approaches engender a sense of ownership of the process and are consistent with educational theory.¹⁶

However, although these training programmes may help professionals to assimilate the philosophy and skills required for involving patients more in decision making, more is still required. Clearly, professionals need to engage with such training and this is not automatic. Motivation for participation in the training is achieved in some healthcare systems by financial incentives or the requirements of revalidation or re-certification. However, a further stimulus should not be neglected—namely, the expectations of patients and patient advocate groups. At present, in the UK at least, a substantial proportion of consumers do not apparently wish to be involved in making choices about their treatment or care,¹⁷ but evidence is also accruing about the benefits of involvement and decision support.³ There is therefore justification for continued pressure on professionals from patient advocate groups to promote and expect newer consulting approaches. This may prove to be the most crucial influence. At a wider level, it may also be a case study in making explicit the links between patient expectations, professional development requirements, and training programmes. It may provide a model in which professionals identify their needs for continuing professional development directly from the needs of patients and seek new training opportunities.

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Ensuring patients' satisfaction with information about their medicines

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Patients crave information. I am writing this while an in-patient at a London teaching hospital, and the need for information is almost palpable. Patients exchange whispered conversations in which they pass on intelligence (or not) about the ward, its staff, and medical procedures. Visiting time is characterised by families getting cross with the patients because they can't answer detailed questions and "should ask the doctor". Nurses are generally amiable but know little about the individual patients. The pharmacist stalks the end of the beds, reading drug charts while avoiding eye contact and failing to introduce him/herself. Doctors parry questions with the deftness of an Olympic fencer, or give a direct answer which, while factually correct, leaves one yearning for context within which to interpret the facts.

While a patient can be dissatisfied yet cured in hospital (because things are done to the patient), in primary care patients generally look after themselves so they need to be willing partners. The importance of the active cooperation of patients is never more clear than in the case of medicines, the mainstay of treatment in primary care. It has been known since Hippocrates' time that patients do not always take their medicines as directed (sic) by the physician. We now divide these people into intentional and unintentional non-adherers, recognising that, although the end point may be the same, the issue of intentionality is crucial. Why should a patient follow medical advice? Anthropologists have taught us about medical pluralism, a term describing the ways in which patients take advice from more than one specialist or individual. The advice

from the doctor is therefore weighed with that of the daughter, the neighbour, the person in the health food shop, and so on. Doctors may believe in science, but that is no reason why patients should.

Patients increasingly require some sort of rationale before following advice. We know that about a third to a half of patients on chronic medication do not follow the advice of their prescribers when it comes to medicine taking. Some of these are doing so unintentionally, perhaps because they cannot remember complicated polypharmacy regimes, and others do so intentionally, perhaps because they have beliefs that medicines are bad, or addictive, or just that the doctor did not understand their problem.¹ The only way we can deal with these problems is to engage with patients and to explain our knowledge and views to their satisfaction. If patients are not satisfied with the amount of information they have received about their medicines, questions remain in their mind and they are more likely to become non-adherent.

How can we know if patients are satisfied with the information they received about their medicines? Help is now at hand in the form of a questionnaire, described by Horne and colleagues in this issue of *Quality in Health Care*.² Several questions probe two broad agendas—do patients understand how to take the medicine and what it does, and do they know the risks of taking it? The authors show not just that their instrument (the Satisfaction with Information about Medicines Scale (SIMS)) is reliable, but that it broadly predicts self-reported adherence.

Non-adherence can extend suffering and allow unnecessary disease progression; it also has significant financial consequences. In the UK the NHS spends approximately £6 billion each year on medicines, of which about 80% is spent in primary care. There are few estimates of the economic consequences of non-adherence, but one of the most quoted estimated that 1.7% of healthcare expenditure in the USA was spent on hospital admissions following non-adherence.³ Something that helps to predict this event must be of practical use in the health service.

When should we check that patients are satisfied with information? There should not be a single time point, but many, as patients' satisfaction with information could not be expected to be static. They may first receive information in the consultation. Most prescribers could certainly give far more information in the consultation⁴; however, not all would be remembered.⁵ When the patient gets home, questions arise as they first use the medicine and integrate it into their daily lives. They may worry whether the medicine is working and whether it is causing side effects.

If patients' satisfaction with information about medicines varies over time, we need to measure it repeatedly and the SIMS should be used accordingly. Prescribers should try it in the surgery. Pharmacists dispensing repeat prescriptions could give it out (and respond to it) routinely when a patient presents with a repeat prescription. Primary care groups in the UK could use it as an audit of their prescribers and pharmacists. It is simple, quick to administer, and easy to record the findings.

The SIMS is not a complete solution. There is debate over what the exact role of information should be in the prescribing relationship; however, all sides agree that more information should be given. At present, when patients take a medicine they give tacit consent to the associated risks—perhaps, as Sharp has argued,⁶ we should have informed consent for medicines. Satisfaction with information is just a small part of this large agenda, but it is measurable, achievable, and embodied in an instrument that is easy to use. While we work on the big picture, the SIMS gives us a useful tool for the present day. It is not perfect, but it is here and should be used.

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What changes are needed to provide better standards of stroke care?

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About 4.5 million people worldwide die from stroke each year, and 9 million are estimated to be living with its consequences. One in every three deaths in the UK results from stroke, and it is the single greatest cause of disability in the adult population. Given that the incidence of stroke is estimated to rise by as much as 30% over the next 20 years,¹ it represents a major and ongoing challenge for society. For the people who survive the initial insult, there can be residual difficulties with self-care and mobility, communication, cognition, or emotional wellbeing. Such limitations can bring about major changes in “life”, impacting on roles and relationships within the family, social circle, and work. Stroke can clearly be a devastating condition for the individual and his or her family, but dedicated stroke services have been shown to reduce the impact both in terms of mortality and morbidity.

Quite why stroke units work is yet to be clearly established. They rely on a complex combination of skilled staff in a range of professions, acute treatment with thrombolytic agents, early mobilisation, patient motivation, and a host of other factors. Discerning and monitoring the most active ingredients is therefore a difficult task. However, a number of aspects of management^{2–3} have been identified as key components of improved care for people with stroke, and the paper by Rudd and colleagues in this issue of *Quality in Health Care*⁴ is a timely exploration of how the UK is performing in providing that care.

Rudd *et al* outline a number of areas where there has been improved compliance with standards of best practice in stroke care since the first stage of the national sentinel

audit of stroke in 1998. They explore the degree of this improvement and evaluate whether the audit process itself has contributed to the gains. A number of interesting issues are raised in the paper, which hopefully will stimulate ongoing attention to what constitutes “good stroke care” and how best to provide it, as well as what constitutes “good audit” and how best to do it.

Given what we know about aspects of management linked to improved outcomes, it is somewhat depressing to read that the organisation and process of care for people who have a stroke remains geographically variable and less than optimum in many ways. Nevertheless, the paper describes some very positive changes between the two phases of the audit, including:

- an increase in the number of stroke units;
- an increase in the number of consultants specifically responsible for people following a stroke;
- the development of interdisciplinary documentation.

Such structural developments are impressive and, if audit has helped to bring those changes about, all credit must go to healthcare professionals and management for responding positively. There seems little doubt that the efforts to involve relevant stakeholders in developing the audit tool and the wide dissemination of results has contributed to the successes reported. Obtaining strong participant involvement is vital to the success of audit. Johnston *et al* propose a number of success inducing strategies including the introduction of a modern (preferably electronic) system of medical records, the appointment of dedicated staff, and provision of protected time. It