Abstract

Objective:
Patient feedback is considered integral to maintaining excellence, patient safety, and professional development. However, the collection and reflection on patient feedback may pose unique challenges for psychiatrists. This research uniquely explores the value, relevance, and acceptability of patient feedback in the context of recertification.

Methods:
The authors conducted statistical and inductive thematic analyses of psychiatrist responses (n=1,761) to a national census survey of all doctors (n=26,171) licensed to practice in the UK. Activity Theory is used to develop a theoretical understanding of the issues identified.

Results:
Psychiatrists rate patient feedback as more useful than some other specialties. However, despite asking a comparable number of patients, psychiatrists receive a significantly lower response rate than most other specialties. Inductive thematic analysis identified six key themes: (1) job role, setting, and environment, (2) reporting issues, (3) administrative barriers, (4) limitations of existing patient feedback tools, (5) attitudes towards patient feedback, and (6) suggested solutions.

Conclusions:
The value, relevance, and acceptability of patient feedback is undermined by systemic tensions between: *division of labour*; *community* understanding; *tool* complexity; and restrictive *rule* application. This is not to suggest that patient feedback is 'a futile exercise'; rather existing feedback processes should be refined. In particular, the value and acceptability of patient feedback tools should be explored from both a patient and professional perspective. If issues identified remain unresolved, patient feedback is at risk of becoming a "futile exercise" that is denied the opportunity to enhance patient safety, quality of care, and professional development.

Declaration of interest:
The authors state that there is no conflict of interest.

Key words:
Patient feedback, psychiatry, revalidation, regulation, thematic analysis

Patient feedback is considered integral to professional development, patient safety, and quality of care.(1, 2) As a result, the activity of collecting and reflecting upon patient feedback is frequently incorporated into educational curricula and regulatory processes on an international scale.(3-6) For example, in the UK, as part of their medical revalidation all doctors are required to collect six types of supporting information, including patient feedback, at least once during each revalidation cycle (typically five years).(7) Similar to other countries,(8) patient feedback is often collected through validated paper-based questionnaires where patients are asked to evaluate their doctor's performance against standardized questions and scales.(7, 9). However, in contrast to service evaluations, patient feedback for revalidation purposes seeks to evaluate the performance of an individual doctor and not that of the wider team or service. Patient feedback in a regulatory context is therefore designed to be indicative of an individual's performance, with the intention of promoting reflective practice and subsequent behaviour change.

However, while identified as one of the most useful tools for facilitating reflective practice,(10) a recent evaluation of revalidation identified patient feedback as the most problematic type of supporting information to obtain. (10-14) Specific concerns about patient feedback in the context of psychiatry have also been raised. These include assumed biases given psychiatric diagnoses, patient capacity concerns, and limited patient involvement in the design, administration and evaluation of patient feedback tools.(15, 16) As a result, the value, validity, and acceptability of existing tools in facilitating educational, personal, and professional development have been called into question.(1)

One theory that may help facilitate a more nuanced understanding of the complexities that underpin patient feedback is Activity Theory. Commonly applied in relation to policy implementation and education,(17-19) Activity Theory conceptualises activities such as the collection of patient feedback as the interaction of six interdependent elements: i) the *subject*, the individual or group whose perspective the activity is being viewed from; ii) *outcome*, the activity's purpose; iii) *tools*, the instruments used to complete the activity; iv) *rules,* both explicit and implicit; v) *community,* multiple individuals or groups involved in the *object*, in this instance patient feedback; and vi) *division of labour,* the horizontal division of tasks between *community* members and the vertical division of power and status.(20, 21) However, Activity Theory has yet to be applied to the activity of patient feedback, specifically in the context of psychiatry, accentuating a unique contribution of this research.

This research addresses a further gap in the existing educational literature by exploring and comparing psychiatrist, and other specialities' experiences of collecting patient feedback for regulatory purposes in the UK. Rather than re-identifying issues that have already been reported,(15) this research advances existing understanding through its innovative application of Activity Theory,(21) leading to the identification of complex contradictions, disruptions, and possible solutions. A theoretical understanding of patient feedback as a regulatory and educational activity may lead to more effective strategies and techniques in regulation, professional development, and education more broadly.

Methods

Recruitment and Sample

Following a pilot and opt-out exercise,(10) we distributed a census survey designed in consultation with stakeholders, including a Patient and Public Involvement Forum to all UK General Medical Council licence holders not in training (n=156,610). The survey was circulated using *Qualtrics* (Provo, UT) or in paper format where requested (*n*=16), was available between June and August 2015. Of the 77,373 doctors who received the survey, 36,137 (47%) respondents started and 26,171 (34%) completed it.

For this analysis we collated data from respondents who identified themselves as members of the Royal College of Psychiatrists (n=1,761). Comparative data from the complete census survey and specialty specific data are also provided for context and comparison.

Respondents were asked how many patient feedback requests they made and how many were returned. Average response rates were calculated within each specialty. Cases where individuals reported asking no patients or those who received feedback despite not requesting it (n=262) were excluded. Respondents also indicated the usefulness of each type of supporting information used in the UK revalidation process.

Analysis

Statistical analyses were conducted in R (v3.1.3, The R Foundation) including cross tabulation and pairwise comparisons to explore the effects of interest. Descriptive statistics are presented first, providing an overview of requests, returns, and perceived usefulness. Analyses of variance were conducted on these measures to evaluate variation between distribution methods and across specialties. Question details and scoring specifics are presented along with each analysis.

Free-text responses were thematically analysed using an inductive approach.(22) One researcher analysed all responses using QSR International NVivo (v11) software (23) to develop an initial coding framework which was discussed and refined by the wider research team. A randomly selected 10% were coded by a second researcher to ensure reliability.(22)

Results

Quantitative analysis

Perceived usefulness of patient feedback for informing reflective practice
Respondents who reported that they had submitted patient feedback as part of their latest appraisal were asked to rate its perceived usefulness for informing reflective practice ("To what extent did each type of supporting information that you submitted for your most recent appraisal help you to reflect on your practice?") using a 4-point rating scale anchored at 'Not at all' (1), and 'Extremely' (4) [Table 1]. Results demonstrate that on average, psychiatrists find patient feedback more useful in comparison to most other specialties [Table 1].

Requests for patient feedback

On average, psychiatrists made the same number of patient feedback requests as all other surveyed specialties, with the exception of Occupational Medicine and GPs, who reported asking significantly more patients, and AICU and Paediatrics who reported asking significantly fewer [Table 2]. Despite asking a comparable number of patients, Psychiatry had a significantly lower response rate than all other specialties except Pathology and Public Health.

When analysed across all specialties (2 Distribution Type x 14 Specialty ANOVA), self-distribution versus other-distribution appears to have little effect on the response rates [$F(1, 13)=2.493$, $p<0.114$, $\eta^2_p=0.001$]. However, a separate analysis of response rates for psychiatrists showed that self-distribution had a beneficial impact on patient response-rate (M=75.86%, SD=22.55%) versus other-distribution (M=70.06%, SD=23.77%), [$t(998)=3.91$, $p<0.001$, $d=0.250$].

Thematic Analysis

Survey responses (n=421) to the three-part question "For your most recent appraisal, which of the following types of supporting information did you submit?", "Did you have any difficulties collecting patient feedback?" (if 'Patient Feedback' was selected), and "Can you describe the difficulties you had collecting patient feedback, and any solutions you identified?" (if 'Yes' was selected) were thematically analysed . Six main themes were identified, with each one briefly summarised below.

Job role, setting, and environment

Over 40% of respondents attributed patient feedback difficulties to their job role, setting, or environment. Those working in specific areas of psychiatry including dementia found the collection of patient feedback particularly difficult, this was often attributed to concerns of patient capacity, "*patients … lacked the capacity to complete the questionnaire*" (UID 22341272). Limited patient contact also appeared problematic as it made it "*difficult*" to meet response rate requirements. Four respondents discussed the use of old data as a solution to achieving feedback completion rates. This included using data from a previous employer, role, or setting in which the respondent no longer worked.

Reporting issues

Incomplete, late replies, or a general lack of response were identified as problematic by a number of respondents (n=112) although this was not unanimous. Survey respondents stated that patients had difficulty understanding the purpose, target, and content of patient feedback tools. For example, some "*patients had difficulty understanding the questions"* (UID 31309818) and *"it was difficult to find the time to explain the process to patients and families."* (UID 89341596) Others "*became suspicious"* because they thought their psychiatrist was *"being investigated"* (UID 51341341). In some cases, respondents reported that a fear of "*being done"* (potential repercussions for future health care) and concerns about "*anonymity"* deterred patient engagement and response authenticity.

Feedback fatigue or "*saturation"* were also identified as problematic, with some psychiatrists "*competing*" for feedback participation.

Administrative barriers
A lack of administrative and financial support was also identified by some respondents (n=77). This often led to unfavourable alternatives. For example: *"There are insufficient admin staff to distribute questionnaires reliably, so I had to leave patients with them and then exit the room, leaving them to complete it, put it in a sealed envelope and drop it at reception on their way out."* (UID 97328133) Furthermore, when support was provided, its reliability was often described unfavourably: *"I depended on admin staff to hand out and collect the forms which they would often forget to do"* (UID 1304866) Seven psychiatrists also reported experiences of completed forms being lost or misplaced with anonymity making the redistribution of patient feedback forms problematic.

Limitations of current patient feedback
The relevance, appropriateness, and difficulty of existing feedback questions was criticised by respondents. The provision of English-only, or online questionnaires was also deemed to be exclusionary.

Issues of response and selection bias were identified as a particular limitation of existing patient feedback tools: *"Patients who might not have given positive feedback refused to complete the surveys."* (UID 43315837);*"I only included those who would in my view probably be able to complete the assessment which is self-selection and open to bias."* (UID 59315696) Concerns over biases appeared to be amplified by distribution methods: *"It was difficult for the patients to give negative feedback as they were asked to hand the forms back in person"* (UID 1304866)

Attitudes towards patient feedback
Negative attitudes towards the process of patient feedback were expressed by a small number of survey respondents (n=31). Some respondents viewed current patient feedback methods as *"administratively burdensome and time consuming"* (UID 55316222)*;* others explained how *"Many of [their] colleagues have filled these up themselves to satisfy the college. It's a futile exercise… with no value"* (UID 79311415). Others expressed concerns regarding *"professional objectivity"*, *"therapeutic relationships"* and paradoxical requests. One respondent described the experience of patient feedback as "*degrading to the role of a psychiatrist.*" (UID 36327002)

Solutions
Finally, 144 respondents discussed solutions they had either used or planned to use in future feedback exercises. Sending reminders, encouraging onsite completion, involving carers or family members, and self-distribution were the solutions most frequently identified. Other suggested solutions included the provision of both staff and patient education, more time to collect patient feedback, and asking a greater number of patients in anticipation of low response rates.

Discussion

This research advances existing understanding by exploring and comparing psychiatrist experiences of collecting patient feedback for regulatory purposes. Our research findings suggest that while psychiatrists find patient feedback more useful in facilitating reflective practice, they also receive the lowest number of patient feedback responses in comparison to all other specialties (with the exception of pathology and public health). The self-distribution of patient feedback forms also

appears to have a beneficial impact for psychiatrists with regard to response rates. However, reasons behind this effect remain relatively unknown. Possible explanations may include the provision of a clear explanation regarding the intended purpose and use of patient feedback, the intentional selection of patients who are more likely to complete patient feedback forms, or a reflection of significant concerns regarding a fear of reprisals as previously discussed. The extent to which self-distribution, of feedback invitations affects the honesty, or authenticity, of patient feedback responses also remains unclear and is an important area for future research to consider.

Through its innovative application of Activity Theory,(20) this research also provides a theoretical understanding of the issues that underpin patient feedback in regulation, professional development, and education more broadly. Our research findings and its implications are therefore discussed in relation to Activity Theory and its six interrelated constructs; ï) the *subject*, the individual or group whose perspective the activity is being viewed from, in this instance psychiatrists ii) the *outcome*, in this case the collection and reflection on patient feedback that informs a revalidation decisions; iii) *tools*, the tools used to complete the activity; iv) *rules,* both explicit and implicit; v) *community,* multiple individuals or subgroups involved in the *object*, in this instance patient feedback; and vi) *division of labour,* the horizontal division of tasks between *community* members and the vertical division of power and status. (20, 21)

While considered a useful tool in facilitating reflective practice, survey responses identified systemic tensions between existing *rules, community* understanding, and *division of labour*. The majority of respondents reported working in a resource-deficit model whereby the administrative and financial support needed to satisfy the required criteria (*rules*) were not available. Although our quantitative analysis showed that self-distribution had some effect on patient response rates for psychiatrists specifically, the *rule* that actively discourages this practice is often overridden in light of ineffective *division of labour*, i.e. lack of administrative support, *community* understanding, and individual practitioner settings. For example, while the requirement for patient feedback tools to be administered independently is grounded in empirical research,(24, 25) it is also perceived as a hindrance by many psychiatrists, particularly for those working in limited patient contact environments. Some psychiatrists reported simultaneously engaging in the conflicting roles of both patient feedback administrator and clinician to achieve the necessary response rate (*rules)* to ensure validity.(24, 25) Others reported getting colleagues to fill out patient questionnaires due to insufficient patient contact, or using historic data from a setting or patient population they no longer worked with to satisfy requirements. As acknowledged by the respondents, such actions undermine the validity of patient feedback causing some psychiatrists to view the activity of patient feedback as a "*futile exercise.*" A systemic contradiction therefore exists between the rhetoric and *rules* of validity and reliability as prescribed by governing bodies, and the reality of patient feedback collection.

The *division of labour* between *communities* involved also creates substantial tensions, particularly in the context of selection bias. Some psychiatrists considered participating in patient feedback opportunities to be beyond the mental capacity of some patients and used such rhetoric to justify their exclusion. While this may be a clinically informed decision at a specific point in time, it is unlikely to be universally, or continually true. No survey respondents reported discussing issues of capacity in the context of feedback participation with patients, family members, or carers. 'Capacity' is therefore often inferred by psychiatrists alone with limited patient input. This may reflect the

traditional paternalistic approach to medicine, implicit norms in psychiatry, or the unique power relationships sometimes inherent in psychiatric care.(26)

However, an alternative explanation of capacity, is *tool* acceptability or capacity. Some survey respondents perceived current patient feedback *tools* to be inaccessible, inappropriate, and confusing. For example, respondents criticised the relevance, appropriateness, and difficulty of questions asked and discussed how their current content, presentation (i.e. English and Welsh only), and often favoured online method of distribution presented a barrier to the inclusion of all patient groups. The use of generic questionnaires across all psychiatric sub-specialties also appeared problematic, particularly for those working in learning difficulties or dementia-related settings. *Communities* with authoritative status have typically been the ones to govern patient feedback content.(16) The tensions identified between *subjects, rules,* and *tool* accessibility may therefore be a result of ineffective communication between the different communities involved.

Finally, limited patient and staff understanding regarding the purpose, target, and intended use of patient feedback *tools* appears to exclude, or at least inhibit, patient feedback engagement and authenticity due to fear of reprisals. Such issues are further complicated by "feedback fatigue" or competition, where patients are being asked to complete a myriad of patient feedback forms *(division of labour)* with limited evidence of change or response.(27)

Implications
The implications of this research for regulation and education more broadly are clear. Firstly, the purpose, target, and intended use of any patient feedback tool must be clearly communicated to all those involved. The potential of patient feedback to act as a catalyst for change, reflection and development will only be achieved if the intended purpose, i.e. whether it is summative or formative, and use of patient feedback is made clear. Secondly, the relevance and acceptability of a patient feedback tool should be examined from both a patient and professional perspective. Ideally, patient feedback tools should be co-designed from the outset to ensure patient feedback tools include areas of mutual importance, and are presented in a way that is relevant and valued by both patients and psychiatrists. Thirdly, in recognition of a fear of reprisals, significant efforts should be made to assure patients of steps taken to protect anonymity, with further assurances provided that patient feedback responses will not have a detrimental impact on future care delivery – the aim of patient feedback is to improve care quality and patient safety, not diminish it. Attention should also be paid to limiting patient feedback fatigue and competition, and focusing on feedback invitations. Ensuring feedback initiatives do not occur simultaneously may help facilitate this process, or amalgamating existing patient feedback tools. Creating opportunities for patients to provide patient feedback when they would like to, as opposed to when they are required to, is also an important step in addressing this issue. Patient feedback should be patient initiated, not physician dictated. Efforts should also be made to ensure the quality of educational supervisors and facilitators. As previously identified, patient feedback data should be delivered in a way that facilitates reflective discussion and encourages the formulation of actionable behaviour change.(1)Finally, the importance of creating a culture of feedback acceptance and value should not be underestimated (1). With patient feedback becoming ever more commonly integrated into regulatory and educational processes, educators will play an increasingly important role in developing a culture where feedback is valued. This includes, but is not limited to, fostering a respect for patients, their

time, and feedback, among healthcare students of all levels. More frequent patient feedback opportunities and an enhanced awareness and focus of the benefits and barriers to patient feedback should be incorporated into educational curricula more centrally. This may help to normalise patient feedback as a central activity and prepare students from the outset of their medical careers, enabling them to make best use of patient feedback for their continued professional development. Our findings illustrate some of the particular barriers that may be encountered within the psychiatry and suggest ways in which these may be addressed, managed, and ultimately overcome.

Finally, while the strengths of this research include its unique application of Activity Theory and its use of, to the authors' knowledge, the largest sample of UK psychiatrists surveyed to date, its limitations must also be acknowledged. This research was conducted in the UK only, limiting its generalisability. However, as previously acknowledged, many countries are watching how the UK's recertification programme develops.(25) The findings are therefore applicable to countries looking to implement or refine patient feedback within recertification or educational systems more broadly and improve relationships with patients. Limitations associated with questionnaire methodologies including a reliance on self-reported data must also be acknowledged. Finally, this research only focuses on the perspective of one *community*, i.e. psychiatrists. Future research should examine the activity of patient feedback from other community perspectives including patients.

In conclusion, the value, relevance, and acceptability of patient feedback is currently undermined by systemic tensions. This is not however to suggest that patient feedback is a futile exercise. Rather, existing processes that underpin the activity of patient feedback need to be refined. In the context of psychiatry, the validity of patient feedback is at times unintentionally undermined by tensions identified between: *division of labour*; *community* understanding; *tool* complexity; and restrictive *rule* application, i.e. required response rates. This is unlikely to be unique to feedback collected for recertification purposes and will undoubtedly resonate across other regulatory and educational processes. If patient feedback mechanisms are to be improved, such tensions must be resolved. If they are left unaddressed, the activity of patient feedback is at risk of becoming a "futile exercise", denied the opportunity to develop excellence, patient safety, and professional development.

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Table 1: Mean reported usefulness of patient feedback by specialty.

Specialty	Mean	N	SD	95% Confidence Interval	
				Lower	Upper
Public Health	2.286	28	1.117	1.935	2.637
Pathology	2.443	61	1.009	2.205	2.68
General Practice (GP)[1]	2.493	3216	0.920	2.460	2.526
Anaesthetics and ICU (AICU)[1]	2.552	1168	0.976	2.498	2.607
Occupational Medicine[2]	2.563	197	0.864	2.431	2.696
Radiology	2.656	384	0.970	2.562	2.751
Surgery	2.721	965	1.000	2.661	2.781
Emergency Medicine	2.743	428	0.941	2.653	2.833
Ophthalmology	2.749	358	0.984	2.651	2.847
Medicine	2.775	1250	0.959	2.723	2.828
Orthopaedics	2.775	511	0.993	2.693	2.857
Psychiatry	2.847	1047	0.926	2.790	2.905
Obstetrics and Gynaecology	2.857	516	0.957	2.775	2.938
Paediatrics	2.857	673	0.888	2.786	2.929

[1] Psychiatry mean differs from these specialties at p<0.001, after Bonferroni adjustment
[2] Psychiatry mean differs from these specialties at p=0.010, after Bonferroni adjustment

Table 2: Average number of self-reported patient feedback requests by doctors in each specialty that sought patient feedback (N), self-reported patient feedback responses, and the average of individual response rates (%)

Specialty	N	Requests Made (M)	Returned (M)	Resp. Rate (M)
Occupational Medicine	311	35.56	30.20	101.21*
Radiology	749	27.72	24.66	96.39
Orthopaedics	836	28.68	25.46	92.36
Surgery	1669	28.39	24.53	91.24
Ophthalmology	581	29.34	25.33	90.26
OBGYN	820	29.18	24.99	89.78
Medicine	2416	26.94	22.97	89.62
Emergency Medicine	793	28.47	23.75	87.30
Paediatrics	1181	26.40	21.82	87.15
Public Health	252	19.82	10.81	85.89
General Practice (GP)	6743	44.40	35.29	85.60
Anaesthetics and ICU	2146	26.78	21.15	85.36
Pathology	497	25.34	17.05	84.96
Psychiatry	1761	29.13	19.28	72.53

*Reported value exceeds 100% due to some individual doctors self-reporting that they received more feedback responses than they originally requested.