lead to a change in the patient’s self-perception, enhancing his/her ability to accept the changes that illness and ageing will bring. The GP can probably improve the consultation outcome by simply discussing the outcome with the patient.
This thesis suggests a two-step model for the development of a questionnaire to investigate consultation outcomes and other aspects of practice, in the first by qualitative studies and in the second by shaping questions from the concepts found. But as there are no ideal levels for the responses it cannot serve as an instrument for graduating GPs or clinics. Knowledge about the total picture of consultation outcomes has other implications. Besides helping GPs to understand the patients’ outlooks it can give patients a realistic picture of possible consultation outcomes.

The concepts could also make up a basis for further research. The mapping of concepts, old and new, could also serve as a bank of outcome concepts.

Other items for future research would be to compare the outcome picture from GPs’ consultations with that of outcomes from other caregivers in primary care such as community nurses and midwives and comparisons to outcomes from consultations with specialist doctors.

Politicians, caregivers and controllers have a need to see that care of good quality will be delivered to the patients/tax-payers. Unfortunately the difficulty in understanding outcomes from such a multifarious activity as general practice has contributed to that good quality has been observed and measured in place of outcomes, quality has even been mistaken for outcome. But if good quality is not followed by realistic and desirable outcome –what value will it then have? Quality measuring will need to be supplemented with discussions and evaluations about possible and desirable outcomes. This thesis is an attempt to open up and lay a ground for such a discussion.
CONCLUSIONS

Outcomes from GPs’ consultations as described by patients and by GPs have been accounted for together in this thesis. The mapping of outcome concepts can be a ground for further research and serve as a basis for prioritising. The outcome concepts seen together can help both GPs and patients to understand what can be possible and realistic consultation outcomes.

Of the patient outcomes all but one have been asked for in outcome instruments. A change in self-perception has not been considered as a consultation outcome before, but was a common experience. Patient understanding must occur within the patient’s own pre-understanding and in the patient’s own context to be achieved. The patients’ experience of confirmation has a more profound importance for patients than has been observed. All the outcomes described have never before been investigated together.

GPs’ descriptions of outcomes included patient outcomes as well as GPs’ self-evaluations, enhancement of the doctor-patient relationship and a discovery of a need to change surgery routines. The GPs’ evaluated their achievements in relation to a collegial consensus about right and wrong. Such self-evaluations ought to have an inherent possibility to serve as a basis for development of general practice.

Three types of differences between GPs’ and their patients’ experiences of consultation outcomes were found; consultation outcomes were described with partly different concepts, their interpretations of the concepts could be different and their perceptions of outcomes from the same consultation could differ. This was particularly the case with their assessment of patient understanding and expectations about cure/symptom relief.

The GPs seemed to adjust their problem solving (immediate or gradual) to the registered problem and furthermore adjust the immediate problem solving, focusing either on the problem or on the patient as a person. High psychosocial content in the consultation was associated with less satisfaction and reassurance. Immediate problem solving was associated with more positive outcomes.
SUMMARY IN SWEDISH

Denna avhandling handlar om resultatet av allmänläkarens arbete. Vilka begrepp används av patienter och av allmänläkare för att beskriva resultat av konsultationer? Uppllever allmänläkare och patienter resultat på samma sätt? I vilken omfattning förekommer de resultat som upplevs av patienter respektive allmänläkare?


Patientens bedömning att vara nöjd har beskrivits som resultat i ett stort antal studier. Sjukdomskontroll och symtomlindring, patienters allmänna hälsa, enablement, följsamhet (till ordinationer) och effektivitet avseende fortsatt vårdkonsumtion är begrepp som används för att beskriva resultat av allmänläkarvård. Enablement är ett begrepp som konstruerats för att beskriva om patienten fortsättningsvis bättre kan ta hand om sitt problem och sin hälsa.

Under en lång yrkesverksamhet som allmänläkare har insikter om att konsultationer får resultat som inte uppmärksammas eller ens benämns vuxit sig starkare. Denna avhandling kom till för att söka efter sådana resultat och att förstå om de resultat som beskrivs i studier eller utvärderingar faktiskt också upplevs av patienter och allmänläkare.

Först intervjuades patienter och allmänläkare om resulataten av nyligen genomgångna konsultationer. Därefter gjordes enkätfrågor med hjälp av de begrepp som framkommit och patienter och allmänläkare fick besvara dessa enkäter avseende samma konsultation. Slutligen användes läkarenkåtens frågor tillsammans med frågor om hur allmänläkare uppfattade den kliniska situationen och fattade beslut.

Patienter intervjuades inom en vecka efter en konsultation hos en allmänläkare om vad de fått ut av den. De använde begreppen bot/lindring, lugnande, bekräftelse, ökad förståelse, förändrad självbild och om de var nöjda för att beskriva resultat.

Allmänläkarnas uppfattning av vad deras patienter fick för resultat beskrevs med begreppen bot/lindring, lugnande, ökad förståelse, förmåga att klara sig, kontroll av sjukdom/riskfaktor samt om patienten var nöjd.

En enkätstudie gjordes för att förstå mer om hur vanligt förekommande olika resultaten var och hur de kunde tänkas hänga ihop. Läkare och patient besvarade varsin enkät rörande samma konsultation. Frågorna var utformade efter de resultat som framkommit i intervjuerna med patienter respektive allmänläkare. Patienter och allmänläkare besvarade alltså delvis samma och delvis olika frågor. Både patienter och läkare var nöjda i hög utsträckning, läkarna både med sin egen insats och trodde de att patienterna var nöjda. Över 90% av patienterna var lugnade och kände sig bekräftade vid konsultationen. För patienterna var en ökad förståelse det viktigaste och den hade uppnått i 75 % av besöken, men bara i drygt hälften av besöken trodde läkaren att patienten förstått mer när så verkligen var fallet. Patienterna trodde på bot/lindring betydligt oftare än vad läkarna gjorde. Patienterna upplevde att de fått en förändrad bild av sig själva och sitt sätt att fungera efter hälften av besöken, det var alltså ett mycket vanligare resultat än förväntat.

Slutligen länkades kliniska strategier till hur läkare uppfattade resultatet av konsultationen. Omedelbar problemlösning användes i ungefär hälften av konsultationerna. Patienterna antogs ha blivit lugnade, nöjda och kunna klara sig bättre i högre utsträckning då omedelbara beslut fattats än då besluten varit mer gradvisa. Ju mer psykosocialt innehåll konsultationen hade, desto mer missnöje registrerades. Både så att läkaren själv var missnöjd och tolkade att patienterna var det.

Några begrepp har framkommit som inte tidigare angetts som resultat av konsultationer hos allmänläkare. Patienten kan som ett resultat få en förändrad självbild. Fenomenet har studerats då det gäller hur människor anpassar sig till handicapp eller kronisk sjukdom, men finns inte tidigare beskrivet som resultat av konsultationer hos allmänläkare. En sådan förändring är värdefull att känna till så att den kan underlättas då patienten
kan tänkas ha nytta av den, men även undvikas då den kan vara till förfäng för patienten.

Att allmänläkare gör en värdering av sin insats i konsultationen i relation till vad som upplevs som kollegialt consensus om rätt och fel har tidigare inte uppmärksammats som konsultationsresultat. En sådan värdering förklarar varför patienter och läkare inte alltid är nöjda med samma konsultationer.


Skillnader mellan allmänläkares och patienters uppfattning om konsultationens resultat kunde vara av tre slag. Dels uppfattade de konsultations resultat med delvis olika begrepp. Dels kunde de lägga något olika innebörd i samma begrepp, t ex nöjd, och dels upplevde de ibland resultatet från den faktiska konsultationen på olika sätt, bland annat för att de värderade den med olika förutsättningar. Allmänläkare har nytta av att känna till dessa möjliga skillnader då de möter patienter.

Eftersom begreppen här framsprungit ur verkliga konsultationssituationer har avhandlingen även bekräftat begrepp som redan används för att beskriva konsultationens resultat. Några av dessa får här en lite annan betydelse än tidigare. I patientintervjuerna framkom att patienterna lägger stor vikt vid att få bekräftelse på huruvida deras egna föreställningar och idéer om vad som händer i kroppen är riktiga eller inte, bekräftelse var alltså något utöver att patienten blir lyssnad på och sedd som person.

Avhandlingen visar att det är viktigt att ta ställning till varför man vill värdera resultat av allmänläkarvård när man bestämmer hur det ska göras. Värderingsinstrument som utförs för att mäta kvalitet på vården ska inte förväxlas med resultat av vården.
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