

## **Does questionnaire-based patient feedback reflect the important qualities of clinical consultations? Context, benefits and risks**

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## **Abstract**

### **Objective**

To explore perceptions of clinical consultations and how they relate to questionnaire-based patient feedback.

### **Methods**

Telephone interviews with 35 junior doctors and 40 general practice patients who had used the Doctor's Interpersonal Skills Questionnaire (DISQ).

### **Results**

Doctors and patients had similar views of 'good consultations' as relying on doctors' listening and explaining skills. Preferences for a consultation style focused on an outcome or on the doctor-patient relationship may be independent of informational and/or affective consultation content. Respondents felt the important consultation elements were similar in different contexts, and so DISQ feedback would be useful in different settings. Benefits of feedback were identified in the form of patient empowerment and doctors' learning. Risks were identified in the inappropriate use of feedback, both inadvertent and deliberate.

### **Conclusion**

The style and content of consultations may be considered as separate dimensions, an approach that may help doctors adapt their communication appropriately to different consultations. Patient feedback focused on communication skills is appropriate, but there are potential risks.

### **Practice Implications**

Doctors should consider the transactional or relational preference of a patient in approaching a consultation. Patient feedback can deliver benefits to doctors and patients, but risks must be acknowledged and mitigated against.

## **Does questionnaire-based patient feedback reflect the important qualities of clinical consultations? Context, benefits and risks**

### **1 Introduction**

Patients' views are increasingly important for doctors' clinical practice and professional development. Reviews show the area is of international interest [1,2,3], although much of the research base stems from the UK, where public and patient involvement is encouraged in areas as diverse as healthcare policy [4], resource allocation [5,6], care planning [7] and revalidation [8].

Patient involvement takes different forms, but frequently involves gaining feedback through questionnaires [9,10,11]. Some of these evaluate a practice or service as a whole [12,13,14,15], while others focus on individual doctors [16,17,18,19,20,21]. The latter tend to address communication between doctor and patient, as communication is a key element of the clinical consultation [22,23,24,25]. Communication shapes the affective context of a consultation, the information exchange within it, and the power relationship between doctor and patient [26,27,28,29]. Modern medical education reflects this, placing great importance on patient-centred communication skills [30,31,32,33].

Questionnaire-based patient feedback has been found to improve interpersonal skills [34, 35, 36, 37], although the most useful feedback may be limited to that from difficult cases [38]. Improvements in performance may need a concerted effort on the part of the recipient [39, 40], and may vary with context [41].

It is important that a tool measures the important elements of a consultation, which means having a good understanding of what those elements are, from the points of view of patient and doctor. Importantly, patients have been found to vary in their preference for communication behaviour, some preferring to be more involved than others [42,43,44,45,46,47,48], and so they may value different behaviours and qualities. It is also known that communication varies with elements such as the clinical context [49,50,51] and qualities of the patient and doctor such as age and gender

[52,53,54,55], and clinical condition [56]. Patient feedback systems must be robust to different consultations associated with these variables.

While studies have reported the reliability and construct validity of feedback tools [57,58,59,60,61,62], little is known about the attitudes of doctors and patients towards patient feedback. These attitudes are important because perceptions of validity in practice are essential for the effectiveness of patient feedback processes. The perceived benefits and risks of patient feedback will be important in the acceptance of such processes by doctors and patients.

### **1.1 The current study**

This paper reports on data collected as part of a wider project that also looked at the feasibility and logistics of implementing patient feedback for trainees in different settings [63], and at possible influences on feedback scores. The qualitative component reported here focused on perceptions of the doctor-patient relationship and patient feedback using the Doctors' Interpersonal Skills Questionnaire (DISQ) [64,65,66]. This asks patients to rate the consultation on twelve items: two global, and ten asking about specific communication elements of the consultation (see Box 1).

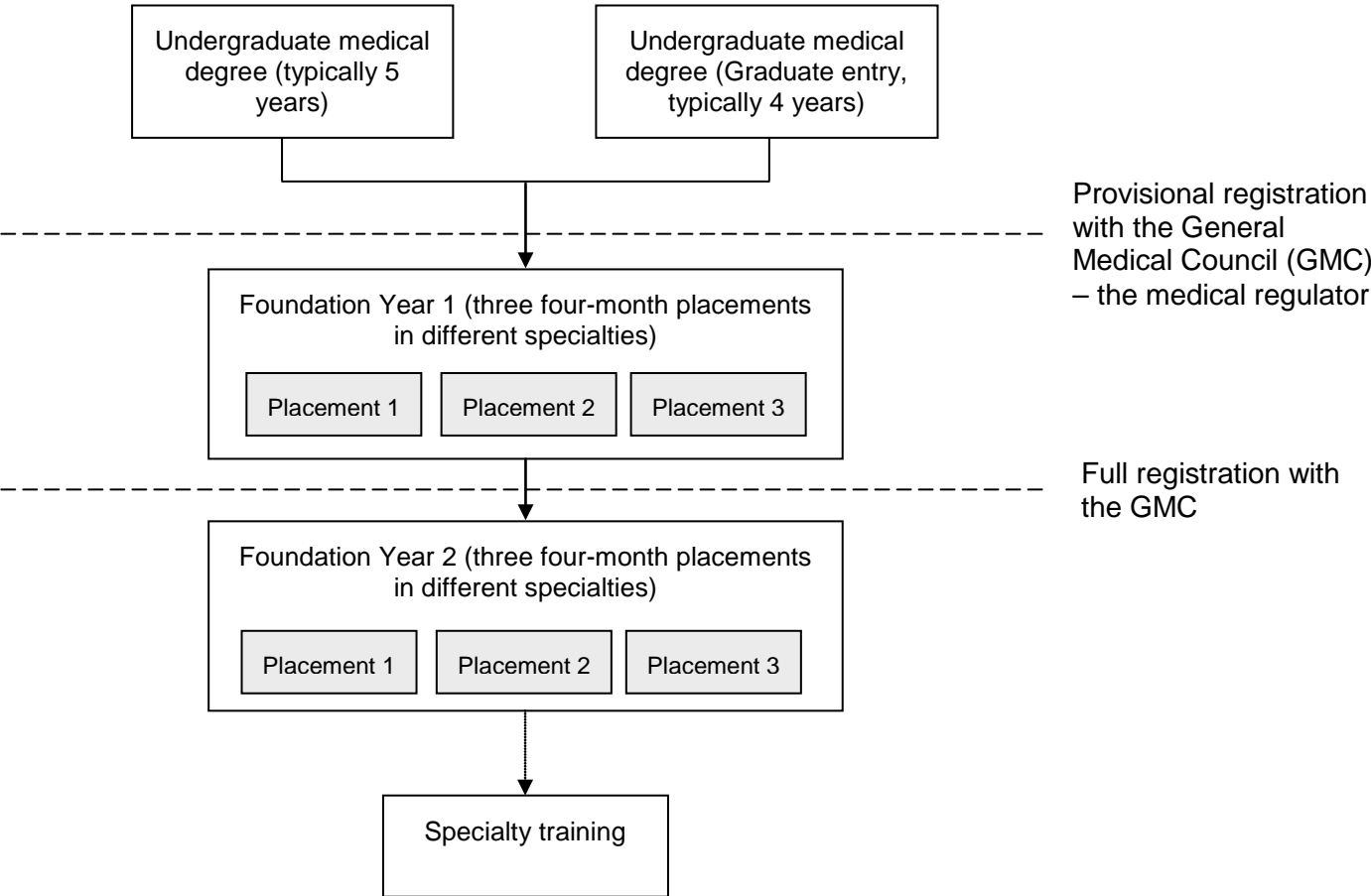
**Box 1. Areas covered by the 12 items of the Doctor's Interpersonal Skills Questionnaire (DISQ). Questions are answered on a five point scale with anchors 'Poor', 'Fair', 'Good', 'Very good' and 'Excellent'. Items marked \* are global.**

1. Satisfaction with visit \*
2. Warmth of greeting
3. Listening skills
4. Explanation skills
5. Reassurance
6. Confidence in ability
7. Able to express concerns and fears
8. Time in consultation
9. Respect shown
10. Patient's personal context
11. Patient as a person
12. Recommend doctor to a friend \*

The DISQ is owned and operated by CFEP UK Surveys.

The study involved UK doctors in their first two post-qualification years (the Foundation Programme). Figure 1 illustrates the UK medical training path.

**Figure 1. UK medical education pathway**



### **1.1.1 Aims and objectives**

The study aimed to explore doctors' and patients' perceptions of a good consultation, and consequently the validity, benefits and risks of patient feedback for the doctor-patient relationship.

## **2 Methods**

### **2.1 Participants and recruitment**

Foundation Year 1 doctors (F1s) in acute hospital placements and Foundation Year 2 doctors (F2s) in general practice placements were invited by letter to take part in the study (to receive patient feedback and/or provide a telephone interview). Trainees were reassured that participation was voluntary, and that feedback was for their own formative use only.

Thirty-five doctors were interviewed in total (13 male, 22 female). Twenty-nine were F2s, interviewed after completing a four-month placement in general practice (GP) during which they had collected patient feedback using the DISQ (receiving feedback at the beginning and end of the placement, with some taking part in a communication skills workshop part-way through). The remaining six were F1s who had attempted feedback collection in acute placements (not all were successful due to logistical problems [67]).

Patients were recruited during the F2s' general practice placements (none were recruited in acute settings). They were offered a questionnaire by receptionists, with an information sheet explaining the research and a consent form inviting them to take part in a telephone interview. It was made clear that the research was voluntary, and that all data would be anonymous. For patients under 16, the DISQ and consent form were to be completed by a parent or other adult.

Forty patients (20 male, 20 female) were selected from over 200 consent forms returned. Selection was at random, with substitution ensuring representation of all age groups. Selection was stratified on age and gender as the available variables which have been found to influence communication.

Completed DISQs were returned to CFEP UK Surveys. If at least 10 questionnaires were returned, a report was sent to the trainee's supervisor, in order to deliver feedback in a supportive context.

## **2.2 Interviews**

Interview questions were developed from the project's research questions and literature review. Initial drafts were reviewed by the authors and refined following piloting with the first few respondents. Telephone interviews were used for logistical reasons – participants were spread across a large geographical area.

Box 2 gives the main questions, and ancillary prompts for F2 and patient interviews. The interviews were semi-structured, meaning the sequence and focus of questions could adapt to responses. Most questions were open ended, although some more focused questions were added to follow up issues raised in earlier interviews (e.g. whether a feedback questionnaire should include clinical questions).

**Box 2. Example of interview schedules, including preamble. Structure and wording were used as a guide only.**

<p><b><u>Interview schedule for F2s who have been in GP placements *</u></b></p> <p>The interview is about how you feel about receiving feedback from patients. I will not be asking about specific consultations, or asking any personal questions, but in any case everything you say will be strictly confidential. You do not have to answer any questions you don't want to.</p> <p>Do you agree to the interview being recorded, just to make sure I can be more accurate when I'm analysing the interviews? Everything you say will be strictly confidential</p> <ol style="list-style-type: none"> <li>Do you think patient feedback is a positive thing? <ul style="list-style-type: none"> <li>Why is that/why not?</li> <li>What use do you think patient feedback is? - for you and for patients</li> </ul> </li> <li>What concerns might you have about receiving patient feedback?</li> <li>What sort of patient feedback would you like to receive – in what areas of practice? <ul style="list-style-type: none"> <li>Were there any questions that should have been on the questionnaire that weren't – anything missing?</li> <li>The questionnaire is focused on communication skills, do you think patients could also give feedback on clinical aspects of the consultation (whether they have been examined, given a prescription etc)?</li> </ul> </li> <li>Were you aware of which patients had received a questionnaire? <ul style="list-style-type: none"> <li>Did it affect the way you interacted with patients if you knew they were giving feedback afterwards?</li> </ul> </li> <li>What sort of communications skills training have you had before? <ul style="list-style-type: none"> <li>Have you had any formal patient feedback before (e.g. as an undergraduate)?</li> </ul> </li> <li>How did it feel to receive patient feedback? <ul style="list-style-type: none"> <li>Were you surprised by any of the feedback?</li> </ul> </li> <li>Will you or have you responded the feedback (e.g. changed any behaviour)? <ul style="list-style-type: none"> <li>Did the feedback identify specific goals?</li> <li>If you attended the workshop, how useful was it?</li> <li>How useful was the way in which your supervisor delivered your feedback?</li> <li>What do you think your supervisor thinks about patient feedback?</li> </ul> </li> <li>What do you think constitute 'good communication skills' in GP and does that differ from hospitals?</li> <li>If patient feedback becomes commonplace, do you think it will affect the doctor-patient relationship (they way they regard each other)? <ul style="list-style-type: none"> <li>what are the important qualities or elements of that relationship</li> </ul> </li> </ol>	<p><b><u>GP patient interview</u></b></p> <p>The interview is about how you feel about giving feedback to your doctor. I won't be asking anything about why you went to see your doctor, or about your doctor personally. You do not have to answer any questions you don't want to.</p> <p>Do you agree to the interview being recorded, just to make sure I can be more accurate when I'm analysing the interviews? Everything you say will be strictly confidential</p> <ol style="list-style-type: none"> <li>You will have been given a questionnaire by a receptionist, did you complete it? <ul style="list-style-type: none"> <li>Why did/didn't you?</li> </ul> </li> <li>Do you think it is a good idea for patients to give feedback to their doctor? <ul style="list-style-type: none"> <li>Why/why not?</li> <li>Do you think it would be useful for the doctor?</li> <li>Do you expect your doctor to change in response to feedback from patients?</li> <li>Is it useful for you as a patient?</li> </ul> </li> <li>Did you have any concerns about giving feedback? <ul style="list-style-type: none"> <li>Are there any occasions you wouldn't give feedback?</li> <li>Would you give feedback again?</li> </ul> </li> <li>Have you ever been asked to give feedback about a doctor before? <ul style="list-style-type: none"> <li>When</li> <li>Was it the same questionnaire or a different one</li> </ul> </li> <li>Have you ever told your doctor if you were unsatisfied with him or her, or with a consultation? (you don't have to give details) <ul style="list-style-type: none"> <li>Would the questionnaire have allowed you to do so?</li> </ul> </li> <li>What sort of thing would you like to give feedback on? <ul style="list-style-type: none"> <li>What things are important to you when you see a doctor?</li> <li>Were there any questions that should have been on the questionnaire that weren't – anything missing?</li> <li>The questionnaire is focused on communication skills, do you think patients could also give feedback on clinical aspects of the consultation (whether they have been examined, given a prescription etc)?</li> </ul> </li> <li>Was the questionnaire easy to complete? <ul style="list-style-type: none"> <li>Was it clear to you what you were being asked on the questionnaire?</li> </ul> </li> <li>Did you think about what would happen to the feedback? <ul style="list-style-type: none"> <li>Did you feel anonymous</li> </ul> </li> <li>How well do you know your regular doctor? <ul style="list-style-type: none"> <li>Do you visit him or her often?</li> <li>Would you feel differently completing a questionnaire for your regular GP?</li> </ul> </li> <li>If questionnaires like this become commonplace, do you think giving feedback will change the doctor/patient relationship in general? <ul style="list-style-type: none"> <li>what are the important qualities or elements of that relationship</li> </ul> </li> </ol>
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\* The interview for F1s who had been in acute placements was similar, but omitted questions on receiving feedback and on the workshop, while question 8 referred to 'communication skills in different placements'.

All interviews with doctors, and most of those with patients, were carried out by the first author. The remainder were carried out by an experienced qualitative researcher subcontracted to carry out those interviews. Interviews with doctors were generally longer (35-50 minutes) than those with patients (15-30 minutes).

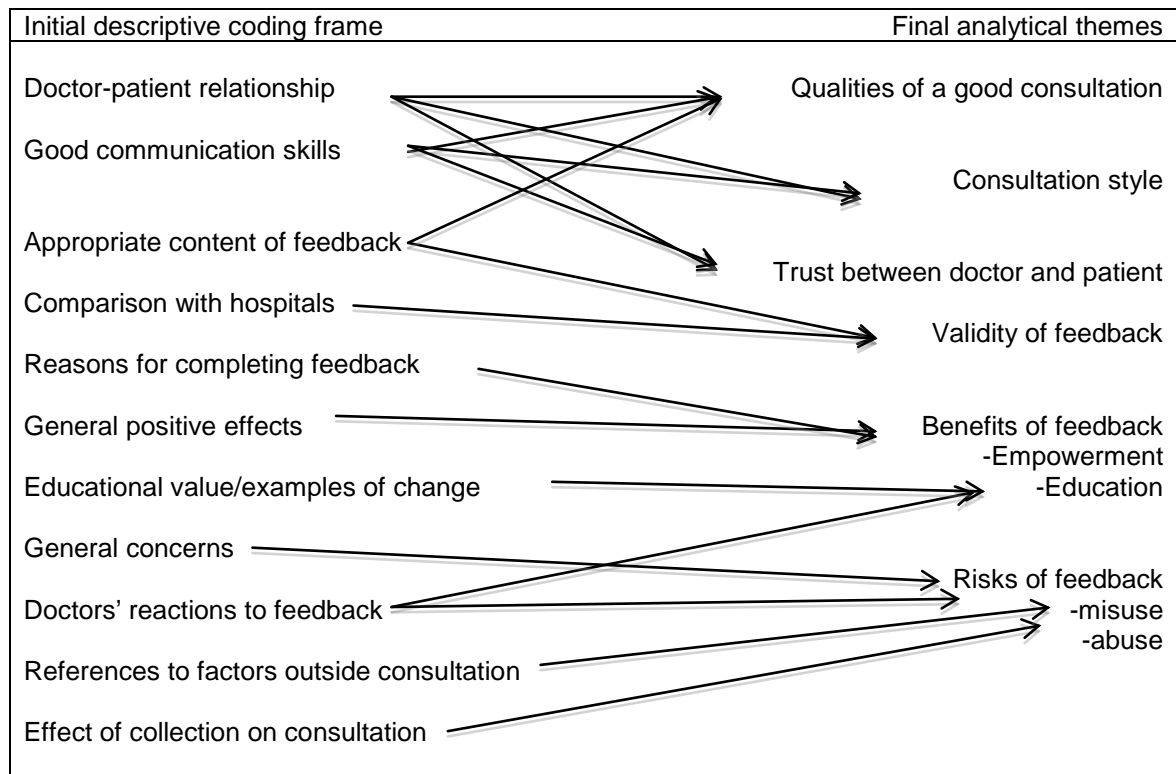
Interviews were tape-recorded with participants' consent, and transcribed 'semi verbatim', that is excluding some paralinguistic elements. This level of transcription was appropriate for the planned analysis.

### **2.3 Analysis**

The transcripts were analysed using a framework approach [68]. Following initial familiarisation and identification of themes by the first author, all transcripts were coded using NVivo 7 [69]. Broad codes were used to avoid imposing too fine-grain a framework in the early stages of analysis. This stage of analysis allowed relevant comments throughout the interview to be aggregated. Coding was checked and confirmed by CK and GM who second-coded a sample of transcripts. Analytical themes were then developed in discussion and through the drafting and revision of the results section.

## **3 Results**

Figure 2 illustrates how the initial descriptive codes mapped to the final thematic analysis. The inclusion of a theme does not indicate that it was universal, but does indicate a substantial presence in the data. Themes are complex, and counter-examples are included where found.

**Figure 2. Themes identified by framework analysis, mapped to final analysis**

Quotes are included with a respondent identifier, whether a doctor was an F1 or F2, gender and where available the patients' age-group (anonymisation meant that this was not linked to all transcripts). These are provided for context only: analysis was blind to the age and gender of respondents, and no conclusions are drawn with regard to these variables.

The results presented fall into three areas: what constitutes a good consultation, the validity of patient feedback, and the benefits and risks of patient feedback.

### **3.1 Qualities of a good consultation**

Patients were positive about the consultations they had with the doctors in this study. Descriptions of good consultations reflected two elements: one affective, relating to the emotional content and context of the consultation, and one informational, relating broadly to the clinical content, with the two often inter-related (Box 3). This distinction was apparent in the three areas discussed below – communication behaviours, trust, and consultation style.

### Box 3. Elements of a good consultation

#### Affective and informational content

*That's very important for the doctor to do, kind of, you know when you enter the room to be friendly and make you feel relaxed, especially something you don't particularly want to talk about. (patient 35, male)*

*I think the best thing in constituting a good consultation...is to make a good rapport between the doctor and the patient, and the first question...should be concentrating on ice breaking otherwise you can get a bad consultation and it could be sort of formal interview and nothing else. (doctor 23, male, F2)*

#### Listening behaviour

*I think for a start one that listens to you. I think that looks interested in your problems and I think just their general demeanour I think that makes you feel better rather than talk to somebody where you get the impression that you're in and they can't wait to get you out again (patient 18, male, 60s)*

*Obviously listening is a massive part...sometimes we cut patients short too quick because we have time restraints...I think you'd get most of your information if you just let a patient talk. (doctor 30, female, F1)*

#### Explaining behaviour

*[A good doctor is] one who takes time with you and explains what's, if there's something wrong ...they'll sit there and explain what is wrong with you and everything like that. There's some of them er, you go and see a doctor and they don't seem maybe interested some of them – like to get you in and get you out as quick as possible. (patient 14, male, 50s)*

*Being able to communicate things back to the patient, so being able to explain things in a, in a straightforward easy to understand fashion. (doctor 27, male, F2)*

#### Trust

*I would trust my doctor enough to, you know, to do what is necessary medically and I think what worries most people is the approachability of the doctor, you know? (patient 27, female)*

*[Trust] can be earned by the perception of the doctor listening and taking account of the patient's problems and acting quickly to kind of deal with those problems... it's obviously done by the good communication skills and things but it's also to do with competency of the doctor to actually manage medical problems. (doctor 33, male, F1)*

### **3.1.1 *Behaviours***

The behaviours associated with a 'good consultation' were similar for both patients and doctors – mainly the doctors' ability to listen and to explain. Both listening and explaining behaviours fulfilled affective and informational functions, but listening had a stronger affective role in setting set the patient at ease. This was particularly true from the patients' point of view.

'Explaining', on the other hand, was more clearly about the transmission of information from doctor to patient, ensuring patients understand what they are being told, and what is happening in the consultation. Information may have affective consequences, but there is a distinction between content which informs the patient and that which only has an affective aim (such as 'sympathy').

There were indications that the affective aspect of the interaction was more important for patients and the informational more important for the doctors. Both groups saw them as related and complementary elements though, with the affective context setting the scene for a successful information-based clinical consultation. One doctor even indicated that the affective component may be the most important: "you may not even treat this patient with the right medication but as long as you speak to them nicely that is something reassuring" (doctor 13, male, F2).

### **3.1.2 *Trust between doctor and patient***

While some respondents described 'a good consultation' in behavioural terms, others used more abstract terms, particularly referring to trust between patient and doctor. It was seen as reciprocal: "They trust that you will do the right thing, and you trust that they're telling you the truth" (doctor 31, male, F1), although most comments referred to the patient's trust in the doctor.

Trust reflected an expectation, on the part of the patients, that the doctor will "do whatever has to be done" (patient 6, male, 50s). However this expectation was often a global, affective, judgement, rather than a reasoned (informational) prediction of what

the doctor would do. One doctor (doctor 33, male, F1) illustrated the interdependency of informational and affective elements, describing trust as the outcome of listening providing affective reassurance, and 'acting' providing reassurance on clinical competence.

### **3.1.3 Consultation style**

Interviews revealed that different styles of consultation are identified, specifically focused on a particular outcome, or seen as part of an ongoing relationship. We do not know how consultations actually differed, but patients' descriptions of the two indicated attention to, and implied preference for, different approaches (Box 4).

## Box 4. Consultation style

### Outcome focus (transactional)

*When I go to the doctors it's very specific and basically I just want somebody to fix the problem...I want a result. (patient 29, male)*

*Sometimes it's nice just to go and be told there is nothing wrong with you but just to have that, how can I put it, personal interest, sympathy. (patient 30, male)*

### Relationship focus (relational)

*One who takes time with you... There's some of them er, you go and see a doctor and they don't seem maybe interested. Some of them – like to get you in and get you out as quick as possible. (patient 14, male)*

*if you've seen a doctor on a regular basis they know you, they know your case...if you go and see a locum...you have to sit and you either have to explain it to them...or they're trying to read through your notes...that has a knock on effect and people in the waiting room are getting angry (patient 25, female).*

### Control

*Well quite often...they ask you what you are there for and nothing more, you know they could say 'is there anything else that you would like to talk about?', though they never do. (patient 9, male, 60s)*

*I am awfully conscious that there are other people behind me and you have a small allotted time...it is really up to the doctor to try and execute as much as [they can] in that timeframe. (patient 1, male, 50s)*

### Patient-centredness

*it's not just the doctor telling the patient what to do, it's getting their ideas, getting them involved with the process, making them feel that they're... don't know, really, making it more patient centred rather than doctors telling patients what to do (doctor 25, female, F2)*

*I gave him direct to what was wrong, he was coming out with 'well have you got this you know, have you got this pain have you got that pain?', and I'm going no...when I walked out I did feel a bit sort of dejected in once sense ... he was good he went through everything but it took such a long time to go through it all (patient 13, male, 50s)*

Patients who noted an outcome focus were not solely thinking in clinical terms. While some are specifically 'wanting a solution', 'sympathy' is described as a specific outcome by one patient. Outcomes may therefore be informational, or affective. Consultations focused on the broader relationship were more often described in purely affective terms. The focus is on the doctor 'knowing' the patient, but that knowing is at 'a personal level' rather than about their clinical situation. However, one patient (patient 25 in Box 6), did indicate that a consequence of knowing the patient was 'knowing your case', indicating an informational element.

The importance of the relationship is stressed in one patient's comment about her doctor's retirement: "He's been a family doctor right through for me...I felt as if I could say anything to him, then all of a sudden he's retiring and I just felt let down" (patient 15, female, 50s).

Where patients indicated a preference about the conduct of the consultation, they felt that it was the doctor's responsibility to control it. However this was not expressed in a passive or deferential way, but rather as an active expectation of the doctor's responsibility: patients simply saw it as the doctor's job to take control.

In contrast to patients, doctors tended to describe more holistic consultations, perhaps reflecting their training in patient-centred care. However, one patient expressed frustration with their doctor's patient-centred approach: "it took such a long time to go through it all" (patient 13, male, 50s).

### **3.2 *Validity of feedback***

Interviews identified perceptions of different elements of the DISQ's validity (Box 5). Both doctors and patients felt that the content of the DISQ was relevant, addressing as it does the communication elements important to them. Neither patients nor doctors felt gaining feedback on clinical elements would be appropriate, or necessary.

### Box 5. Validity of feedback

#### Overall validity

*I think the patients probably give you better idea of how you are doing because you actually see them for a longer period of time. (doctor 5, female, F2)*

*I'm a junior doctor...I think it'd be more useful to be fed back by my seniors because they'll obviously have a better idea of how I've been doing...I think that's more useful than having patient feedback. (doctor 33, male, F1)*

#### Clinical content

*The patient isn't always in a position to actually assess whether the GP has done the right thing or not. (patient 23, female)*

*I don't think clinical questions would be particularly appropriate. Because I think...they will all come back down to how a doctor communicates. (doctor 30, female, F1)*

#### Clinical context

*In the hospital we tend to tell them what's wrong with them. In GP...they come to the doctor and they express what they think is wrong with them. (doctor 11, female, F2)*

*I've used [skills] dealing with relatives, sometimes they're impatient and almost angry if they've been waiting for information, I let them talk, and take it at their own pace. It's very transferable. (doctor 17, female, F2)*

The validity of feedback was perceived to be high because patients directly experience doctors' practice, and as such have a better viewpoint than colleagues, although one doctor did feel that at this stage in their career, feedback from senior doctors was more important.

There were differences in opinion as to whether the skills required were applicable across clinical settings, with different contextual pressures, and relationships with patients. Patients were felt to be actively involved in general practice, but in hospital "silent observers of everything that goes on...a lot of the time the staff forget [that]" (doctor 31, male, F1). Doctors felt that the agenda is explicit in a secondary care

referral, but must be uncovered in primary care. This implies a different relationship, and also a difference in how feedback may be informed. Some differences were also identified between particular specialities in secondary care.

However, despite these differences, the overall feeling was that the skills required for a good and effective consultation are the same (and may even generalise to interactions with relatives in acute settings). The relevance of the feedback received on the DISQ was therefore felt to transfer to different domains.

### **3.3 Benefits of patient feedback**

Doctors and patients were generally positive about the use of patient feedback (Box 6). Specific ways in which it may be useful were described in terms of increasing patients' empowerment in the relationship, and educational value in improving doctors' practice.

#### **Box 6. Benefits of feedback**

##### **Empowerment**

*It makes the patients slightly more in power of things...you know like they have a valid opinion. (patient 5, female, 30s)*

*I think patients might feel that they are actually contributing as well to improving how we're taught and trained and I think it's good for them to feed back ...so I think it helps both sides. (doctor 31, female, F1)*

##### **Educational benefit**

*The first round I had quite a clear weakness in setting the agenda at the beginning...I concentrated on that particular point. (doctor 12, male, F2)*

*In the workshop we had the opportunity to practise, and then to see you know in a real situation how we can manage that kind of problem, which I found very, very useful. (doctor 6, male, F2)*

#### **3.3.1 Empowerment**

Many patients felt that the feedback process gave them a voice they did not otherwise have, involving them and validating their opinions. While some felt they would normally be comfortable taking a concern directly to a doctor, others felt that routine written

feedback would make a practical difference, providing a means of expressing views which they may not otherwise have volunteered.

Doctors recognised affective benefits for themselves, with one comment that “positive feedback is rewarding” (doctor 9, female, F2), but often saw benefit in patients’ having a means of expressing their opinions.

### **3.3.2 Educational impact**

Most doctors’ comments describing potential benefits related to the educational impact of feedback. The majority of respondents had received feedback before being interviewed, and some were able to talk about specific instances of learning – in several cases elements of their communication skills about which they had been unsure were confirmed by the feedback. Others had not identified any direct learning from the feedback report, but had felt they were reassured that there were no major problems.

Some doctors had attended a communication skills workshop after receiving feedback. Many of these were able to identify explicit ways in which working with a simulated patient allowed them to make sense of questionnaire feedback and how to respond to it.

Patients also anticipated benefits of doctors’ learning from feedback, although educational benefits were felt to be more likely with younger doctors, older ones being seen as more resistant, although one doctor’s comment indicated this stereotype may not be valid. Several doctors and patients felt that the educational value depended on the doctor’s engagement with the feedback.

### **3.4 Risks of patient feedback**

No respondents identified any negative consequences of the feedback process emerging during the study, although some doctors felt the process was initially stressful. However, doctors and patients did identify potential risks – some arising from inadvertent misuse, others from deliberate abuse of the system (Box 7)

## Box 7. Risks of feedback

### Misuse

*I would hope that it didn't get used as a tool for negative feedback, with the system that they're upset with rather than... not a doctor that they're upset with (doctor 20, female, F2)*

*I would be very frightened of a time where doctors were so scared of getting negative feedback that they were so awfully nice to their patients that clinical took a back seat to communication skills. (doctor 18, female, F2)*

### Abuse

*There are some patients with quite wrong expectations, I mean a patient comes for some sort of painkiller which they are not allowed to take...they are left angry and so that would be some sort of concern...it could affect their feedback. (doctor 4, male, F2)*

*If there was going to be a comeback on myself, if it would spoil the relationship between patient and doctor...then I might be more reluctant. (patient 7, female, 30s)*

### 3.4.1 Misuse

Misuse, defined as the well-intentioned but inappropriate use of a system, was identified as a potential risk by both patients and doctors. Doctors identified a risk that patients may express frustration about details not directly relevant to a consultation. Some patients' responses to questions about 'a good consultation' suggested this concern may have some validity.

Risks of misuse by doctors related more to how they may respond to the feedback process as patients become "more demanding" (doctor 26, female F2). Doctors may aim too much to give patients what they want, fearing the consequences of negative feedback, rather than seeing feedback as a means of improving their practice.

Some doctors felt they had modified their behaviour in specific consultations because they were aware that the DISQ was being distributed. The risk of this was exacerbated by some patients entering the consultation room "waving a questionnaire" (doctor 1,

male, F2). Doctors noted that some had already begun completing it, raising further concerns about validity.

Another risk identified was that feedback might become over-routinised and so less effective, while doctors also felt that patients might be “more motivated” to give negative feedback, with those who had positive experiences less likely to complete a questionnaire.

### **3.4.2 Abuse**

Abuse of the feedback process may be defined as the *deliberate* use of the tool for purposes other than giving honest feedback, or using feedback other than to improve performance. Most risks of abuse were identified by doctors, and stemmed from explicit differences in the agendas of doctor and patient, and more general personality clashes. These risks were identified as hypothetical, but realistic: there was a feeling that some patients are essentially dissatisfied, and “like to complain about everything” (doctor 1, male, F2), and that “There are always going to be conflicts between what a patient wants and what the doctor will offer them” (doctor 27, male, F2). It is not clear whether these perceptions come from experience, or indicate a stereotyping of patients received from others.

Patients on the other hand identified a small risk of doctors abusing the system if they did not respond well to the feedback. More realistic perhaps was the perceived risk that doctors may disregard feedback.

Doctors also identified a risk that the process may be manipulated by “cherry picking” (doctor 34, female, F1) consultations on which to receive feedback. This would mean only asking for feedback from those patients with whom they felt they had a positive consultation. Processes should avoid this risk, but that cannot be guaranteed.

Respondents also identified ethical issues in the distribution of questionnaires – feeling that patients who may be distressed following a consultation should not then be asked to complete a questionnaire.

## **4 Discussion and Conclusion**

### **4.1 Discussion**

Interviews identified the views and preferences of junior doctors and general practice patients concerning the clinical consultation, and the validity and usefulness of the Doctor's Interpersonal Skills Questionnaire (DISQ).

#### **4.1.1 The doctor-patient relationship**

On a practical level, doctors' and patients' had similar views of a good consultation, identifying listening and explaining behaviours which have previously been found to be important [70,71,72,73]. Agreement on what constitutes a good interaction may be positive for patient satisfaction, understanding and adherence [74,75,76], although attitudes towards specific behaviours may differ [77], and personality differences may confound perceptions of, and preferences for, different behaviours [78,79].

Interview questions intended to identify appropriate feedback content also discovered interesting views of consultations. Analysis identified two ways in which consultations may differ, and for which patients have implicit preferences. Firstly, consultations may contain both affective and informational *content*, linking to a literature describing the generation of trust [80,81]. Secondly, the *style* of the consultation may be focused on a single outcome (which importantly may be informational or affective), or on the longer-term relationship.

Drawing on a literature on consumer behaviour [82], the terms 'transactional' and 'relational' may be used to describe these styles – transactional focused on a short-term outcome, relational on the long-term. (These may reflect 'transactional' and 'interactional' discourse [83,84], but the consumer-based terms are more apt here).

Other approaches in the literature differentiate consultations in similar ways [85,86,87,88]. However, these often conflate content and style. There will be overlap, but an important point is that the affective focus indicated by 'being listened to' (where it is the listening, not the information transferred, which is seen as important) may constitute a discrete, transactional interaction in medicine.

Previous distinctions may contain value judgments by using constructs such as ‘power’ to distinguish between consultations. The preference identified here for doctors to take control of a consultation may be styled as ‘passive’ [89] or as a ‘patriarchal’ consultation [90] – terms which may have negative connotations for patient and doctor respectively. Such preferences were often expressed as an active expectation of the doctor’s role – control was not an expected or necessarily welcome component from the patient’s point of view. The literature suggests that many patients do not want to take control [91,92,93,94,95], but such a doctor-led consultation can be felt to be contrary to the principles of patient-centredness [96,97].

It may be that a transactional preference – simply wanting a solution or reassurance – is more typical of patients who attend their GP infrequently [98], in contrast to those receiving longer-term care, for whom the relationship is more important [99,100]. The clinical consultation has changed over the years [101], and there may be a risk that forms seen as ‘out-dated’ are still appropriate for some patients, in some circumstances. Some doctors may be more able to respond to patients’ needs than others [102], but it is important that all doctors can adapt consultations to patients’ preferences [103,104], and a framework separating style and content may provide a useful approach.

#### **4.1.2 *Benefits and risks of patient feedback***

Reassuringly, the DISQ was felt to have appropriate and robust content. Benefits for patient empowerment and doctors’ learning were identified, and potential risks from inappropriate use. There was general agreement that feedback focusing on communication skills, not clinical aspects of the consultation, was appropriate because patients do not have the expertise to judge clinical elements [105]. There is evidence in the literature that patient feedback can lead to improvements in consultation behaviour [106,107,108], and both doctors and patients here were able to give examples of potential benefits – empowerment for patients and learning for doctors.

These benefits are related – feedback does not directly give patients a voice while in the consultation, but relies on the doctor’s engagement with it afterwards. This engagement may be helped by training, specifically the opportunity to rehearse behaviours. Doctors in this study who attended a communication skills workshop reported being able to rehearse specific communication micro-skills in areas identified by their DISQ feedback – real-time feedback from a simulated patient gave the questionnaire feedback meaning, and vice versa. This may inform the literature indicating that communication skills training can improve performance [109,110,111,112], but not in every instance [113]. The contextualisation and application of feedback is important.

Potential risks were identified in the inadvertent misuse and deliberate abuse of feedback. Many of these may be reduced by system design, but perceptions of consultations may always be biased by factors such as waiting time [114], and doctor-patient conflict arising from differing agendas [115]. These risks may be small, and the aggregation of scores should minimise their impact, but risk, and perception of risk, should be addressed in any high-stakes implementation.

#### **4.1.3 Limitations and further work**

The findings presented here, from a geographically limited sample, where most doctors had trained at the same medical school, may not generalise across a universal population. The proposed model, separating consultation style and content, is based on perceptions, and further work looking at how real consultations map to these dimensions is necessary. Further work should also consider the role of gender and other demographic variables in patient preferences for different consultations.

#### **4.2 Conclusion**

Doctors’ and patients’ views of what makes a good consultation are broadly similar, and consequently of the validity of patient feedback as well as its benefits and risks. Listening and explaining skills relate to the affective and informational content of the consultation, together developing trust. However, viewing the content (informational

and affective) of the consultation separately from the style (transactional or relational) may be useful in education and practice, for identifying the appropriate approach for a specific consultation.

#### **4.3 *Practice implications***

The findings have two main implications for clinicians, educators and regulators:

- Doctors and educators should be aware that patients may have preferences for a consultation to be transactional or relational, but that either may focus on affective or informational content;
- Patient feedback may benefit patients and doctors, but there are risks, and high stakes use of patient feedback should contain checks and balances to mitigate against deliberate abuse and inadvertent misuse.

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

Ethical approval was obtained from the Cambridgeshire (1) NHS Research Ethics Committee.

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