

Beyond needs and expectations: identifying the barriers and facilitators to written medicine information provision and use in Australia

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Abstract

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Purpose This study aimed to explore peoples' needs and expectations of written medicines information (WMI), and to determine the barriers and facilitators experienced or perceived in the context of WMI provision and use.

Methods We conducted eight focus groups with 62 participants over 6 weeks in late 2008 in New South Wales, Australia. Using a semi-structured topic schedule and examples of WMI from Australia and other English-speaking countries as a guide, we explored themes relevant to WMI, including participant experiences, attitudes, beliefs and expectations.

Findings Our findings suggest less than half had previously received WMI, with many unaware of its availability. Many, but not all, wanted WMI to supplement the spoken information they received but not to replace it, and it was predominantly used to facilitate informed choice, ascertain medicine suitability and review instructions. The current leaflets were considered technical and long, and a summary leaflet in addition to comprehensive information was favoured. Accurate side-effect information was the most important element that participants desired. The most common barriers to effective WMI use were time constraints and patient confidence, with participants citing empowerment, time and health-care professional (HCP)–patient relationships as important facilitators.

Conclusion The findings provide insight and understanding of peoples needs and expectations, and clarify issues associated with use and non-use of WMI. Challenges include addressing the barriers, especially of time and HCP attitudes to drive changes to workplace practices, and learning from the facilitating factors to encourage awareness and accessibility to WMI as a tool to empower patients.

Introduction

Increasingly priority is being given to patient-centred care, underpinned by a model of shared decision making about treatments between patients and health-care professionals (HCPs). Particular emphasis is now placed on 'patient empowerment', patient's views and understanding their needs, priorities, social context and experiences.^{1,2} To make informed choices about medicines, patients want to know more about their medicines.³ Consequently, they need reliable and usable information to use their medicines safely and effectively, and assist with decision making based on possible risks and benefits of the medicine.⁴ Providing patients with medicine information can increase knowledge, satisfaction and may be an important tool in developing health literacy through patient education about medicines.⁵⁻⁸

Written medicine information (WMI) is medicine-specific information for patients, commonly produced by pharmaceutical manufacturers, government bodies or third parties from drug monographs. Many countries have implemented regulations surrounding access and supply of WMI. In 1999, the European Union introduced mandatory, comprehensive package insert WMI known officially as the package leaflet (PL)⁹, but commonly referred to as Patient Information Leaflets (PILs).⁹ Since the 1970s attempts in the United States to legislate for WMI have resulted in government regulations limited to specific high-risk medicines. In 1996, an action plan was developed, but targets set by the Food and Drug Administration to implement this plan were not met, and new consultations have begun.¹⁰ Australian legislation requires manufacturers to produce WMI known as Consumer Medicine Information (CMI), for prescription and pharmacist-only medicines, but does not mandate its availability as package inserts or its provision to patients by HCPs.¹¹ The Pharmaceutical Society of Australia and Society of Hospital Pharmacists of Australia have produced guidelines to assist pharmacists to meet legal and professional obligations in ensuring that patients receive the necessary information to make informed decisions.^{12,13} Despite CMI being available for

over 16 years, provision rates remain low with <30% of patients reporting receiving CMI.¹⁴ The introduction of pharmacist incentives and remuneration (although minimal and now part of the dispensing fee), along with stakeholder consultations, and consumer lobbying, has not seen the desired impact on CMI provision and utilization.¹⁴⁻¹⁶

Although WMI is available for patients internationally, there are reports of patient dissatisfaction with quantity, quality and content.^{2,17,18} WMI is frequently developed without patient input, often written by manufacturers or persons who may be far removed from the user. As a result, WMI content may not meet patients' expectations, needs or priorities – rather serving the agenda of legislators, medico-legal professionals or HCPs of increasing medicines adherence.^{1,19,20}

Considering the widespread availability of WMI, a systematic review found only a small number of research studies (27 over a period of 30 years) on patient perspectives.¹⁹ There is limited research exploring the underlying reasons why WMI is not more frequently provided and utilized, and what might facilitate increased uptake and use by patients. Numerous studies have investigated issues associated with verbal counselling or service provision by HCPs, with a small number focusing on community pharmacists' barriers and facilitators.²¹⁻²³ However, less attention has been directed to patient perceptions.

In understanding the patient perspectives regarding the barriers and facilitators to the provision and use of WMI, we can inform future research, increase awareness and uptake, enhance effective use, and encourage patient involvement in their medicine treatment. Thus, the aim of this study was to explore people's opinions on their WMI needs and expectations, and elicit the barriers and facilitators to provision and use.

Methods

Setting and participants

We undertook a qualitative study, using focus groups, to explore people's attitudes to and beliefs about WMI. The participant frame was

people of 18 years of age and over, who were taking or had taken at least one prescription medicine in the last 12 months. People who could not take part without the help of an English translator were excluded from the study. Eligible participants were purposively sampled with respect to ethnic and socio-economic backgrounds and were recruited through a market research company from their large consumer database. Focus group sizes were limited to six to eight participants. The study received approval from the Human Research Ethics Committee of The University of Sydney.

Sixty-two people participated in eight focus groups. Six groups were held in Sydney and two in rural areas of New South Wales over 6 weeks in late 2008. The characteristics of the focus group participants are shown in Table 1. The groups were held in a convenient and informal environment, each lasting between 1 and 1.5 hours and were audio-recorded with permission. Participants were reimbursed a nominal amount for their time.

Focus group conduct

A research team member and experienced health services researcher (PA) facilitated the focus groups, with another researcher (KH) observing

and taking notes. Both introduced themselves and their affiliation, but not their specific profession (pharmacists), to avoid any bias in responses. We used a semi-structured interview guide to allow the discussion to evolve. The groups began with a general discussion about participant experiences with WMI, before specifically exploring the following key dimensions: *needs and expectations* of medicine information; *awareness* of the availability of WMI; medicine information *seeking* behaviour; and the *barriers and facilitators* to WMI provision and use by patients and HCPs.

Participants were asked to comment on a selection of WMI leaflets from English-speaking countries (Australia, USA, Canada, New Zealand, United Kingdom and Ireland), with the main discussion concentrating on Australian CMI. Leaflets were selected to be sufficiently different to provide participants with a sense of the scope of styles and lengths currently available worldwide, and put the Australian CMI into context.

Following each focus group, the two researchers held a debriefing, discussing emergent themes alongside observation notes. Focus groups were conducted until no new themes emerged.²⁴

Table 1 Characteristics of focus group participants

Participant characteristics	<i>n</i> = 62	%
Gender		
Male	24	39
Female	38	61
Country of birth		
Australia	46	74
Overseas	16	26
Language spoken at home		
English	59	95
Other	3	5
Education level		
High school	40	65
Diploma or certificate	7	12
Bachelors	11	18
Post graduate	4	5
Age		
21–40	18	29
41–60	20	32
61–80	24	39

Data analysis

The audio-recordings were transcribed and reviewed before thematic content analysis, using techniques adapted from the grounded theory method.²⁵ The transcripts were initially open-coded in conjunction with observation notes. Open-coding was followed by second-level coding, to further explore and extract themes to develop the theoretical framework.²⁶ A system of 'constant comparison' through cross-referencing of emerging and recognized themes was used, with data periodically grouped and regrouped into similar themes through an inductive process. Two researchers (KH and PA) independently reviewed the transcripts, providing separately tabled coding categories and summaries, which were crosschecked and reviewed for consistency. Discussion and

refining of the coding frames reconciled any discrepancies, with finalized coding frames charted then mapped to analyse the range and interaction of themes.

Findings

The major themes were grouped into five broad categories in alignment with the key dimensions we aimed to explore. There were no observed differences in opinions about WMI between participants from metropolitan and rural areas. However, there was considerable reliance on pharmacists for medicine advice and WMI in rural communities. These communities frequently had issues of accessibility to doctors, and pharmacists were identified as a valuable consultation point. Participants from rural areas expressed greater satisfaction with, and more frequent receipt of, WMI from the pharmacist than their city counterparts.

General experiences with WMI

Significantly, most participants did not want WMI to replace the spoken information they received from their HCP, stating the face-to-face interaction with the doctor or pharmacist, however brief, was valuable because they felt part of the treatment process.

It is really important when you have that face to face contact. These [leaflets] are great, having information you can read, but when you have got a pharmacist that can say "Righto, this might happen, that might happen", you can say, "What will I do?" ... I think having a good pharmacist makes the world of difference, especially for someone who may not be well educated, to try and read this and maybe not know where to start.
(Focus Group 7, Female 1)

Most of these participants thought it important to receive written information, believing that WMI is needed post-consultation as a tool for reviewing instructions, assisting in informed decision making and clarifying questions not raised during prescribing or dispensing. Some participants wanted WMI, as they felt uncomfortable relinquishing control, acknowledging

the possibility that their HCP can make an error or overlook crucial information. They were generally active players in their health and felt responsible for ensuring that decisions about treatment were not left entirely to others. However, a number of participants were uninterested in receiving WMI, being content with spoken information, often stating they had a trusting or positive relationship with their doctor, and saw no need to question the doctors' expertise and training with regard to treatment decisions.

The majority of participants reported that the WMI shown could be more patient-centred, raising the issue of the technical and wordy nature, and the overall poor usability of most WMI for the average layperson. Many found the information to be ambiguous and difficult to comprehend especially because of the frequent use of medical jargon and lack of explanations, thus creating concerns about causing unnecessary worry or alarm for recipients, especially those with English as a second language or limited literacy.

There was no consensus on the amount of information participants wished to receive, as this would depend on individual circumstances and the perceived seriousness of their condition. Participants generally indicated a preference for concise information that summarized a medicine's main points, with access via the internet or their HCP, to comprehensive leaflets that included supplementary disease and lifestyle information. Some felt that concise medicine leaflets may facilitate HCP provision, allow time for a brief review with patients and alleviate concerns of feeling overwhelmed or intimidated by the visual appearance of the leaflet, as many participants indicated they did. Most stated they would be more likely to read information that was shorter and to the point, however, some agreed that there would be times where more complete information was desired. Others wanted nothing left out, expressing concern about the decision making process associated with omission of information and felt uneasy with loss of what could be potentially crucial information.

You know I would want everything. I wouldn't want them to leave out something that might be important to me. Do you know what I mean? There might be that one thing (FG4, F2)

Most participants felt that a summarized version of WMI could be delivered as a package insert to ensure accessibility.

There was a general feeling of suspicion about the trustworthiness of WMI. The language used in the leaflets produced was perceived as legalistic and many questioned the credibility of its source.

If anything goes wrong 'see your doctor'. It is encapsulated in all these pages. It is sort of covering itself. Maybe I have got a suspicious mind, but it just seems to me that they are sort of shedding any responsibility from their company onto somebody else. (FG7, M2)

They felt that an independent source and not the manufacturer should write the leaflets to make the information valid and unbiased.

Information needs and expectations

Participants discussed the core information needed to take their medicines safely and effectively. The common areas identified were as follows: side-effects, how to take the medicine, interactions with drugs and food, how long to take it and monitoring/expectations of the medicines effectiveness, how it works, storage and disposal. Other points of information discussed were dosage strength, missed dose, ingredients, allergies, expiry date and the long-term effects of taking the medicine.

The most important element of information identified by participants was side-effects, with many expressing serious concerns about experiencing or being affected by them, especially regarding their quality of life. Side-effect information caused a dilemma for participants; there was the important element of 'knowing' what could happen, a desire for preparedness, yet statements by some indicated they intentionally avoided information due to fear of potential side-effects and the ensuing worry this caused them.

We say, why didn't they tell us. We want it both ways don't we? We want to know then we complain when they give us the information. Its your choice isn't it, when you have that choice it comes back to you. (FG4, F4)

Most participants, however, wanted side-effect information, and its frequency described both textually and/or numerically, to aid decision making and ascertain their personal risk of experiencing side-effects. Despite the concerns about side-effects, the majority stated this would not influence their adherence.

Participants frequently needed information on monitoring a medicine's effectiveness, noting a current lack of information both verbally and written on expected results and timeframes to achieve these, as an assurance of their medicines efficacy, and a prompt to seek further consultation if necessary. Furthermore, many considered current WMI to be predominantly risk-oriented.

I have yet to read anything that gives you a positive side effect, you know, you are going to become better looking if you take it. Every side effect is always negative. So if you concentrate on the side effects no-one is ever going to put a tablet in their mouth (FG3, M2)

They suggested the inclusion of benefit information had the potential to offset the negative side-effect information and provide a balanced viewpoint, assisting in their assessment of side-effect risks vs potential benefits of a medicine.

Participants expected to receive information about alternative medicines or treatment options, including non-pharmacological and complementary medicines, to determine the 'rightness' of the prescribed treatment for them personally. Some felt that HCPs were generally unwilling to discuss options other than traditional medicines and were frustrated that a more holistic approach was often not adopted. As a result, they frequently looked for this information elsewhere.

Overall, there was a lack of consensus on the 'right' level of interaction between the participant, WMI and HCP. During consultations, some desired a discussion of the medicine leaflet, whilst others wanted it provided on the understanding of asking further questions later if

needed. Some simply wanted to know where to access a leaflet if required.

Awareness and sources of information

Less than half of the participants had received WMI (as CMI) in the past, and those that did had requested it whilst seeking further information. Few had received a CMI without asking; the main supplier being the pharmacist, with a minority receiving it from their doctor. Overall, there was limited awareness about CMI availability, with awareness resulting from pharmacy advertising, friends or relatives, or through the prompted (or unprompted) supply by pharmacists. Interestingly, despite limited numbers of medicines containing CMI as package inserts (in Australia), most participants were aware of them.

The time and situation of delivery of WMI was seen as crucial. Participants thought the doctor should logically provide WMI at the time of prescribing, as many wanted to read it prior to collecting their medicine to determine its suitability for them, offering an opportunity to engage with their doctor in the decision making process, and to address any concerns or questions promptly.

If the doctor gave it that would be good because you leave the doctors surgery with a script, you think 'oh yes I'm going to get better because they've given me this script'. Then you're reading it on the way or waiting in the pharmacy line, then at least you know well maybe I don't want this.... at least you've got the information before you fill the script. (FG2, F3)

Doctors were able to prescribe and alter medicine therapy, knew the patients' medical history and consultations were more 'personal' than with a pharmacist. Some participants felt that doctors were generally more abreast of current information than pharmacists, received payment for their time and expertise, and had a duty of care to provide WMI. Most participants conceded that time constraints during consultations were an issue and seemed resigned to the fact this was unlikely to change.

In contrast, others thought pharmacists were a more readily accessible source of medicine information, typically having more time and expertise to be able to deal with questions. Many envisaged the doctor as the diagnostician and the pharmacist as the medicines expert. The pharmacist was often seen as the 'back-up' to the doctor for medicine information and was regularly relied upon by several participants for advice about their medicine.

Participants frequently used the Internet to search for WMI, predominantly using 'Google', mainly due to a lack of information provided by HCPs, to double check on spoken information provided, or to check a medicine's suitability. However, a number of participants were concerned about the quantity of information on the Internet, the difficulties in identifying 'legitimate' information and their subsequent ability to disseminate the information.

Barriers

Overwhelmingly, the most commonly reported barrier to receiving WMI was a lack of time, both HCP consultation and patients' time. Participants complained that doctor consultation times were generally too short and they frequently felt conscious of people waiting, often preventing them from asking for further information, including WMI, about their medicines. Observations specific to pharmacists were that business considerations and shopfront sales often took precedence over what should be professional obligations concerning patient medicine information needs.

Interestingly, many participants saw themselves as a barrier. Some felt uncomfortable approaching or discussing medicine information with their HCP because of a lack of confidence or the necessary communication skills, a lack of positive HCP-patient relationship or a feeling of powerlessness within this relationship.

... there is a power imbalance; they are the authority and you are not... I think patients have to take responsibility, but not everyone is like that.

If you are sick, you are a vulnerable person, and you really go there for help. There is this power imbalance and I think this is a real problem.
(FG7, M1)

Others thought insufficient demand for WMI by patients had led to the lack of routine provision by HCPs during prescribing or dispensing; predominantly because patients believed it was available as package inserts in all medicines or that there was no need for this information until a problem arose.

Educational limitations, language barriers (English not primary language) or lack of literacy were other important factors that many felt influenced their or other patients desire to seek WMI. Several participants were not native English language speakers or had family members who relied on them to translate information for the safe administration and use of medicines, so they were concerned about the lack of availability of WMI (as CMI) in Australia in other languages and the consequent potential for harm.

The attitude of HCPs to medicine information provision was seen as not conducive to shared decision making or patient autonomy by several participants. The common perception was of reluctance by HCPs to provide WMI. Participants thought this may be due to HCP beliefs that patients might find the information 'scary' and 'anxiety-causing' or feel a sense of 'nervousness' of patients' responses to side-effects and risk information, with HCPs concerned this could translate to 'ghost' adverse effects, non-adherence or ceasing the medicine. Some believed HCPs withheld such information because it may generate questions they could not answer, or result in time-consuming or return consultations.

Accessibility was problematic, with inconsistency of provision evident. Although participants perceived that mandating compulsory WMI provision in Australia as package inserts or via HCPs would address the issue, some felt that the meaningful interaction between HCPs and patients could be jeopardized.

Facilitators

Interestingly, despite all the barriers participants experienced or perceived, many felt ultimately the responsibility to ask for medicine information (written or otherwise), lay with the patient. They believed it was up to the individual to facilitate and be proactive about their own health information needs and that WMI should be promoted as a tool to empower patients.

The importance of continuity of care through a regular HCP was seen as a significant facilitator in fostering a relationship of information sharing, trust and empathy.

I think everybody should have a relationship with a pharmacist at least, well equivalent to the doctor. When you are talking to your doctor there is a sort of intimate bond between you and the doctor, because you are relying on him for your health needs. And then you take the prescription along to the chemist who knows exactly ... my prescriptions.... I believe in having that same relationship with my pharmacist as I do with a doctor, and in return they respond in a similar way (FG7, M2)

Participants also wanted more time with their HCP during consultation, stating they would be more likely to ask questions and discuss or seek clarification about their medicines. Some indicated their HCP was more likely to offer or provide, often unprompted, additional medicine information, including WMI, when unhurried. They welcomed this worthwhile interaction, with some commenting that a simple offer of information made them feel valued and involved, feeling as if they had received an 'extra' service, despite perhaps not initially wanting further information.

Practically, many participants thought HCPs could implement software or workflow systems changes to prompt provision. Some suggested (and had used) self-serve medicine information kiosks in the past and proposed these be made more readily available in HCP practices. The use of internet and multimedia technologies such as text messaging, emailing and audio files was advocated, although there was resistance to this by several participants because of privacy concerns and/or accessibility by certain sections of

the community e.g. the elderly. Participants also recommended advertising WMI availability within the community, through targeted awareness campaigns, and medicine-focused education programmes at varying stages of life to encourage patient awareness and responsibility for their medicines.

Discussion

It was clear participants welcomed and valued written medicine information, and the need for usable, manageable information was evident. Despite efforts focusing on readability and visual presentation, we are still not producing medicine leaflets patients want to use.^{27,28} Australian CMI has the highest compliance on recommendations for readability and visual presentation, compared with those from selected English-speaking countries, yet complaints persist.²⁹ Participant preference was for straightforward and easy to understand information that takes into account the context, logic and experiences of the patient, in a language they understand. The varying needs and expectations of WMI based on personal circumstances suggest that serious consideration be given to the availability of leaflets in different formats, as the current one-size fits all approach may no longer be adequate in meeting patient needs. The initial tiering of levels of information through the shorter style summary leaflets, with longer comprehensive leaflets available, could facilitate improved access and use by HCPs and patients. Others have proposed this and the future challenge will be in providing customized tailored information relevant to patient needs.³⁰

Whilst it was evident that participants wanted written information about their medicines, they did not want it to substitute spoken information from their HCP, echoing other findings.^{31–33} Research suggests that around one-third of patients prefer the doctor to make decisions for them.³⁴ This may explain the proportion of participants reporting they were content receiving no further written information. Our findings support existing research concerning patients accessing and using information in the written

format for use in risk-benefit analysis, informed decision making and control over their health.^{31,35} We confirmed evidence of WMI being used for reviewing or checking information provided by the HCP, for reassurance, to manage treatment or to ascertain a medicines' suitability.^{19,36–38} In addition, our participants specified wanting written information about their disease and other treatment options. Providing and using WMI may not guarantee decisions about taking medicines will be made simpler for the patient, but may be the catalyst necessary to change practice from one of a unilateral decision by the HCP to that of collaboration with the patient, supporting the transition away from the 'patient information' discourse to one of 'patient empowerment'.^{1,2,39}

Unsurprisingly, the most important information participants wanted to know about was side-effects.^{3,18,40} Patients use WMI to prepare for what they may experience, to identify actions to take, the likelihood of side-effects, and to decide whether to take the medicine.^{3,19} Many participants felt the leaflets were predominantly risk-oriented and worried that the information could cause unnecessary concern and anxiety. Evidence suggests patients want the concomitant presentation of benefit and harm information owing to a relationship between risk and benefit appraisal, providing an explanation of participants desire for the inclusion of benefit information and meriting further research into the area.^{33,41}

As the majority of participants indicated they were unaware of the availability of, nor had received WMI, the option of mandatory provision as package inserts or through HCPs was a remedy considered by some participants. A UK study showed 97% of people noticed and 83% retained the PIL since implementation of mandatory package inserts in Europe. Although 71% of first-time UK users read some of the leaflet, 60% of repeat-users had subsequently never or rarely looked at the leaflet, indicating use is still limited, signifying package inserts may not be the panacea they might seem.⁴² Furthermore, WMI (as CMI) in Australia is essentially developed without patient input, and the

perception that a medico-legal theme predominates has been noted previously.^{2,18,19} Unfortunately change could prove difficult, as in practice strict regulations and legal frameworks govern the development of patient information by manufacturers. Differing manufacturer views and priorities of patients' information needs, and divergent readability and comprehensibility considerations may contribute to the lack of patient-centred leaflets, highlighting the necessity for substantial emphasis and research on patient-centred development and testing of leaflets, especially involving the end users.^{43,44}

The desire for more time in HCP consultations to receive and discuss written information about their medicines was common among participants. Pharmacists have also reported time as a barrier to providing WMI.^{21,45} Given the increasing strain on the health-care system, it is unlikely that consultation time pressures will reduce. Broadening of paid medicine reviews, counselling services, and delivery of medicine information by and beyond that of HCPs, could be important facilitators to increased provision and access, and in reducing time burdens upon HCPs. Considerable progress has been made in accessibility to health and medicine information on public websites, supporting a growing trend of patients searching the Internet for medicine information, filling the void left by a lack of HCP provision.^{46,47} Recent changes in Australia provide a centralized patient access point to WMI (both CMI and Product Information) through the Therapeutic Goods Administration website.¹⁵ However, access to the Internet has created challenges for patients in identifying credible information, and strategies to educate patients may need to be introduced. With this in mind and within the context of rapid technological change and emerging multimedia options, effective and strategic harnessing of these technologies could improve access and communication to patients in their own time, as well as offering the potential for additional benefit to those with literacy, language and visual impairment challenges.^{48,49}

The HCP–patient relationship and continuity of care are important facets of our analysis that

should not be undervalued. The ability to engage effectively with WMI is a prerequisite to informed decision making.⁴⁸ A lack of HCP relationship may affect a patients' trust and confidence to discuss their information needs and is an influential consideration when contemplating the problems with WMI provision and utilization.³⁵ Participants were more likely to receive information, written or otherwise, ask for further information, and seek clarification of their medicine when they had a positive relationship with their HCP. Interestingly, participants indicated satisfaction with even the simple intervention of the HCPs offering WMI. The influence of the HCP–patient relationship should not be underestimated as HCPs play a vital role in initiating and encouraging open discussion about a patient's medicines'.

Lastly, concerns were raised about the role literacy played in using WMI. Patients need to be familiar and confident with the language and terminology used, increasing the likelihood of them reading or using it. The implementation of educational tools and 'how-to' programmes have the capacity to act as important facilitators in assisting patients ability to find, understand and act on information they read, resulting in improvements in health literacy.⁴⁹ The improvement of health literacy may empower patients, providing them with the knowledge and confidence to navigate and understand health information.⁸

This study contributes to the debate surrounding the patient's view of WMI. Many of our findings build on prior research on patient opinions of WMI access, comprehensibility and use in informed choice and shared decision making, whilst shedding fresh light on the barriers and facilitators to its provision and use. The study itself is, however, qualitative and not generalizable to the entire Australian population. We recognize it was conducted with volunteers and is thus limited by the self-selecting nature. Whilst the study was completed to theoretical saturation on a large group of participants, these findings do not represent a consensus or indeed 'the patients view', rather a series of views that are context dependent,

influenced by various individual health beliefs, narratives and dynamics within the focus groups that took place.⁵⁰ The findings should thus be considered as groundwork for further research into the area.

Conclusion

The factors surrounding the provision and use of WMI by patients are complex. A one-size fits all approach may no longer be suitable or acceptable to patients, and failing to take into account the needs and preferences of patients may result in further wasted effort. People want high-quality information that is legible, comprehensible, usable and set within the context of their needs. WMI should not replace spoken information, but used to effectively supplement it. Personal interaction and HCP–patient relationship is a key component to engaging and empowering patients in a dialogue about their medicines. Awareness and accessibility of WMI should be addressed in conjunction with essential ongoing medicines education, because simply providing information, irrespective of quality, without the ‘how to’ and ‘why’ does not encourage patients to take their medicines confidently, safely and rationally. The issues, especially of time and HCP attitudes, need to be tackled as a priority to drive changes to workplace practices and beliefs. The key to enhanced WMI use may be to learn from the barriers and build on the facilitators.

Declaration of interest

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