How would you ensure that we listen and respond to the voice of patients in ophthalmology?

The NHS White Paper, 'Equity and Excellence' underlined the Government's commitment to shared decision making in modern medicine[1]. Effective communication based on doctors listening more attentively and responding effectively to their patients is vital for this. It is especially important in ophthalmology. But achieving it is challenging given increasing time pressure, medical jargon, impaired senses and - sometimes - high emotions! Moreover, while the range of available electronic communication channels has mushroomed, this is not necessarily conducive to the kind of dialogue required. I consider what we should be aiming at and how to achieve it.

The need to listen and respond

Listening remains one of the most effective ways for doctors to improve patient-doctor communication, for it increases the patient's willingness to share pertinent information, facilitating successful outcomes. It can allow doctors to grasp the range of personal, financial, cognitive and other factors – 'the big picture' - affecting the patient, and thus create an effective long-term care plan.

Moreover, research suggests that patient satisfaction is more closely correlated with the doctor's communication, than her clinical skills[2,3]. Higher patient satisfaction is also associated with better outcomes for several diseases[4,5]. Additionally, it contributes to increased satisfaction for the doctor, reduced work stress and fewer formal and malpractice complaints[6].

Listening is especially important in ophthalmology. Ophthalmic patients are very often the best judge of whether a treatment worked – they alone really know whether their eyes seem right or their vision improved. This is not the case for many other medical specialities, where the patient's symptoms do not necessarily reflect the underlying pathology to anything like the same extent.

Listening also aids policy formulation. Pooling information communicating by individual patients is vital. But sometimes the individual patient voice is effective too, commonly with media backing, to achieve change. In ophthalmology, patient groups successfully campaigned to change the National Institute of Health and Care Excellence's drafted policy regarding intravitreal injections of ranibizumab in age-related macular degeneration, permitting its usage in both eyes, as opposed to one[7].

The digital world

We live in an increasingly consumer-driven market, with new technologies like the internet facilitating the sharing of consumption experiences – think Google reviews and Yelp. 'Tech-savvy' patients openly - including anonymously - review their healthcare experiences. Visually impaired patients can participate using screen readers and refreshable braille displays. The expanding range of online platforms available provides channels for patients to broadcast their ideas, experiences and thoughts. Moreover, since the information

provided is not only in ‘read only’ format, it is possible for medical service providers to respond with patients directly and to survey with the click of a button.

Prior to this revolution there was no widely available vehicle for patient ‘learning’ to be shared. The question now is how can we improve our care by listening effectively to the patient’s digital voice.

Lessons can be learned from other industries such as aviation, where customer relations staff with strong IT skills play a key business role. Sadly, there has been limited appetite for extending the remit of their NHS counterparts to the digital realm. Admittedly, some hospitals have charged ‘chief listening officers’ to actively listen to and collect data from patients on their experiences[8]. The ‘big data’ that is accrued in this way has considerable potential value to healthcare providers, including the NHS, in highlighting unmet patient needs and enabling them to be met.

Simple point-of-care testing, such as the ‘Smiley Face Survey’ (again, popularised by the aviation industry), is another strategy to listen to patients. This has the benefit of engaging virtually all patients attending hospital or clinic, regardless of their technological ability or vision, monitoring overall patient experience.

Some believe that since a twenty-minute appointment is insufficient to discuss complex issues, pervasive digital connectivity via the internet, subject to privacy and security concerns being addressed, could improve communication. Initiatives such as making patient records accessible on-line and permitting them to leave feedback or update their progress could be beneficial. But such connectivity is likely to further erode face-to-face communication skills. Moreover, contextual issues are often difficult to appreciate electronically, whilst events such as breaking bad news are more appropriately conveyed in person. The increased volume of communication it would trigger could add to doctors’ serious and growing ‘burnout’ problem. Most would not want a continuous patient access, especially if balancing a part-time clinical role in ophthalmology with roles in other fields.

Face-to-face communication

Many of those most in need of healthcare - the elderly, the poor and those with chronic health issues, including visual disturbance - are on the wrong side of the ‘digital divide’. This forces doctors to place a stronger emphasis on their interpersonal listening skills.

But this is difficult since the rise of machines - in the IT/telecommunications area - has diminished human interaction. Computers, which now dominate consultations, provide a portal to access patient records and pathology results, with doctors tasked increasingly to accurately enter data for clinic appointments, consultations and even theatre. Since electronic health records are now legal documents, the priority assigned to such work has increased, especially in an increasingly litigious environment. Given the time it consumes, there is less opportunity for doctor-patient dialogue. The process of data entry also saps the doctor’s cognitive capacity, making it more difficult to provide the bandwidth to communicate adequately with patients, which hinders patient care[9]. Techniques, such as sitting down, facing the patient, maintaining eye contact, giving the patient time to speak

are being devalued. All is not lost, as electronic medical records will become more user friendly, reducing time spent on navigation, but it is a continuing battle to provide sufficient time to listen to patients face-to-face.

Patients have an important role to play in alleviating the situation. They should be encouraged to increase their involvement in medical school curriculums and training boards to ensure a greater emphasis on listening and responding. This is important, for despite an increased focus on listening skills in medical training, there is a tailing off in clinical practice, with holistic patient care downplayed. Moreover, research shows that while communication skill training is initially effective, the benefits lapses over time, which argues for mandatory, monitored refreshment of these skills[10,11].

Simple remedies are also important. Although often difficult in ophthalmology, patient engagement can be enhanced by improving eye contact. The easiest way to do this is by leaving computers out of the consultation, optimising the lighting, sitting down to speak, and ideally employing a scribe to document the discussion, as piloted by some US ophthalmologists[12]. Improved voice recognition software may make this financially feasible in the future. Other methods to facilitate communication with ophthalmology patients include ensuring patients are at appointments on time, creating an environment more conducive for discussion. Examples include colour-coded hospital site maps, and designating floorwalkers to support patients navigating to hospital clinics.

Reflecting time pressures, doctors often fear letting their patients speak uninterrupted - studies show doctors interrupting after 18-23 seconds[13,14]. However, research demonstrates that the average length of uninterrupted patient 'speeches' is only 92 seconds, which means hearing patients out takes less time than we think[15]. Open-ended questions which encourage the patient to divulge useful information are also important. Doctors must also listen to patients at the end of a consultation to check for misunderstandings, especially as studies suggest 80% of the medical information relayed to them is forgotten immediately, with the remaining half factually incorrect[16].

Caveats

An uncritical focus on listening/responding is not desirable. The sheer quantity of data can be unmanageable. Patient experiences are usually specific to them alone. In addition, there is a real risk that paying overdue heed to individual voices leads to the loudest voice holds sway – as with specific media campaigns – which hinders a utilitarian approach conducive to the 'common good'.

Furthermore, despite increasing access to information on search engines, the patient is not always smarter because of it, and it is common to encounter a patient who does not know what is in their best interests. More of the doctor's scarce time has to be spent explaining why such a patient's nostrums are inferior to the doctor's. Often, it may appear easier to placate patients instead of acting in their best interest, for example by providing antibiotics for viral conjunctivitis.

New avenues

While introducing a new communication ethos appears daunting, it has been successfully undertaken. The Rotterdam Eye Hospital has improved patient experiences by trialling new techniques, after consultation with patient advisory groups[17]. Another Dutch hospital improved its poor outcomes by employing a new board with a focused approach of encouraging communication with patients[8].

One fruitful area to work on is research, as in finessing a trial. Listening to patients may help ensure patient-friendly trial medications and identify clinical end-points that are more relevant to everyday-life, for example 'when can I drive again?'

Conclusion

In the face of the crucial contribution that listening and responding can make in ophthalmology, it is vital that an effective strategy is adopted which takes on board the numerous lessons set out above, and encourages continued innovation.

References

1. Health Do. Equity and excellence: Liberating the NHS. 2010.
2. Schoenfelder T, Klewer J, Kugler J. Determinants of patient satisfaction: a study among 39 hospitals in an in-patient setting in Germany. Int J Qual Health Care 2011;23:503-9.
3. Dawn AG, Santiago-Turla C, Lee PP. Patient expectations regarding eye care: focus group results. Arch Ophthalmol 2003;121:762-8.
4. Glickman SW, Boulding W, Manary M, et al. Patient satisfaction and its relationship with clinical quality and inpatient mortality in acute myocardial infarction. Circ Cardiovasc Qual Outcomes 2010;3:188-95.
5. Boulding W, Glickman SW, Manary MP, Schulman KA, Staelin R. Relationship between patient satisfaction with inpatient care and hospital readmission within 30 days. Am J Manag Care 2011;17:41-8.
6. Stelfox HT, Gandhi TK, Orav EJ, Gustafson ML. The relation of patient satisfaction with complaints against physicians and malpractice lawsuits. Am J Med 2005;118:1126-33.
7. Ranibizumab and pegaptanib for age-related macular degeneration 2008. at https://www.nice.org.uk/guidance/TA155/documents/macular-degeneration-agerelated-pegaptanib-and-ranibizumab-final-appraisal-determination3.)
8. Welcome to the hospital of the patient BMJ, 2014. at http://www.bmj.com/bmj/section-pdf/765723?path=/bmj/349/7976/Feature.full.pdf.)
9. Ratanawongsa N, Barton JL, Lyles CR, et al. Association Between Clinician Computer Use and Communication With Patients in Safety-Net Clinics. JAMA Intern Med 2016;176:125-8.
10. Brown JB, Boles M, Mullooly JP, Levinson W. Effect of clinician communication skills training on patient satisfaction. A randomized, controlled trial. Ann Intern Med 1999;131:822-9.
11. Harms C, Young JR, Amsler F, Zettler C, Scheidegger D, Kindler CH. Improving anaesthetists' communication skills. Anaesthesia 2004;59:166-72.
12. The Secret to a Satisfied Patient. 2014. at https://www.reviewofophthalmology.com/article/the-secret-to-a--satisfied-patient.)
13. Marvel MK, Epstein RM, Flowers K, Beckman HB. Soliciting the patient's agenda: have we improved? JAMA 1999;281:283-7.
14. Dyche L, Swiderski D. The effect of physician solicitation approaches on ability to identify patient concerns. J Gen Intern Med 2005;20:267-70.
15. Langewitz W, Denz M, Keller A, Kiss A, Ruttimann S, Wossmer B. Spontaneous talking time at start of consultation in outpatient clinic: cohort study. BMJ 2002;325:682-3.
16. Kessels RP. Patients' memory for medical information. J R Soc Med 2003;96:219-22.
17. How Design Thinking Turned One Hospital into a Bright and Comforting Place. Havard Business Review, 2016. at https://hbr.org/2016/12/how-design-thinking-turned-one-hospital-into-a-bright-and-comforting-place.)