Patient feedback, for the purposes of revalidation, quality improvement or self-reflection, may be measured in three main ways: using patient experience tools, by measuring patient reported outcome or satisfaction, and finally, by seeking patient feedback on communication and interpersonal skills.

Information on the patient ‘experience’ is sought intermittently, but systematically, via mechanisms such as the NHS Inpatient Survey, which is conducted by the Picker Institute Europe. In this, patients are asked to comment on a variety of elements of their total NHS experience, including the attitudes and professionalism of staff, the cleanliness and ambience of their environment, and the efficiency and safety of their transit through the hospital. While this information provides important feedback for trusts as a whole, there are few questions directly related to anaesthesia care, and the information is anonymised so that neither the patient nor individual practitioners can be identified.

Second, since the 2008 publication of ‘High Quality Care for All’ (colloquially known as the ‘Darzi report’), there is an increased drive to collect patient reported outcome measures or PROMs. These are questionnaires which focus on health-related quality of life, and which patients are generally asked to complete twice: once immediately before a planned intervention, and again some time later (usually after six months). This enables the measurement of change in the patient’s perceptions of their health, and thus the success (or otherwise) of the procedure. There are four surgical procedures in which the Department of Health has mandated PROMs questionnaires be provided to patients in all hospitals – primary hip and knee replacement, and varicose vein and groin hernia repairs. The PROMs programme is expected to expand to include coronary revascularisation, and long-term conditions in the near future.

For anaesthetists – while there are no specific PROMs – patient satisfaction questionnaires or quality of recovery scores may be viewed as alternative methods of measuring the patient’s perception of the quality and outcome of delivered care. While some departments measure these data sporadically, we are a long way from systematically recording and reporting these outcomes (see HSRC outcomes working group report on page 19). Finally, we can ask the patients for feedback on our communication and interpersonal skills; this type of feedback is the focus of the rest of this article, and also of newly published College guidance at www.rcoa.ac.uk/node/10208. We should be collecting this information by using any one of the multi-source feedback instruments which have been developed by the General Medical Council or a number of commercial providers. The GMC has recommended, in their guidance on supporting information for revalidation, that all doctors participate in patient feedback exercises, unless there are exceptional circumstances which make this infeasible or impractical.

Clearly, there are hospital specialties where obtaining patient feedback may be difficult or impossible – pathology or other laboratory based specialties being the most obvious. Work conducted at the Peninsula Medical School and on behalf of the GMC looking at the feasibility of obtaining colleague and patient feedback across a variety of specialties (using the GMC’s questionnaires) found that, while anaesthetists were almost universally willing and able to engage with obtaining colleague feedback, approximately half struggled to obtain the required number of patient feedback forms to enable a valid assessment. While it is clear from this study, and indeed from clinical experience, that there are challenges for anaesthetists in obtaining patient feedback, surely we do not want our specialty to be put in the same ‘too hard to do’ category as other groups whose patients are dead or represented by test-tubes?! Furthermore, it is recognised both by anaesthetists and by lay
representatives on our Patient Liaison Group, that anaesthetists require excellent communication skills in order to gain a patient’s trust in a relatively short period of time, and provide reassurance and calm at a particularly anxiety provoking time in the patient’s hospital experience.

Therefore, a working group of anaesthetists and lay members have produced guidance to help anaesthetists meet the challenge of obtaining patient feedback for revalidation. This is an update on the previously published guidance for collecting peer and patient feedback, and the main essence of it is a list of principles that should help to steer departments and individuals through the practical challenges of obtaining patient feedback.

In the discussions which led to this document, we considered carefully whether there was a requirement to develop an anaesthesia-specific feedback questionnaire, and have decided against this for a number of reasons. First, the process of developing, validating and subsequently implementing an anaesthesia-specific feedback instrument would require considerable resources, for limited potential benefit. There are a number of advantages in using the GMC or commercially provided instruments: each of these providers has already set up a system for the collection and confidential reporting of patient feedback; the questionnaires have been developed in a scientifically valid process, and many trusts have already entered into contracts with commercial providers which means that their employees can obtain this feedback (as well as colleague multi-source feedback) at little or minimal personal expense. Second, we do not consider anaesthesia to be sufficiently ‘different’ from other hospital specialties with respect to the doctor-patient interaction, to necessitate a unique feedback instrument. The main areas which such feedback seeks to evaluate are: clarity of communication, politeness, compassion and the extent to which the patient feels involved in their own care. The first three are key tenets of a good doctor-patient relationship; the fourth poses similar challenges for all doctors. A prime consideration for the College, and for appraisers, should be ensuring that the benchmark against which an anaesthetist is compared, is limited to the results from fellow anaesthetists, rather than against other specialties where the doctor-patient relationship may have a different nature (such as those providing on-going care in the primary care setting).

Discussion with colleagues informs us that many (possibly most) consultant anaesthetists have participated in colleague multi-source feedback and found this to be a reasonably straightforward process. Therefore, the guidance on patient feedback focuses on addressing some of the practical hurdles which face us. Some of the questions which we have tried to answer include: ‘when is the most appropriate time to approach patients?’, ‘how will the patient know who they are assessing?’ and ‘what systems does the department need to consider implementing in order to support anaesthetists obtaining patient feedback?’.

When considering the guidance, we urge you to adopt a ‘glass half full’ attitude. Many hospitals specialities face difficulties in gathering patient feedback owing to the nature of their practice: emergency medicine, paediatrics and psychiatry to name but a few. The limitations of measuring our performance based on a quick five-minute consultation on the morning of surgery are well-recognised; however, GPs with ten-minute consultation limits may well also be justified in complaining that the focus on ensuring service delivery does not permit adequate time to ensure that the patient feels ‘listened to’. While it is true that the collection of patient feedback is an imperfect science, we know – because our patient representatives tell us so – that this is a fundamental area of the revalidation process with which we should attempt to engage, in order to satisfy the public. We are keen to hear your views on the guidance, and any suggestions on how it may be improved, including any practical examples of how you have implemented patient feedback processes in your own departments.

Our thanks go to the members of the working group, and in particular to the members of the Patient Liaison Group who contributed to the discussions.

Guidance for ‘Seeking Patient Multisource Feedback in the Perioperative Period’ can be downloaded from www.rcoa.ac.uk/node/10208.

References