

## ***“How would you ensure that we listen and respond to the voice of patients in Ophthalmology?”***

Much as it might not always feel like it, the purpose of the healthcare service is to serve our patient population, according to their wants and needs. This is particularly pertinent in ophthalmology: while we might presume we know what is best for our patient’s liver, or spleen, and make treatment plans in their best interests with relatively limited discussion, we cannot make such paternalistic assumptions in ophthalmology. While everyone uses their spleen for the same things, we use our eyes for a myriad of functions, and an individual’s priorities vary massively regarding their vision, between the lifeguard and the ophthalmologist, for example. This is true both on an individual consultation level, regarding what a patient wants for themselves, and also on a larger commissioning scale: which services should we prioritise and how do we improve in a funding-starved NHS? It is also worth noting that collecting service-level feedback from ophthalmological patients presents some challenges unique to the specialty, as while we use terms like “listen to the patient voice”, most feedback collected is written, via paper/electronic questionnaires that provide much more of a barrier to visually-impaired patients than those in other departments. In ophthalmology, maybe we should instead literally *listen* to the voice of our patients. I shall now attempt to unpick how we might ensure that we do so, and why.

### **The Case for Listening**

Sight is the sense people most fear losing<sup>1</sup> and approximately 50% of sight loss is thought to be preventable<sup>2</sup>. As such, ophthalmology provides an incredible opportunity to positively impact patients’ health and quality of life. That said, we cannot have this positive impact with a uniform service. One of the most obvious examples of this is the target refraction in IOLs after phacoemulsification. Even within members of the ophthalmic profession itself optimal refractive result is a personal choice, with emmetropia, or a small discrepancy between OD and OS (mini-monovision) being two popular strategies<sup>3</sup>, but many patients might prioritise driving without glasses, or might have stopped driving years ago and love to read, and it is unsurprising that these people would have different refractive preferences<sup>4</sup>. We can’t provide the best treatment if we don’t know what our goals are.

Patient mindset (and our awareness of it) is also a key player in the increasingly common practice of intravitreal injections. While we might not choose a different anti-VEGF based on patient choice, the likelihood of success of a course of injections is massively dependent on patient attendance for each appointment, and this is not likely in the needle-phobic if we don’t listen to our patient’s fears and, at least attempt to, allay them. Pre-injection anxiety

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<sup>1</sup> College of Optometrists. *Britain’s Eye Health in Focus*. 2011

<sup>2</sup> UK Vision Strategy. 2015

<sup>3</sup> Amon, M et al. *Which IOL would you choose?* CRS Today 2011. <https://crstodayeurope.com/articles/2011-mar/which-iol-would-you-choose/>

<sup>4</sup> Anon. *Cataract monofocal far or near?* Patient UK Forums 2017.

<https://patient.info/forums/discuss/cataract-monofocal-iol-far-or-near--566559>

increases experienced pain<sup>5</sup> so even if we overlook ‘objective’ success of treatments, we need to notice these anxieties and assuage them if we don’t want to cause suffering.

A third argument for listening to our patients is in deciding, on a grander scale, what to fund: what research to pursue and what kind of surgeons to train. If our open-angle glaucoma patients were actually all quite happy with their progressively absent peripheries, would it still be worth performing 5 to 6,000 trabeculectomies a year (as we did in the noughties<sup>6</sup>)? Presumably yes, but without gathering the data about our patients’ quality of life and the impact our procedures make, it may become more difficult to justify the cost of treating non-life threatening conditions when vying for funds with trauma or cardiothoracic surgeons in the future.

### **Teaching Eye Doctors to Use Their Ears**

So how should we go about obtaining this feedback? The GMC strongly recommends the importance of patient and multi-source feedback in the context of appraisal of doctors<sup>7</sup> or e-portfolio assessment, and the Royal College sensibly advises to utilise large-font questionnaires or the assistance of an Eye Clinic Liaison Officer to make standardised questionnaires accessible to visually impaired patients<sup>8</sup>. This is probably sufficient when acquiring feedback regarding an individual doctor, but doesn’t affect either that patient’s own care, or service provision.

In terms of a patient’s own treatment, first of all we must continue to explain to each patient what the likely outcomes of their management are, and give them realistic options to choose from. We also need to find out afterwards if patients are happy with their results. For example, if a large proportion of patients who think they would prefer monovision are actually unhappy with their post-op vision, we cannot say we are 100% successful just because they all wanted IOL power differences and they got it. We would know that we are not sufficiently enabling our patients to make the best decision for themselves, and need to do more for future patients, e.g. by trying to simulate post-op vision with contact lenses of appropriate powers. We could then reassess the number of patients choosing monovision who can tolerate it in the long run. (This could be a relatively simple closed-loop audit.)

This discussion and feedback already happens organically during a consultation, but if we want to be able to measure it and tweak our service we need a more structured set of questions and an efficient and cost-effective method of getting answers. It might also be naïve to assume that feedback directed orally to a patient’s own ophthalmologist is 100% truthful, if the stereotypical British “Yes, of course I love my haircut” scenario can be carried

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<sup>5</sup> Segal et al. *Anxiety levels and perceived pain intensity during intravitreal injections*. Acta Ophthalmologica 2016.

<sup>6</sup> Keenan, Wotton and Goldacre. *Recent trends in the rate of trabeculectomy in England*. Eye 2011.

<sup>7</sup> General Medical Council. *Supporting information for appraisal and revalidation*. 2012.

<sup>8</sup> Royal College of Ophthalmologists. *Peer and Patient Feedback*. <https://www.rcophth.ac.uk/professional-resources/revalidation/preparing-for-appraisal/peer-and-patient-feedback/>

over to healthcare. Working through a questionnaire during an appointment is not feasible with clinic time pressures, and asking patients to complete a paper questionnaire themselves afterwards, although not entirely out of the question, might require help from third parties, and is likely to discourage participation for patients after appointments where they often can't see well enough to drive themselves home (even if only briefly due to mydriatics). One option is the "Press 1"-style phone survey, but this feels outdated and a chore for patients. An area of development that could be perfect for this issue is that of voice-recognition software, which though previously dramatically underwhelming, is becoming much more trustworthy. Software such as Dragon, or Google Docs Voice Typing<sup>9</sup>, could be used alongside recorded questions, to complete questionnaires on the way out of a clinic, without any need for vision whatsoever. This would still necessitate someone to sit down and read/tabulate the results, but the eager medical student could potentially still carry out this role. Alternatively, if Likert scale answers were used for at least some of the questions, analysis of results could also be automated.

### **Putting it into Practice**

Once data is gathered regarding which aspects of treatment are most important to patients, and where we are or aren't meeting their expectations, changes need to be put in place to raise the game. This is the basis of the quality improvement PDCA (plan-do-check-act) cycle. For an individual ophthalmologist's own practice this could occur by flagging any specific areas that their patients aren't satisfied with and making a concerted effort to improve those. Within a department in one hospital, the head of department would likely be involved in planning areas for change, and within a trust, clinical commissioning groups would need to use the data gathered in these "exit polls" to conclude that, for example, our strabismus patients need more support and funding. Although feedback is best anonymised, it could be possible to automatically book a patient an extra follow-up appointment (perhaps with a different doctor) if they have flagged that they are struggling with their post-treatment vision in a survey, and thereby catch unhappy individuals who might otherwise fall through the cracks.

**In conclusion, it is essential to good ophthalmic practice that we make our patients' priorities our own, both when planning their specific treatment, and advancing Ophthalmology within the NHS. If we want to do this successfully, we need to enable patients to speak honestly at all stages of their healthcare journey, and we need to listen to what they have to say. The combination of voice-recognition technology, high standards of communication skills during consultations, and patient-orientated CCGs, will be key to the success of ophthalmology in an uncertain future.**

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<sup>9</sup> Allan, D. *The best voice recognition software of 2017*. TechRadar 2017.