

Colleague and patient feedback for revalidation

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The GMC has identified a number of areas where 'core supporting information' should be provided during appraisal, to demonstrate that a doctor is keeping up to date and that their practice is of sufficient standard to be able to revalidate. An important area is 'feedback on your practice', which requires both patients and colleagues to provide their views on the doctor's professional performance. The College convened a working group to evaluate the available methods for obtaining such feedback, and provide guidance for anaesthetists to help them achieve this requirement.

Colleague feedback

Many anaesthetists already participate in colleague feedback exercises (also known as multi-source feedback or MSF) as part of their professional development and appraisal; indeed, it is a requirement for trainees in anaesthesia. The GMC and a number of commercial organisations provide online resources allowing doctors to select and invite colleagues to give confidential feedback on their practice. We believe that over 70% of NHS trusts have a contract with a commercial MSF provider currently. These systems provide the opportunity to give 'free text' comments, as well as the requirement to answer specific

questions, the responses to which are benchmarked against national averages for colleagues of the same grade and specialty. Discussions with providers of colleague feedback resources and anaesthetists have led the working group to conclude that the available GMC or commercially provided options for completing MSF are sufficient for our specialty to fulfil this requirement of the revalidation agenda. A key GMC requirement, which the College endorses, is the use of a feedback tool which has been piloted and validated and in which the questions map to the GMC's Good Medical Practice guidance. Thus, simply creating an online survey, which can be used within a department or trust, will not be sufficient to fulfil the revalidation agenda. A robust and validated quality assurance process must be undertaken on any new colleague feedback tool in order to meet the GMC's requirements.¹

We have considered the possibility of developing a specialty specific colleague feedback tool for anaesthetists, but concluded that the generic questionnaires are 'fit for our purpose'. However, we have provided guidance specific to anaesthesia, critical care and pain medicine specialists, about the number and types of colleagues who should be invited to respond. These include trainees, managerial staff, allied health professionals, and consultant colleagues from other specialties. We hope that this guidance will not be viewed as 'overly prescriptive', rather that it will provide helpful assistance for anaesthetists in complying with this aspect of the process. Another key recommendation is the necessity for the results of colleague feedback to be delivered to doctors by an individual who has been trained in the process. Such training is available from commercial providers, and we hope that

it will also be available from the College from 2012. Furthermore, there should be a robust system for reporting the results of such feedback to an individual's appraiser in every department, including mechanisms that ensure the exercise is repeated within a five year revalidation cycle if the results are deemed unsatisfactory.

Patient feedback

Obtaining reliable and valid patient feedback about communication skills poses a much greater challenge for anaesthetists. The GMC, commercial providers and anaesthetists all identified a number of issues that were considered by our working party. These include the methodology for selecting patients who might provide such feedback and the timing and method of distribution and collection of the questionnaires. Furthermore, questions about whether 'generic' patient feedback tools are appropriate for use in all the patient sub-groups we are responsible for, and the necessity for benchmarking anaesthetists against each other rather than against other medical professionals, need to be considered. Several logistical problems have to be overcome.

Firstly, it is intuitive to believe that, in order for patient feedback to be un-biased, a neutral third party should be responsible for selecting which patients should be invited to participate. This is a relatively straightforward process in outpatient clinics (for example, a receptionist could randomly select patients to complete the forms), but perhaps more challenging in the perioperative period, when patients cared for by a particular anaesthetist may be scattered across the hospital.

Secondly, at what point in the hospital stay should patients be asked to complete the feedback forms? The GMC's guidance

indicates that patients should be given feedback forms as soon as possible after a consultation, but this may not be suitable in anaesthetics, a view shared by the RCoA's Patient Liaison Group. Immediately after a preoperative consultation, the patient may be too anxious about the forthcoming surgery to want to participate; immediately after surgery they may not have recovered sufficiently to be able to comply, whilst after discharge the return rates for postal questionnaires are known to be poor. Furthermore, some patients may have forgotten the anaesthetist, and their specific role in their perioperative experience. Linked to this, there is a risk that anaesthetists may be held to account for factors affecting the patient's experience that are beyond their control such as delays in operation start times and problems in the healthcare environment. Such factors may lead to unfair bias against the anaesthetist. Thirdly, our specialty provides care for a number of specialist patient groups, including the critically ill, obstetric and paediatric patients. It is clear that obtaining patient feedback from each of these sub-groups poses different challenges such that they may require different questionnaires; consequently the results of feedback from these types of patients may not be directly comparable against each other. Finally, the information given by commercial providers confirmed the practical difficulties which anaesthetists experience in administering patient feedback questionnaires: only a small percentage of anaesthetists who currently participate in MSF also submit patient feedback questionnaires for evaluation.

Despite these challenges, it is important for our profession to provide patient feedback where available and possible. The GMC has provided the 'get out clause' for specialties that do not have direct patient contact (histopathology being an obvious example), allowing

them not to recommend to their doctors the mandatory participation in patient feedback processes. However, despite possible public perception to the contrary, we know that anaesthetists are excellent communicators generally, and that they have to gain the patient's trust in a time-limited environment, and often at a time of great stress to the patient. Therefore, we believe that our specialty should be willing participants in the patient feedback process. The RCoA's recommendations on patient feedback include guidance on the use of specific questions about the 'patient experience'. These are provided by the annual NHS Inpatient Survey, and may be used to provide a summary representation of the patients' views on the whole department, which can then be used by individual anaesthetists if other feedback is not possible. We also recommend that all anaesthetists who have outpatient responsibilities (for instance, in preoperative assessment, pain, or sleep clinics) should use a GMC or commercially provided and validated patient feedback tool to assess their communication skills. However, we have stopped short of mandating this as a part of the revalidation process for anaesthetists whose practice is entirely 'surgical' whilst we undertake further work in addressing the challenges outlined.

Work in progress

We are aware that obtaining patient and colleague feedback will take time and resources for individual anaesthetists and their trusts and, therefore, whilst we are required to engage with these processes, we are also keen to evaluate a number of associated factors. Although there is a large body of work evaluating patient and colleague feedback in practice, the evidence available offers few answers about the benefits of participation with regard to professional development. A systematic review of the use of 'workplace based assessments' found that there was

variation in the impact of such feedback based upon both the grade and specialty interest of doctors who participated.² However, we have been unable to identify any studies which examine the effect of participating in colleague and patient feedback on the practice of anaesthetists.³ Other issues include the lack of evidence about whether allowing the clinician to choose their own appraisers makes any difference to the outcome and the difficulties related to the timing of administration of patient questionnaires for anaesthetists.

Therefore, while we have provided guidance for anaesthetists on how to meet this requirement of the revalidation process, we are also committed to further research and developing solutions to some of the problems aforementioned. This might include evaluating whether engaging with these processes leads to performance improvement in anaesthetists, and considering the development and validation of patient feedback questionnaires specific to our specialty. The Health Services Research Centre will be asked to consider undertaking this work and we would welcome information from clinicians and trusts about their approaches to any of the challenges associated with obtaining patient feedback. The College's guidance on colleague and patient feedback can be accessed at www.rcoa.ac.uk/revalidation, and queries can be sent to revalidation@rcoa.ac.uk.

References

- 1 Guidance on colleague and patient questionnaires. GMC, London 2011 (www.gmc-uk.org/Colleague_and_patient_questionnaires.pdf_41683779.pdf).
- 2 Miller A, Archer J. Impact of workplace based assessment on doctors' education and performance: a systematic review. *BMJ* 2010;341:5,064.
- 3 Moonesinghe SR, Tomlinson AA. Quality improvement and revalidation: two goals, same strategy? *Br J Anaesth* 2011;106:447-450.