



BMJ Open Patient, carer and healthcare professional experiences of complex care quality in multidisciplinary primary healthcare centres: qualitative study with face-to-face, in-depth interviews and focus groups in five French multidisciplinary primary healthcare centres

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ABSTRACT

Objectives To explore care experiences in multidisciplinary primary healthcare centres from the patients, carers and healthcare professionals perspectives.

Design This qualitative study used face-to-face, in-depth interviews and focus groups. Patients with multimorbidity monitored by a General Practitioner (GP) and another professional from the health centre were recruited through purposive sampling and included with their carer. They were interviewed together while professionals were interviewed separately. Verbatims were coded with subsequent blind analysis, using an inductive approach, to find aspects and features. The constant comparative method highlighted data consistencies and variations.

Participants Twenty-six patients, 23 family carers and 57 healthcare professionals.

Setting Five multidisciplinary primary healthcare centres, in France, between March 2017 and December 2018.

Results This unique study grouped perspectives into nine core quality of primary care aspects: having accessible, available, and varied care; feeling welcome and enjoying comfortable, well-equipped, and clean premises; having quality medicotechnical care (medical knowledge and technical skills); having a reliable GP; receiving appropriate care from healthcare professionals other than the GP; maintaining an efficient relationship with healthcare professionals; benefiting from organised and coordinated care; being an informed, supported and involved patient; having an informed, supported and involved carer. New areas of interest include the multidisciplinary nature of the centres, appreciation of other professionals within the centre, medicotechnical dimensions of care and the carer's role in maintaining patient autonomy.

Conclusions This is the first study to interview patients and carers alongside healthcare professionals. This enhanced knowledge improves understanding of these

Strengths and limitations of this study

- This is the first qualitative study to explore care experiences in multidisciplinary primary healthcare centres from the patients, carers and healthcare professionals perspectives.
- The appreciation of other professionals, besides general practitioners, was explored for the first time.
- Four members of the research team conducted blind analysis of the codes using an inductive approach in a content analysis perspective.
- The constant comparative method was used to highlight data consistencies and variations.
- This study provided a new perspective by interviewing carers alongside the patient and healthcare professional which has not been done before.

aspects and can guide implementation of evaluation tools that truly reflect patient and carer needs and enable an efficient experience in terms of quality. To address deficiencies in existing questionnaires, the new perspectives found will be added to former aspects to create a comprehensive quality of primary care evaluation tool.

Trial registration number NCT02934711, Results.

INTRODUCTION

The increased prevalence of multimorbidity is associated with medical advances, an ageing population and lifestyle risk factors.^{1 2} Providing effective healthcare for patients with multimorbidity is a global challenge and an increasing priority.³ Carers, often a family member, play a central role in

patient care alongside healthcare professionals (HCPs) and patients. They are involved in decision-making, monitoring treatment adherence and coordinating care⁴ but are often overlooked. Nevertheless, healthcare systems are slowly shifting away from disease-focused models to chronic disease management models that are centred around patients and carers.⁵ General practitioners (GP) manage these complex cases and their associated social and psychological problems using a holistic approach.⁵ Multidisciplinary primary healthcare centres (MPHCCs) could therefore provide the best care for these patients with multimorbidity.^{6–8}

In France, GPs are considered to be the cornerstone of the healthcare system. Patients are free to choose their GP and GPs are able to organise their practices as they see fit. Different configurations exist including single professional practices with one or multiple GPs in one centre or multidisciplinary centres.⁹ For several years, the French Health Authority (HAS) has financed multidisciplinary centres¹⁰ and therefore monitors their productivity and economic value closely. However, the HAS recently concluded that quality of care and patient experience in these centres should also be assessed.¹⁰ Assessing patient care experience may be an important element in understanding the relationship between multimorbidity and the quality of care that healthcare systems deliver. Patient experience is defined as the sum of all interactions influencing patient perceptions across the continuum of care, and is increasingly recognised as one of the three pillars of healthcare quality alongside clinical effectiveness and patient safety.¹¹ Patient experience is also considered the most effective quality measure of patient centredness, which is defined as providing care that is respectful of and responsive to patient preferences, needs and values.¹¹ When patient experience is positive, health outcomes improve with better patient behaviours, treatment adherence and healthcare resource use.¹¹

To measure multidimensional patient experience, a robust, reliable, valid and responsive instrument is required which assesses all quality-of-care dimensions. A systematic review (submitted for publication) conducted by these authors revealed that numerous instruments are available,^{12–15} but they have many deficiencies including insufficient quality and psychometric properties, heterogeneous construction which does not cover all aspects of primary care, poor validity and feasibility, inability to measure change and wide variability. Furthermore, many of them measure patient satisfaction which provides a limited view of care as an experience and does not enable potential improvements to be assessed. Furthermore, few studies have focused on both patient and carer experiences, most focus on either patients or GPs.^{16–18} A previous systematic literature review revealed that no studies explored the patient, carer and HCP perspective regarding quality of care^{19 20} and no instruments exist which examine the carer experience alongside that of the patient and HCP or assess the patient's role in managing their condition. Yet to fully understand the management issues and appropriately address and improve quality of care in MPHCCs, all stakeholders in patient care must be involved.

Patient care experience is increasingly seen by healthcare providers, administrators, policy-makers and patients themselves as a judgement of quality,²¹ where negative evaluations indicate the need for improvements. Patients have important insights into delivery of care that healthcare providers cannot assume. Healthcare providers often subjectively perceive the patient's needs and experiences and these perceptions can prove incorrect. Systematically gathering information on patient needs and experiences, using methodologically sound instruments such as validated questionnaires, should therefore be an integral part of routine primary care.²²

This study aimed to explore care experiences in MPHCCs from the patient, carer and HCP perspective. The aspects found during this study will be used in the next phase of the project to create a patient reported experience measurement tool to address the deficiencies present in existing instruments.

METHOD

Design

This qualitative study was performed in five MPHCCs, in France, between March 2017 and December 2018. The study was designed by a team of senior researchers in sociology and primary care.

Face-to-face, in-depth interviews were conducted with patients and carers together and HCPs separately. An additional focus group to discuss the centre's organisational structure was conducted in each MPHCC (including at least the GPs and nurses).

Sample

Participants were recruited through purposive sampling. Patients varied in gender, age, chronic conditions, HCP type and the presence or absence of a carer. Carers were invited to participate if they were currently supporting the patient. For HCPs, the goal was to include one representative from each profession per MPHCC. Patient, carer and HCP recruitment stopped at data saturation (regarding SRQR criteria (Equator)).

Patients with multimorbidity (at least two chronic conditions) who were monitored by a GP and another HCP from the MPHCC were included. Patients with a condition affecting cognition (Mini Mental State < 23) were excluded.

The GPs from each MPHCC approached patients meeting these inclusion criteria during their consultation. The investigator (GP or final year medical students) contacted the patient by telephone to explain the aim and focus of the research. HCPs were contacted by telephone or email. No-one refused to participate, and informed consent was signed by all interviewees.

Patients chose whether to be interviewed at home or in an MPHCC meeting room, while HCP interviews took place in the MPHCC. All interviews were conducted once face-to-face by an independent GP, assisted by medical students, and an independent sociologist (PhD), who

were of either gender, and all had experience in qualitative research and interviewing.

Interviews were only audio recorded and transcribed verbatim by a transcriptionist. Verbatims were returned to participants for approval.

Data collection

Two interview guides were developed by the research team: one for patients and carers (online supplemental data 1) and one for HCPs (online supplemental data 2). Prior to use they were tested between members of the research team to ensure they were easily understood. The interview guide has been adapted over the course of the first interviews. Interviews were conducted in French and translated by a native English speaker (Charlotte Wright BVM&S MRCVS DipTrans of Speak the Speech Consulting).

Patient and carer interviews lasted between 30 and 90 min, HCP interviews lasted between 26 and 120 min and the focus groups lasted between 90 and 150 min.

Field notes were made on the participant sociodemographic characteristics and MPHCC organisational structure.

Analysis

Two different researchers per MPHCC coded the verbatims. Four members of the research team conducted blind analysis of the codes using an inductive approach in a content analysis perspective^{23 24} by reading the text and organising it into core categories. Results were pooled and emergent categories pertaining to aspects from the patient and carer perspective were discussed. The coding book was regularly presented and discussed with the research team. Category denominations were refined, and disagreements were resolved consensually. A description was written for each aspect detailing the key features. Qualitative data analysis followed the coding paradigm of the grounded theory method. Open coding was conducted initially to break the textual data into discrete parts. Next, axial coding made connections between the codes and then selective coding was used to select one central category connecting all codes.

The constant comparative method²⁵ was used to highlight data consistencies and variations by looking for connections within and across focus groups, interviews and codes. HCP analysis was performed initially and then the patient views were mapped enabling direct comparison between the two. Five syntheses (two for patients and family carers, two for HCPs and one global) were issued by five senior researchers (two primary care researchers and three sociologists) working blind and pooling their data at each synthesis step.

We considered data saturation achieved when no new codes emerged from verbatim analysis. This occurred after the 55th interview and 4th focus group in the HCP group, and after the 24th interview in the patient and carer group.

RESULTS

Fifty-seven HCPs were interviewed representing 11 professions and 5 focus groups were conducted (table 1).

Twenty-six patient interviews were performed, 23 of which included a carer (table 2).

Nine core aspects were identified, each being relevant for both patients/carers and HCPs with some detailed nuances. Table 3 provides a summary of each aspect and its features.

Having accessible, available and varied care

Patients and HCPs highlighted that accessible care was an element of quality care. This starts with making an appointment. Patients preferred the physical presence of a receptionist as many felt uncomfortable with new technologies. Then, MPHCCs enable patients to have joint consultations with different HCPs in the same centre. Also, patients appreciated being able to group consultations on a particular day, which limits the number of times the patient visits the centre. Offering home visits for those unable to travel was also important.

Feeling welcome and enjoying comfortable, well-equipped, and clean premises

Patients appreciated well-maintained premises with a welcoming receptionist and entertainment in the waiting room. They emphasised the importance of soundproofed rooms and a layout to guarantee confidentiality, especially for psychologist consultations. HCPs reiterated the importance of confidentiality.

Having quality medicotechnical care (medical knowledge and technical skills)

Staying at home, or reducing the need for medication or hospitalisation, were major concerns for patients. HCPs discussed complementarity of the different professions, which is essential for comprehensive and effective patient care.

Patients stated that the speed and quality of diagnosis, and therapeutic management were important. HCPs stressed the importance of following recommendations and updates.

Patients highlighted that a dynamic GP performing diagnostic re-evaluation, further examinations, and monitoring chronic conditions improved quality of care. When the diagnosis was in doubt, patients appreciated undergoing further examinations, being referred quickly to a specialist, and being informed rapidly about the results.

HCPs mentioned equipment being available within the MPHCCs for managing life-threatening emergencies and stated that effective care should also reduce emergency service use. Patients pointed out the lack of physical therapy equipment.

Having a reliable GP

Patients valued thorough clinical examinations and other GP skills including knowing about the patient and their preferences, beliefs, wishes, and their medical, social, and family history.

Table 1 Healthcare professional characteristics

	MPHCC no. 1	MPHCC no. 2	MPHCC no. 3	MPHCC no. 4	MPHCC no. 5	Total
	n=12	n=13	n=12	n=9	n=11	n=57
Age						
20–39	7	5	6	6	5	51%
40–59	3	6	6	3	6	42%
≥60%	2	2	0	0	0	7%
Sex						
Female	7	10	8	7	7	68%
Male	5	3	4	2	4	32%
Profession						
General practitioner	4	4	2	5	4	33%
Nurse	1	4	3	1	1	18%
Physiotherapist	1	1	2	0	1	9%
Psychologist	1	0	1	2	1	9%
Podiatrist	1	2	1	0	1	9%
Speech therapist	1	1	1	1	1	9%
Psychomotor therapist	0	1	0	0	0	2%
Dentist	2	0	0	0	0	3%
Dietician	0	0	1	0	0	2%
Midwife	1	0	1	0	0	3%
Pharmacist	0	0	0	0	2	3%

Furthermore, GPs helping with administrative tasks such as completing chronic condition applications (providing 100% reimbursement for any treatment linked to the condition), applying for transport vouchers, and making appointments with specialists or other medical professionals was appreciated. However, HCPs did not mention this.

Receiving appropriate care from HCPs other than the GP

Patients and HCPs mentioned the competency of HCPs other than the GP. It was mainly reflected in the nurses' consideration of pain and cleanliness.

Respecting protocols was particularly important for HCPs. Patients focused on the importance of the other HCPs respecting prescriptions, monitoring their condition, and keeping the doctor informed and updated. This was reiterated by the HCPs.

Maintaining an efficient relationship with HCPs

Both patients and HCPs explicitly highlighted the central role of an efficient HCP relationship as a key element of quality care.

Patients and HCPs agreed on the need for a trusting relationship, which HCPs felt was promoted by working in a common care structure. This trusting relationship seems to be based on listening carefully to one another, paying attention to the patient, and communicating easily. In addition to attentive listening, patients also described the importance of empathy, respect and ensuring both

the patient and carer are given the same information without contradiction.

Importantly, HCPs described the way communication had changed since working in an MPHCC, particularly the ease of obtaining a colleague's opinion and the opportunity to approach things differently to provide patients with quality care. This concept was not described by the patients.

All participants highlighted the importance of maintaining and respecting confidentiality, particularly within the secretarial office, and respecting the patient's consent to share information about them within the MPHCC.

Benefiting from organised and coordinated care

Patients and HCPs agreed on the importance of continuity of care within the centre, underpinned by easily shared medical files, secure messaging, or report books at home—all of which are elements of quality care.

Although HCPs insisted on the permanence of care, which they felt was improved by creating MPHCCs with substitute doctors available in cases of absence, they emphasised that patients preferred stable follow-up with the same doctor and mentioned that some patients struggled to adapt if the HCP changed. Patients and HCPs wanted more continuity of outpatient care within the centre.

Participants agreed that coordinated care, made possible by interprofessional communications or multi-professional consultations was necessary. HCPs described

Table 2 Patient characteristics

	MPHCC no. 1 n=3	MPHCC no. 2 n=6	MPHCC no. 3 n=6	MPHCC no. 4 n=5	MPHCC no. 5 n=6	n=26
Age						
<50	0	1	1	2	3	27%
50–74	2	3	5	1	1	46%
≥75%	1	2	0	2	2	27%
Sex						
Female	2	2	2	4	3	50%
Male	1	4	4	1	3	50%
Chronic conditions						
Cardiovascular diseases (ischaemic heart disease, diabetes, high blood pressure, high cholesterol, arteritis, etc)	1	4	3	2	4	54%
Mental health (dementia, anxiety, depression, etc)	0	0	1	2	0	12%
Neurological handicap (stroke, learning disability, epilepsy, etc)	1	3	3	1	3	42%
Rheumatic disease (osteoarthritis, polyarthritis, etc)	1	2	3	2	3	42%
Skin diseases (ulcer, eczema)	1	0	1	0	1	12%
	N=3	N=6	N=5	N=3	N=6	N=23
Carer						
Husband	1	4	5	1	4	65%
Children	0	1	0	1	1	13%
Parents	2	1	0	1	1	22%
Healthcare professionals treating the patient						
General practitioner	3	6	6	5	6	100%
Nurse	3	3	5	2	3	62%
Physiotherapist	3	6	6	2	2	73%
Psychologist	2	0	0	3	0	19%
Podiatrist	2	4	2	1	0	35%
Speech therapist	1	2	0	1	1	19%
Psychomotor therapist	0	1	0	1	0	8%
Dentist	1	0	0	0	0	4%
Dietician	0	0	3	0	0	12%
Midwife	1	0	1	0	0	8%

MPHCC, multidisciplinary primary healthcare centres.

learning to work together, for the patient, by sharing a common work structure, resulting in homogeneous discourse to promote therapeutic education and alliance. The patients also highlighted this notion, emphasising the benefits gained from the care protocols and pooling of knowledge.

Notably, patients felt this support was reassuring for HCPs, and, conversely, the latter found it reassuring for patients and their carers.

Despite patients and carers sometimes being unaware of the whole range of care the MPHCC offered, they emphasised the importance and advantages of this diversity, as did the HCPs.

Although HCPs discussed interprofessional relationships more, patients also valued them and felt they impacted their quality of care.

Being an informed, supported and involved patient

Patients, carers and HCPs all agreed that informing patients about their condition, treatments, outside help or discussions between professionals are essential elements of quality care.

Patients and carers particularly emphasised the psychosocial impact the condition has on the patient's life. This appeared to be a quality-of-care criterion and was based as much on the psychological repercussions linked to the

Table 3 Aspects and corresponding features

Aspect	Description	Features	Illustrative quotes
1. Having accessible, available, and varied care	This aspect refers to methods facilitating access to care and the availability of healthcare professionals	<ul style="list-style-type: none"> ▶ Easy to make an appointment with their GP ▶ Several ways to make an appointment (phone, internet) ▶ A physical reception is present ▶ The structure of care is accessible to all ▶ A lift is available Parking is provided close to the health centre ▶ Home visits can be made if necessary ▶ Travel is limited ▶ Group appointments are available ▶ Joint consultations are available ▶ The cost of care burden is limited ▶ Referral to a specialist is organised (for example, cardiologist, pulmonologist etc) ▶ The doctor is reliable. The doctor is available on the phone for advice and reassurance ▶ An effective direct communication system between the patient and their doctor is implemented ▶ Emergency consultation slots are available ▶ Consultations can be had without an appointment ▶ A locum is provided during absences ▶ Financially accessible care is offered 	<p><i>'When I found out that there was a physiotherapist, podiatrist, dietician and nurses I chose this centre, everything was in the same place.'</i> (PA1-289/291 MPHCC no. 3) <i>'Previously, we were with another doctor, but the problem was that he didn't do home visits and it was becoming more complicated for me to move so I was forced to change doctors.'</i> (PA1-218/231 MPHCC no. 3)</p>
2. Feeling welcome and enjoying comfortable, well-equipped, and clean premises	This aspect refers to the methods implemented to provide patients with a safe and friendly reception area when entering the health centre	<ul style="list-style-type: none"> ▶ Secretaries give patients a warm welcome ▶ Comfortable premises ▶ Quality sound proofing to ensure confidentiality ▶ Well-insulated premises ▶ Proper maintenance of the premises ▶ Clean toilets ▶ Patients offered something to do in the waiting room ▶ Magazines, music, entertainment ▶ Health information documents 	<p><i>'The secretaries are very nice, kind, they always ask how you are, they ask for news about the family and the children, we feel at home, we don't feel like we're bothering them.'</i> (PA2-351 MPHCC no. 2) <i>'The users, the doctors, the podiatrist, all of them... we found that we could hear everything that was happening nearby.'</i> (PA1-1139/1140 MPHCC no. 1)</p>
3. Having quality medicotechnical care (medical knowledge and technical skills)	This aspect refers to the effectiveness of care	<ul style="list-style-type: none"> ▶ The doctor makes an effective diagnosis ▶ Quick diagnosis ▶ The doctor is reactive in his care ▶ The doctor quickly informs the patient about requested examinations ▶ The doctor questions their diagnosis and treatments in the event of an unfavourable event ▶ The doctor establishes good follow-up ▶ The doctor offers regular blood tests ▶ The doctor relies on scientific evidence to suggest treatments ▶ Effective treatment Improved health status ▶ Improved quality of life ▶ Staying at home ▶ Reduced need for medication ▶ Hospitalisations avoided 	<p><i>'The care we provide is to make her feel better. We know that she can't be cured.'</i> (PA2-882/883 MPHCC no. 1) <i>'At times when she is not doing so well, during times of crisis, he often tries to change the treatment so she feels better. He also tries to adapt the treatment to (the patient)... he always tries to make things better.'</i> (PA2-888/892 MPHCC no. 1)</p>
4. Having a reliable GP	This aspect refers to the core competencies of the GP beyond medicotechnical skills	<ul style="list-style-type: none"> ▶ The doctor knows their patients well <ul style="list-style-type: none"> – Knows their preferences, beliefs, wishes – Knows the family and social context ▶ The doctor listens carefully to the problem presented by the patient <ul style="list-style-type: none"> – Shows interest and asks questions ▶ The doctor performs a careful examination ▶ The doctor offers patient-appropriate care <ul style="list-style-type: none"> – Based on their preferences, beliefs, and wishes ▶ The doctor is open to complementary medicines ▶ The doctor helps the patient with their administrative procedures ▶ The doctor helps making appointments with specialist doctors 	<p><i>'For me, the most important thing is having a doctor who knows their patient.'</i> (PA12-570/572 MPHCC no. 4) <i>'I think he consults better than Dr X, he examines everything, the whole body.'</i> (PA6-684/686 MPHCC no. 3)</p>
5. Receiving appropriate care from healthcare professionals other than the GP	This aspect refers to the technical competencies of healthcare professionals other than the GP	<ul style="list-style-type: none"> ▶ Healthcare professionals are careful to respect medical prescriptions <ul style="list-style-type: none"> – They adjust treatments according to disease progression ▶ They quickly refer to the doctor in case of change or doubt ▶ The nurse has good hygiene standards ▶ The nurse manages pain well ▶ The physiotherapist is motivating and encouraging 	<p><i>'He encouraged me, he gave me hope. And that's great. I continue to have physiotherapy with him. Because he told me it was important ... I stayed in bed for 3 weeks, I lost all my muscle mass, my thighs were ... So I need physiotherapy, and it makes me feel good. I feel that I still need it, in terms of my muscles.'</i> (PA3-362/366 MPHCC no. 1) <i>'When it came to the protocol for the pressure ulcers, they were very much in communication with Dr X.'</i> (PA1-488/490 MPHCC n°1)</p>

Continued

Table 3 Continued

Aspect	Description	Features	Illustrative quotes
6. Maintaining an efficient relationship with healthcare professionals	This aspect refers to the quality of the patient's relationship with their healthcare professionals: trust, loyalty, openness	<ul style="list-style-type: none"> ▶ Healthcare professionals listen attentively ▶ They do not interrupt; they take the time to listen ▶ They put the patient at ease <ul style="list-style-type: none"> – They ask questions on all subjects, taboo or not, without making the patient feel uncomfortable ▶ Healthcare professionals are respectful and empathetic ▶ Healthcare professionals tell the patient and carer the same thing and there is no contradiction between them ▶ Confidentiality is guaranteed ▶ Particularly by secretaries and receptionists 	<i>'Listening to one another is a good thing, being listened to is important to me'. (PA5-672/673 MPHCC no.2)'Maybe it was talking about it differently. After, if the patient doesn't want to... we may discuss it again regularly and explain the benefits. Or explain our expectations'. (PRO2-845/846 MPHCC no.2)</i>
7. Benefiting from organised and coordinated care	This aspect refers to the continuity of care within the centre, the coordination of care between all healthcare professionals and the permanence of care	<ul style="list-style-type: none"> ▶ The patient is treated by the same doctor over time <ul style="list-style-type: none"> – Another doctor is available if the patient's normal doctor is absent – The substitute doctor has the patient's medical files ▶ The paramedical team remains stable over time <ul style="list-style-type: none"> – They know the patient and their problems well ▶ Healthcare professionals communicate with each other to share information <ul style="list-style-type: none"> – They implement ways to pass on information (notebook, computer support, telephone call) – Information quickly goes back to the doctor ▶ Healthcare professionals hold meetings to discuss complex care cases ▶ Second consultations are offered ▶ The centre helps prevent medical desertification by attracting young healthcare professionals 	<i>'Each doctor actually has access to the file quickly when you speak to him about something, this is the advantage of this technique. He can quickly access and refer (to the medical records) and rapidly knows a little about the patient's health.' (PA4-151/157 MPHCC no. 2)'The positive aspect of having everyone under the same roof is that the doctors and nurses can very quickly meet up, see one another, question one another and support one another and I think that is very important'. (PA4-813/820 MPHCC no. 2)</i>
8. Being an informed, supported and involved patient	This aspect refers to how the patient receives the right information and is supported and involved in their care	<ul style="list-style-type: none"> ▶ Healthcare professionals keep the patient well informed <ul style="list-style-type: none"> – About their illness, prognosis, possible treatments – Healthcare professionals tell the patient the same thing, there is no contradiction between them ▶ Healthcare professionals support the patient <ul style="list-style-type: none"> – They ask questions about the psychological and social aspects of their health – They offer the patient a psychological follow-up – They inform the patient about possible support and help them put together applications for assistance ▶ The doctor involves the patient in decisions that concern them <ul style="list-style-type: none"> – Involvement varies according to patient preferences 	<i>Interviewer: 'Do you understand the purpose of the medical care and treatments you receive and the activities you are asked to do by physiotherapy for example?' Patient: 'Yes, I feel it is well explained to me'. (PA2-252/254 MPHCC no. 2) Interviewer: 'In your opinion, does the patient have a role to play in the quality of their care?' Patient: 'Yes, we must ensure we speak to our carers and ensure we are listened to. Trust cannot be one sided; it has to be given on both sides otherwise it cannot work'. (PA3-1008/1019 MPHCC no. 3)</i>
9. Having an informed, supported and involved carer	This aspect refers to how the carer receives the right information and is supported and involved in the care.	<ul style="list-style-type: none"> ▶ Healthcare professionals keep the family carer well informed <ul style="list-style-type: none"> – About illness, prognosis, possible treatments – Healthcare professionals tell the carer the same thing, there is no contradiction between them ▶ Healthcare professionals support the family carer <ul style="list-style-type: none"> – They ask questions about the psychological and social aspects of their life – They offer the family carer a psychological follow-up – They inform the family carer about possible support and help them put together applications for assistance ▶ The doctor involves the family carer in decisions that concern the patient <ul style="list-style-type: none"> – Involvement varies according to family carers 	<i>'Even when we have to be transported by ambulance to appointments at some clinics, the doctor ensures I go too so that I am present'. (PA5-315/319 MPHCC no. 2)'I tell her to take deep breaths, go out, take care of herself. These are somewhat general instructions to help her relax so that she does not become exhausted'. (PRO2-L318/319 MPHCC no. 3)</i>

Items in green are specific to patients/carers; items in blue are specific to health care professionals; items in black are common items. GP, general practitioner.

condition and the loss of autonomy as on the impact on housing and employment.

Carers also highlighted the importance of patient support and the need for psychological support, whether through referral for psychological treatment or the doctor providing it themselves. Patients emphasised the importance of implementing and reassessing home support workers, but HCPs did not discuss this concept as much.

Patients and HCPs agreed that a beneficial therapeutic alliance in which patients participate in their health through shared medical decisions and are involved in their treatments and future is essential. Patients felt that patient-centred care was essential with their wishes and needs being considered.

HCPs felt the objective was to help patients become independent, particularly through therapeutic education. Patients agreed as it allowed them to acquire knowledge and benefit from the group dynamics which are inherent in this form of practice.

Having an informed, supported and involved carer

HCPs and patients reported that carer involvement is essential. They agreed that considering the carer's opinion when discussing treatments or the patient's future was an essential element for providing quality care. Having the carer present during consultations or home visits was particularly important as was the carer's role in organising care, which is essential in home settings.



Patients and HCPs agreed on the value of the carer receiving information and therapeutic education to ensure coordinated care and on the importance of carer support. Patients emphasised providing psychological support and home help for the carer but HCPs emphasised the support provided through the multidisciplinary nature of the centre; a concept absent in the patient interviews.

Carers highlighted the repercussions that the patient's condition had on them, particularly the impact on their social life, hobbies, and daily living activities especially when the patient refused care. HCPs also discussed this.

The importance of providing information about financial support and help available to carers was only mentioned in the HCP interviews. The notion of carers trusting the HCPs emerged throughout the interviews.

DISCUSSION

Summary

This study provided a new perspective by interviewing and considering carers alongside the patient and HCPs which has not been done before. Our study highlighted some new areas of interest and features which have barely been described previously.^{19 26–29} These include MPHCCs enabling HCPs to have meetings quickly and easily and enabling patients to have joint consultations with several professionals at once. Furthermore, patients greatly appreciate the skills of other professionals within the centre, besides the GP. To our knowledge, no other questionnaire has explored these aspects relating to the other professionals. Organisational elements were also raised, possibly linked to the concerns about medical desertification.

Comparison with existing literature

Patients, carers, and HCPs agreed on all the aspects and their features but with slightly different perspectives. *Having accessible, available and varied care* was an important aspect for all participants, particularly patients, even though some mentioned it was occasionally difficult to see their GP outside of normal consulting times. Patients highlighted the importance of features such as drop-in consultation slots and a physical desk with a receptionist for guiding, directing and reassuring the patient. *Feeling welcome and enjoying comfortable, well-equipped, and clean premises* was also an important aspect for all participants.

For the aspects *having a reliable GP, receiving appropriate care from HCPs other than the GP and maintaining an efficient relationship with HCPs*, all participants agreed that the most important features were empathy, clear communication and confidentiality. This confirms what has been found in previous studies.^{28 29} Features highlighted as promoting good quality of care were communicating easily with HCPs, a relationship of trust and being a good listener.

The role of the GP is fundamental to ensuring quality of care,²⁹ while organised and coordinated care are

also essential.^{30 31} HCPs focused more on coordinated follow-up while patients and carers wanted stability within the healthcare team. However, this could be the same thing since coordination relies on stability. Patients with multimorbidity often require hospital care in addition to primary care thus excellent cooperation and coordination between hospital and primary care staff is essential to ensure quality of care. This is further enhanced by good coordination between the primary care team.³²

Every participant emphasised that patient and person-centred care were essential for quality which is consistent with a previous study.³³ However, the present study provides more extensive information than previous studies about the importance of providing patients and carers with appropriate medical information.^{28 34} Providing patients and carers with therapeutic education and ensuring they are informed, listened to, involved and supported in all aspects of care appeared essential and were extensively discussed. The common goal was ensuring patient autonomy through clear and consistent information. HCPs also emphasised the importance of support for carers.

There are few patient reported experience studies concerning the medicotechnical dimension of care so the present study provides a new perspective on this aspect which has not been previously described. It confirms that patients not only value HCP technical skills but also the human aspects including receptionist assistance, the doctors and nurses being good listeners and the physiotherapist giving encouragement. However, discrepancies concerning quality of medicotechnical care were revealed which is consistent with existing literature.²⁸ Specifically, HCPs insisted on evidence-based-medicine and recommendations whereas patients and carers looked for efficient care and improvements in their health.

Going beyond the data in the literature,³⁵ carers particularly highlighted their role. Previous studies have reviewed elements of the carer role but were mainly limited to providing information and support. The present study reveals information about their role in helping patients remain autonomous which supports concepts highlighted in recent scoping reviews.^{35–38} In complex care situations, carers are essential. They not only need to support and care for the patient, who is dependent on them, but also continue their normal social, family, and professional life. Once HCPs accept the carer role, they can fully engage in patient care. Carers improve the therapeutic relationship between the patient and HCP and sometimes enable patients to remain at home and avoid hospitalisations.

Prevention was never cited as important for quality of care in this study which contradicts data from the literature.³⁹ This may be because this study focused on patients with multimorbidity whose care focuses on management of their chronic condition rather than prevention. It could also be due to the absence of this specific point in the interview guide which concentrated on the patient and their condition, not public health. Prevention is

present in many quality of care scales and indices¹⁹ but was not identifiable in this study.

Strengths and limitations

This study did have strengths and limitations. Selection bias was limited through purposive sampling and participant diversity. Information bias was limited by the number of researchers, blinded analysis, data pooling within the research team and the mixed culture of a sociologist research team working with a primary care research team. Social desirability bias could have been present with participants providing information they felt was more desirable or acceptable rather than their true thoughts or feelings, possibly resulting in information loss. Information may also have been lost since patients and their carers were interviewed together so they may have been more candid. Confusion bias in this study should be minimal due to the multiprofessional nature of the interviews, the number of analysts and their perspectives and the mixture of individual interviews and focus groups. Interviewer bias may have been present as the interviewers were interested in evaluating quality of care and some interviewed HCPs had previously met the interviewers through their university roles.

Conclusion and implications for future research and practice

This study reveals that patients, carers, and HCPs share a common vision to improve the quality of primary care through nine core aspects. The present study is the first to present an exhaustive picture of HCP, patient and carer experiences. It also reveals new areas of interest such as features relating to the multidisciplinary nature of the centres, appreciation of other professionals within the centres, medicotechnical dimensions of care and the carer role in helping patients remain autonomous.

This unique study considered patient, carer and HCP experiences which provided a more comprehensive overview of these perspectives, thus enhancing insights from previous studies.

This enhanced knowledge improves understanding of these quality-of-care aspects and their associated features and can guide efforts to implement MPHCC evaluation tools that truly reflect patient and carer needs and enable an efficient experience in terms of quality.

Existing questionnaires all have deficiencies, and a robust, reliable, valid, and responsive instrument is required which can be used to evaluate and improve health service provision and quality. To address these deficiencies, the new perspectives found in this study will be added to former aspects to create a comprehensive quality of primary care evaluation tool aimed at improving MPHCC quality.

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REFERENCES

- 1 Le Reste JY, Nabbe P, Manceau B, *et al*. The European general practice research network presents a comprehensive definition of multimorbidity in family medicine and long term care, following a systematic review of relevant literature. *J Am Med Dir Assoc* 2013;14:319–25.
- 2 Nicholson K, Terry AL, Fortin M, *et al*. Prevalence, characteristics, and patterns of patients with multimorbidity in primary care: a retrospective cohort analysis in Canada. *Br J Gen Pract* 2019;69:e647–56.
- 3 Moffat K, Mercer SW. Challenges of managing people with multimorbidity in today's healthcare systems. *BMC Fam Pract* 2015;16:129.
- 4 Park M, Giap T-T, Lee M, *et al*. Patient- and family-centered care interventions for improving the quality of health care: a review of systematic reviews. *Int J Nurs Stud* 2018;87:69–83.
- 5 Bower P, Macdonald W, Harkness E, *et al*. Multimorbidity, service organization and clinical decision making in primary care: a qualitative study. *Fam Pract* 2011;28:579–87.
- 6 Doekhie KD, Buljac-Samardzic M, Strating MMH, *et al*. Who is on the primary care team? Professionals' perceptions of the

- conceptualization of teams and the underlying factors: a mixed-methods study. *BMC Fam Pract* 2017;18:111–24.
- 7 Ploeg J, Yous M-L, Fraser K, et al. Healthcare providers' experiences in supporting community-living older adults to manage multiple chronic conditions: a qualitative study. *BMC Geriatr* 2019;19:316–29.
 - 8 Ploeg J, Matthew-Maich N, Fraser K, et al. Managing multiple chronic conditions in the community: a Canadian qualitative study of the experiences of older adults, family caregivers and healthcare providers. *BMC Geriatr* 2017;17:1–15.
 - 9 Ray M, Bourgueil Y, Sicotte C. French multi-professional healthcare homes: an organizational model at the interface of multiple logics. *Revue française des affaires sociales* 2020;1:57–77.
 - 10 Bourgeois I, Fournier C. Setting up a contract with the National health insurance fund (assurance maladie) – one task among others for primary care teams. *Revue française des affaires sociales* 2020;1:167–93.
 - 11 Doyle C, Lennox L, Bell D. A systematic review of evidence on the links between patient experience and clinical safety and effectiveness. *BMJ Open* 2013;3:e001570.
 - 12 Baker R. Development of a questionnaire to assess patients' satisfaction with consultations in general practice. *Br J Gen Pract* 1990;40:487–90.
 - 13 Ware JE, Snyder MK, Wright WR, et al. Defining and measuring patient satisfaction with medical care. *Eval Program Plann* 1983;6:247–63.
 - 14 Safran DG, Karp M, Coltin K, et al. Measuring patients' experiences with individual primary care physicians. *J Gen Intern Med* 2006;21:13–21.
 - 15 Wensing M, Mainz J, Grol R. A standardised instrument for patient evaluations of general practice care in Europe. *Eur J Gen Pract* 2000;6:82–7.
 - 16 Bayliss EA, Edwards AE, Steiner JF, et al. Processes of care desired by elderly patients with multimorbidities. *Fam Pract* 2008;25:287–93.
 - 17 Morris RL, Sanders C, Kennedy AP, et al. Shifting priorities in multimorbidity: a longitudinal qualitative study of patient's prioritization of multiple conditions. *Chronic Illn* 2011;7:147–61.
 - 18 Sinnott C, Mc Hugh S, Browne J, et al. GPs' perspectives on the management of patients with multimorbidity: systematic review and synthesis of qualitative research. *BMJ Open* 2013;3:e003610.
 - 19 Lévesque J-F, Haggerty J, Beninguissé G, et al. Mapping the coverage of attributes in validated instruments that evaluate primary healthcare from the patient perspective. *BMC Fam Pract* 2012;13:20–8.
 - 20 Mangin D, Stephen G, Bismah V, et al. Making patient values visible in healthcare: a systematic review of tools to assess patient treatment priorities and preferences in the context of multimorbidity. *BMJ Open* 2016;6:e10903.
 - 21 Donabedian A. The Lichfield Lecture. Quality assurance in health care: consumers' role. *Qual Health Care* 1992;1:247–51.
 - 22 Donabedian A. The quality of care: how can it be assessed? *J Am Med Assoc* 1988;260:1743–8.
 - 23 Starks H, Brown Trinidad S, Trinidad SB. Choose your method: a comparison of phenomenology, discourse analysis, and grounded theory. *Qual Health Res* 2007;17:1372–80.
 - 24 Elo S, Kyngäs H. The qualitative content analysis process. *J Adv Nurs* 2008;62:107–15.
 - 25 Hewitt-Taylor J. Use of constant comparative analysis in qualitative research. *Nurs Stand* 2001;15:39–42.
 - 26 Jung HP, Wensing M, Olesen F, et al. Comparison of patients' and general practitioners' evaluations of general practice care. *Qual Saf Heal Care* 2002;11:315–9.
 - 27 Jaworski M, Rządkiwicz M, Adamus M, et al. Primary care patients' expectations regarding medical appointments and their experiences during a visit: does age matter? *Patient Prefer Adherence* 2017;11:1221–33.
 - 28 Wensing M, Grol R, van Montfort P, et al. Indicators of the quality of general practice care of patients with chronic illness: a step towards the real involvement of patients in the assessment of the quality of care. *Qual Saf Heal Care* 1996;5:73–80.
 - 29 Papp R, Borbas I, Dobos E, et al. Perceptions of quality in primary health care: perspectives of patients and professionals based on focus group discussions. *BMC Fam Pract* 2014;15:128–41.
 - 30 Blumenthal KJ, Chien AT, Singer SJ. Relationship among team dynamics, care coordination and perception of safety culture in primary care. *Fam Pract* 2018;35:718–23.
 - 31 Okunogbe A, Meredith LS, Chang ET, et al. Care coordination and provider stress in primary care management of high-risk patients. *J Gen Intern Med* 2018;33:65–71.
 - 32 Stockdale SE, Rose D, Darling JE, et al. Communication among team members within the patient-centered medical home and patient satisfaction with providers. *Med Care* 2018;56:491–6.
 - 33 de Boer D, Delnoij D, Rademakers J. The importance of patient-centered care for various patient groups. *Patient Educ Couns* 2013;90:j.pec.2011.10.002:405–10.
 - 34 Goetz K, Jossen M, Rosemann T, et al. Is patient loyalty associated with quality of care? Results of a patient survey over primary care in Switzerland. *Int J Qual Heal Care* 2019;31:199–204.
 - 35 Sakanashi S, Fujita K. Empowerment of family caregivers of adults and elderly persons: a concept analysis. *Int J Nurs Pract* 2017;23:ijn.12573:e12573–9.
 - 36 Foglino S, Bravi F, Carretta E, et al. The relationship between integrated care and cancer patient experience: a scoping review of the evidence. *Health Policy* 2016;120:55–63.
 - 37 Vaartio-Rajalin H, Fagerström L. Professional care at home: patient-centredness, interprofessionality and effectivity? A scoping review. *Health Soc Care Community* 2019;27:270–88.
 - 38 Dooley J, Booker M, Barnes R, et al. Urgent care for patients with dementia: a scoping review of associated factors and stakeholder experiences. *BMJ Open* 2020;10:e037673.
 - 39 O'Malley AS, Renteria-Weitzman R, Huerta EE, et al. Patient and provider priorities for cancer prevention and control: a qualitative study in Mid-Atlantic Latinos. *Ethn Dis* 2002;12:383–91.