

# Assessing the public's attitudes and receptivity to follow-up communication from healthcare providers

---

→ **Parisa Aslani<sup>a\*</sup>**

PhD  
parisa.aslani@sydney.edu.au

→ **Vivien Tong<sup>a</sup>**

PhD  
vivien.tong@sydney.edu.au

→ **Ines Krass<sup>a</sup>**

PhD  
ines.krass@sydney.edu.au

→ **Stephen Robson**

MBS  
Healthy Thinking Group, 154 Pacific Highway,  
St Leonards, NSW 2065, Australia  
steve@healthliteracyaustralia.com.au

<sup>a</sup>Faculty of Pharmacy,  
Pharmacy and Bank Building (A15),  
Science Road,  
The University of Sydney,  
Camperdown,  
NSW 2006, Australia.

\*Correspondence

## SUMMARY

**Introduction:** Requiring patients to consent to receiving follow-up health information from healthcare professionals (HCPs) is not universal and varies between countries. Limited research has explored the public's views on an opt-out process for receiving such follow-up from HCPs in Australia, where the current norm is an opt-in process.

**Aims:** To explore the Australian public's attitudes, perceptions, and receptivity to an opt-out approach for the provision of tailored health-related information to patients by registered HCPs.

**Materials and Methods:** Six focus group discussions (1–1.5 hours in duration) were conducted with a total of 46 participants in Sydney during October–November 2016. People's views on an opt-in or opt-out approach to receiving ongoing follow-up health information were sought. Discussions were audio-recorded, transcribed verbatim and thematically analysed.

**Results:** Mixed opinions were identified regarding opt-in or opt-out approaches to receiving information. A few participants queried the need for consent (opt-in), as it was seen as the HCP's duty of care to follow-up and provide information. An opt-out process was seen to facilitate informed choice. Those preferring to opt-in felt it would offer them more control in receiving follow-up and could help ease pressures on HCPs. They agreed that consent was only needed once for a HCP to provide ongoing information. The logistics of offering follow-up information services at every consultation was queried. Previous follow-up may influence preferences for an opt-in or opt-out process.

**Conclusions:** There is some support for opt-out, HCP-provided follow-up information. Further research is needed to quantify broader population views on the consent process for follow-up information and factors that influence these views.

**Keywords:** Medicines information, health information, opt-in, opt-out, preferences

## INTRODUCTION

Medicines are the most common treatments applied in healthcare. When used correctly and responsibly, medicines result in improved health outcomes. However, to use medicines appropriately, patients must be well informed about their purpose, correct administration, how to monitor their impact, and to identify and act on issues arising from using the medicine(s), such as adverse drug reactions. The predominant approach to informing patients has been through spoken information, delivered primarily by doctors and pharmacists (Aslani et al. 2010). However, over recent decades, there has been an increase in the availability of written medicines and health information. Key drivers of this trend have been rising consumer demand for more medicines and treatment information than they have routinely received from healthcare professionals (HCPs) and a noticeable shift in healthcare towards patient-centred care, underpinned by concordance and shared treatment-decision making between HCPs and patients (Aslani et al. 2010).

Written medicines and health information, provided with spoken information, may improve self-management and adherence to medicines, through increased knowledge and awareness (Raynor et al. 2007, Aslani et al. 2010). Consequently, information provision and patient education are key components of intervention programs aimed at improving self-management and medication adherence.

A number of channels, including face-to-face consultations, websites, social media, mail and email are available for dissemination of written medicines and health information. However, if patients are to use written information to learn about their medicines and their correct use, they must first be prepared to accept this information. It is therefore important to know how receptive people are to receiving information.

Current Australian legislation (Privacy Act 1988, c2017) requires patients to consent to receiving follow-up information from HCPs; that is, an opt-in system, where patients actively agree to receiving direct follow-up information regarding their health, medical conditions and/or medicines. This can be challenging to ensuring that patients receive appropriate information in a timely manner. Alternatively, in an opt-out process, all patients continue to receive information directly from their HCPs, and can still actively choose not to receive further information at any time.

This study therefore aimed to explore the public's

attitudes, perceptions, and receptivity to an opt-out approach for the provision of tailored health-related information to patients by registered HCPs.

## MATERIALS AND METHODS

Ethics approval for the study was obtained from The University of Sydney Human Research Ethics Committee (ethics approval number 2016/728).

Focus groups were chosen as the qualitative method to achieve the study aims, as the group dynamic can assist in stimulating rich discussions among participants (Kitzinger 2006).

### Participants

Participants were recruited using a market research company. Potential participants were identified through their database, contacted, and screened against the inclusion criteria. Individuals were eligible if they were 18 years of age or older, able to take part in focus group discussions without the help of an English translator, and had at least one chronic medical condition (defined as a medical condition that has been, or is likely to be, present for at least 6 months). To ensure diversity, participants were recruited from a range of geographic locations, medical conditions and age groups.

### Focus group protocol

A series of 6 focus groups, approximately 1-1.5 hours in length, were conducted in October-November 2016 at various locations in metropolitan Sydney. The focus groups were conducted by an experienced facilitator (PA), supported by other researchers (VT and/or IK). Field notes were also taken (VT). All discussions were guided by a semi-structured focus group protocol, which broadly focused on:

- 1) Participants' information sources with respect to their medical conditions, medicines, and/or lifestyle/health and wellbeing;
- 2) Perspectives on systems facilitating receipt of health and/or medicines information;
- 3) Perspectives on receiving information directly from their HCPs; and
- 4) Perspectives on an opt-out system approach to receiving information and follow-up.

This paper reports on the findings from topics 3 and 4.

### Data analysis

All focus group discussions were digitally audio-recorded with participant permission. All recordings

were transcribed verbatim and subsequently verified against the original audio-recording and de-identified in preparation for analysis. Thematic analysis (Green and Thorogood 2014) was conducted independently by two researchers (PA and VT) to ensure validity and reliability.

Preliminary data analysis involved systematically reading transcripts to identify broad trends and differences between participant responses. These were then grouped into distinct subthemes and themes inductively derived from the data. Themes and subthemes were then discussed among research team members. Thematic saturation (Krueger and Casey 2009) was achieved by the fifth focus group, verified at the sixth, and therefore, no further focus groups were conducted.

## RESULTS

A total of 46 participants took part in the 6 focus groups, with equal numbers of males and females, a wide age distribution (Table 1), and a range of reported medical conditions. The number of participants in each group varied between 7 and 8.

### Sources of health and/or medicines information

For most participants, their primary provider of information was their doctor(s) (Table 2). Pharmacists were also recognised as sources of medicine-related information by some participants, in particular those who had received information on generic substitution, drug interactions, and dosing information. On occasion, pharmacists also supplied patients with a print-out of the relevant patient information leaflet for their medicine. Although many voiced satisfaction with the information they received, others reported information gaps and receipt of conflicting information.

Of the non-HCP sources of information reported, the Internet was utilised by participants to obtain information regarding adverse drug reactions and insights into the lived experiences of others with the same medical condition and/or taking the same medicine.

### Follow-up received and desired by participants from HCPs

Participants reported that their previous follow-up experiences from HCPs were predominantly via a phone call from the doctor in relation to recent treatment, hospitalisation/medical emergency, or on occasion, post initiation of a new medicine. In general,

these were for the purposes of monitoring the person's condition and response. No one reported follow-up in relation to their regular chronic medicines.

All participants reached a general consensus and expressed a strong desire for their treating HCP to be proactive in managing their health and to provide necessary information. Participants were amenable to the provision of information as part of follow-up from their HCP, for instance after initiation of a new medicine. Most participants placed significant emphasis on the importance of receiving tailored information relevant to their specific needs as part of follow-up; participants also questioned the appropriate amount of information to be received (Table 3). However, there was no consensus regarding the optimal frequency of HCP follow-up. This was considered to be determined on a case-by-case basis. A few participants said that they would not want ongoing follow-ups as they would reach out only when needed (Table 3).

Participants valued valid, concise, and tailored information. Follow-up was only wanted if new information was being provided. Generalised information was less valued due to the lack of universal relevance to all patients. Tailored information that participants wished to receive included updates pertaining to novel medical developments/medicines/trials; online social support groups, where members had the same medical condition(s); lifestyle advice; reminders; self-management support; lived experiences of those with similar medical condition(s); and medication-specific information.

Participants discussed a number of considerations in relation to communication via spoken and written means (Table 3). Spoken information was regarded as a more personal method of communication compared to written forms. Written communication was preferred in some instances, for example when the patient was unable or unwilling to speak with a HCP. Participants generally preferred follow-up information to be delivered via email or a telephone call, and provided their thoughts on advantages and disadvantages (Table 4).

### Perspectives on providing consent for HCP-initiated information provision

There were mixed opinions about whether the provision of information by HCPs should be driven by an opt-in or opt-out process of consent, with participants providing pros and cons for both approaches (Table 5). Several participants questioned the need

**Table 1. Summary of participant demographics**

	<b>Demographic</b>	<b>Total (n=46)</b>
<b>Gender</b>	Male	24
	Female	22
<b>Age</b>	18-29	7
	30-49	15
	50-69	19
	70+	5
<b>Country of birth</b>	Australia	35
	Overseas	11
<b>Main language spoken at home</b>	English	46
	Other <sup>a</sup>	5
<b>Marital status</b>	Married	19
	De-facto	5
	Single	12
	Separated/divorced/other	10
<b>Highest level of education<sup>b</sup></b>	School Certificate (Year 10) or below	7
	Higher School Certificate (Year 12)	9
	Technical and Further Education (TAFE) or college qualification	16
	University qualification	9
	Other	4
<b>Employment status</b>	Full-time job outside home	23
	Part-time job outside home	9
	Home duties	1
	Full-time student <sup>c</sup>	2
	Retired	10
	Not currently working	2
<b>Parent/carer of child(ren)</b>	Yes	21
	No	25
<b>Carer of an adult</b>	Yes	5
	No	41

a) Some participants indicated that they spoke more than 1 main language at home. Therefore, the combined total exceeds 46.

b) Missing data for 1 participant.

c) One participant also indicated that they had a part-time job outside home.

for consent as information provision as part of follow-up was considered part of the HCP's duty of care (Table 3). An opt-out process was viewed as a means for ensuring access to such a service, thus facilitating informed choice. Those in support of an opt-in process felt that it would offer more control for the individual and could assist in alleviating pressures on HCPs. Participants who supported an opt-in process agreed that for a HCP to provide information on a regular basis, consent should only be required to be given once. However, regardless of whether an opt-in or opt-out process was supported, participants expressed concern about the practicality of regular information provision/follow-up by HCPs at every consultation.

## DISCUSSION

Participants in this study valued the opportunity for follow-up and preferred it to be provided by either a phone call or an email from their treating HCP, with various advantages and disadvantages discussed. Notably, patients wanted to obtain follow-up advice when it was needed, and thus valued a flexible, responsive approach to continuity of care to meet evolving needs (Naithani et al. 2006). Further to this, there may also be the potential for information desired by patients from HCPs engaged in follow-up to vary. For instance, a survey conducted by Huibertse et al. (2017) found a broad distinction regarding the information that cancer survivors preferred to be discussed between different HCPs; a general preference was seen for lifestyle topics to be discussed with the general practitioner whereas topics regarding cancer heredity and recurrence were preferred to be discussed with the specialist (Huibertse et al. 2017).

Telephone and email follow-up were preferred modes of contact for participants. Murchie et al. (2016) however, observed a strong preference for face-to-face follow-up, whereby telephone and Internet-based follow-up (video conference, Skype, webcam) were not preferred. The fact that the study focus group discussions on follow-up were not specific to a particular medical condition, such as cancer, may explain these differences. Another explanation is that there may also be a perceived distinction between follow-up for the purpose of information exchange (which was the focus of the focus groups) and the need for a follow-up HCP consultation or physical examination/monitoring. Undoubtedly, a "one-size-fits-all" approach to follow-up will not ca-

ter to the needs of individual patients. Based on the study findings, when considering how to develop a follow-up health and/or medicines information provision service, tailoring of the information provided would need to consider factors such as, firstly, the medical condition(s) experienced; e.g. patients recently discharged from the intensive care unit highly value follow-up appointments as an opportunity to receive tailored health information critical for their overall recovery (Prinjha et al. 2009). Secondly, existing medicine(s); e.g. new versus chronic medicine(s), where follow-up post initiation of a new medicine was welcomed by participants. Thirdly, patients' existing knowledge versus information gaps; as participants stated that follow-up would be valued if it provided new information. Fourthly, the patient's relationship with their HCP and topics that would be appropriate to discuss and provide information on. Fifthly, the mode and frequency of communication tailored to the preferences of the individual (as perceptions regarding follow-up can still vary among patients with the same condition (Rozmovits et al. 2004)). And finally, the current health status and needs of the patient for which the follow-up is intended (as some patient needs have remained unmet and could be better addressed with follow-up (O'Brien et al. 2011)).

From a healthcare system or HCP perspective, workflow and time considerations will need to be considered when moving forward to implement the provision of follow-up information by HCPs, a practice which is not "routine" at present. In Australia, patient consent is required for a HCP to provide ongoing follow-up and information to the patient (Privacy Act 1988, c2017), which can act as a barrier to the provision of follow-up. This may explain why there were limited examples given of previous follow-ups that were not associated with an acute medical situation/emergency or an upcoming or recently conducted consultation. Accordingly, policy changes may be an avenue to explore in contexts like Australia, where an opt-in approach to follow-up information provision is the norm, in order to adapt to the changing healthcare and information landscape in the digital age. This is particularly relevant for Australia, considering there was support by the participants in this study for an opt-out process for follow-up.

People have previously expressed that they would like to receive follow-up emails from their doctor post consultation, along with electronic receipt of tailored medicine information, test results, and the ability to

**Table 2. Summary of providers of information regarding participants' medical condition(s) and medicines**

Information provider(s)	Medical condition(s) information (n=45 <sup>a</sup> participants)	Medicine(s) information (n=45 <sup>a</sup> participants)
Pharmacist only	0	1
Doctor only	28	19
Doctor and pharmacist	9	17
Doctor and specialist doctor	1	0
Doctor, pharmacist, and nurse	4	2
Doctor, pharmacist, nurse, and oncologist	1	1
Doctor, pharmacist, MedAdvisor app	1	1
Other	1 [1 (Doctor, Internet)]	4 [1 (Myself) <sup>b</sup> ; 1 (Specialist doctor - asthma); 1 (Pharmacist, Internet); 1 (Doctor, pharmacist, diabetes educator)]

a) Missing data for 1 participant. b) Person felt that s/he knew

electronically send through documents/information related to the monitoring of chronic medical conditions (Car and Sheikh 2004). In a study conducted across 14 European countries, Denmark had the highest proportion who had communicated with their HCP via email (Newhouse et al. 2015). A point of interest is that in Denmark, policies stipulate that primary care doctors must be accessible via email, and reimbursement is provided to ensure that email/electronic communication is a viable communication method

between patients and HCPs (Newhouse et al. 2015).

In the Australian context, local policies may have a potential influence on routine communication between HCPs and patients. The Royal Australian College of General Practitioners, for instance, has published recommended security measures to help reduce the risks associated with email use (Royal Australian College of General Practitioners). However, no examples of email follow-up by HCPs were cited by participants in the present study, with previ-

**Table 3. Exemplar quotes**

Theme and sub-theme	Quote	Participant
<b>Follow-up received and desired by participants from HCPs</b> Participants' attitudes to follow-up undertaken by HCPs	<i>"The follow-up's saving us from ourselves."</i>	FG4P4**
	<i>"If you get too much information..... it takes control of your life..... You've got to have control of your own life."</i>	FG3P7
	<i>"Personally I think it's impossible, really. They're so busy. As if they would call every single person. But I'd like it the other way around where I can call and say 'I've been given this and duh duh duh.', if I need to call. If I don't need to call, it doesn't matter. There's one less phone call for us."</i>	FG2P6
<b>Follow-up received and desired by participants from HCPs</b> Preferred methods of HCP-initiated follow-up	<i>"I think that once you talk to someone, you kind of, you kind of automatically think 'Oh, this person is concerned about my wellbeing.' So I think that call, a phone call, is better than than like letter or something like that. I think people would feel more, more close to it."</i>	FG5P5
	<i>"Maybe verbal because then you can ask questions whenever you want. Like when he's saying something..... you can ask a question like 'Wait, I don't understand that part.', have it explained more, and understand it more."</i>	FG4P3
	<i>"Because you can't always talk. You may not feel up to talking. 'Cause I found that when I wasn't well, I really didn't have the energy to talk to people. So texting is easy. Or emailing, if it was easier."</i>	FG5P6
<b>Perspectives on providing consent for HCP-initiated information provision</b> Opt-in versus opt-out*	<i>"I'd be happy if it fell under their duty of care. I'm happy not to sign."</i>	FG4P1
	<i>"I want to ultimately be educated on how to be, you know, responsible for my conditions in a bigger sense than just the drug taking."</i>	FG1P8

\* Opt-in refers to when patients actively agree to receive direct follow-up information regarding their health, medical conditions and/or medicines. Opt-out refers to when patients continue to receive information directly from their HCPs, and can still actively choose not to receive further information at any time.

\*\*Focus Group 4, participant 4

**Table 4. Perceived advantages and disadvantages of commonly reported modes of communication for providing information to patients**

Form of communication	Pros	Cons	Considerations
<b>Phone</b>	<ul style="list-style-type: none"> <li>• Might be more advantageous for those who are not as technologically literate e.g. elderly population</li> <li>• Demonstrates that the HCP is kind and caring</li> <li>• Useful if there has been a change e.g. new medication</li> <li>• Fast</li> <li>• Can easily clarify information being given verbally</li> </ul>	<ul style="list-style-type: none"> <li>• Cannot always answer a phone call e.g. whilst at work</li> <li>• Guilt associated with declining follow-up/information over the phone compared to email</li> <li>• May reduce available consultation times (if doctors are spending time following up)</li> <li>• May not adequately recall what was said over the phone</li> <li>• May have taken the call when notes cannot be taken- disadvantageous if wanting to remember information</li> <li>• Further “time-waster” as memory introduced as a variable e.g. poor recall of complex information provided over the phone (which may then lead to a request for the information to be provided via email)</li> <li>• May not be the most appropriate if complex instructions/information is to be provided</li> </ul>	<ul style="list-style-type: none"> <li>• Not appropriate in all instances e.g. complex treatment regimen instructions may require face-to-face consultation; language barriers</li> </ul>
<b>Email</b>	<ul style="list-style-type: none"> <li>• It is in written format, and easier to read and refer back to, when needed</li> <li>• Can be easily deleted if not desired</li> <li>• Convenient</li> <li>• Privacy better protected compared to mail</li> <li>• Faster</li> </ul>	<ul style="list-style-type: none"> <li>• Less of a “personal touch” in comparison to a phone call</li> </ul>	<ul style="list-style-type: none"> <li>• Accessibility is dependent upon whether the individual has a computer/ technological literacy</li> </ul>
<b>Other written forms of communication e.g. mail, SMS</b>	<ul style="list-style-type: none"> <li>• Mail would be good if a hardcopy of the information is preferred</li> <li>• Mail or SMS preferable for those who do not have access to computers</li> <li>• SMS useful to receive reminders and people can contact the HCP when it is convenient for them</li> </ul>	<ul style="list-style-type: none"> <li>• Waste of paper (mail)</li> </ul>	<ul style="list-style-type: none"> <li>• Not averse to receiving mail however letter box may not be frequently emptied/ checked</li> </ul>

ous follow-up experiences being predominantly via a phone call. Email communication between HCPs and patients has been shown to be appropriate in terms of content and can facilitate communication regarding a number of different issues (Sittig 2003, White et al. 2004). Email communication can also promote increased patient engagement e.g. in reviewing notes made by their doctor (Mafi et al. 2016). Thus, considering that participants were amenable to receiving follow-up communication via email and noted fewer disadvantages associated with this mode of outreach compared to telephone calls, it would be useful to explore ways in which email could be more widely utilised to provide tailored health and medicines information as part of follow-up within both Australian and other international contexts. Future quantitative research is needed to ascertain the views of broader populations with respect to the provision of

non-promotional health information by HCPs as opt-in or opt-out approaches.

## CONCLUSIONS

Patients want their treating HCPs to be proactive in the management of their health. Patients are open to being provided information about their health and/or medicines by their HCP as part of follow-up. However, it is imperative that this information and the frequency of follow-up is tailored to the individual and their needs. Patients voiced mixed perspectives on whether an opt-in or opt-out process for provision of information by HCPs was preferred. Thus, further research is needed to explore optimal ways in which health and medicines information provision can be tailored to best meet the needs of the public with respect to content, method of communication, and frequency of provision.

**Table 5. Pros and cons to an opt-in versus opt-out process for ongoing information provision/ follow-up services by HCPs**

Process of consent	Pros	Cons	Considerations
<b>Opt-in*</b>	<ul style="list-style-type: none"> <li>• Increased control for the individual</li> <li>• Decisions can be made that are best for the individual</li> <li>• Can help alleviate potential pressures on HCPs</li> <li>• Not desired or needed by all</li> </ul>	<ul style="list-style-type: none"> <li>• Query regarding how patients would be made aware of the service to opt-in</li> <li>• May not be practical for a HCP to promote the service with every consultation conducted</li> </ul>	<ul style="list-style-type: none"> <li>• Not expected to be offered with every consultation due to inherent pressures within the healthcare system</li> </ul>
<b>Opt-out*</b>	<ul style="list-style-type: none"> <li>• Would ensure access to the service</li> <li>• Can see the service first in order to determine its value</li> <li>• Access to the service allows for informed choice</li> </ul>	<ul style="list-style-type: none"> <li>• Increased work burden for HCPs (who are already time-poor)</li> </ul>	<ul style="list-style-type: none"> <li>• Not pragmatic to automatically offer the service and ability to opt-out to every patient, from a time perspective</li> </ul>

\* *Opt-in* refers to when patients actively agree to receive direct follow-up information regarding their health, medical conditions and/or medicines. *Opt-out* refers to when patients continue to receive information directly from their HCPs, and can still actively choose not to receive further information at any time.

## TIIVISTELMÄ

### Väestön asenteet ja vastaanottavuus terveydenhuollon ammattilaisten hoidon seurantaan liittyviin yhteydenottoihin

#### Tausta

Eri maissa on vaihtelevia käytäntöjä siihen, täytykö potilaan antaa suostumus terveydenhuollon ammattilaisen yhteydenottoihin vastaanottokäynnin jälkeen. Tutkimustietoa väestön näkemyksistä terveydenhuollon ammattilaisten yhteydenottoihin ilman suostumusta on vähän Australiasta, jossa tyypillisesti suostumus yhteyden ottamiseen pyydetään etukäteen.

#### Tavoite

Tutkimuksen tavoitteena oli selvittää australialaisten asenteita, näkemyksiä ja vastaanottavuutta terveydenhuollon ammattilaisten hoidon seurantaan liittyviin yhteydenottoihin ilman etukäteen pyydettyä suostumusta. Yhteydenotoissa terveydenhuollon ammattilaiset antavat räätälöityä terveyteen liittyvää neuvontaa potilaille.

#### Aineisto ja menetelmät

Kuusi 1–1,5 tunnin mittaista ryhmäkeskustelua järjestettiin yhteensä 46 haastateltavan kanssa Sydneyssä loka-marraskuun 2016 aikana. Ryhmäkeskusteluissa haettiin haastateltavien näkemyksiä terveydenhuollon ammattilaisten yhteydenottoihin suostumuksen kanssa (opt-in) tai ilman (opt-out). Ryhmäkeskustelut nauhoitettiin ja litteroitiin sanataarkasti, minkä jälkeen aineisto analysoitiin teemoittelemalla.

#### Tulokset

Haastateltavat esittivät monenlaisia mielipiteitä terveydenhuollon ammattilaisten yhteydenottoihin suostumuksella tai ilman suostumusta. Muutama haastateltava toivoi suostumuksen pyytämistä, ja he näkivät hoidon seurannan ja potilaan informoinnin terveydenhuollon ammattilaisten velvollisuudeksi. Ilman suostumusta (opt-out) tehtävät yhteydenotot nähtiin edistävän tietoisuuden saamista. Ne haastateltavat, jotka suosivat suostumuksen etukäteen pyytämistä, kokivat, että tämä antaa heille enemmän kontrollia oman hoitonsa seurannasta. He myös ajattelivat, että suostumuksen pyytäminen potilaalta etukäteen helpottaa terveydenhuollon ammattilaisten yhteydenottoa. Nämä haastateltavat oli-

vat sitä mieltä, että suostumuksen pyytäminen yhden kerran riittää toistuviin yhteydenottoihin. He toivoivat, että jokaisella vastaanottokäynnillä sovittaisiin yhteydenottotapa. Haastattelujen perusteella aikaisemmat kokemukset hoidon seurannasta voivat vaikuttaa siihen, toivooko potilas suostumuksen pyytämistä yhteydenottoihin jatkossa vai ei.

#### Päätelmät

Tutkimuksen tulosten perusteella terveydenhuollon ammattilaisten yhteydenottoihin ilman suostumusta (opt-out -prosessi) on jonkin verran kannatusta. Lisätutkimuksia kuitenkin tarvitaan laajemmilla potilasjoukoilla sen selvittämiseksi, onko joitakin tiettyjä potilasjoukkoja, joille yhteydenotot ilman suostumusta erityisesti sopisivat.

**Avainsanat:** Lääkeinformatio, terveysinformaatio, yhteydenotto ilman etukäteen pyydettyä suostumusta (opt-out), yhteydenotto suostumuksen kanssa (opt-in), mieltymys

---

#### Conflict of interest:

Stephen Robson is employed by the Healthy Thinking Group P/L.

## ACKNOWLEDGEMENTS

The research team wish to thank all study participants who took part in the focus groups. This study was funded by the Healthy Thinking Group and Commonwealth Department of Industry, Innovation and Science (Innovation Connection), AusIndustry.

## REFERENCES

Privacy Act 1988, Australia [statute on the Internet], 2017. <https://www.legislation.gov.au/Details/C2017C00283> (Accessed 14.2.2018)

Aslani P, Hamrosi K, Feletto E, et al: Investigating Consumer Medicine Information (I-CMI) Project. Sydney, NSW: The Pharmacy Guild of Australia, Australian Government Department of Health and Ageing, 2010

Car J, Sheikh A: Email consultations in health care: 2—acceptability and safe application. *BMJ* 329 (7463): 439-442, 2004

Green J, Thorogood N: Qualitative methods for health research. 3rd ed. London: Sage Publications, 2014

Huibertse LJ, van Eenbergen M, de Rooij BH, et al: Cancer survivors' preference for follow-up care providers: a cross-sectional study from the population-based PROFILES-registry. *Acta Oncol* 56 (2): 278-287, 2017

Kitzinger J: Focus groups. In: Pope C, Mays N, editors: *Qualitative research in health care*. 3rd ed. Oxford: Blackwell Publishing Ltd, 21-31, 2006

Krueger RA, Casey MA: *Focus groups: A practical guide for applied research*. Thousand Oaks, CA: Sage Publications, 2009

Mafi JN, Mejilla R, Feldman H, et al: Patients learning to read their doctors' notes: the importance of reminders. *J Am Med Inform Assoc* 23 (5): 951-955, 2016

Murchie P, Norwood PF, Pietrucin-Materek M, Porteous T, Hannaford PC, Ryan M: Determining cancer survivors' preferences to inform new models of follow-up care. *Br J Cancer* 115 (12): 1495-1503, 2016

Naithani S, Gulliford M, Morgan M: Patients' perceptions and experiences of 'continuity of care' in diabetes. *Health Expect* 9 (2): 118-129, 2006

Newhouse N, Lupiáñez-Villanueva F, Codagnone C, Atherton H: Patient use of email for health care communication purposes across 14 European

countries: an analysis of users according to demographic and health-related factors. *J Med Internet Res* 17 (3): e58, 2015

O'Brien R, Rose P, Campbell C, et al: "I wish I'd told them": a qualitative study examining the unmet psychosexual needs of prostate cancer patients during follow-up after treatment. *Patient Educ Couns* 84 (2): 200-207, 2011

Prinjha S, Field K, Rowan K: What patients think about ICU follow-up services: a qualitative study. *Crit Care* 13 (2): R46, 2009

Royal Australian College of General Practitioners: Using email in general practice- privacy and security matrix. <http://www.racgp.org.au/download/Documents/e-health/using-email-in-general-practice-privacy-and-security-matrix.pdf> (Accessed 14.2.2018)

Raynor DK, Blenkinsopp A, Knapp P, et al: A systematic review of quantitative and qualitative research on the role and effectiveness of written information available to patients about individual medicines. *Health Technol Assess* 11 (5): iii, 1-160, 2007

Rozmovits L, Rose P, Ziebland S: In the absence of evidence, who chooses? A qualitative study of patients' needs after treatment for colorectal cancer. *J Health Serv Res Policy* 9 (3): 159-164, 2004

Sittig DF: Results of a content analysis of electronic messages (email) sent between patients and their physicians. *BMC Med Inform Decis Mak* 3 (1): 11, 2003

White CB, Moyer CA, Stern DT, Katz SJ: A content analysis of e-mail communication between patients and their providers: patients get the message. *J Am Med Inform Assoc* 11 (4): 260-267, 2004