Patients’ Communication with Primary Care: A Pre-study for a new communication system.

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Acknowledgements

The authors wish to express sincere thanks to their supervisor Jon Engström for sharing his expertise and providing valuable supervision throughout their study and research. Without his help the thesis would not have been possible.

The authors would like to thank Stina Gäre Arvidsson and Ulrika Elmroth from SKL for the sincere and valuable guidance they provided and for letting the authors be a part of this amazing and interesting project. Both of you are truly an inspiration and have lovely personalities and ambitions.

The authors also want to thank their thesis opponents Yann and Jules for giving their advices about this study and research every week during the thesis writing process. The authors are very appreciative of their help.

The authors also take this opportunity to express gratitude to all of the patients for their time and energy to answer their questions and be a part of the research. Without them this research would not have been possible.

And a special thank you to Louis and Waleed for their continued support throughout the writing of this thesis.
Abstract

The purpose of this study is to explore patients’ experiences and preferences concerning communication with primary care, as well as their attitude towards a future digital system to manage communication. The Swedish county councils and municipalities (SKL) is developing a new digital tool as a complement in the communication between patients and physicians, thus this research is a preliminary investigation of a larger approach. The research has been based on 20 semi-structured interviews with patients in ages between 21 and 86 from 13 different health care centers in Sweden. The interviews indicate that the communication between patients and physicians needs development in numerous ways and that the system used by the primary care contributes to negative outcomes in the communication. Patients' attitudes towards a new digital system to manage communication were investigated and a majority was positive. The study’s results pointed out the importance of the physicians’ attitudes in the physician-patient communication, and brought some possible improvements to be done in the actual primary care system; as for example implementing new communication channels to allow an easier contact of patients with their health care center. The new communication tool was overall well received and even appeared to be a suitable solution for some of the problems discovered along the patients’ journey. The overall results obtained are positive and promising towards its implementation in Sweden.

Keywords: Physician-patient communication, Health care, Primary care, Digital communication tool, Patient-centered care, Co-creation, Service design, Patient journey, Swedish county councils and municipalities.
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1. Introduction

In today’s health care, one of the biggest shortcomings, and especially within the primary care, is a lack in the communication and the information exchanged; in Sweden (IVO, 2014) and also abroad, for example in the UK (Coulter, 2005). Behind a large proportion of complaints, the underlying reasons are communication limitations between the patients and the health care providers. It is one of the most common causes that has been notified (IVO, 2014). This confirms what Coulter (2005) and Rosenstein (2012) point it out as a dissatisfaction of the patients in the physician-patient communication. It is very important that the patient is satisfied with the physician/patient communication (Bower et al., 2003), and all current problems are discussed to avoid that the patients experience deficiencies in the communication.

Communication with patients is more than politeness and honesty; skills in communication and other necessities are needed for a patient-centered care (Levinson et al., 2010). Patient-centered care is defined by Levinson et al. (2010), as “respecting and responding to patients’ wants, needs and preferences so that they can make choices in their care that best fit their individual circumstances” (p.1311). Patient-centered care is a core competency for delivering high quality care (Lind, 2014). To aim towards having a patient-centered care, the communication has to be wholesome and efficient, and this will lead to positive outcomes such as patients’ satisfaction. And it has been demonstrated during research that the patient-centered communication has improved medical results (Bower et al., 2003).

There is a lack in the communication today. Patients feel that the doctors have shortcomings regarding listening and giving enough information to them (Levinson et al., 2010). Some research that was conducted in the UK gave insights about what are the patients preferences concerning the conduct of their consultation with primary care (Coulter, 2005). It states that the great majority of patients now want to get more information about their health condition and the different treatment options, but also, expect their preferences to be taken in account when decisions are taken. The latter are major factors to make patients feel safe and confident regarding their physician and treatment.
Beck et al.’s (2002) review about physician-patient communication in the primary care pointed out a total of 22 physician behaviors that were associated with positive health outcomes. Among them, 3 are important to keep in mind regarding the aim of this thesis, including:

- Patient-centered behavior (encouragement of the physician for patient’s questions).
- Patient leading the conversation.
- Psychosocial talk (physicians who addressed problems of daily living, social relations, feelings and emotions of the patients).

All the previous concepts about healthcare, communication and patients’ involvement state the importance of the physicians’ communication skills, and can be related to the concept of co-creation. Co-creation (Vargo et al., 2004) consists of a partnership between the service users and the service organization; where users take part in the value creation during the delivery of the service (Vargo et al., 2004). The latter stated that the focus should now be on intangible resources, co-creation of value and relationships with the customers. Thus, it is essential to understand the needs in patient’s communication as it is at the core of value co-creation between patients and the health care. Taking the case of diabetes, communication in relation to value co-creation is important as the patients need to be educated by the medical staff to have the knowledge and the self-consciousness that is necessary for the self-regulation of their own insulin injections to control the level of sugar in their blood. Communication is key in such medical cases as a failure in their insulin self-regulation could be fatal for the patients.

Moreover, when designing a service, one method that can be used is the customer journey mapping. It helps to understand and get an overview of the whole customer experience of a single company (or organization) through time from the customer’s point of view (Zomerdijk and Voss, 2010). This method can act as a support for the service organization to redesign and control the potential failure points and prevent the customer’s dissatisfaction. Therefore, understanding the customer journey is of primordial importance when designing or improving a service (Payne, Storbacka, and Frow, 2008; Teixeira et al., 2012).
In summary, the customers becoming co-producers are involved in the process of creating value by understanding, adapting and answering to their own individual needs. This concern and mobilize them as customers and not only “targets” anymore (Vargo et al., 2004). Thus, communication remains a priority as it is important for both co-creation, which is essential for a performant and innovative public service, as healthcare for example (Osborne et al., 2014); and service design, which could help designing a service matching the organization’s goal as well as the future users’ expectations.

1.1 An ongoing project

To make improvements in the Swedish health care regarding the communication and co-creation with the patients there is a new tool that is being developed and implemented by the Swedish county councils and municipalities (SKL). SKL is the organization responsible for the primary care quality in Sweden. This new tool will increase the patients' involvement in the health care’s work and will allow the use of the patients' knowledge and experience for new developments (Lind, 2014).

This study was done in partnership with SKL, as a preliminary investigation of a larger approach regarding both research in general and the development of a communication system called PROM by SKL. PROM is a short for Patients’ Reported Outcome Measures. PROM is a measurement that is used to get information about how the patients experience their illness and their health after a treatment or other medical interventions. PROM is composed mostly of questionnaires, which includes measures of disease symptoms, functional capacity and health-related quality of life (Lind, 2014).

The project that is being developed will enable the patients to provide their health care center much more personal insights about their symptoms, everyday life aspects and consequences of the latter, as well as their personal expectations and feelings. Patients’ interaction is a major factor in the improvements of the health care. As Lind (2014) pointed out patient-centered care is essential for delivering high quality care. And the new tool, that can also be called the quality register, is an important part in the development and
improvements in the health care quality. The quality records (Lind, 2014) will be made so that the patients can take part of it thanks to the possibility of interacting with the primary care.

PROM includes an online platform, developed by SKL, to which the patients will be able to connect and write personal impressions on their personal page. This platform will then be accessible by the health care medical staff in charge of this particular patient in the corresponding center. The idea is that this tool will provide the patients’ feedback to the health care center at three different steps of their customer journey: before, during and after their primary care appointment. This way, more information is shared, but also, the risks of forgetting essential details is reduced. The medical staff will check on this information before the appointment and the follow-up appointment(s) to be able to provide the most suitable treatment and/or advises possible to each patient. This way, the diagnostics can be more accurate and the time can be spent more efficiently and effectively during the appointments.

An illustration of the online platform could not be provided yet as it was not available at the time when this study was conducted. However, the following Figure 1. (Process map) is a presumptive model of what the communication tool might be like. It was provided by SKL.

![Figure 1. Process map (SKL, 2016)]

The first contributor is the Swedish county councils and municipalities (SKL). Their constant work to make improvements in the whole system includes the project of developing the online communication tool that has been described earlier.
Then come the patients, both as co-creators and users. After some of them contributed to the communication tool improvement, they would all have to accept and adapt to the platform settings to use it properly. At first, it will cost them some time to fill out the different requirements online.

And finally, the primary care medical staff, as they would have to go through the information provided before the appointments to update their knowledge about the patients’ data.

As communication is a determinant factor in the primary care core, and to bring an input to the development of that new system, it was decided to conduct an exploratory research to understand more about the current health care communication; especially about the patients’ experiences and preferences regarding communication with their health care center, and to find out whether or not, the Swedish patients more particularly, would be interested to use a new online tool aimed to improve the physician-patient communication.

1.2 Purpose & Research questions

This study’s aim is to explore patients’ previous experiences of, and preferences concerning communication with primary care, as well as their attitude towards a future digital system to manage communication. The research questions are formulated as follows:

- How do patients experience the current communication with primary care?

- What are patients’ preferences concerning communication with primary care, before, during and after the appointment?

- What are patients’ attitudes towards sharing information using a future digital system to manage communication?

This study could beneficiate, in the first place, to the primary health care in Sweden, which is looking forward to improving in this field, and which the authors were collaborating with for this study.
To a greater extent, it could be useful to every health care system that has the same, or a similar, functioning model.

Beyond helping the whole system, the possible improvements this study will propose for the communication tool would actually benefit both physicians and patients. Providing health care centers’ staff with more personal insights from their patients, helps them to know and understand more about their patients’ daily life. This way they would be able to adapt more accurately the treatment options to each patient’s particular needs. It also reassures the patients about the fact that physicians actually know them enough to provide them with the care that is best for them.
2. Theoretical perspectives

In this section, the theories that will help answering the research questions will be explained. First, the emphasis will be put on the communication in health care and patient-centered care. Then the concept of co-creation and its outcomes will be exposed. And to finish, a point will be made on service design and patient journey.

An effective communication is essential in the health service; it is necessary for the physicians to know important information about patients to deliver appropriate care and prescribe appropriate medication.

2.1 Communication in health care and patient-centered care

To be capable of performing effectively in medicine the physicians need to have competence in communicating (Schirmer, 2005). This encourages the medical education to have focus on the upcoming physicians’ abilities in communication. It is hard to develop competences in communication since it takes more than a theoretical learning to acquire. It is also complicated since effective communication differs with different patients. Which can be linked to the concept of heterogeneity of the receivers in marketing communication exposed by Gherasim, A., Gherasim, D., & Vasiloaia, M. (2012). The latter stated “for the desired reactions to occur, it is necessary for recipients to receive the message, decode it (decipher), understand it and be aware of its information content” (p.42). The content of the message needs to be adapted to each receiver; meaning that each client is unique and that the company has to adapt to provide them what best fits their particularities and needs. To develop competences in communication there has to be specific teaching during the physicians’ education (Levinson et al., 2010).

Someone having an effective communication has the skills to adapt, the responsiveness, the knowledge and awareness of one’s way of talking and listening (Schirmer, 2005). According to Levinson et al. (2010), physicians define patient-centered care as “respecting and responding to patients’ wants, needs and preferences, so that they can make choices in their care that best fit their individual circumstances” (p.1311). Schirmer (2005) also states that an effective communication is reliant on the behavior and perception of the
patient. What creates effectiveness with one patient might not with a different patient. Hence, it is hard to have an effective and consistent communication with all patients, it will require a more customized communication (Schirmer, 2005).

Competence in communication is an essential part in patient-centered care. It has been proved that it has good influences on the patients’ being more satisfied, listening more to recommendations concerning treatments, and handling things themselves regarding chronic disease (Levinson et al., 2010). The patient-centered approach works towards physicians appreciating the perspectives, values and needs of the patients (Levinson et al., 2010). This will enable the delivery of relevant information to the patients for them to be involved and contribute to the trusting and understanding between patients and physicians. The communication between the two parts can exist both through talking and through other communication channels (Levinson et al., 2010). Throughout the communication with the patients there is a numerous communication tasks the physicians have to accomplish that is showing genuine involvement and personal engagement (Levinson et al., 2010).

To be able to achieve this tasks, the physicians can be trained through practice and constructive feedback about their communication skills (Levinson et al., 2010). Today the physicians do not get training for their communication skills after finishing school. And lot of them are unaware of their possible need for improvement in communication skills (Levinson et al., 2010). For the doctors to be aware of what they need to develop regarding their communication skills, feedback is needed to map what has to be done and improved.

Communication is therefore an essential component of the health service, because it facilitates co-creation, which is based on creating value together with the customer of the service (Vargo and Lusch, 2008). Communication needs to be efficient to allow value creation.
2.2 Co-creation of value with patients in individualized healthcare

As stated in one of the service dominant logic premises, all social and economic actors are resource integrators (Vargo, 2008). Vargo and Lusch (2008) stated that “the customer is always the co-creator of value” (p.8). For Elg et al. (2012), customers are referred to as resource integrators “who operate on resources made available to them by a given provider, by other market actors or by themselves to increase their well-being” (p.330). Vargo and Lusch’s definition of co-creation includes the co-creation of value. Meaning that the firm jointly creates value together with the customer during consumption, value is not made by the firm only and then transferred to the customer.

The company’s aim is not anymore about being only customer centric (Sheth, Sisodia, and Sharma, 2000). The customers becoming co-producers are involved in the process of creating value by understanding, adapting and answering to individual needs, that concern and mobilize them as customers and not only as targets anymore (Vargo et al., 2004). This value co-creation process has been described by Grönroos and Ravald (2010) as follows: “The simultaneously occurring supplier and customer processes are coordinated and merge into one joint process, where the customer, operating inside the supplier process, co-produces service, and the firm as the provider, operating inside the customer’s process of value creation, gets opportunities to co-create value with the customer” (p.16).

Osborne et al. (2014) stated that co-creation was at the core of public service delivery and enabled effective performance and innovation. McColl-Kennedy et al. (2012) focused their research on customers co-creating value in health care with a direct impact on “service provision activities, such as self-service, service design, and new service development” (pp.376-377). It is stated that the perceived roles, interactions* and activities** of the customers, as well as their quality of life, influence health care patients’ value-creation. The study of McColl-Kennedy et al. (2012) also gave some insights about what co-creation in health care could bring; stating that co-creation “could include activities such as assisting with administering drugs or other treatments with clinic staff and/or others (i.e., self-service), providing new service ideas to the service provider, such as how to reduce
the waiting time at the clinics and assisting in the redesign of treatments, and reconfiguring the composition of the medical team, including “hiring” and “firing” of the doctors” (p.377).

According to McColl-Kennedy et al. (2012) it exists 5 different styles of value co-creation practices for the patients, linked to their quality of life, including:

- **Team management**: patients “manage their respective “team” that includes friends and family (private sources), medical experts (market-facing sources), and support groups (public sources)”, it is linked to a relatively high quality of life.

- **Insular controlling**: “their interactions seem superficial; individuals tend to be self focused; [have a] strong emotional labor; preferring to be alone and not to share their feelings and problems with others”, it is linked to a relatively low quality of life.

- **Partnering**: is “characterized as demonstrating collaboration primarily with doctors and a limited number of professionals”, it is linked to a relatively high levels of quality of life.

- **Pragmatic adapting**: “characterized by the action of changing and being adaptive”, it is linked to a moderate quality of life.

- **Passive compliance**: “characterized by acceptance [in their] interactions with the medical profession; following orders of the doctors”, it is linked to a relatively low quality of life.

All of the 5 styles of value co-creation are represented in the following Figure 2 (Customer value co-creation practice styles (CVCPS) framework) taken from (McColl-Kennedy et al., 2012). It illustrates the level of interactions* compared to the level of activities** of the patients to better understand their profiles, expectations and needs.

*Interactions can occur “with different individuals from the focal firm, other market-facing and public sources, private sources, and self-generated activities”.

**Activities can include “cooperating, collating information and connecting, combining complementary therapies (such as diet, exercise, herbal medicines), connecting with family, friends, doctors, nurses, and other health professionals, engaging in cerebral activities such as positive thinking, reframing and sense-making, psyching themselves up, emotional labor, and have a high number of interactions with different individuals from the focal firm, other market-facing and public sources, private sources, and self-generated activities, co-learning (such as actively seeking, sharing, and providing feedback)”.
Both team management and partnering styles should be encouraged as they are associated with higher quality of life and could have other beneficial contributions to the healthcare.

The co-creation concept can lead to co-creation for use, as well as, co-creation for others (Witell et al., 2011). Which are respectively, understand and adapt the service to meet the need of a specific patient; and a more general approach that can benefit one to a larger number of customers. The latter participate in the service development. This study is based on co-creation for others, as primary care must be able to meet the needs of each patient with a general operating base, which must nevertheless remain adaptable.
The co-creation theory underlines that individual patient experiences matter (Elg et al., 2012). Which can be linked to the customer journey theory that helps to identify the critical incidents within the service system. Moreover, involving users in public service design projects enable relationship development and a deeper understanding of the users and their everyday activities (Trischler & Scott, 2016).

2.3 Service design and Patient journey

Ostrom et al. (2010) defined service design as “the orchestration of clues, places, processes, and interactions that together create holistic service experiences for customers, clients, employees, business partners, or citizens” (p.17). When designing a service several visualization and mapping techniques can be used, including both customer journey mapping and blueprinting (Zomerdijk and Voss, 2010). These latter claimed that the customer journey mapping allowed to better depict the “touchpoints” with the service system and the overall user’s experience during their customer journey. The “touchpoints” are defined as the precise points of contacts, or interactions, between service organizations and their customers (Secomandi & Snelders, 2011; Fichter & Wisniewski, 2015). Voss and Mikkola (2007) claimed that all the “touchpoints” actually form the customer journey. Thus, identifying these “touchpoints” and understanding the customer journey in the service system are the most determinant factors to master when designing a service as it will define the whole customer experience (Payne, Storbacka, and Frow, 2008; Teixeira et al., 2012).

This method can also serve as an important communication tool to transform ideas and complex processes into visible dimensions (Segelström, 2009). Trischler and Scott (2016) pointed out the importance of identifying the critical “touchpoints”, or critical incidents, that are defined as specially satisfying or dissatisfying service encounters that will affect the perception the customers will have of their own experience. This way the service organization can redesign and control the potential failure points and prevent the customer’s dissatisfaction.
3. Method

3.1 Choice of method

There are two main approaches in research, the deductive and inductive theories (Bryman & Bell, 2011). The approach chosen for this thesis is primarily inductive which is based on theories, and explores links between the selected theories and research (Bryman and Bell, 2011). An exploratory inductive approach will be used as the authors aim to look into what the theories state to analyze their findings and compare to the theories to develop ideas of improvements to be made. The research method has been developed to answer the research questions in the best possible way. The aim was being able to understand and analyze the patients’ preferences and needs regarding communication with the doctors in the Swedish primary care. A qualitative study is suitable for creating an insightful comprehension concerning the view of the patients today and their future preferences regarding the communication with the doctors (Trost, 2012). The authors used a qualitative research to be able to understand the patients’ preferences concerning the communication and information exchanged with the primary care, and also to understand their attitude towards a future digital system as a complement to the communication. As stated in the article of Trost (2012), a qualitative research gives a deeper insight. This convinced the authors to choose a qualitative research method since it gives an opportunity to gain a deeper understanding of the patients’ preferences and attitudes.

The qualitative method that will be used is a semi-structured interview questionnaire. This makes the questions adaptable and enable the people being interviewed individually to formulate their answers with their personal input. The respondents have the opportunity to express themselves openly which contributes to a better depicting of their views, and thus, a better understanding of the authors. This way of structuring the interviews gives a chance to ask relevant follow-up questions and also to change the order of the questions if necessary (Bryman & Bell, 2011). Since it is unknown what the patients want to communicate about with the doctors, it is important for them to have the possibility to formulate answers openly, and also to develop their answers further than the original questions. Thus, to answer the research questions it is important to have several main questions and follow-up questions prepared.
The authors created a semi-structured questionnaire with 12 questions covering the themes of their research and one additional open question about the health care center and communication theme. The questionnaire can be found in Appendix 7.1. (Questionnaire). The questions themes were about the patients’ experiences and preferences regarding communication with the primary care; as well as patients’ attitude towards a future digital system. Some questions were rather overall, to give the respondent the opportunity to share their personal story; and some more specific in case the patients did not give adequate information when responding to the open questions.

Patients being interviewed will be treated with respect and the interviewers will be good listeners and give appropriate responses. It is important to be neutral and not argue with the patients being interviewed (Nilsson, 2009). As Elg et al. (2012), pointed out in their study, it is important to set rules to protect the patients’ identity when they participate in research where they have to provide personal insights and experiences. This way, patients can feel secure when sharing information knowing that it will have no influence on their future contacts with the health care system and/or their treatment. That is the reason why the authors chose to expose their findings on an anonymous manner.

In the beginning of the interviews the authors started with introducing themselves and told the respondents that they were students at Linköping University and that they were cooperating with SKL. After introducing themselves the authors introduced why their project was important and what their goal was. The authors started to ask open questions about the research themes continuing with more specific subsequent questions. And before finishing each interview, they asked if the patients had something more to add. The last question was a good opportunity for them to discuss things that came to their mind during the interview. As a parallel to how Elg et al. (2012) conducted their study with patients’ diaries, the authors asked as well questions about: “(1) Everyday situations related to the health-care problem; and (2) Contacts with health-care providers (such as examination, rehabilitation, treatment, advice)”. This way the authors were able to learn from patients’ ideas and patients’ narratives (Elg et al., 2012).
3.2 Interviews

A total of 20 interviews were conducted. Each interview was 15 to 50 minutes long and all of them were conducted in Swedish. The interviews were made at health care centers face to face with the patients that could come to the health care center. The rest of the interviews were conducted at the patients’ homes face-to-face. The patients interviewed were in different age groups, but a majority of patients were over the age of 40. The youngest patient was 21, the oldest 86, and the average age of the patients was 47. The authors wanted to have a wide-ranging age group as people from different age groups may have different experiences and preferences. 11 of the interviewees were women and the remaining 9 were men. These characteristics can be found in the following Table 1 (Patients’ characteristics table).

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<th>Number</th>
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The goal with the interviews was to be able to understand and analyze the patients’ preferences and needs regarding communication with the doctors in the Swedish primary care. At first, the authors decided to conduct the interviews in two health care centers. Then, in order to try to broaden their field of research the authors interviewed patients from 13 different healthcare centers, since the healthcare centers can be different, for example in terms of organization and work culture. By doing this the authors were able to get a greater overview of the communication between patients and primary care in Sweden, rather than only the communication at two healthcare centers. The patients that were interviewed were from healthcare centers located into cities situated between Stockholm and Malmö in the south of Sweden. Due to a lack of time, the authors were not able to interview any patient north of Stockholm. All the interviews were recorded and then transcribed on a 30 pages’ document in Swedish.

3.3 Analyzing method

The analyzing method that has been used is content analysis. “Content analysis is an approach to the analysis of documents and texts that seeks to quantify content in terms of predetermined categories and in a systematic and replicable manner” (Bryman and Bell, 2011) (p.289). The data will be analyzed through interpreting the content of the interviews. The content analysis can be used when analyzing non-structured information such as the information out of semi-structured interviews (Bryman & Bell, 2011). Since the authors used semi-structured interviews, it is a suitable way for them to analyze their data.

According to Bengtsson (2016), the content analysis described in literature has similarities regarding the process. 4 main stages were identified in the content analysis throughout the literature: the decontextualisation, the recontextualisation, the categorization, and the compilation. When analyzing their data, the authors followed these stages. The decontextualisation is about getting familiar with the data thorough reading it carefully before dividing it into small “meaning units” (Bengtsson, 2016) (p.11). These units includes insights that are needed for the authors to be able to answer their research questions. When the authors had found their meaning units they followed the next step “the recontextualisation”; making sure that the results cover the aim of the thesis. The authors went through the transcribed data once again to see if what they found was sufficient for
covering the aim. Then, the authors followed the step of “categorization”, here they recognized processes, themes and categories. The final step, “the compilation”, contains the analysis. When analyzing the text, the authors’ personal values will not be a part of the result (Bryman and Bell, 2011).

When presenting the findings, the authors categorized the content from the interviews and found some main points in the categories, they also presented some citations that were suitable for the analysis. Then the authors chose to develop a table with the main points to make it clear and easier for the reader to perceive those categories. During the process, the authors kept in mind that the findings should more or less resemble or oppose the selected theories.

3.4 Quality of research design

To define how trustworthy a qualitative research design is, there is four components to consider: credibility, transferability, dependability and confirmability (Bryman and Bell, 2011). Credibility refers to how credible the findings are, transferability refers to the validity of the findings in other settings, dependability refers to the applicability of the findings at a different occasion, and confirmability refers to the interference of the personal values of the interviewer (Bryman and Bell, 2011).

The credibility of the findings can be considered reasonable since the authors designed a questionnaire with additional questions and explanations in case the respondents would need a better explanation. Many of the questions were open to give the respondents the opportunity to answer honestly. The credibility is high for this study referring to Bryman and Bell (2011). Qualitative studies have high internal validity, because the long participation in a social group allows to have promising results concerning theories and observations.

One thing that could have affected the confirmability is the interviewer. When using qualitative interviews as a method, the confirmability can be higher with the opportunity to explain and ask additional questions which can decrease the chance of respondents to
misunderstand. The respondents were given the opportunity to be anonymous, this can increase security in providing honest answers which results in higher confirmability.

It is hard to achieve high dependability when doing a qualitative study according to Bryman and Bell (2011), since it is almost impossible to do a research in the same social environment and social conditions. To achieve high dependability, the authors chose to interview patients from different cities in different age groups.

To make the transferability of this thesis higher the respondents were chosen randomly (Bryman and Bell, 2011).

3.5 Ethical principles

During the research, ethical principles have been considered. The patients that were interviewed were informed about the study’s purpose and how the research will be done; this is called the information requirement (Bryman and Bell, 2011). All patients’ participation was optional and they also had the choice of discontinuing their participation (Bryman and Bell, 2011). The patients were also informed that all the information they shared would be used internally and would only be used in the research process. It is important that all the participants get informed truly and clearly (Bryman and Bell, 2011). The authors will make sure that they stick to their promises and that it was clear when they inform the participating patients.

3.6 Self critique

The authors thought it would be easy to find patients to interview with the help of SKL, but it turned out to be much more of a challenge than they initially thought. Once the authors got to interview a few different patients from two healthcare centers, they realized the answers were very similar. This is when they decided to interview patients from other healthcare centers. If it was not due to time limitations, they could have even broader their results through interviewing more patients from different other healthcare centers.
Also, the length of the answers received varied a lot among the different patients. This resulted in the authors expecting more detailed answers than what they actually received, and thus, the interviews produced less material to analyze than what they originally imagined.

The authors also expected more patients to be comfortable to speak in English, whereas they said they were not when they were asked. This resulted in the integrality of the interviews conducted in Swedish, while one of the researchers did not speak Swedish. It would have been an advantage if both of them were able to participate to the interviews that both of them could comprehend in Swedish; or if the patients agreed to speak English during the interviews.
4. Findings

The mission the authors had was to recognize the patients' previous experiences of, and preferences concerning the communication with primary care as well as their attitude towards a future digital system to manage communication. The interviews were transcribed before being processed. The following part exposes the results obtained out of the 20 interviews conducted for this study.

4.1 Patients’ experiences

- Before the visit

Getting in touch with the health care

The first thing that was recurrent throughout the interviews was the communication when trying to book an appointment at the primary care center. At first the patients are only able to get an appointment the same day if they call between 7:30 and 8 in the morning, Monday to Friday, and if they are lucky. Sometimes there are no appointments available the same day even though the patient called during that time span. This makes it impossible to get urgent care if they need it the same day. “Usually you have to wait for a while before you get an appointment because they are always busy,” Male 24 said. Moreover, Male 43 said, “the primary care is not available, they communicate as it suits them”. There were also patients who had a positive experience. For instance, Female 24 said “I have called and booked appointments, and it has worked well, I got appointments”. The only alternative is to go to the emergency room of the closest hospital, open 24/7; which might not be necessary in every case. This can also be disturbing for the patients if they are sick and have to wake up early to call the primary care center. This leads to the patients’ question: “Who is the service built for?”. When contacting the primary care through telephone it is possible to have them calling you back in a specific timespan.

Some patients thought was a good system and some others felt like it was a system built for the primary care and not for the patients. Male 43 said “They call you back between certain times, it is ineffective and then they need to question if the system is for them or for the patients”. Male 47 said “It worked well, they usually call you back if you want them to, so that you don’t need to wait in a telephone queue”. And Female 45 said “You call during
their telephone times and they call you back instead of having to stay in a telephone queue, this is good since their telephone queues are very long”.

**Difficulty to get an appointment**

“How and what should I do to get an appointment?” Female 21 said. Female 86 described what happened when she tried to book an appointment “I called the health care center three times and they said we do not have a work schedule, and then I called again and she said there was not a work schedule. The fourth time I called the health care center they said the doctor would decide if he had time for it, and they did not say anything else, but then they sent me a summons by post”. The patient did not understand why they said there was no work schedule and did not give her an appointment the first time she called. Male 77 pointed out that the receptionist determines too much the outcomes of the phone calls. “If you want to see a doctor, they rather push it forward and let you see a nurse instead”. It was also mentioned that the instructions regarding where you can book an appointment were unclear. Male 26 said “I thought the instructions were unclear online regarding that it is only possible to book an appointment through the telephone and not physically over desk”.

**Getting in touch with a doctor**

The patients’ also pointed out that it is not possible to get in contact with a doctor before a visit, which in some cases would be a more effective way since it is not always necessary to have a physical appointment. For instance, Female 86 said “you can not get in contact with a doctor at the health care center, it is impossible”. Some experienced that the nurses do not always listen nor make the right decisions when a patient call, which could be avoided with the possibility to contact a doctor directly on the phone. Male 43 said, “when you call the health care center you get to speak to a nurse and the nurse can not answer every questions which is extremely irritating”.

- During the visit

Many patients are satisfied with their communication during their visits with the doctors and nurses, however some of them were not. Usually, during the patients’ visits they talk about their symptoms, problems, receive advice and discuss about how to proceed.
Doctors’ ability to listen and show interest
Some of the doctors were dedicated to listen to their patients, but some were not, which affected the outcome of the overall communication. Some patients had experiences with doctors not listening or not having any interest in communicating with them. Male 43 said, “I met this doctor who was not very interested in me and what I had to say, I got fed up”. A lot of patients mentioned the importance of how the doctor treats them and how it shapes the communication. When the patients felt like the doctor was not interested or listening, they felt like there was no need in telling the doctor anything. It was also mentioned that sometimes a patient felt like a health problem was necessary to look into, but the doctor showed no interest in this problem and did not tell the patient why it was not investigated further. Female 86 said a doctor told her “It can be like that” and she did not get an explanation for what can be like that.

Lack of time
One thing that many of the patients pointed out is that the short amount of time available for each appointment affects the communication. There is not always enough time to communicate about everything that seems necessary. Male 43 said, “For the time to be effective most of requisites have to be done before you arrive to your appointment. A lot can be done through the telephone; if you need to do 3 blood tests you can solve it through the phone. But everything takes so much time with the system today, time that makes me pre-occupied from work just because the system is ineffective, it bothers me tremendously”. The duration of the appointments is not sufficient to communicate about everything that seems necessary, and then, the patients find it difficult to get a new appointment.

Patients’ opportunities to influence what the conversation was about
Overall, the patients were happy with the extent to which they could influence what the conversation was about. Female 69 said, “I could influence what the conversation was about and [we] communicated with each other”, and Male 60 said “I have had many doctors and most of them have been nice and I have got everything said. I have been able to tell the doctor what I wanted, they replied and asked questions”. Female 25 said “I have
noticed that if you tell them that you have more things you wonder about; they want to take one thing at a time. And then you have to call to book a new appointment instead”, this is perceived as extra work since it is hard to get a new appointment and there might not be any availabilities other than appointments way ahead of time.

Do patients think the primary care knows enough about their personal insights
Some patients feel that the primary care knows enough about their personal information, needs and requirements. And there are also some patients who think that the primary care does not know, but should ask more. Whereas, some others feel that the primary care does not know, but does not need to know about it. When asking if the primary care knew enough about her, Female 24 said: “No, I do not think so, and maybe they should have asked more, since it can be things that are important”. Another patient thought the doctors had a holistic way of working and that this is because of their lack of time caused by the system. “What are they going to do with 15 minutes, I think the doctors are aware and sometimes avoid asking some questions that could end up in complicated social problems. And if they do not take care of the main cause they will be returning all the time with small concerns instead of the doctor asking from the start” Male 43 said.

What patients feel comfortable communicating about
Most of the patients were comfortable communicating about everything, even sensitive subjects. They think that it is important and necessary not to keep any information away that could be important to share with the primary care to be able to solve their health problem(s) and to get them the right care and medication. Female 69 said “You have to tell them everything that is a problem otherwise it does not make sense to go to the doctor, then you do not get any results on the problems you have”. Also for the patients to feel comfortable it is determinant who they are talking to and how comfortable they make them feel. “It depends on what type of people they are, if they are not nice and respectful I do not tell them anything; and a person who is not interested in listening, you do not tell them anything either”. Male 43 said that it is important that they are “communicative and able to have a conversation, the health care staff needs to have the ability to adapt otherwise it will be pointless. They have to be aware of how they are perceived”.
After the visit

*Feedback regarding health analyzes results after the visit*

The communication occurring after the patients' visits has mostly been when there is something abnormal in their results. When patients take a medical test and the outcome is good, the medical staff put it aside and do not give the patients any feedback about it. Female 69 said, “I have met a different doctor and he made me take various tests, and then you do not get any answer, which in my opinion is not good”. Moreover, it is not always clear from the start when they receive the instructions if the patients should continue with the medication after the test, or if they only should use it temporarily.

*Lack of information delivered to patients*

One common issue the patients agreed about is the lack of information given to them. Questions often remain unclear after the visit, such as: How often should I take these pills? Is this temporarily or permanently? When do I need to see the doctor again? When can I book the next appointment? There are doctors who really care about patients and want them to know which kind of disease they have and what they need to do step by step; but it is quite rare unfortunately. Information about medication is very important, and can sometimes be wrong. Female 69 declared “I change my medication prescription every week because of the very strong pills I get. The information about my pills is so bad and the doctors can not even calculate how many I should take every day”. “After collecting information patients believe it is almost impossible to get a doctor as good as “my doctor”. I’d rather stay sick than meeting another doctor” she said.

*One-way communication*

When the primary care communicates after the appointment, they often send letters which makes it harder to ask counter questions. The patient will have to go through the process of contacting the primary care again to be able to ask questions; and then, the person they get in contact with might not be able to answer their questions anyhow. “They send you a letter which makes it impossible to ask counter questions, their way of communicating is a one-way communication that suits their needs” Male 43 said.
4.2 Patients’ preferences

- Before the visit

**Getting in touch with the health care**

The patients would prefer to be able to get an appointment the same day even when calling at different times during that day. And not be constrained to call during a 30 minutes’ timespan early in the same morning to get an appointment later the same day. The availability needs to be developed to meet the patients’ preferences. For instance, Male 43 said “*I think they need to be more available through their website and much more available when the patients call*”. They think the opening hours should be longer to match today’s 24 hours’ society. Male 43 suggested that the primary care should always be open between 8 and 22. Male 43 also pointed out “*It is important with availability, and I think that this 8-17 Monday-Friday system is outdated, since we have a 24-hours community today*”. There were patients who did not have any additional preferences. Male 65 said “When I called I got an appointment and I did not need any more communication than that before a visit. Female 71 said “*I have no preferences regarding the communication before, during and after. I am satisfied with how it is*”.

**Preferences concerning the content in the communication**

The patients also feel it is important that the people answering the phone when they call present themselves and their title clearly, such as nurse, doctor or receptionist. The primary care should be able to answer professionally so that the patients feel like it is useful to call them to get advice and help. Female 24 said “*I want them to give advice and that they have the knowledge because sometimes it feels like it is easier to Google it than to ask the primary care*”. Patients would like to talk about their symptoms, what eventual health tests need to be done and get advices from the physicians, so that they are as prepared as possible before their appointment. This way the time they have when they meet the doctor is more efficiently spent.

**Possibility to communicate with a doctor through telephone**

One thing that was recurring in the patients’ preference regarding communication was being able to contact a doctor through a phone instead of calling and getting the answer “*he/she is not here*” and “*there are no appointments within the 14 next days*”. Being able
to contact a doctor by phone would make “the patients feel much safer” female 86 said. This would also make it possible to decide what the patient should do when they arrive which would make the visit more efficient since there is lack of time during the appointments. Female 25 said “Being able to communicate with a person with the right experience enables the whole process to be more effective than when you get an appointment with a doctor who cannot directly help you and then get you a referral to go to the right one”. Male 43 said “I think as much as possible should be solved by telephone before you arrive at the health care center, so that you have something to discuss and also the doctor can ask if there is something the patient worries about before the appointment”.

- During the visit

**Patients’ preferences regarding content in communication**

During the visit the patients want to discuss about their symptoms and what could have caused them with the primary care, for the physician to be able to decide what has to be done. Female 69 said, “You should be able to communicate about everything” and “You tell the doctor about the problems you have and discuss together, and then the doctor decides what needs to be done”. The patients are overall satisfied with the communication during the visit, however there are two things they would like to change: having more time during the appointment, and also that the doctor listens to them carefully; because these are the main problems pointed out in the communication during the visits. The medical quality itself is seen as mandatory for the primary care to work properly.

**Doctors’ ability to listen and show interest**

It is important for the patients that the doctors listen carefully to what they have to say and also ask questions that they will proceed with. “Many times when I have been there, they have asked me if school was stressful and if it affected me, but they never proceed with it, which they should do if they think it is a reason for me being there” Female 24 said. The patients want the doctor to show interest in what they have to say, to give them advice, proceed with what is needed and prescribe the right medication. For instance some of the patients mentioned that when they came to the health care center with a cold or a fever that the physicians only said “Go home and take aspirin” and nothing more, and that they would rather not contact the primary care because they will not think it is important enough.
to get an appointment. It is very important that every patient gets in touch with a familiar doctor, so there is no lack of confidence, information, misunderstanding etc. “It is very important that I have the same doctor every time so that I don’t need to repeat myself” Male 43 said. “We have been very unfortunate at our health care center, the doctors come and go which affect the medication quality” Male 60 said. It is clear that having the same doctor frequently makes patients more comfortable and it seems easier for them to receive the right treatment from the beginning. “Availability of course, I have had the same doctor every time and that is also important for me. It is probably the most important thing to me, so I do not have to repeat myself”, Male 65 said. It was also mentioned during the interviews that the language is important for the communication and the primary care should be multicultural with many languages, without the non-Swedish speakers suffering. Personal contact is also important for many patients, for them to be able to feel comfortable talking about sensitive things and for the patient to feel like a person, not like it is a mechanical or business thing.

 Longer appointments
The patients wish to have more time during appointments. They feel like the time affects the communication and that the doctors do not ask all questions that are needed since the time is not enough to go through everything. Female 24 said, “More time for every patient, you should not have to feel stressed when you are there, that they treat you well and that they answer your questions”. “I started to bring notes with all questions I wanted to ask the doctor before the meetings because of the impossible communication system. And even when I prepare there is not enough time” Female 69 said.

• After the visit
Feedback
Some patients expect “Clear feedback about every measures taken and what it has resulted in” Male 43 said. The patients find it important to get feedback whether it is good or bad news. They need to have in mind that they are working with people. Male 43 said, “For them it is not important since there is nothing that has to be done, but wait, it is a human they need to give feedback to”. The doctors must not forget that they are working
with humans that have feelings and worries, rather than working with something mechanical for instance.

Communication channel
The patients would rather get results in a way where they can ask questions back if needed. When they send a letter, it is hard to ask questions about it as you have to try contacting them again. A communication where it is possible to ask questions back easily is desired. Suggestions were made by patients, for the health care to have a mail system where you can reply, or a specific telephone number on the letter they send that they can call without having to wait in a telephone line, or have them calling you back afterwards to have an answer right away by someone experienced enough to give you the right answers.

4.3 Patients’ attitude towards a future digital system to manage communication

- Patients’ attitudes and ease to communicate about uncomfortable topics
The patients’ attitudes towards the use of untraditional methods differed from person to person. Some felt like it was not for them, because it might reduce the personal contact; and some others were totally positive or willing to use both. Male 43 said: “If I was to discuss sensitive topics, I would rather have a personal contact in some way, so I can guarantee who I have in front of me instead of having a computer doctor who I do not know”. Two other respondents also preferred discussing uncomfortable topics in person, Female 86 said, “I prefer in person” and Male 24 said, “I prefer in person, you cannot discuss uncomfortable topics through the Internet”. There were also some patients who were overall negative against using computer. Male 77 said “I can not handle computers, paying bills with the computer is more than enough”. As mentioned earlier, there were also respondents who thought an online tool could be preferred when discussing uncomfortable topics. For instance, Female 24 said, “I think it can be preferred with an online tool sometimes since you don’t always feel comfortable sharing things”. Some respondents did not have a preference regarding the communication channel. Male 73 said: “Both options would be as good as the other one”.

Technology as a complement to the healthcare communication

During the research, a few of the patients were strictly negative towards using technology as a complement to the healthcare communication; while many were positive as long as it is used only as a complement and the personal contact still remains. Male 24 said: “Positive, since the world is moving forward and I think the better development the primary care has in technology, the faster the process will go and they will be able to solve the problem faster”. Female 24 suggested that it is a good solution if you live far away, “Sounds good, especially if you live far away from the health care center and you are very sick and do not have the energy to get to the health care center”.

One of the respondents had experienced using technology before and said “I am diabetic and there is a system today but it is rarely used” (Male 65). Male 60 said “It is good if it works” with the technologies weaknesses in mind. Some of the respondents thought that it was suitable occasionally. For instance, Female 69 said “There is nothing wrong with using technology. It depends what it is about, sometimes in person and sometimes through an online tool”. One of the respondents was very positive towards using technology as a complement. Female 86 said “I can’t, but as I understand it is very positive being able to communicate through technology”. As mentioned earlier some respondents were strictly negative. Female 78 said “I do not like that, I want human contact”.

5. Discussion

This study’s aim was to explore patients’ previous experiences of, and preferences concerning communication with primary care, as well as their attitude towards a future digital system to manage communication. As a reminder, the 3 theories chosen as a base for this study, aim towards innovation, service improvement, a better efficiency and improved solutions for the user’s future interactions with the service organization. The authors goal was to identify some critical incidents during the service encounters through the interviews they conducted, as well as the patients’ readiness to accept and use technology to improve the communication between physicians and patients. This way, the authors could bring some feedback from the patients’ point of view to SKL, specially regarding patients’ experience of the primary care system in Sweden and their preferences regarding the current communication, as well as their views about a new communication tool. These insights could help SKL to improve the existing system and to better design the communication tool they want to implement. In this part, some answers to the research questions will be given in correlation to the theories exposed earlier.

- How do patients experience the current communication with primary care?

- What are patients’ preferences concerning communication with primary care, before, during and after the appointment?

The answers to the 2 previous research questions are detailed in the Findings section and in the following table. The following Table 2 (Summary of findings) includes the previous findings overall ideas sorted by the experience and preferences of the patients before, during and after their medical appointment and the possible solutions that could remedy to some of their dissatisfactions. The columns of experiences and preferences contains only content from the patients’ interviews, while the column exposing the possible actions propose ideas both from the patients’ interviews and the authors suggestions regarding the results of the study.
### Table 2. Summary of findings

<table>
<thead>
<tr>
<th></th>
<th>Experiences</th>
<th>Preferences</th>
<th>Possible actions</th>
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<tbody>
<tr>
<td><strong>Before</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Difficult to get an appointment</td>
<td>Getting in touch with the health care (same day appointment and longer opening hours)</td>
<td>Improve existing appointments booking; or add a tab to the online tool</td>
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<tr>
<td></td>
<td>Hard process of getting in touch with the health care</td>
<td>Rules for the content in the communication exchanged through the phone</td>
<td>Staff should announce their names and titles when answering the phone</td>
</tr>
<tr>
<td></td>
<td>Difficult to get in touch with a doctor</td>
<td>Possibility to communicate with a doctor through telephone</td>
<td>New position created for a doctor to answer phone calls</td>
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<tr>
<td><strong>During</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Lack of time</td>
<td>Longer opening hours</td>
<td>Lengthen opening hours or Have a physician on duty or Take turn between the neighbor centers to have one making a permanence for the others</td>
</tr>
<tr>
<td></td>
<td>Doctors’ unequal abilities to listen and show interest</td>
<td>More time during appointments</td>
<td>Physicians’ education should be complemented with specific training focused on communication skills</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patients’ preferences regarding content in communication (communicate about everything)</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Doctors’ ability to listen and show interest</td>
<td></td>
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<tr>
<td><strong>After</strong></td>
<td></td>
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<tr>
<td></td>
<td>Hard to get feedback on non-alarming results</td>
<td>Receiving every results after medical visit and analyzes tests</td>
<td>Implement new channels for questions regarding results through: Mail; Emails; a Special phone line; or an Additional interactive tab in the communication tool</td>
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<tr>
<td></td>
<td>One-way communication</td>
<td>Communication channels to be revised</td>
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The previous results confirm an existing flaw in the communication process between patients and primary care centers. The principal factors that were pointed out were the difficulty to reach a doctor, the importance of the attitude of these latter during consultations and the limited time for each appointment.

The findings show a mismatch between the current situation and some patients’ preferences. For example, patients said they are discontent with the duration of the appointments, as the limited time did not allow them to go through everything they would have liked with the physicians. The length of the visits has to be controlled to allow a better efficiency of the health centers. The health care system set up that rule to allow to the maximum of patients that booked an appointment to be auscultated. And it seems hard to reshape the system from its bases. Moreover, regarding how the organization structures the communication, it is hardly possible for the patients to access to a cost-effective communication with their primary care center. Which made some patients wonder if the primary care service was designed for the organization’s interests more than for the patients’. It seems that some patients experience the primary care as a non patient-centered service. Therefore, a number of solutions that could be adopted are proposed, including the implementation of the new online communication tool for the patients to provide important information before medical visits.

The results obtained by the authors of this study in Sweden confirmed the same observations made by Coulter (2005) and Rosenstein (2012) in both the UK and the US about patients’ dissatisfaction regarding the communication skills of their physicians. Patients’ impression of doctors’ communication shortcomings exposed by Levinson et al. (2010) were confirmed by the interviews as well. The results have shown that the doctor’s way of communicating is crucial in order to have an effective communication. Which means to have the skills to adapt to different responsiveness, knowledge and awareness of one’s way of talking and listening (Schirmer, 2005). The results of the interviews described both physicians who were dedicated to listen to their patients, and physicians who were not. The patients having doctors who were dedicated to listen felt like the communication was more effective. In cases where patients felt the doctors were not dedicated to listen, they said it affected the communication as a whole and also their
perception of the overall quality of the care. As earlier mentioned the “touchpoints” are determinants since they define the whole customer experience (Payne, Storbacka, and Frow 2008; Texeira et al. 2012). In this case, it is very important that the physicians have good communication skills for the patients to have a good experience of the service. Which also validates Schirmer’s theory (2005) regarding the physicians’ need to have competence in communicating to be capable of performing effectively in medicine. For the communication to be effective, the physicians need to know how to individualize it, since effective communication differs with different patients. As Schirmer (2005) pointed out, physicians need to have competences in communicating effectively with their patients. Both the importance of having a patient-centered behavior and of letting the patient lead the conversation pointed out by Beck et al.’s (2002) were highlighted by the patients during the semi-structured interviews. The results of this study showed that patients’ level of comfort rely heavily on their perception of the physician’s behavior towards them. Patients want to discuss about their symptoms and what could have caused them with the primary care staff. As Female 69 said “You should be able to communicate about everything”. Patients declared to feel more comfortable to talk about everything during appointments as frequently have the same doctor, and it seems easier to receive the appropriate treatment right away since the doctor already knows its patients and their singularities. Some patients said personal contact also played an important role in making them feel more comfortable. As a result, one of the authors’ suggestions relate to including specific teaching about communication in the physicians’ education (Levinson et al., 2010).

The customer journey mapping helps to map the “touchpoints” of the service system and overall user’s experience during their customer journey (Zomerdijk and Voss, 2010). The results of this research display flaws in the very first “touchpoint” with the primary care, which is when the patients contact the primary care to book an appointment. When doing so, the patients have to call during a short timespan in the morning. They perceive that as a service designed for the primary care instead of a service designed for its patients. There were also patients who experienced having to call 4 times to finally get an appointment. Each of these “touchpoints” is determinant and needs to be considered when designing a service since it will define the customer experience (Payne, Storbacka, and Frow 2008; Texeira et al. 2012). Because of the way the service in the primary care is
designed today, the first “touchpoint” will affect the experience of the service negatively for a majority of patients. Moreover, even if they would prefer to do so, the patients are not given the opportunity to communicate with a doctor before the visit. This results in patients getting an appointment when it is not always necessary.

It was also said that the primary care communicates through letters announcing the results of the health analyzes after appointments at the primary care centers. This makes it impossible to ask counter questions about these results. The patient-centered approach works towards physicians appreciating the perspectives, values and needs of the patients (Levinson et al., 2010). The primary care has to appreciate the patients needs and meet them. In this case, the patients inquire for a communication designed to have the possibility to ask questions back. Many of the patients ask for answers even if the results are positive, which today is not part of the service the primary care offers. This is one additional “touchpoint” (Payne, Storbacka, and Frow 2008; Texeira et al. 2012) that could be implemented to meet the patient’s needs, in order for them to have a better experience of the primary care service.

- What are patients’ attitudes towards sharing information using a future digital system to manage communication?

A quite positive reception of the new project was observed over a sample where the 20 respondents’ ages where between 21 and 86; knowing that 8 of them were over 60 years old. These characteristics can be found in the Method section, Table 1 (Patients’ characteristics table). It was found that, to discuss sensitive subjects, the majority of patients preferred a face-to-face interaction than a computer interaction; but were not opposed to the use of the online tool as a complement to personal interactions with the medical staff. Some did not have a preference. One 24 years old even said he would rather use a computer. However, only a few elder people rejected the idea of using technology to improve communication, because they were sometimes not able to deal
easily with technology. These results are promising for the adoption and use of the online tool by the patients as a complement to communication in the future.

The overall attitude was positive as long as the new communication tool was implemented to improve the communication and not to decrease, nor replace personal interactions. Some patients also pointed out that it was a good solution for people living far away from the primary care center, and that the health care system should go forward and evolve with technology to improve its outcomes.

Moreover, this communication tool can contribute to the psychosocial talk behavior – defined as: physicians who addressed problems of daily living, social relations, feelings and emotions of the patients – proposed by Beck et al. (2002). Patients using the tool will help the health care center gather their personal insights that will be taken into consideration during the following appointments without having to discuss them again. The communication tool can as well serve as a way to bring physicians a constructive feedback on their performances and may reveal some needs for improvements (Levinson et al., 2010). It was the case in this study when interviewing the patients about their experiences and preferences regarding the health care centers at different stages in time; however, the communication tool would allow a direct feedback to the health care centers themselves, and permit a much more targeted issues solving process.

Both Payne, Storbacka, and Frow (2008) and Teixeira et al. (2012) pointed out the importance of mastering the customer experience when designing a service. Users’ participation in public service design projects enable relationship development and an understanding of the users’ everyday activities. This way the critical incidents can be identified and controlled for an optimum service quality (Trischler & Scott, 2016). As the communication tool will complete and broaden the existing health care service, the understanding of the customer journey is of tremendous importance. Hence the focus of this study on the customers’ experiences and preferences, before approaching the subject of the communication tool.

However, as McColl-Kennedy et al. (2012) pointed out, there are different types of styles of value co-creation practices for the patients. Meaning that, in parallel with their
communication skills, the physicians should be aware that different patients can have different profiles, and thus, different expectations. While both team management and partnering styles should be encouraged in the healthcare because of their valuable outcomes on the other patients and their surroundings; the other profiles of insular controlling, pragmatic adapting, and passive compliance would not like to be forced into more activities and/or interactions they do not think they need. In the case of this study, the great majority of the patients interviewed underlined how important human interactions are to them and the importance for them to know they can contact doctors easily. Patients said they were interested in the new IT-system; however, the authors feel like it is not the priority compared to the healthcare improvements the patients suggested. Maybe the patients want something else than what SKL thought, or at least they see other things to be fixed first. One suggestion would be for SKL to allow the patients to interact with doctors through the new online system, and implement the corresponding positions with healthcare centers’ organization to answer to this need they have.

5.1 Unexpected facts and Proposed solutions

Some of the findings surprised the authors during this study. For example, only doctors were pointed out during the interviews when questions were asked about the primary care’s staff, nurses or physiotherapists were hardly or not mentioned at all. Also, the authors found surprising that, when talking about the communication physician/patient, many patients both declared that they would talk about everything with their doctor, but also that their ease talking about everything would be determined by the doctor’s attitude, personality and skills. This seemed a bit contradictory. The authors think it might be explained by the fact that the patients are conscious it is important to talk about everything that could be useful to the doctor; however, they sometimes need some encouragements before they can talk openly. And finally, in the beginning of the study, the authors thought it would be interesting to focus specifically on the content exchanged between patients and their healthcare centers. However, even being aware that it was totally anonymous, during the interviews patients hardly gave concrete examples of the content exchanged at the different “touchpoints” with the healthcare centers. They were also very evasive about the symptoms or reasons that made them book an appointment in the first place. This lead the
authors to redirect their analysis differently, only based on the research questions, so that the results would still be of interest for SKL.

5.2 Conclusion

This study relied on the concept of co-creation to get insights about possible improvements that could be made in the health care service. The interviews conducted by the authors provided lots of useful data that can serve SKL to improve the existing system and better design the new tool to come. As Elg et al. (2012) pointed out, individual experiences matter; especially when talking about co-creation and service design. The feedbacks given by patients relating to their experience of the service contributed to get several insights from different points of view. The results align with the co-creation of value of Vargo and Lusch (2008) and the co-creation for others (Witell et al., 2011), as the analysis of the interviews of only a few patients lead to some possible solutions that would beneficiate to a large number of patients of the primary care in Sweden. The final aim is for the health care service to reach a better performance and move towards innovation (Osborne et al., 2014). This study permitted to discover some possible improvements in the current primary care system that could be made to adapt more to the patients' point of view and needs. These are detailed in the column called “Possible actions” of the previous Table 2 (Summary of findings) and consist of the following propositions:

- Physicians’ education should be complemented with some specific training focused on the development of their communication skills.

- Healthcare centers should have longer opening hours, have a physician on duty, or organize turns between the neighbor centers to always have one of them making a permanence when the others are closed.

- Improve the existing appointments booking process, or add a function to the online tool to facilitate the procedures the patients have to go through.

- Have the possibility to get in contact with a doctor through the phone, or allow them to interact directly with the patients through the new online platform. And/or at least, to have the staff present themselves and their title clearly at the beginning of every phone call.
Patients should get feedback concerning health analyzes results anyway whether it is good or bad news and some communication channels should be implemented for follow-up questions by mail, emails, a specific telephone line, or through an additional interactive tab in the online communication tool platform.

This online communication tool intended for the Swedish public health service is on a promising path to be tested and launched across the primary care centers of the country. Regarding the tool, the flow of information would need to be treated and processed efficiently in the system to allow an effective use of only the useful and determinant information by the primary care staff. If it is previously sorted out, referenced and categorized, the time spent to check on the patients’ personal information would allow the physicians to keep up with the tight timing, and even to save them time because they would not have to ask extra questions to which they already would have the answers. Through this study, it seems that this communication tool would lead to an innovative way to access and use health related information, remedy to some of the critical encounters observed along the customer journey and make the health care system more effective globally.

5.3 Delimitations and Future research directions

The study’s scope is based on the communication in the primary care. This choice was made since researching on all of the health care in Sweden would be too wide and the different departments also work in different ways. The primary care has a more recurrent contact with the patients. The communication between the patients and the doctors in the emergency care differs from the communication in the primary care and what the patients want the communication to be like and about.

About the scale of this study, the sample of 20 people was taken out of 13 random primary care centers inside Sweden, and the patients were interviewed on a voluntary basis. However, this exploratory study allowed the authors to get enough insights to answer this study’s research questions and identify determinant encounters that will be useful to the Swedish county councils and municipalities organization (SKL) that is willing to make
improvements, as well as investigating the technology acceptance of their new communication tool project by the Swedish patients.

If the time had allowed it, a quantitative study would have been a good complement to the qualitative interviews especially regarding patients’ attitude towards the concept of a future digital system as a complement in the communication. The next step would be to investigate at a bigger scale, over a more representative sample, to be able to provide more relevant results and confirm or not the trends the authors identified. During the development of the communication tool, these results could have an influence on the project progress when taken into account by the company.

Then, a pilot study should be organized. Some trials of implementation of the communication system should be done in some health care centers, with analysis of the reaction measurements observed both from patients and primary care staff. Before a complete launch of the new communication system, it seems appropriate to do it at a smaller scale to evaluate its performance and benefits to the health care centers’ professionals and patients.

After the launch of the communication system at a national level, it will be necessary to keep track on the feedback and level of use of the communication system by the professionals and patients. This will constitute the operational support allowing maintenance and improvements of the service after it’s public launch.

At a much bigger scale, this system could be beneficial to the health care system of different countries. A research regarding the compatibility to their organization of the healthcare service, and also a research similar to this study regarding the patients’ attitude towards its implementation, could be made.

The authors believe it would be fruitful to use technology to offer the best service possible in the health care in general. It would help in providing an overall better performance of the health care service, as well as a better care for the patients.
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7. Appendix

7.1 Questionnaire

Introduction about the project:

In today’s health care one of the biggest shortcomings and especially within the primary care is a lack in the information and communication. Thereof it is very important that the patient is satisfied with the communication and all current problems are discussed to avoid that the patient experience deficiencies in the communication.

Our goal is to explore patients’ previous experiences of, and preferences concerning communication with primary care, and specifically the content of the information exchanged, as well as their attitude towards a future digital system to manage communication.

Thank you for participating in this study. Also, all information you will provide us will be used internally and kept anonymous.

Interview questions:

Experiences:

1. Can you describe your communication with the healthcare center before going there, during and after the meeting?
   - What could be better?
   - How was the response?
   - Is there anything in your past contacts that you have experienced as unnecessary? For example, any matter or action.
   - Who communicated with you, about what, how did you experience it? (Before, during and after.)

2. To what extent could you influence what the discussion was about?
- Was there something you wanted to say but didn’t get the opportunity to say it?

3. Do you think the doctors know enough personal insights about your daily life, symptoms and feelings?
- Have there been things in life that are important/matters to you, but you still don’t share it with the health care? Specify which!

Preferences:

4. If you had the opportunity, what would you want to communicate about before, during and after your visit/contact?

5. What do you feel comfortable to communicate about, or not (alcoholic, sexual diseases, etc.)?

6. What is your attitude towards talking about what your goal/forecast concerning your health and illness/illnesses?
- Is there a difference if the prognosis is good or bad?

7. What is important to you in contact with the Primary Care? (Accessibility, personal contact, security, medical quality, etc.)?

8. What are you missing in your current contacts with primary care? (Info, control over the planning, forecasting, side effects, personalization, fixed contact? Communication, times, etc.)

Attitudes:

9. What is your attitude towards the use of untraditional methods, to measure and evaluate the severity of your symptoms?
- Such as questionnaires on different symptoms, own measurements at home for a period, etc.
10. Would it be easier for you to communicate, about the previous uncomfortable topics that you mentioned, with the online tool or in person at the health center?

11. What is your attitude towards using technology as a complement to the healthcare communication?
   - Deal with machines/less humans contacts, or safety of personal information online. (Technology readiness).

12. Is there anything else that you want to pick up on the health center/patient communication theme?