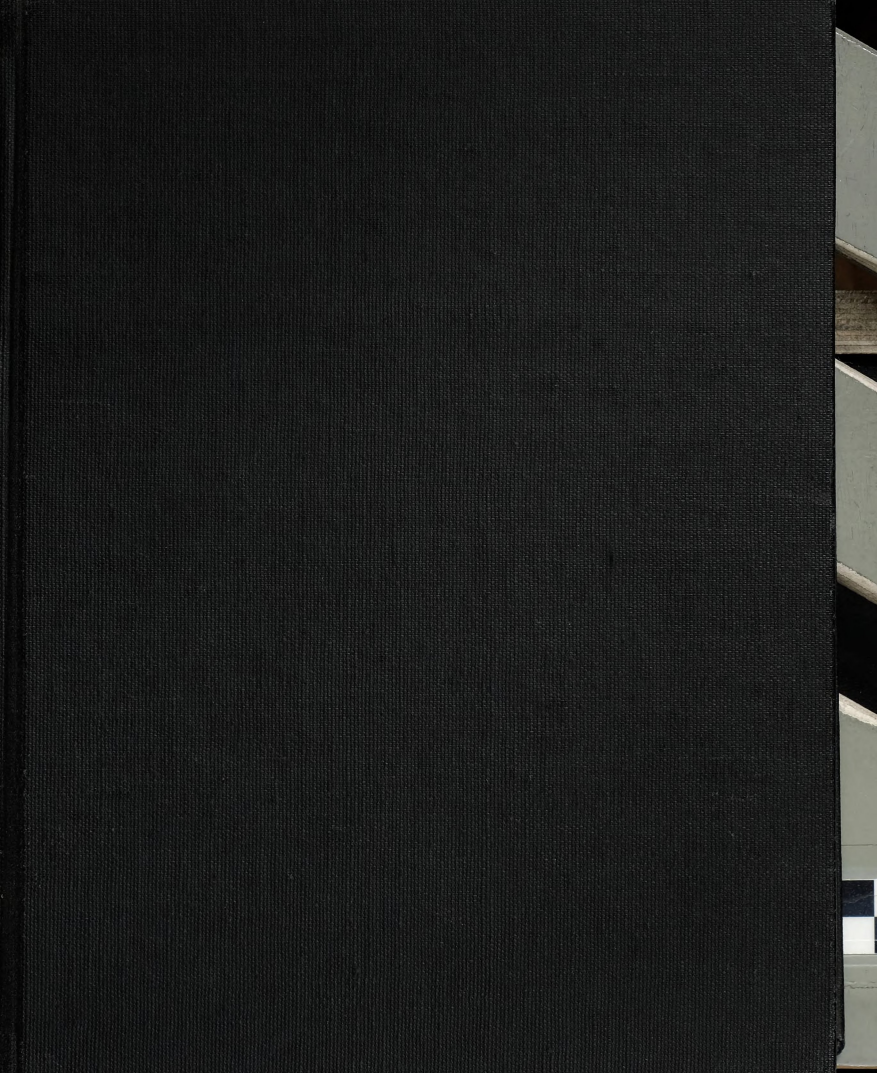






This is to certify that the

thesis entitled

OPINIONS OF HEALTH CARE PROFESSIONALS CONCERNING
PATIENT EDUCATION FOR THE INPATIENT HOSPITAL
POPULATION, WITH IMPLICATIONS FOR PROGRAM
PLANNING AND STAFF DEVELOPMENT

presented by

Rosemary S. Caffarella

has been accepted towards fulfillment
of the requirements for

Ph.D. degree in Education

Major professor

Date January, 1978

~~4~~ 072

~~B~~ 133

~~60~~ 1001

~~2~~ 022

~~AUG 24 '81~~

100 D185

~~JAN 7 '85~~

300 A005

~~JUN 09 '86~~



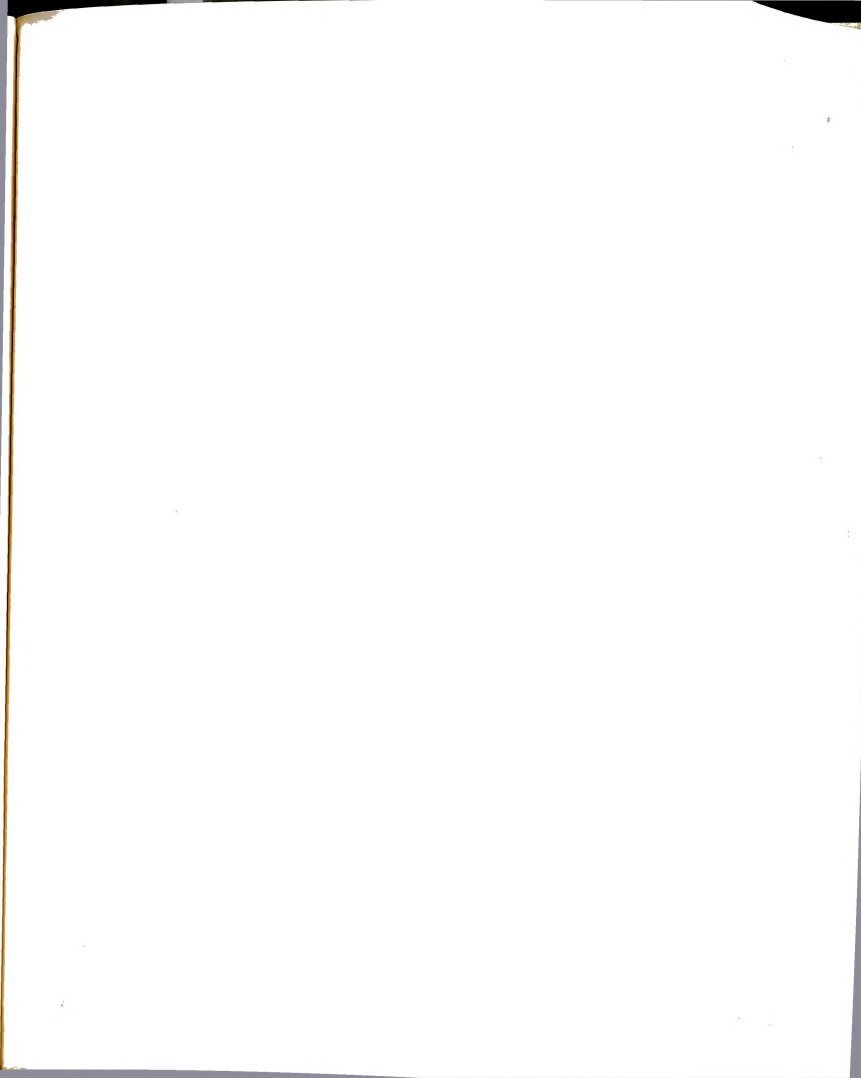


1978

ROSEMARY SHELLY CAFFARELLA

ALL RIGHTS RESERVED







OPINIONS OF HEALTH CARE PROFESSIONALS CONCERNING
PATIENT EDUCATION FOR THE INPATIENT HOSPITAL
POPULATION, WITH IMPLICATIONS FOR PROGRAM
PLANNING AND STAFF DEVELOPMENT

By

Rosemary S. Caffarella

A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

DOCTOR OF PHILOSOPHY

Department of Administration and Higher Education

1978



ABSTRACT

OPINIONS OF HEALTH CARE PROFESSIONALS CONCERNING PATIENT EDUCATION FOR THE INPATIENT HOSPITAL POPULATION, WITH IMPLICATIONS FOR PROGRAM PLANNING AND STAFF DEVELOPMENT

By

Rosemary S. Caffarella

The purpose of this study was to investigate how health care professionals in Maine community hospitals viewed patient education for hospital inpatients. Twenty-two, approximately one-half, of Maine's community hospitals were selected as a stratified random sample. Equal proportions had and did not have operating formal patient education programs. All physicians, allied health professionals, and administrators, and one-third of the nurses, from these hospitals and patient education staff from all of Maine's community hospitals were surveyed by mailed questionnaires.

The data generated from the survey were presented in several ways. First a display of the data showed how all professionals, collectively and by sub-groups, responded in each question area. The data were then analyzed using Chi-square tests of independence to ascertain relationships among judgments of professional sub-groups. Finally, the data were analyzed, again using Chi-square tests of independence, to ascertain how responses varied in relation to four factors (size of hospital, whether the hospital had a formal

1012

1013

1014

1015

1016

patient education program, respondents' experience with formal patient education programs, and respondents' training in patient education).

Major conclusions of the study were that health care professionals in community hospitals agree that:

1. Patient education is an important component of patient care;
2. Adequate patient education requires a hospital to develop a program which is comprehensive in that it:

- a. includes both formal and informal elements intentionally developed and integrated,

- b. incorporates significant contributions from each professional group, and

- c. provides basic educational services for all patients and additional services appropriate to health-related problems of categories of patients, e.g., diabetes or cardiac illness;

3. At least eight general areas of content are important to include in patient education programs:

- a. explanation of diagnosis and treatment,
 - b. teaching patients to administer their own treatment,
 - c. teaching patients self-care independent living skills,
 - d. teaching short- and long-term life style adjustments,
 - e. teaching about appropriate community resources,
 - f. teaching about general preventive medicine,
 - g. teaching about financial management of the health

problem, and

- h. orientation to hospital facilities and services;

gate

each

:

in p

tion

est

atti

be

4. Patient education is a complex process which requires a systematic effort within the professional health care community in each hospital;

5. Various staff units within the hospital should be represented in planning and execution of patient education activities. Physicians, nurses, and allied health professionals should make the greatest contribution, especially in the operation of patient education activities.

6. Provision should be made for instruction related to at least twelve health problem areas:

- a. diabetes,
- b. cardiac-related illness,
- c. cancer,
- d. hypertension,
- e. alcoholism and drug abuse,
- f. pre- and post-natal care,
- g. stroke,
- h. ostomy care,
- i. pulmonary disease,
- j. pre- and post-operative care,
- k. personal health habits, and
- l. mental health problems;

7. Patient education staff should facilitate and coordinate the planning and execution of patient education activities;

8. The involvement of patients and families in planning and conducting patient education should depend on the health problem;

9. A variety of people and agencies should be involved in the evaluation of patient education;

10. Hospitals and community agencies should work together to provide educational services for discharged patients;

11. It is feasible to develop or expand organized patient education programs within community hospitals;

12. While there are no insurmountable factors preventing development or expansion, the lack of staff time or special personnel to coordinate patient education activities are the principal inhibiting factors;

13. Health care professionals in community hospitals who have been associated with formal patient education programs, i.e., have training or experience, have more positive reactions to patient education than those not previously associated with it;

14. Because of differential definitions of role by professional groups, special care will be required to diminish intergroup and intragroup conflict on implementing patient education; and

15. The development of an adequate and effective patient education program is essentially a community development enterprise.



To my husband, Edward, I dedicate this study.

For all of his patience, proofreading, editing,
and above all his love and support during my
doctoral study.

not
not
com
to
his
not
the
in
re
th
a
L

ACKNOWLEDGMENTS

I would like to express my appreciation to the following individuals and organizations for their assistance and encouragement in the completion of my dissertation.

To Professor Russell Kleis I am indebted for the original conceptualization of the study. His long hours of work helped me to understand the importance of a well-designed research study. His continual expectation of excellence was a guiding light throughout both my course work and my research. He has been and will continue to be my mentor in the field of continuing education.

To Dr. Robert Price I am thankful for his guidance concerning the specific topic of patient education and his knowledge of resources in this area. His suggestions for the methodology of the study were most helpful during the design phase. I especially appreciated his continuing guidance and review of the study after leaving Michigan State University to take a new position at the University of Arkansas.

To Dr. Sheldon Cherney and Professor Edmund Alchin I am thankful for exposing me to the areas respectively of international education and community development. Their insights and encouragement throughout my course work and execution of this study were helpful in balancing my doctoral program.

pages
office

pages

Dr. W.

re

stan

st

To the Maine Health Education Resource Center for their sponsorship of the mail survey segment of the study and their specific endorsement of the study.

To two professional health associations in Maine for their specific endorsement of the study:

Maine Medical Association
Research and Education Trust of the Maine Hospital Association

To the many individual professionals in Maine, both at the University of Maine at Orono and in the health field, who assisted me in working through some of the specific methodology for the study:

Dr. Richard Chamberlain
Mrs. Lois Estes
Dr. Stanley Freeman
Dr. Kenneth Hayes
Douglas Kramer
Laurence Nanney

Wayne Persons
Dr. Louis Ploch
Dr. John Rosser
Michael Skaling
Ann Spencer

To the Maine community hospitals and their professional staff who participated in the study:

Blue Hill Memorial Hospital
Calais Regional Hospital
Castine Community Hospital
Community General Hospital
Henrietta A. Goodall Hospital
Houlton Regional Hospital
James A. Taylor Memorial Hospital
Maine Medical Center
Miles Memorial Hospital
Mount Desert Hospital
Northern Maine Medical Center

Penobscot Bay Medical Center
Penobscot Valley Hospital
Plummer Memorial Hospital
Regional Memorial Hospital
Rumford Community Hospital
St. Andrews Hospital
St. Joseph Hospital
Stephens Memorial Hospital
Van Buren Community Hospital
Westbrook Community Hospital
York Hospital

To my secretary, Edith Thibault, for all of her support services.

To my mom and dad, Mr. and Mrs. R. W. Shelly, from whom
came a large part of the inspiration and motivation to undertake
a research study in patient education.

157

157

Page

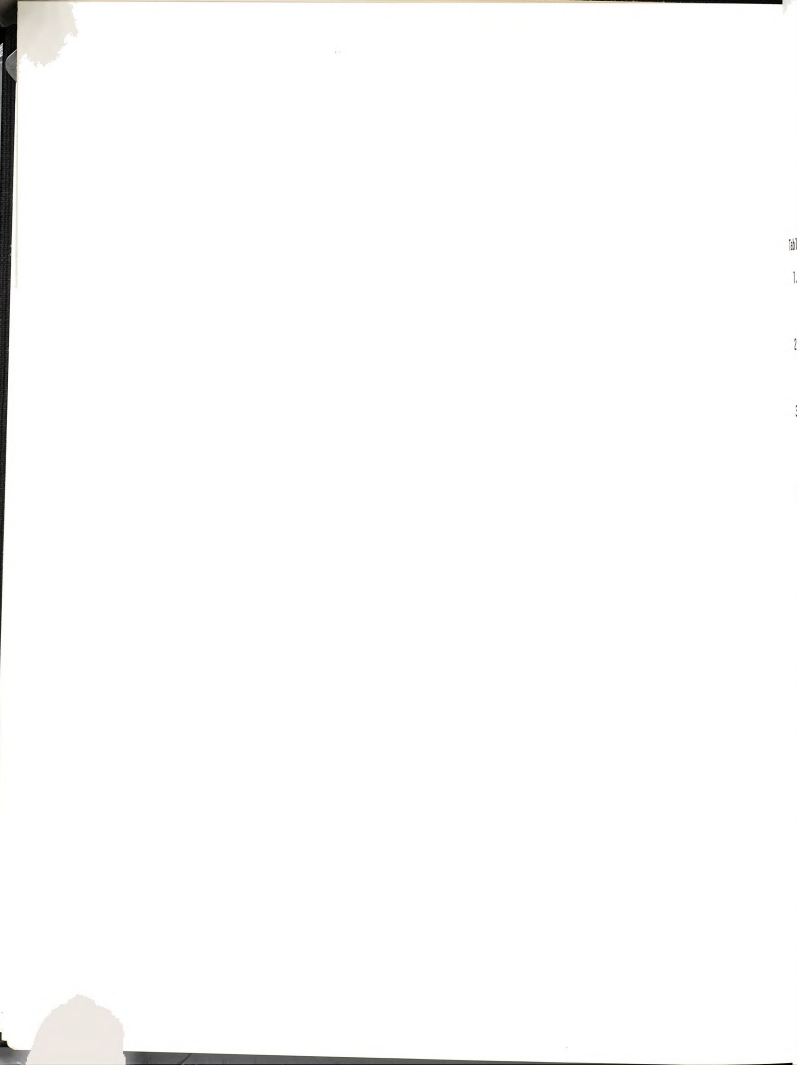
TABLE OF CONTENTS

	Page
LIST OF TABLES	x
LIST OF FIGURES	xv
Chapter	
I. INTRODUCTION	1
Purpose of Study	3
Significance of Study	4
Procurement and Analysis of Responses	7
Limitations of Study	8
Definition of Terms	8
Summary of Chapter I and Overview of Succeeding Chapters	10
II. REVIEW OF LITERATURE	12
Patient Education Defined	13
Informal Patient Education Activities	13
Formal Patient Education Programs	14
Importance of Patient Education	21
Process Model of Formal Patient Education Programs	27
Identification of Needs	29
Establishment of Educational Objectives	31
Selection of Educational Methods and Personnel	31
Implementation	33
Evaluation	33
Settings for Patient Education	34
Hospital-Based Patient Education	35
Community Activities	35
Out-Patient Activities	36
Inpatient Activities	37
Linkages Between Hospital-Based Programs	39
Content of Patient Education Activities for Inpatients	40
Orientation to Hospital Facilities and Services	40
Explanation of the Diagnosis of the Health Problem	40
Explanation of the Treatment for the Health Problem	41

Chapter	Page
Teaching of the Medical Management of the Health Problem	42
Assisting Patients to Learn or Relearn Self-Care, Independent Living Skills	42
Teaching Patients and Their Families About Short- and Long-Term Life Style Changes Due to the Health Problem	43
Educating Patients and Their Families About Appropriate Community Resources	44
Teaching About the Financial Management of the Health Problem	44
Teaching of General Preventive Activities	45
Roles of Professional Staff, Patients, and Families of Patients in Hospital-Based Inpatient Education Programs	45
Physician's Roles	46
Nurse's Roles	48
Allied Health Professional's Role	50
Hospital Administrator's Role	50
Patient's Role	51
Family Members' Roles	52
Constraints to the Development and Implementation of Patient Education Activities	53
Need for Further Study	54
Task Assumed in This Study	56
III. METHODOLOGY	59
Objectives of the Study	59
Endorsements for the Study	67
Pre-Survey	67
Sample	73
Instrument	77
Administration of Instrument	79
Display and Analysis of Data	80
IV. RESULTS OF THE STUDY	84
Respondents	84
Rating of Importance of Patient Education and Selected Content Areas	94
General Importance of Patient Education	94
Importance of Selected Content Areas	97
Roles Deemed Appropriate for Health Care Professionals, Patients, and Families of Patients in the Planning and Conducting of Patient Education Activities	107
Role Deemed Appropriate for Patient Education Staff	108

Chapter	Page
Roles Deemed Appropriate for Physicians	124
Roles Deemed Appropriate for Nurses	144
Roles Deemed Appropriate for Allied Health Professionals	166
Roles Deemed Appropriate for Hospital Administrators	184
Roles Deemed Appropriate for Former Patients	193
Roles Deemed Appropriate for Families of Present and Former Patients	197
Ascribed Responsibility for Evaluation of Patient Education Activities	199
Judgments About Organization of Patient Education Activities	202
Types of Patient Education Activities	203
Categories of Health Problems Which Professionals Would Choose First for Developing Organized Patient Education Programs for Hospital Inpatients	205
Ascribed Responsibility of Hospital and Community Agencies for Discharged Patients Who Need Further Educational Services	208
Factors Believed to Impede or Prevent the Development and Implementation of Patient Education Activities for Hospital Inpatients . . .	208
Coordination of Organized Patient Education Programs	213
Summary	215
Judgments as to Feasibility of Developing or Expanding Organized Patient Education Programs . .	216
V. SUMMARY, CONCLUSIONS, AND IMPLICATIONS	229
Summary of Purpose and Procedures of Study	229
Review of Findings	231
Conclusions	237
Implications for Practice	242
Implications for Research	245
Reflections on the Study	248
APPENDICES	
A. PRE-SURVEY FORM AND LETTER	251
B. SUMMARY OF PRE-SURVEY RESULTS AND FOLLOW-UP LETTERS . .	258
C. LETTERS TO HOSPITAL ADMINISTRATORS REQUESTING SAMPLING LIST, THANK-YOU LETTER TO HOSPITAL ADMINISTRATORS FOR LISTS, AND LIST OF PARTICIPATING HOSPITALS . . .	268

Chapter	Page
D. COVER LETTERS AND SURVEY INSTRUMENT	272
E. FOLLOW-UP POSTCARDS AND FOLLOW-UP LETTERS	283
F. PEOPLE CONSULTED ON DEVELOPMENT OF SURVEY INSTRUMENTS .	290
G. PERCENTAGE OF RESPONDENTS BY PROFESSIONAL SUB-GROUP WHO INDICATED THAT SPECIFIED CONTENT AREAS ARE IMPORTANT FOR INCLUSION IN HOSPITAL PATIENT EDUCATION PROGRAMS FOR INPATIENTS	291
BIBLIOGRAPHY	296



LIST OF TABLES

Table	Page
1. Number of Professional Personnel in Maine Community Hospitals by Professional Category and Size of Hospital as of March 1977	71
2. Distribution of Patient Education Programs in Maine Community Hospitals by Size of Hospital and Stage of Development as of March 1977	72
3. Number of Hospitals in the Population, in the Survey Group, and From Which Responses Were Received by Hospital Size and Whether the Hospital Had a Formal Patient Education Program	74
4. Number of Professional Workers Included in the Survey by Professional Group, Size of Hospital and Whether or Not the Hospital Had a Formal Patient Education Program	76
5. Questionnaires Mailed and Returned by Number and Percentage	85
6. Numbers and Percentages of Persons in Professional Sub-Groups in Maine Community Hospitals and the Percentages of All Professional Workers, Questionnaire Recipients, and Questionnaire Respondents Represented by Each	88
7. Percentages of Professionals and of Respondents Who Practiced in Hospitals With and Without Formal Patient Education Programs by Hospital Size	90
8. Percentage of Each Professional Sub-Group Involved and Levels of Their Involvement in Formal and Informal Patient Education Activities for Hospital Inpatients	91
9. Percentage of Respondents by Professional Sub-Groups Who Had Previously Attended Programs or Classes on or Related to Patient Education	93

Table

10.

11.

12.

13.

14.

Table	Page
10. Percentage of Respondents by Professional Sub-Groups and Total Respondent Group Who Accorded Selected Levels of Importance to Patient Education for Hospital Inpatients	95
11. Percentage of Total Respondent Group Who Indicated That Specific Content Areas Are Important for Inclusion in Hospital Patient Education Programs for Inpatients	98
12. Percentage of Patient Education Staff Members Who Judged That Their Own Professional Role Should Include Primary Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and of the Total Respondent Group Who Judged That Patient Education Staff Should Have Such Primary Responsibilities	109
13. Percentage of Patient Education Staff Members Who Judged That Their Own Professional Role Should Include Supportive Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and of the Total Respondent Group Who Judged That Patient Education Staff Should Have Such Supportive Responsibilities	118
14. Percentage of Physicians Who Judged That Their Own Professional Role Should Include Primary Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Physicians Should Have Such Primary Responsibilities	125
15. Percentage of Physicians Who Judged That Their Own Professional Role Should Include Supportive Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Physicians Should Have Such Secondary Responsibilities	135

16. Percentage of Nurses Who Judged That Their Professional Role Should Include Primary Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Nurses Should Have Such Primary Responsibilities	145
17. Percentage of Nurses Who Judged That Their Professional Role Should Include Supportive Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Nurses Should Have Such Supportive Responsibilities	157
18. Percentage of Allied Health Professionals Who Judged That Their Professional Role Should Include Primary Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Allied Health Professionals Should Have Such Primary Responsibilities	167
19. Percentage of Allied Health Professionals Who Judged That Their Professional Role Should Include Supportive Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Allied Health Professionals Should Have Such Supportive Responsibilities	174
20. Percentage of Hospital Administrators Who Judged That Their Professional Role Should Include Primary Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Hospital Administrators Should Have Such Primary Responsibilities	186
21. Percentage of Hospital Administrators Who Judged That Their Professional Role Should Include Supportive Responsibility for Planning and Conducting Patient Education in Nine Selected Content Areas and Percentages of Four Other Professional Groups and the Total Respondent Group Who Judged That Hospital Administrators Should Have Such Supportive Responsibilities	189

Table

22.

23.

24.

25.

26.

Table	Page
22. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Believed that Former Patients Should Have a Role in the Planning and Conducting of Patient Education Activities	195
23. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Believed Families of Present and Former Patients Should have a Role in Planning and Conducting of Patient Education Activities	197
24. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Indicated That Specific Groups or Agencies Should Have a Role in Evaluating Patient Education Programs for Hospital Inpatients . .	200
25. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Judged That Patient Education Activities Should Be Principally Formal, Principally Informal, or an Intentional Combination of Formal and Informal Activities	204
26. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Indicated Selected Health Problem Areas as Ones Which They Would Choose First for Developing Organized Patient Education Programs	206
27. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Identified Principal Responsibility for Educational Services to Discharged Patients With Hospitals and With Other Community Agencies	209
28. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Believed the Development and Implementation of Patient Education Activities for Hospital Inpatients Were Impeded or Prevented by Designated Factors	210
29. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Judged That Organized Patient Education Programs Could Best Be Coordinated in Designated Departments of Hospitals	214

Table	Page
30. Percentage of Respondents by Professional Group and for the Total Respondent Group Who Indicated the Feasibility of Developing or Expanding Organized Patient Education Programs in Their Hospitals	217
B1. Number of Beds, Number of Staff Members in Each Professional Sub-Group, and Presence of Formal Patient Education Programs in Maine Community Hospitals by Hospital Name and Capacity Category	263
G1. Percentage of the Physicians Who Indicated That Specified Content Areas Are Important for Inclusion in Hospital Patient Education Programs for Inpatients .	291
G2. Percentage of the Nurses Who Indicated That Specified Content Areas Are Important for Inclusion in Hospital Patient Education Programs for Inpatients . .	292
G3. Percentage of the Allied Health Professionals Who Indicated That Specified Content Areas are Important for Inclusion in Hospital Patient Education Programs for Inpatients	293
G4. Percentage of the Patient Education Staff Who Indicated That Specified Content Areas Are Important for Inclusion in Hospital Patient Education Programs for Inpatients	294
G5. Percentage of the Hospital Administrators Who Indicated That Specified Content Areas Are Important for Inclusion in Hospital Patient Education Programs for Inpatients	295



LIST OF FIGURES

Figure	Page
1. Percentage of Nurses and Allied Health Professionals Who Had and Who Had Not Had Special Training in Patient Education Who Rated Selected Content Areas as Extremely Important	102
2. Percentage of the Total Respondent Group Who Had and Did Not Have Experience With Formal Patient Education Programs Who Rated Selected Content Areas as Extremely Important	104
3. Percentage of Physicians, Nurses, and Allied Health Professionals Who Had and Did Not Have Experience With Formal Patient Education Programs Who Rated Selected Content Areas as Extremely Important	106
4. Mean Percentage of Nurses by Hospital Size Who Judged That Patient Education Staff Should Have Primary Responsibility for Planning Patient Education Activities in Selected Content Areas	115
5. Percentage of Total Respondent Group Who Had or Did Not Have Experience With Formal Patient Education Programs Who Judged That the Patient Education Staff Should Have Primary Responsibility for Planning Patient Education Activities in Selected Content Areas	117
6. Percentage of Nurses by Hospital Size Who Judged That Patient Education Staff Should Have Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	122
7. Percentage of Nurses Who Had and Had Not Previously Attended Programs on or Related to Patient Education That Judged Patient Education Staff Should Have Supportive Responsibility for Planning or Conducting Patient Education Activities in Selected Content Areas	123

8. Percentage of Total Respondent Group With and Without Experience in Formal Patient Education Programs Who Judged That Physicians Should Have Primary Responsibility for Planning of Patient Education Activities in Selected Content Areas	130
9. Percentage of Physicians With and Without Experience in Formal Patient Education Programs Who Judged That Their Own Role Should Include Primary Responsibility for Both Planning and Conducting of Patient Education Activities in Selected Content Areas	132
10. Percentage of Physicians Who Had and Who Had Not Attended Programs on or Related to Patient Education Who Judged That Their Own Role Should Include Primary Responsibility for Patient Education Activities in Selected Content Areas	133
11. Percentage of Total Respondent Group With and Without Experience in Formal Patient Education Programs Who Judged That Physicians Should Have Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	138
12. Percentage of Physicians With and Without Experience in Formal Patient Education Programs Who Judged That Their Role Should Include Supportive Responsibility for Conducting Patient Education Activities in Selected Content Areas	139
13. Percentage of Nurses With and Without Experience in Formal Patient Education Programs Who Judged That Physicians Should Have Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	140
14. Percentage of Total Respondent Group Who Had and Had Not Attended Programs on or Related to Patient Education Who Judged That the Physician's Role Should Include Supportive Responsibility for Conducting Patient Education Activities in Selected Content Areas	142
15. Percentage of Total Respondent Group With and Without Experience in Formal Patient Education Programs Who Judged That Nurses Should Have Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	151

Figure	Page
16. Percentage of Nurses With and Without Experience in Formal Patient Education Programs Who Judged That Their Role Should Include Primary Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	153
17. Percentage of Physicians With and Without Experience in Patient Education Programs Who Judged That Nurses Should Have Primary Responsibility for Planning Patient Education Activities in Selected Content Areas	154
18. Percentage of Allied Health Professionals With and Without Experience in Patient Education Programs Who Judged That Nurses Should Have Primary Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	155
19. Percentage of Nurses Who Worked in Hospitals With and Without Formal Patient Education Programs Who Judged That Their Role Should Include Responsibility for the Planning and Conducting of Patient Education Activities in Selected Content Areas	161
20. Percentage of Nurses With Experience and Without Experience in Patient Education Programs Who Judged That Their Role Should Include Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	162
21. Percentage of Physicians With and Without Experience With Formal Patient Education Programs Who Judged That Nurses Should Have Supportive Responsibility for Planning of Selected Content Areas	164
22. Percentage of Allied Health Professionals With and Without Experience Who Judged That Nurses Should Have Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	165
23. Percentage of Allied Health Professionals Who Worked in Hospitals With and Without Patient Education Programs Who Judged That Their Professional Role Should Include the Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	172

Figure	Page
24. Percentage of Allied Health Professionals Who Worked in Hospitals With and Without Patient Education Programs Who Judged That Allied Health Professionals Should Have Supportive Responsibility for Conducting Patient Education Activities in Selected Content Areas	178
25. Percentage of Total Respondent Group With and Without Experience in Formal Patient Education Programs Who Judged That Allied Health Professionals Should Have Supportive Responsibility for Planning and Conducting Patient Education Activities in Selected Content Areas	180
26. Percentage of Allied Health Professionals With and Without Experience in Formal Patient Education Who Judged That Their Role Should Include a Supportive Responsibility for the Planning and Conducting of Patient Education Activities in Selected Content Areas	181
27. Percentage of Nurses With and Without Experience in Formal Patient Education Programs Who Judged That Allied Health Professionals Should Have Supportive Responsibility for the Planning and Conducting of Patient Education Activities in Selected Content Areas	182
28. Percentage of the Total Respondent Group With and Without Experience in Formal Patient Education Programs Who Judged That Hospital Administrators Should Have Supportive Responsibility for Planning and Conducting of Patient Education Activities in Selected Content Areas	192
29. Percentage of Allied Health Professionals With and Without Experience in Formal Patient Education Programs Who Judged That Hospital Administrators Should Have Supportive Responsibility for Planning and Conducting of Patient Education Activities in Selected Content Areas	194
30. Percentage of Total Respondents by Hospital Size Who Believed It Was Feasible to Develop or Expand Formal Patient Education Programs	220
31. Percentage of Nurses by Hospital Size Who Believed It Was Feasible to Develop or Expand Formal Patient Education Programs	221

Figure	Page
32. Percentage of Allied Health Professionals by Hospital Size Who Believed It Was Feasible to Develop or Expand Formal Patient Education Programs	222
33. Percentage of Allied Health Professionals Who Worked in Hospitals With and Without Formal Patient Education Programs Who Judged That It Was Feasible to Develop or Expand Formal Patient Education Programs	223
34. Percentage of Total Respondent Group With and Without Experience in Formal Patient Education Programs Who Indicated That It Was Feasible to Develop Formal Patient Education Programs in Their Hospitals	225
35. Percentage of Total Respondent Group Who Had and Had Not Previously Attended Programs on or Related to Patient Education Who Indicated That It Was Feasible to Develop Formal Patient Education Programs in Their Hospitals	226
36. Percentage of Physicians With and of Those Without Experience in Formal Patient Education Who Indicated That It Was Feasible to Develop Formal Patient Education Programs in Their Hospitals	227

CHAPTER I

INTRODUCTION

This study was an investigation of the opinions of health care professionals who work in hospital settings toward the topic of inpatient education. The topic of patient education was subdivided into several questions concerning the various aspects of the subject. The responses to the questions were analyzed within and between the types of professionals, programs, and hospital settings.

Patient education is the educational component of patient care. It encompasses education about specific health problems and ways to prevent or manage the problems. Patient education on an informal basis has long been a part of medical care. Prior to the development of sophisticated medical care treatment and facilities, one of the physicians' prime tasks was to teach patients and family members to care for their own illnesses. The responsibility for one's health was primarily the individual's. With the development of specialized medicine and institutions of health care, the responsibility for health tended to move from the patient and the family to the physician.¹ In this shift patient education

¹Ivan Illich, Medical Nemesis (New York: Pantheon Books, 1976).

activi

compo

patie

adipr

inter

edito

of ch

ness

awa

gran

to

cia

rel

pro

ess

ty

on

—

Pa

h

h

c

p

activities have become somewhat fragmented and in some cases a lost component of patient care.

During the last twenty to twenty-five years, however, patient education as a formal part of patient care has become a major concern of professional health care personnel. This rise in interest has been caused by several reasons including the cost of medical care, the consumer advocate movement, the increasing rate of chronic illness, and the need to dispel the myth that all illnesses can be completely cured or at times even treated.¹

This thrust in patient education activities has been towards the development of organized, formal patient education programs, and away from the informal activities characterized by the "old doctor-patient relationship." This movement has been especially strong in hospitals.²

The development of formal patient education programs has raised many questions as to what should be the content of these programs, how and by whom they should be taught, and who should be served by them. This study sought, from one important perspective, to provide answers to these and closely related questions on patient education programs for hospital inpatients.

¹Robert E. Canfield, "The Physician as a Teacher of Patients," Journal of Medical Education 48 (December 1973): 80.

²American Hospital Association, Health Education in the Hospital (Chicago: American Hospital Association, 1964); American Hospital Association, "Overview of AHA Patient Education Project Results," Chicago, 1976. (Mimeographed); American Hospital Association, Strategies in Patient Education (Chicago: American Hospital Association, 1969).

profes
in com
for th
in thi
health
nine
quest

Purpose of Study

The purpose of this study was to learn the opinions of professionals collectively and by professional specialty groups in community hospitals in one state concerning patient education for the inpatient hospital population. The professionals included in this study were physicians, nurses, administrators, allied health professionals, and patient education staff who worked in Maine community hospitals. Answers were sought for the following questions:

1. Do these professionals judge patient education activities to be important for adequate hospital care?
2. How do these professionals define the scope of patient education for the inpatient hospital population?
3. What content areas, as judged by these professionals, should be included in hospital inpatient education programs?
4. How do these professionals define their own roles and the roles of other professionals in the planning, implementation, and evaluation of patient education activities?
5. How do these professionals define the roles of former patients and families of present and former patients in the planning, implementation, and evaluation of patient education activities?

base
class
edu
lary

the
pri
The
edu
pro

6. What role do these professionals identify for the hospital in the follow-up of discharged patients who need further educational services?
7. What constraints do these professionals see in both the development and implementation of patient education activities?
8. Which major illness categories do these professionals believe present the greatest need for patient education activities?
9. What hospital department can best coordinate organized hospital patient education programs?
10. Do these professionals believe it is feasible to develop or expand formal patient education programs?

Significance of Study

There is a need for a synthesized and comprehensive data base on hospital inpatient education programs. Some literature describing how professionals in hospital settings view patient education has existed previously. However, this material is largely unorganized and seriously limited in scope.

Most previous studies have examined patient education from the perspective of one profession or another, and they are reported principally in health education, nursing, and hospital literature. There has been an especially serious lack of material on patient education for hospital inpatients from physicians and allied health professionals.



Many of the earlier studies have addressed patient education in general and have not been specifically related to patient education for the inpatient hospital population. In addition, most of the material written in this area has spoken only to the importance of patient education and not to the issues of program planning and operation.

In conducting this study an attempt has been made both in the review of literature and through the inquiry itself to synthesize several facets of patient education. As a contribution to the body of patient education literature, it provides a different way of looking at patient education for the inpatient hospital population, that of a composite description from the perspectives of all health care professionals involved in the situations studied.

Having a composite description of how professionals view patient education can aid in the planning and implementation of patient education programs. Though formal patient education programs are developing at a rapid rate,¹ the programs for the most part are aimed only at specific types of illnesses² and not at overall general inpatient hospital populations.³ In dealing with

¹American Hospital Association, Patient Education Project.

²Ibid.; Jeanette Simmons, "An Overview of Patient Education," in Patient Education Workshop: Summary Report (Atlanta: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, 1976), p. 20.

³Donnell Etzwiler, "The Contract for Health Care (editorial)," Journal of American Medical Association 224 (May 14, 1973): 1034; Barbara Redman, The Process of Patient Teaching in Nursing (St. Louis: The C. V. Mosby Company, 1976), p. 18; Michael Skaling,



the introduction of a new idea or innovation (general patient education programs) within an organization, it is important to know the opinions of those who will be carrying through the innovation or will need to change their practices because of the innovation.¹ Both the literature and a review of operating programs demonstrate that it is mostly traditional hospital personnel, especially those with nursing backgrounds, who are administering and executing programs.² The study provides important knowledge of the opinions that traditional hospital personnel (especially physicians and nurses) have of patient education for hospital inpatients.

The study also provides a data base for conducting continuing education programs for patient education personnel. The educational needs of the participants must be considered when designing continuing education programs for professional groups.³ The opinions revealed and analyzed in this study constitute a first-level

interview held at Project RISE, Waterville, Maine, 3 February 1977; Joan M. Wollé, "Multidisciplinary Teams Develop Programming for Patient Education," Health Services Reports 89 (January-February 1974): 8-12.

¹American Hospital Association, Strategies in Patient Education, pp. 28-29; Cyril O. Houle, The Design of Education (San Francisco: Jossey-Bass, 1972), p. 19; Arthur Nichoff, A Casebook of Social Change (Chicago: Aldine Publishing Company, 1966), p. 11; Everett Rogers and Floyd Shoemaker, Communication of Innovations (New York: The Free Press, 1971), p. 239.

²American Hospital Association, Patient Education Project; Simmons, "Overview of Patient Education," pp. 21-22.

³Houle, pp. 32-34; J. R. Kidd, How Adults Learn (New York: Association Press, 1973), pp. 30-52; Malcolm Knowles, The Modern Practice of Adult Education (New York: Association Press, 1970), p. 23.



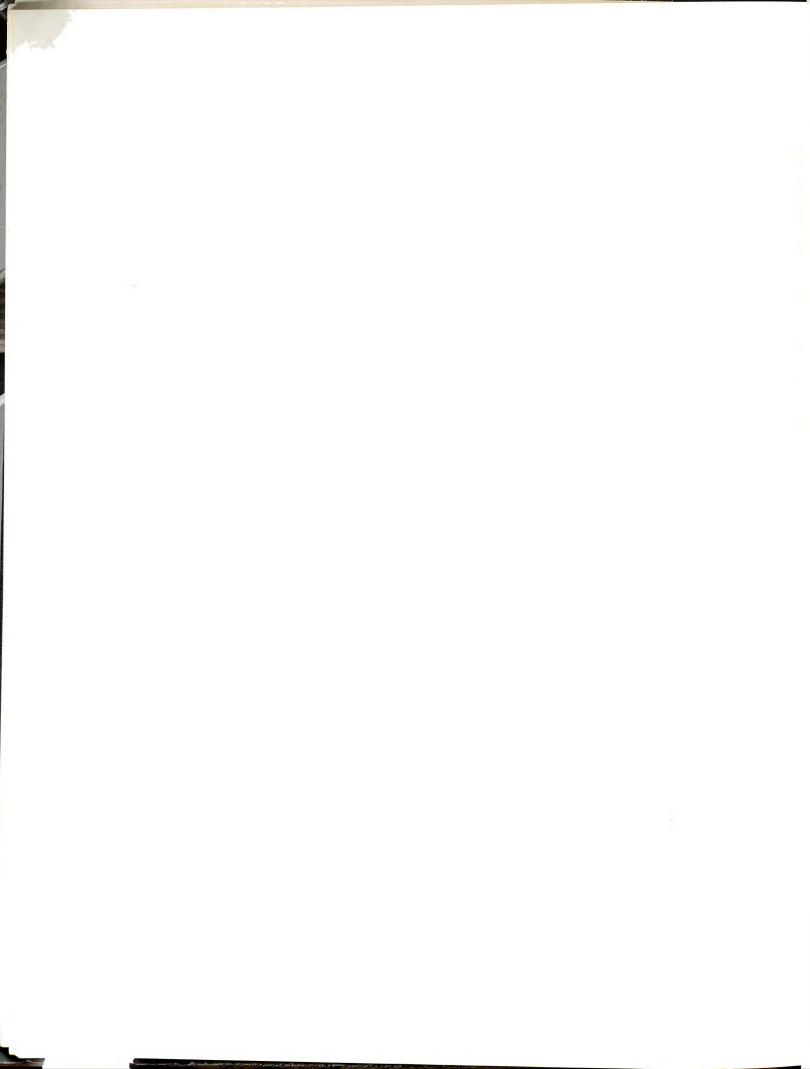
needs assessment for the various professional groups involved in patient education in community hospitals in Maine.

Further, the study provides a model that can be used by other hospitals or groups of hospitals to assess staff opinions of patient education. That way hospitals can generate their own data for specific program planning and staff development programs.

Procurement and Analysis of Responses

Mail questionnaires were used to gather data for answering the questions posed by this study. The questions were developed based on information obtained from reviewed literature, outlines of operating programs, and interviews with people actively involved in patient education.

The data generated from the survey are presented and analyzed in several ways. First, a display of the data shows how all professionals, collectively and by sub-groups, responded to each question area. The data are then analyzed to ascertain the relationships between the judgments of the professional sub-groups on each of the issues in question. Finally, the data are analyzed to ascertain how responses varied in relationship to four additional variable factors. These were: (1) size of hospital, (2) whether or not the hospital had an operating formal patient education program, (3) the professionals' experience with formal patient education, and (4) the professionals' training in or related to patient education. These analyses are done with three of the five



professional groups, with and without regard to professional classification.

Limitations of Study

The study had two principal limitations:

1. The population studied included only those professionals who practice in community hospitals in Maine. Personnel from veteran's hospitals, mental hospitals, and other specialized hospitals or hospitals in other places were not included.
2. Community hospitals in the bed size category of over 200 beds were under-represented. Only one of the five hospitals in this category was included since hospital personnel policies made it impossible to obtain sampling lists from the other hospitals chosen for inclusion in the study.

Definition of Terms

For the purpose of this study the following definitions were used.

Patient Education

Patient education is a process whereby patients and in some cases their families: (1) receive information about specific health problems, (2) learn the necessary competencies to deal with the health problems, and (3) develop accepting attitudes toward the health problems and resulting changes in life style. Patient education includes both formal and informal educational activities.



Formal Patient Education

Formal patient education is an organized process with written goals and objectives. Specially assigned staff members or volunteers execute formal patient education activities.

Informal Patient Education

Informal patient education consists of educational activities that are not separately planned and organized, but usually happen on an intuitive, episodic, and random basis. These types of activities are usually not identified as "patient education," but rather are considered as a routine part of health care.

Community Hospitals

Community hospitals include all short-term general hospitals whose facilities and services are available to the general public. Excluded are Veteran's Administration hospitals and hospital units of prisons, asylums, and similar institutions.

Short-Term Hospital

A short-term hospital is one in which the average length of stay must be less than thirty days or in which more than 50 percent of all patients are admitted to units where the average length of stay is less than thirty days.¹

¹American Hospital Association, Hospital Statistics, 1976 Edition (Chicago: American Hospital Association, 1976), p. xvii.



Professional Hospital Staff

Professional hospital staff consists of all hospital personnel with specialized training in the health field. For the purpose of this study the term professionals refers only to the following groups within the hospital professional staff.

Physicians: Physicians (both medical doctors and doctors of osteopathy) who have active staff privileges and/or are employed by community hospitals.

Nursing Staff: Registered nurses and licensed practical nurses who are employed at least twenty hours a week in community hospitals.

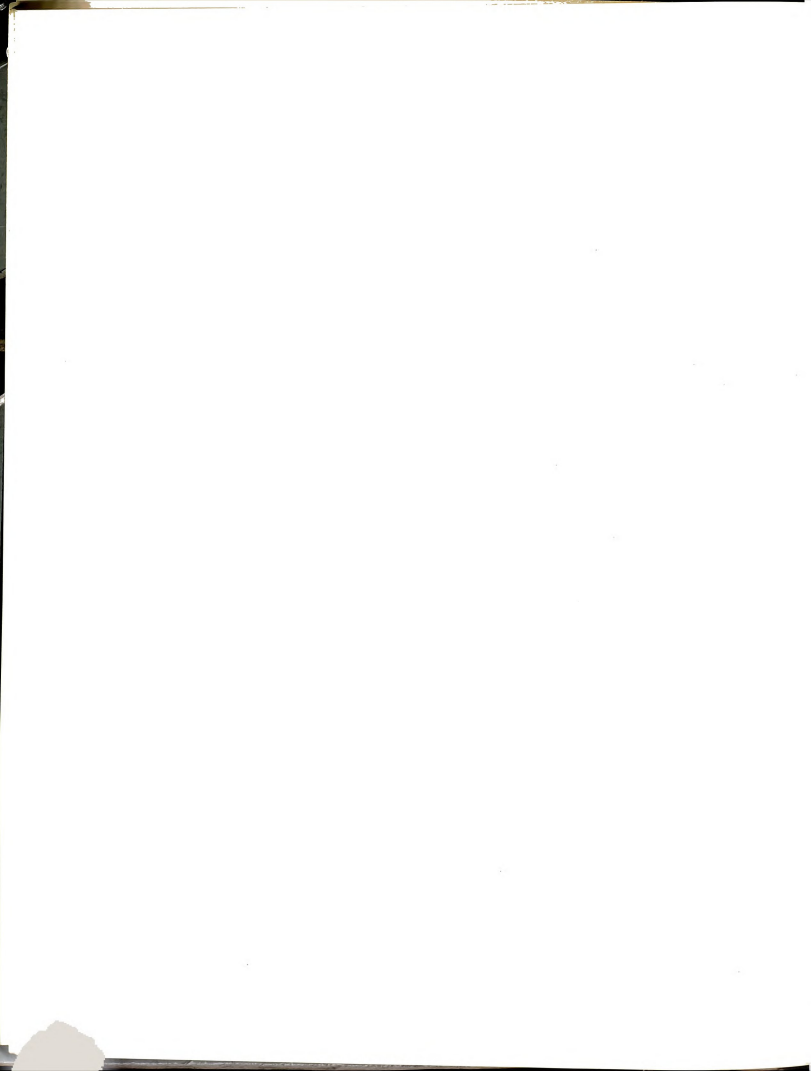
Hospital Administrators: Administrators who are employed by community hospitals as their chief executive officers.

Allied Health Professionals: Physical therapists, occupational therapists, pharmacists, dietitians, social workers, and speech therapists who are employed either full- or part-time by community hospitals.

Patient Education Staff: Staff of community hospitals who are employed either full- or part-time as either coordinators (directors) of patient education programs or patient teachers.

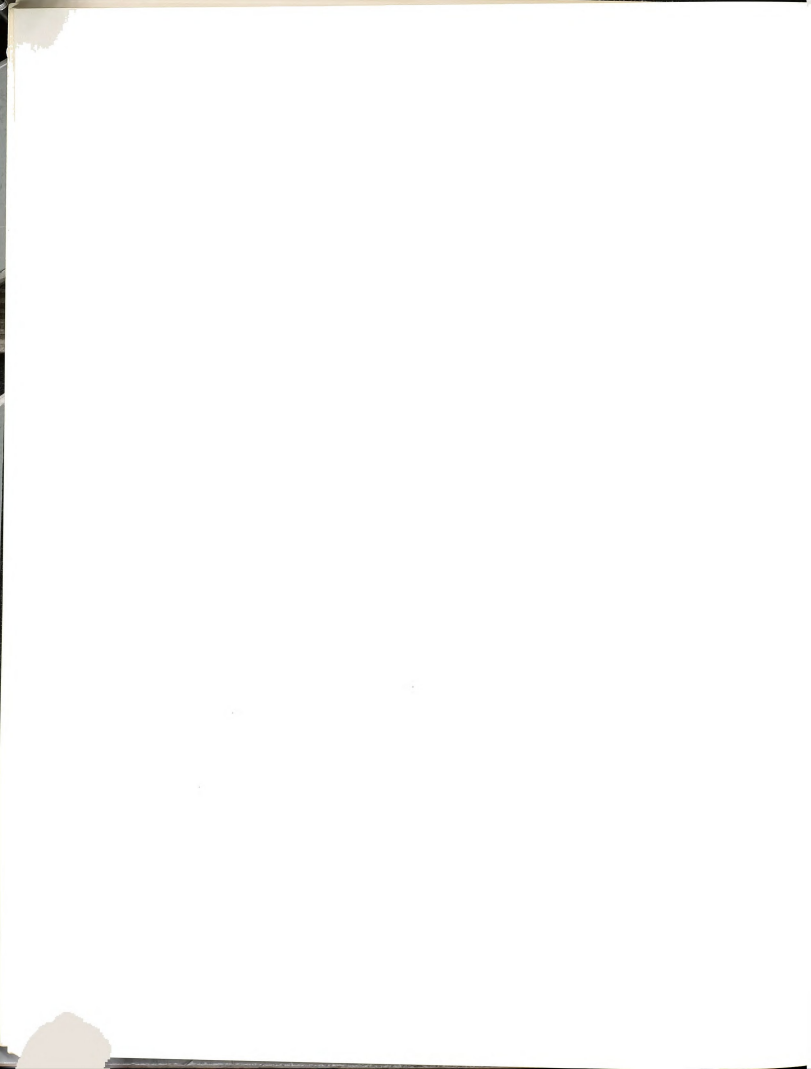
Summary of Chapter I and Overview of Succeeding Chapters

Chapter one provides a basic overview of the entire study. It opens with a brief description of the historical background of



patient education and a general introduction to the study. Next a description is given of the purpose and significance of the study. This is followed by a section on the procurement and analysis of the responses and the limitations of the study. Finally, the chapter provides definitions for the major terms used in the study.

Chapter two is a comprehensive review of the literature on patient education. It provides general background information on patient education, information on hospital-based patient education activities, and data that comprise the basis for the specific research objectives. Chapter three describes the objectives, the methodology, and the analytical procedures for the study. Chapter four provides a description of the respondents and the major findings of the study. The findings include the opinions of both the total respondent group and each professional group on issues relating to basic concepts, organization, development, and implementation of patient education for hospital inpatients. Chapter five provides an overall summary, the conclusions, the implications for practice, the implications for research, and a concluding statement.



CHAPTER II

REVIEW OF LITERATURE

The review of literature is in the form of a bibliographic essay. It attempts to provide a broad overview of patient education. Its purpose is three-fold. The first is to provide general background information on patient education. The second is to present material on hospital-based patient education activities. The third is to provide the rationale for the research objectives identified in Chapter Three.

The review is divided into sections as follows:

1. Definition of patient education
2. Informal and formal patient education activities
3. Importance of patient education
4. Process model of formal patient education programs
5. Settings for patient education
6. Hospital-based patient education programs
7. Content of hospital patient education
8. Roles of professionals, patients, and families of patients in hospital patient education
9. Constraints to the development and implementation of patient education activities in the hospital
10. Need for further study



11. Task assumed in the present study
12. Relating the review to the present study

Patient Education Defined

Patient education is a process whereby patients and in some cases their families: (1) receive information about specific health problems, (2) learn the necessary competencies to deal with the health problems, and (3) develop accepting attitudes toward the health problems and resulting changes in life styles. Patient education includes both formal and informal educational activities. Formal patient education is an organized process with written goals and objectives. Specially assigned staff members or volunteers execute formal patient education activities. Informal patient education is not separately planned and organized and is generally executed as an incidental part of normal hospital routine.

Informal Patient Education Activities

The informal patient education activities are the most prevalent form of educational activities performed by professionals in the health care field. One example of this is a nurse teaching a stroke patient with a disabled arm to dress himself; a second example is a physician answering a mother's questions about how to care for her sick child. These types of activities are usually not identified as "patient education," but rather are considered as a routine part of health care. Informal patient education activities are not separately planned and organized, but usually



happen on an intuitive, episodic, and random basis,¹ depending upon factors such as the health care provider's style of practice and the patient's inquisitiveness.

Descriptions of informal patient education activities are not widespread in the literature. In most cases patient education is defined only as specially organized or planned educational programs.² Though informal patient teaching is less orderly and cannot be easily documented, it is an important component of the total patient education process³ for as Redman asks, ". . . what difference does it make to the patient if learning was or wasn't intended?"⁴

Formal Patient Education Programs

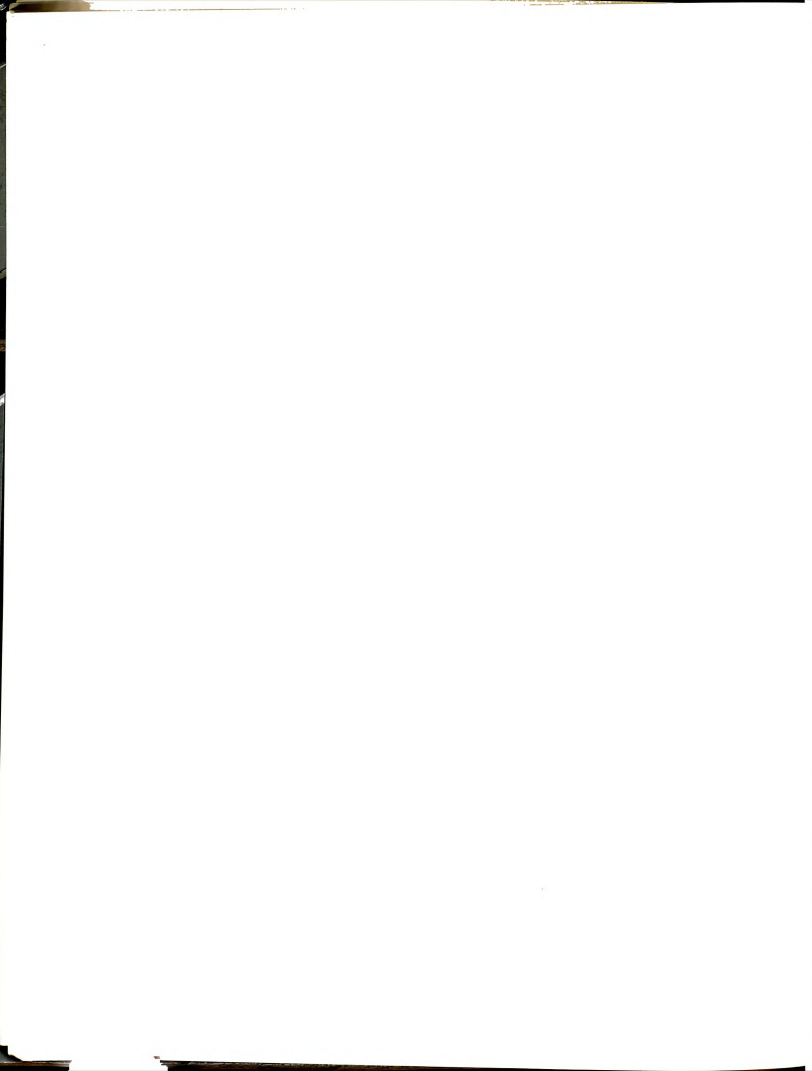
Formal patient education is characterized by terms such as planned, organized, and structured. It is a relatively recent

¹Maryann Fralic, "Developing a Viable Inpatient Education Program: A Nursing Director's Perspective," Journal of Nursing Administration 6 (September 1976): 31.

²American Group Practice Association, "Statement on Patient Education" (Alexandria: American Group Practice Association, November 1974) (Mimeographed); Donald J. Breckon, "Patient Education Programs for the Aged in Michigan Nursing Care Facilities" (Ph.D. dissertation, Michigan State University, 1977), p. 7; Simmons, "Overview of Patient Education," p. 19; Marguerita Vega, "New Focus on the Hospital as a Health Education Center," Hospitals 40 (July 16, 1966): 78-82.

³Lois A. Monteiro, "Notes on Patient Teaching: A Neglected Area," Nursing Forum (1964): 26; Barbara Redman, "Guidelines for Quality of Care in Patient Education," The Canadian Nurse 71 (February 1975): 20.

⁴Redman, "Guidelines," p. 20.



innovation. A comprehensive overview of the historical background of formal patient education is included in two publications by Breckon.¹

Early references to formal patient education appeared in the 1950's from the health education field² and in a report published by the Veteran's Administration.³ The movement was also supported during that time by pre-paid health care groups such as Kaiser-Permanente Medical Care Program⁴ and the Health Insurance Plan of Greater New York.

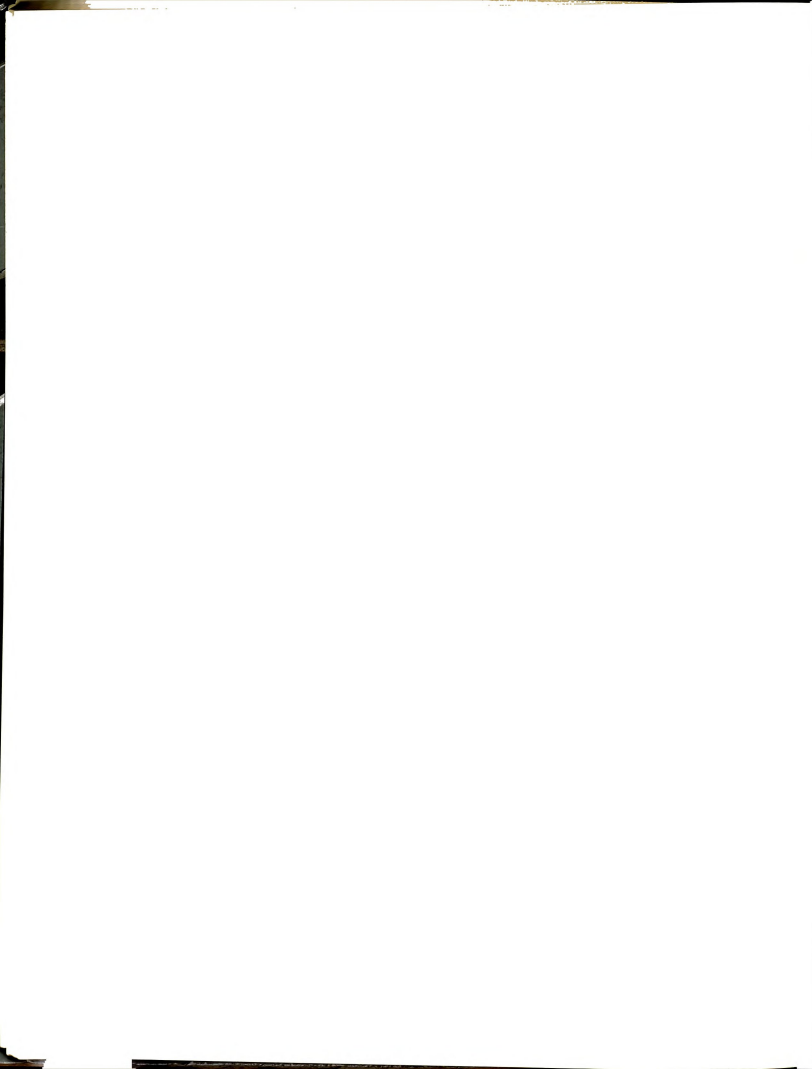
Formal conferences, papers, research reports, and committees on patient education became more prevalent during the 1960's. The Health Education Division of the Society of Public Health held a seminar in 1962 at the University of California on Health Education in Medical Care: Needs and Opportunities. The American Hospital Association held two conferences, one in 1964 and one in 1969 on, respectively, The Role of the Hospital in Health Education

¹Donald J. Breckon, "Highlights in the Evolution of Hospital-Based Patient Education Programs," Journal of Allied Health 35 (Summer 1976): 35-39; Breckon, "Programs for the Aged."

²John Burton, "Doctor Means Teacher," International Journal of Health Education 1 (January 1958): 4-12; Alice M. Johnson and Clifford S. Johnson, "Health Education in the Hospitals," Health Education Journal 10 (July 1952): 175-85.

³U.S. Department of Defense, Veteran's Administration, by George Beauchamp, "Patient Education and the Hospital Program," VA Technical Bulletin (Washington, D.C.: Veteran's Administration, April 27, 1953), pp. 10-88.

⁴Frances Collen, Blanche Maders, Krikor Soghikian, and Sidney Garfield, "Kaiser-Permanente Experiment in Ambulatory Care," American Journal of Nursing 7 (July 1968): 1483-85.



and Strategies in Patient Education. The Russell Sage Foundation commissioned the writing and publication of a series of monographs entitled Newer Dimensions of Patient Care.¹ The American Public Health Association appointed a committee on "Education Tasks in Chronic Illness."²

Even though there is a proliferation of literature, there is little evidence that through the 1960's there was much implementation of formal patient education programs. Major programs reported most frequently in the literature include the programs of Kaiser-Permanente in California;³ the United Hospitals of Newark, New Jersey;⁴ the programs at Charles T. Miller Division of United Hospitals, St. Paul, Minnesota;⁵ and a Beverly, Massachusetts, Hospital program.⁶

¹ Esther Lucile Brown, Newer Dimensions of Patient Care (New York: Russell Sage Foundation, 1965).

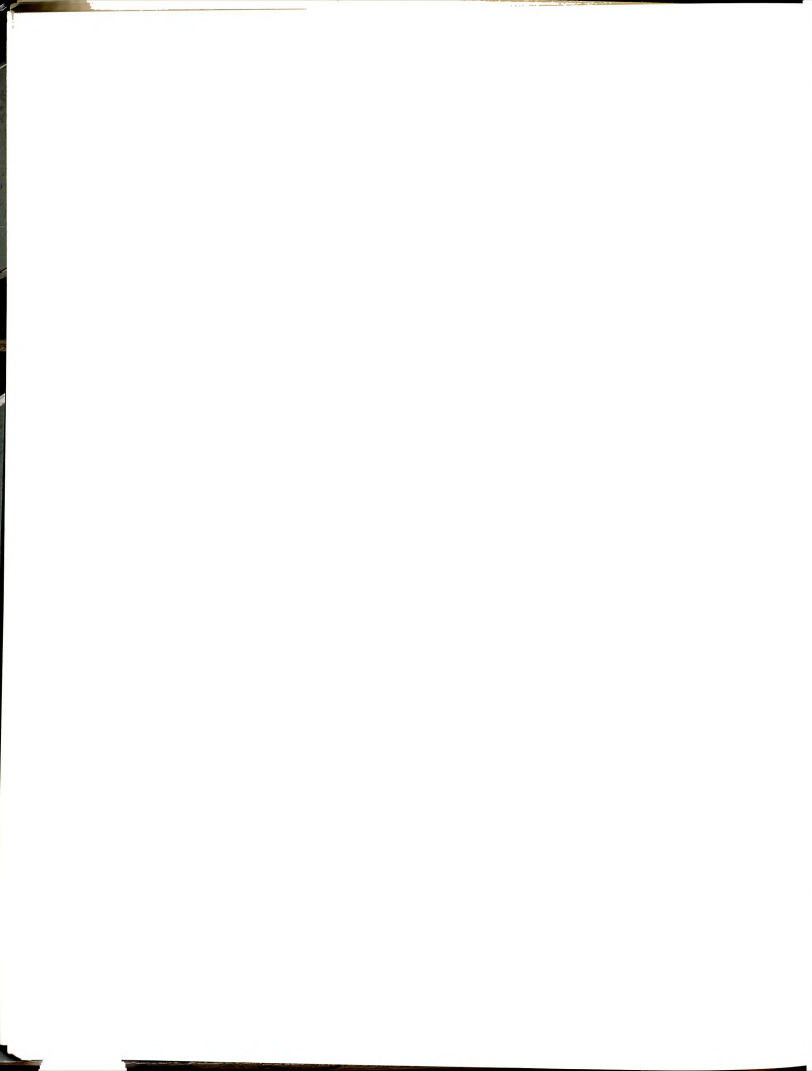
² U.S. Department of Health, Education, and Welfare, Public Health Services, Health Resources Administration, A Model for Planning Patient Education (Washington, D.C.: Government Printing Office, 1972).

³ Collen, "Kaiser-Permanente."

⁴ Vega.

⁵ Marian Ulrich, "The Hospital as a Center for Health Education," Health Education Monographs 31 (San Francisco: Society for Public Health Education, 1972): 99-108.

⁶ Richard Alt, "Patient Education Program Answers Many Unanswered Questions," Hospitals 40 (November 16, 1966): 76-78; Dorothy T. Linehan, "What Does the Patient Want to Know?" American Journal of Nursing 66 (May 1976): 69-71.



Many of the earlier programs did not sustain their momentum and closed. Others came close to closing several times.¹ The reasons for these difficulties appear to have been lack of staff and lack of institutional commitment to the programs.

The 1970's have demonstrated a very different picture of formal patient education programs, both hospital and non-hospital based. The programs are growing and developing at a very rapid rate. A survey conducted by the American Hospital Association in 1972 showed that approximately 15 percent of the community hospitals in the United States had formal patient education programs with another 6.5 percent in the process of planning such programs.² A second survey conducted by the American Hospital Association in 1975 has shown a dramatic increase in community hospital patient education programs in the United States with just over 50 percent of the reporting hospitals having one or more formal patient education programs for their inpatients.³

Part of this rapid growth in patient education programs has come about following actions of the federal government and various professional associations in the health field.

¹Jane S. Shaw, "New Hospital Commitment: Teaching Patients How to Live With Illness and Injury," Modern Hospital 121 (October 1973): 98; D. Etzwiler, M. Tyrell, M. Ulrich, J. Wrynt, and A. Hirsch, "Patient Education in Community Hospitals," Minnesota Medicine 55 (December 1972): 36.

²"AHA Research Capsules: Patient Education Programs in Community Hospitals," Hospitals 46 (December 1, 1972): 102.

³American Hospital Association, "Patient Education Project."



A number of official statements concerning the importance of patient education have been developed by a variety of health care associations. These include: the American Hospital Association's "Patient's Bill of Rights"; the American Medical Association's "Definition and Role of Planned Patient Education Programs"; the American Nurses' Association's "The Professional Nurse and Health Education"; the American Society of Hospital Pharmacists' "Statement on Pharmacist-Conducted Patient Counseling"; the American Hospital Association's "Statement on the Role and Responsibilities of Hospitals and Other Health Care Institutions in Personal and Community Health Education"; a position paper from the Society for Public Health Education on "The Concept of Planned Hospital Based Patient Education Programs" prepared for the President's Committee on Health Education; and the Blue Cross Association's "White Paper: Patient Health Education."¹ All of these documents support the

¹ American Hospital Association, "A Patient's Bill of Rights" (Chicago: American Hospital Association, 1975); American Medical Association, "Definition and Role of Planned Patient Education Programs" (Chicago: American Medical Association's Department of Health Education, 1975); American Nurses' Association, "The Professional Nurse and Health Education" (Kansas City, Missouri: American Nurses' Association, 1975); American Society of Hospital Pharmacists, "Statement on Pharmacist-Conducted Patient Counseling" (Washington, D.C.: American Society of Hospital Pharmacists, 1976); American Hospital Association, "Statement on the Role and Responsibilities of Hospitals and Other Health Care Institutions in Personal and Community Health Education" (Chicago: American Hospital Association, 1974); Task Force on Patient Education for the President's Committee on Health Education, "The Concept for Planned Hospital Based Patient Education Programs," in Patient Education, pp. 1-11, Health Education Monographs, Vol. 2, No. 1 (San Francisco: Society for Public Health, Spring 1974); "Summary of Findings and Recommendations of the President's Committee on Health Education" (Mimeographed), pp. 24-25;



process of patient education as an integral and needed part of patient care.

Patient education and health education in general has become a public policy question. In September of 1971 President Richard Nixon appointed a committee to study health education. Among the committee's recommendations were two addressing patient education and the professional health care providers of that education, namely that:

1. . . . the nation's hospitals be strongly encouraged to offer health education programs to patients and families, both on an inpatient and outpatient basis;
- and
2. . . . skill in providing health education be an essential part in the training and continuing education of all health care workers.¹

A third recommendation of the committee was to establish two national health education centers, one public and one private. In response to this recommendation, the Bureau of Health Education was established in September, 1974, at the Center for Disease Control in Atlanta, Georgia.² The Bureau's staff has been actively involved in gathering data on patient education as well as hosting

Blue Cross Association, "White Paper: Patient Health Education" (Chicago: Health Care Service, Blue Cross Association, 1974) (Mimeographed).

¹"Summary of President's Committee," pp. 24-25.

²Horace Ogden, "Health Education: A Federal Overview," Public Health Reports 91 (May-June 1976): 203.



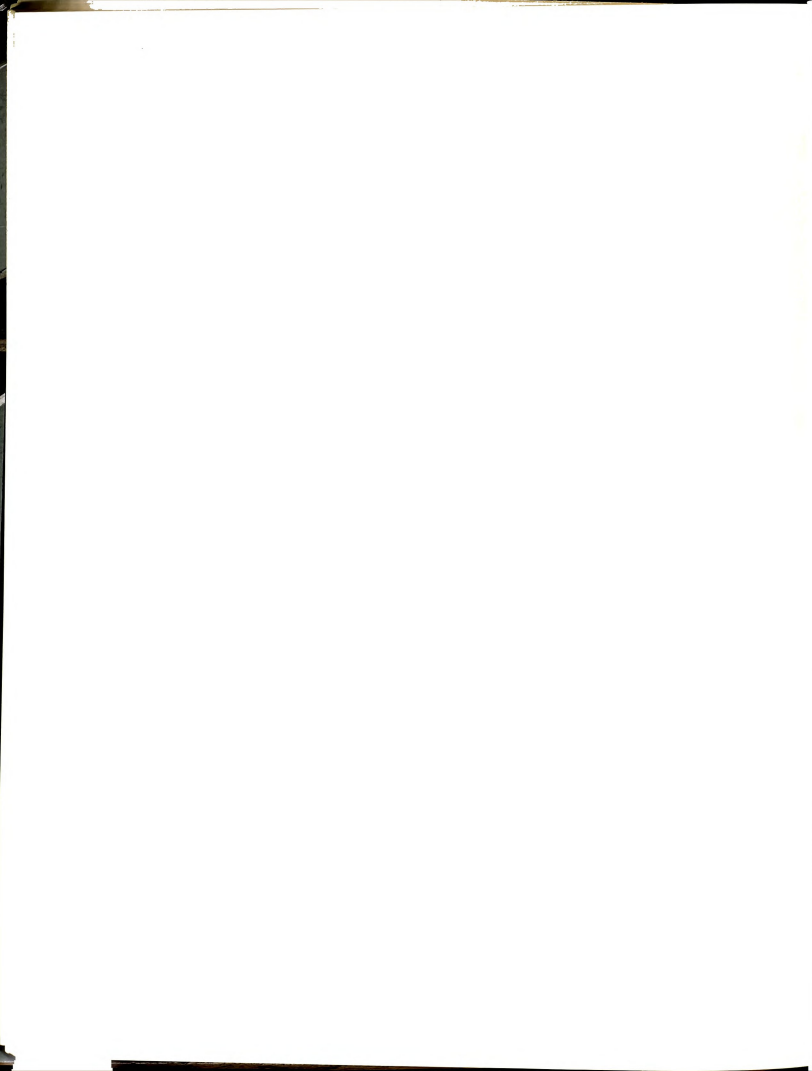
national and regional meetings on the subject.¹ The National Center for Health Education, a private center, was formally brought into being on October 1, 1975, and is located in New York City.²

In addition, patient education was included in two recent Congressional acts. The first, enacted in 1973, contains the federal regulations for Health Maintenance Organizations (HMO's) that receive federal funds. The Health Maintenance Organization Act of 1973 (P.L. 93-222) mandates that HMO's have a health education component. The second, the Health Planning and Resource Development Act of 1974 (P.L. 93-641), authorized a three-year nation-wide program of health planning and resources development. A component of any state health plan, developed as one of the requirements of the law, must provide for health education programs for schools, hospitals, long-term health care facilities, and other types of health settings.

Simonds in a keynote address to the American Association of Medical Clinics' Health Counselor's Workshop in 1974 stated that "We are developing what I would call a 'critical mass'--a sufficient number of key elements that encourage or even require this

¹Milton Davis, Documenting the Need. Strategies in Patient Education (Chicago: American Hospital Association, 1969); U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, Patient Education Workshop: Summary Report (Atlanta: Bureau of Health Education, 1976).

²Ogden, p. 201.



work (patient education) to grow and develop."¹ Many other health care professionals echo his beliefs.²

The results of this increase in programs may not be felt by the "everyday" patient, as the majority of programs are geared towards specific types of illness such as diabetes and not to the general patient population.³

Importance of Patient Education

Patient education is recognized as an important component of adequate patient care by both health care providers and the patients themselves.

Houston⁴ in reporting a study on patients' reactions to hospital care, noted that 93 percent of those patients interviewed wished to know as much as possible about what was wrong with them.

Alt came to a similar conclusion in a study that surveyed patients just prior to leaving a Massachusetts hospital. He concluded that:

¹Scott Simonds, Current Issues in Patient Education (New York: Core Communications in Health, Inc., 1974), p. 3.

²Roy Davis, Director of the Community Program for Development Division, Bureau of Health Education, Center for Disease Control, Atlanta, Georgia, presentation at Project RISE meeting, Waterville, Maine, 3 February 1977.

³Simmons, "Overview of Patient Education," p. 20.

⁴Charles S. Houston and Wayne E. Pasanen, "Patients' Perceptions of Hospital Care," Hospitals 46 (April 16, 1972): 70-74.



The hospital patient wants more understanding about treatments, medicines, diets, diagnosis, and numerous personal and health-related questions that go unanswered.¹

Pender, in reporting a study conducted in a community hospital setting, indicated that patients related that they had a

. . . need for more information before discharge on how to care for themselves at home, the effect of illness on their daily living habits, possible complications of their present illness, and prevention of future illnesses.²

Skillern's³ study on patients reactions to a formal patient education program showed that 95 percent of the patients who went through the program found it to be a worthwhile experience. They were pleased both with the opportunity to learn new information and with the experience itself.

Patient education is shown by the literature to be an important component of patient care for at least seven reasons:

1. Patients have a right to know what is happening to them.

This has been clearly spelled out in the Patients' Bill of Rights which was adopted by the American Hospital Association in 1973. Specifically statements two, three, and twelve refer to patient education. They are as follows:

¹Alt, p. 76.

²Nola J. Pender, "Patient Identification of Health Information Received During Hospitalization," Nursing Research 23 (May-June 1974): 262-63.

³Penn G. Skillern, "Patient Education in the Group Clinic: A New Approach," paper presented at the Third International Congress on Group Medicine, Paris, France, 21-26 June 1976.



The patient has the right to obtain from his physician complete current information concerning his diagnosis, treatment, and prognosis in terms the patient can be reasonably expected to understand. When it is not medically advisable to give such information to the patient, the information should be made available to an appropriate person in his behalf. He has the right to know, by name, the physician responsible for coordinating his care. (Statement Two)

The patient has the right to receive from his physician information necessary to give informed consent prior to the start of a procedure and/or treatment. Except in emergencies, such information for informed consent should include but not necessarily be limited to the specific procedure and/or treatment, the medically significant risks involved, and the probable duration of incapacitation. Where medically significant alternatives for care or treatment exist, or when the patient requests information concerning medical alternatives, the patient has the right to such information. The patient also has the right to know the name of the person responsible for the procedures and/or treatment. (Statement Three)

The patient has the right to know what hospital rules and regulations apply to his conduct as a patient. (Statement Twelve)¹

The Association in turn has encouraged member hospitals to adopt The Patient's Bill of Rights as a part of hospital policy. Either this statement or a similar statement has been adopted by a number of hospitals,² and in one case has become a part of state law.³

Field⁴ has also addressed the question of the rights of patients, more specifically adult patients. She states that:

¹American Hospital Association, "Patient's Bill of Rights."

²"Sisters of St. Joseph, Wichita, Adopt Hospital-Patient Code," Hospital Progress 54 (November 1973): 20.

³"Minnesota Hospitals Must Tell Patients About Their Rights," Modern Hospital 121 (September 1973): 42.

⁴Minna Field, Patients Are People (New York: Columbia University Press, 1967).



As part of his right to be considered an adult, the patient has a right to know what is being done for him and why, to express opinions, and to use judgment in making decisions which ultimately will affect his entire future life.¹

2. Patients are better able to deal with their health problems when better informed.

A number of research studies have demonstrated this premise. Egbert, Bettit, Welch, and Bartlett² studied the effect of education on ninety-seven surgical patients at Massachusetts General Hospital. They showed that when patients were told what to expect in the way of post-operative pain and taught how to relax post-operatively they needed less narcotic medicines after surgery and remembered the operation more favorably than those who were uninformed.

Levine³ demonstrated that teaching hemophiliacs to care for themselves reduced the number of emergency room visits. He clearly favors the self-therapy model of health care delivery.

Based on a study with heart patients receiving treatment in an out-patient clinic, Rosenberg⁴ concluded that a well-organized treatment and education program does provide better medical care

¹ Ibid., pp. 147-48.

² Lawrence D. Egbert, George E. Battit, Claude E. Welch, and Marshall K. Bartlett, "Reduction of Post-operative Pain by Encouragement and Instruction of Patients," New England Journal of Medicine 240 (April 16, 1964): 825-27.

³ Peter Levine, "Efficacy of Self-Therapy in Hemophilia: A Study of Seventy-Two Patients With Hemophilia A and B," New England Journal of Medicine 291 (December 1974): 1381-84.

⁴ Stanley Rosenberg, "Patient Education Leads to Better Care for Heart Patients," HSMHA Health Reports 86 (September 1971): 793-802.



for patients. Total readmissions and total readmission days were significantly reduced for patients who participated in the clinic education program.

An overview of the above articles and other studies relating to patients being better able to care for themselves is reported by Roccella.¹ Roccella also stresses the point that having patient education programs is one way to deal with the increasing costs of health care.

3. Patient education is cost-effective.²

4. Green³ has outlined a number of ways that patient education could be cost-effective. Among these are that patient education could reduce the number of broken appointments, help with patient dissatisfaction, reduce unpaid bills, improve speed of diagnosis, and improve patient compliance with medical regimes.

4. Patient education increases health manpower by adding the patient to the health care team.

¹Edward J. Roccella, "Potential for Reducing Health Care Costs by Public and Patient Education," Public Health Reports 19 (May-June 1976): 223-25.

²Edith Schoenrich, "Patient Education in Contemporary Health Service Delivery," in Proceedings . . . Workshop on Patient Education (Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1973), p. 6.

³Lawrence Green, "The Potential of Health Education Includes Cost-Effectiveness," Hospitals 50 (May 1, 1976): 57-61.



Patient education implies a giving of part of the responsibility back to the patient for both the management and maintenance of his/her own health.¹

5. Patient education increases compliance by patients with medical regimes.

Estimates range from 15 to 95 percent of patients who are non-compliant.² A number of factors have been given as causes of this non-compliant behavior. Among them are a lack of information about one's illness³ and a lack of understanding of the doctor's orders concerning treatment.⁴

6. Patient education is important because there is an increasing incidence of chronic disease and aging.

People are generally living longer; and larger numbers are surviving some of the most serious illnesses and accidents that leave them paralyzed, brain damaged, or with a combination of disabilities. Unless they are to be permanently institutionalized these people and their families must know how to manage their health problems as they primarily will be in charge.⁵

¹"Roundtable/Patient Education: Making Your Patient a Partner in Care," Patient Care 8 (September 15, 1974): 1084; Schoenrich, "Contemporary Health Service Delivery," p. 6.

²Davis, Strategies in Patient Education.

³Marshall Becker and Lois Maimex, "Sociobehavioral Determinants of Compliance With Health and Medical Care Recommendations," Medical Care 13 (January 1975): 10-24.

⁴"Why Patients Don't Follow Orders," Medical World News (New York: McGraw-Hill, Inc., 1972).

⁵Schoenrich, "Contemporary Health Service Delivery," p. 5.



7. The importance of patient education comes also from the increased emphasis on the prevention of illness at all levels, primary, secondary, and tertiary.¹

This involves preventing health problems before they happen, early detection and treatment, and the avoidance of disability and attempts to sustain effective functioning of the person who is predisposed to a health problem.² This preventive process cannot be effectively undertaken unless patients are well informed and involved with the process.

Process Model of Formal Patient Education Programs

A model for formal patient education programs was developed by the Committee on Educational Tasks in Chronic Illness of the American Public Health Association. The committee developed a comprehensive and interdisciplinary approach to the process of patient education which involved a five-step model. This model includes:

- (1) Identification of the educational needs of the patient and family;
- (2) Establishment of educational objectives;
- (3) Selection of appropriate educational methods;
- (4) Implementation of the educational program; and
- (5) Evaluation.³

¹Ibid., p. 4.

²Judith Mausher and Anita Bahn, Epidemiology: An Introductory Text (Philadelphia: W. B. Saunders Co., 1974), p. 10.

³U.S. Department of Health, Education, and Welfare, Public Health Service, Health Resources Administration, A Model for Planning Patient Education (Washington, D.C.: Government Printing Office, 1972), p. 7.



Other authors and organizations have also described the process of patient education. Redman¹ and Pohl,² two of the recognized spokeswomen in the nursing field, have outlined in detail the process of patient teaching in nursing. Linderman³ and Alexander, Schrader, and Knedler⁴ provide guidelines on the more specific topic of pre-operative teaching. The American Group Practice Association (AGPA) members have adopted and are utilizing a process model that was developed jointly by Core Communications Health Inc. and the American Group Practice Association.⁵ The patient education process in an ambulatory clinic setting is described by Herje⁶ and Kucha.⁷

Two workshops held on patient education, one sponsored by the Maryland State Department of Health and Mental Hygiene in

¹Redman, "Guidelines" and Process.

²Margaret L. Pohl, The Teaching Functions of the Nursing Practitioner (Dubuque, Iowa: Wm. C. Brown Co., 1968).

³Carol A. Linderman, "Influencing Recovery Through Pre-operative Teaching," Heart and Lung 2 (July-August 1973): 515-21.

⁴Carol Alexander, Elinor Schrader, and Julia Knedler, "Pre-operative Visits: The Operating Nurse Unmasks," AORN Journal 19 (February 1974): 401-12.

⁵Robert W. Jamplis, "The Practicing Physician and Patient Education," Hospital Practice 10 (October 1975): 93-99.

⁶Pat Angirk Herje, "The Ambulatory Clinic Patient as a Learner," Biomedical Communications 2 (November 1975): 93-99.

⁷Delores Kucha, "The Health Education of Patients: Development of a System," Supervisor Nurse 5 (May 1974): 8-21.



1973¹ and a second by the Bureau of Health Education in January of 1976,² also addressed the process of patient education. At the former, Schoenrich³ outlined the components of an organized patient education program. In the latter the components are given in a paper entitled "Planning for Specific Patient Education Programs."⁴

Each of these studies contains the same basic five steps outlined in the model prepared by the Committee on Educational Tasks in Chronic Illness. Some studies use different words and a somewhat different ordering, but they all describe the same basic process.

Identification of Needs

The identification of the patient's educational needs (and in some cases also the family's needs) involves the determination of information, attitudes, and skills necessary to understand their illnesses and their care, and to cooperate and participate in the treatment programs.⁵ This includes:

¹U.S. Department of Health, Education, and Welfare, Proceedings . . . Workshop on Patient Education Programming (Washington, D.C.: Department of Health, Education, and Welfare, 1973).

²U.S. Department of Health, Education, and Welfare, Patient Education Workshop.

³Schoenrich, "Contemporary Health Service Delivery," p. 3.

⁴U.S. Department of Health, Education, and Welfare, Patient Education Workshop.

⁵U.S. Department of Health, Education, and Welfare, Model, p. 9.



1. becoming familiar with the patient as a person, his social and psychological background;¹
2. assessing the patient's knowledge about his/her health;²
3. determining what the patient and the family want to know;³
4. determination by the physician and other health care personnel of what the patient and family needs to know.⁴

The trend in patient education programs, especially those developed in the last three or four years, seems to be toward the fourth activity mentioned, that of determination of what the patient and family need to know,⁵ with some stress on assessing the patient's knowledge of the health problem.⁶ The first activity (getting to know the patient as a person) and the third (finding out what the

¹ Ibid.; Brown, pp. 15-22; Redman, Process, pp. 22-26.

² Schoenrich, "Contemporary Health Service Delivery," p. 3; U.S. Department of Health, Education, and Welfare, Model, p. 9; Redman, Process, pp. 22-26.

³ U.S. Department of Health, Education, and Welfare, Model, p. 9.

⁴ Ibid.; Schoenrich, "Contemporary Health Service Delivery," p. 3.

⁵ American Hospital Association, "Patient Education Project"; U.S. Department of Health, Education, and Welfare, Patient Education Workshop; Lois Estes, interview held at Eastern Maine Medical Center, Bangor, Maine, on 13 January 1977.

⁶ Schoenrich, "Contemporary Health Service Delivery," p. 3.



patient and family want to know) appear to be lacking in most patient education programs.

Establishment of Educational Objectives

The establishment of educational objectives for the patient and his/her family involves the development of learning objectives statements that outline what the patient specifically should be able to know and do. These ideally should be formulated based upon the needs identified by the health care team, the patient, and the family.¹ Again, in practice, the specific objectives for patient teaching seem to be pre-set for a specific illness category and developed primarily by professional health care personnel.² A few of the authors state that as part of the execution of the learning objectives the patient's needs should be determined first.³ The trend, however, appears to be toward fixed learning objective packages with no provision for including the patient learners in the development of the objectives.

Selection of Educational Methods and Personnel

The selection of educational methods involves choosing the appropriate educational strategies to achieve the specified learning

¹U.S. Department of Health, Education, and Welfare, Model, pp. 10-11; Redman, Process, p. 63.

²American Hospital Association, "Patient Education Project"; Estes; U.S. Department of Health, Education, and Welfare, Model; Vega, p. 79.

³"Patient Education System" (New York: Core Communications in Health, Inc., 1976); Redman, Process, p. 63.



objectives. This includes the selection of both appropriate personnel and types of instruction to be offered.¹ The personnel may include only one patient teacher, such as a nurse, or a multidisciplinary team.² Some patient education programs also use volunteers.

The types of instruction that patient education programs use are as varied as the programs themselves. The programs involve one-to-one teaching,³ group instruction,⁴ access to library and other printed materials,⁵ and use of videotape instruction.⁶ Several authors⁷ have provided excellent descriptions of the types of instruction used in formal patient education programs.

¹U.S. Department of Health, Education, and Welfare, Model, pp. 11-14.

²Etzwiler et al., p. 34; U.S. Department of Health, Education, and Welfare, Proceedings; Simmons, "Overview of Patient Education," p. 21.

³Richard M. Caplan, "Educating Your Patient," Archives of Dermatology 107 (June 1973): 837.

⁴Fralic, p. 34; Carol A. Linderman and Betty Van Aernam, "Nursing Intervention With the Presurgical Patient--The Effects of Structured and Unstructured Pre-operative Teaching," Nursing Research 20 (July-August 1971): 319-332.

⁵Marjorie Bartlett, Ann Johnston, and Thomas Meyer, "Dial Access Library--Patient Information Service," The New England Journal of Medicine 288 (May 10, 1973): 994-97; F. Bobbie Collen and Krikor Soghikian, "A Health Education Library for Patients," Health Service Reports 89 (May-June 1974): 236-43.

⁶Illajejan Horwitz, "Television Provides Patient Education," Hospitals 46 (January 16, 1972): 57-60; "Patient Education System."

⁷Carolyn P. Fylling and Donnell D. Etzwiler, "Administrative Reviews Health Education," Hospitals 49 (April 1975): 95-98; Simmons, "Overview of Patient Education," pp. 22-23; Redman, Process, pp. 114-82.



Implementation

The implementation phase of formal patient education programs involves steps on a continuum; it starts with the individual assessment of needs and continues through the evaluation phase.¹ The primary thrust is on the actual teaching/learning process used to carry out the educational objectives that have been developed. Redman and Pohl have provided descriptions of this primary area.²

An ancillary part of the implementation phase is training of staff needed to execute the patient education programs.³ Very little research has been reported on this particular phase of implementation.

Evaluation

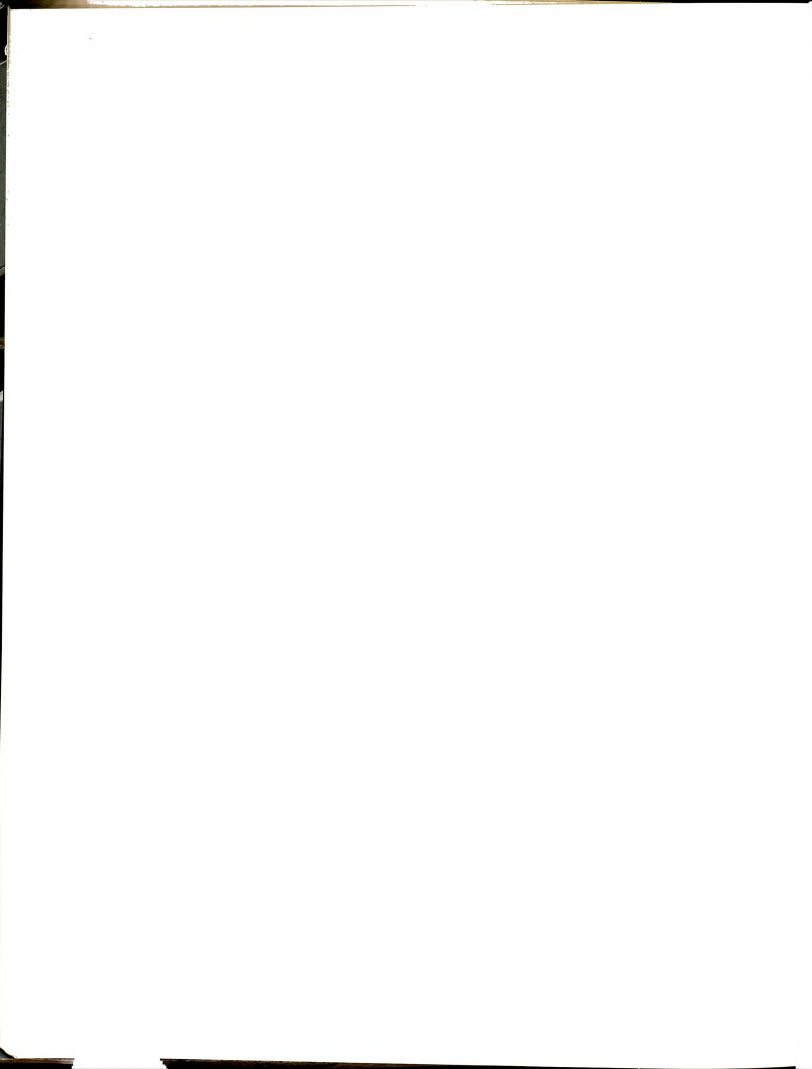
The purpose of the evaluation stage is two-fold. The first is to look at the results of the patient education program in terms of the patient's and family's (if included) learning, and effects of that learning on change in the health behavior of the patient.⁴

¹ Anne L. DeCicco, ed., A Guide to the Development of a Hospital-Based Consumer Education Program (Piscataway, New Jersey: Office of Consumer Health Education, College of Medicine and Dentistry of New Jersey, January, 1975), pp. 9-13; "Make Patient Teaching Visible," Inservice Training 5 (August 1976): 20-27; U.S. Department of Health, Education, and Welfare, Model.

² Redman, Process; Pohl, Teaching Functions.

³ DeCicco, p. 11; U.S. Department of Health, Education, and Welfare, Patient Education Workshop, pp. 6-7; Vega, p. 79.

⁴ U.S. Department of Health, Education, and Welfare, Model, pp. 14-16; "Make Patient Teaching Visible"; Schoenrich, "Contemporary Health Service Delivery," p. 3.



The second is to evaluate the patient education program, the personnel, the instructional methods, the objectives, and the overall administration.¹

Evaluation involves, among other things, the follow-up of patients after they have been discharged from a health care setting or completed their treatment (especially its educational component). The follow-up may include other health care and community personnel, such as visiting nurses in the field, even though they were not involved in the original program.² Evaluation is an important component of patient education programs, but is neither easily nor readily a part of practice.

Settings for Patient Education

Patient education can take place in a variety of settings. These settings include hospitals, ambulatory care clinics, physicians' offices, libraries, public health agencies, university extension programs, and the home. One of the primary places for patient education activities is the hospital setting. Some professionals in the health education field are calling for the hospital to be the center or the hub of all patient education programs. For example, Dr. Scott Simonds³ feels that hospitals should serve as

¹Redman, Process, pp. 183-211.

²U.S. Department of Health, Education, and Welfare, Model, p. 16.

³Scott Simonds, "Health Education and Social Policy," in Health Education Monographs, Vol. 2, No. 1 (San Francisco: Society for Public Health Education, September 1, 1974), p. 9.



centers for the coordination of total health care, including patient education.

Hospital-Based Patient Education

Hospital-based education serves a number of different kinds of clienteles: inpatients, outpatients who attend medical clinics, and the general community. In the latter area it is usually termed health education and in the former, patient education. Three comprehensive overviews of hospital patient education programs are included in a special feature on patient education in the October 1973 issue of Modern Hospital and in publications by Lee¹ and Simmons.²

Community Activities

For the community at large, the programs usually perform principally an informational function. Examples of community programs include A Hall of Health, an exhibit on health-related matters for community groups;³ telephone hotlines which provide tape-recorded answers to people's health problems;⁴ informational programs on specific health hazards, such as hypertension, smoking,

¹Elizabeth Lee, "Annual Administrative Reviews: Health Education," Hospitals 48 (April 1974): 133-39.

²Simmons, "Overview of Patient Education."

³Zeanette Williams, "A Hall of Health," Hospital Forum 18 (May 1976): 4-5, 18.

⁴"Not Primarily a Hospital but a Public School," Hospitals 48 (March 16, 1974): 99.



and drug education;¹ nutrition programs for various community groups; and a personalized exercise program for adults.²

Out-Patient Activities

Hospital-based activities for the out-patient population also involve a range of activities from doctors giving information to their patients³ to more structured individual and group sessions with patients. The most popular form of formal instruction for out-patients is represented by classes held for expectant parents.⁴ Other types of programming include classes for diabetic patients,⁵ community clubs for former heart and stroke patients,⁶ group help sessions for cancer patients,⁷ group instruction for heart patients,⁸

¹"Making the Patient a Part of Patient Care," Modern Hospital 121 (October 1973): 110.

²Ibid., p. 107.

³H. F. Dowling and David Shakow, "Time Spent by Internists on Adult Education and Preventative Medicine," Journal of the American Medical Association 149 (June 1952): 628-31.

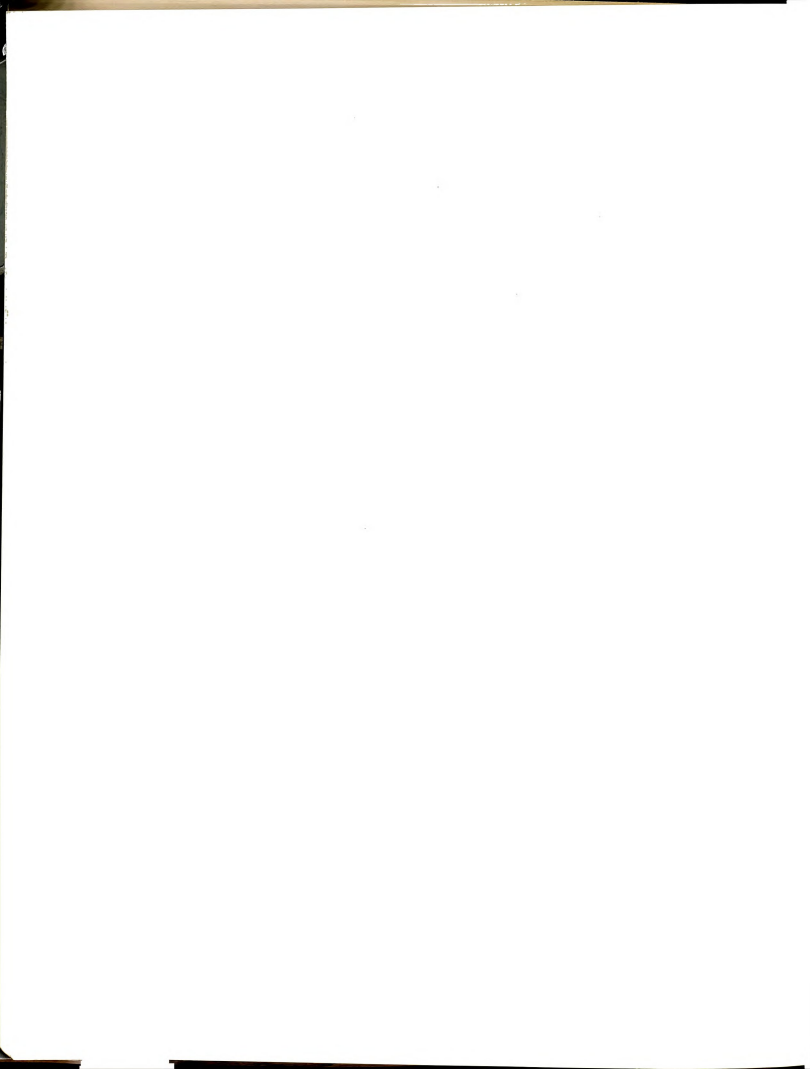
⁴American Hospital Association, "Patient Education Project."

⁵Diggins, interview held at Sparrow Hospital, Lansing, Michigan, 13 December 1976; Estes; Diana Thompson and Jocelyn Elders, "Education of the Juvenile Diabetic," The Journal of the Arkansas Medical Society 72 (November 1975): 239-46.

⁶Helen Kelsey and Virginia Beamer, "A Post-Hospital Health Education Program," Heart and Lung 5 (May 1974): 512-14; "Making the Patient a Part of Patient Care," p. 110.

⁷"Making the Patient a Part of Patient Care," pp. 106-107.

⁸Rosenberg, "A Case for Patient Education," p. 3.



a patient education library service,¹ and videotapes on specific health-related subject areas that patients may review with or without the assistance of health educators.²

Inpatient Activities

Hospital patient education activities for the inpatient population have been given the most attention in the literature and in present hospital programming. The types of educational activities for hospitalized patients and their families are almost as many and varied as the number and types of hospitals. Nurses giving bedside instructions³ represent probably the most common form of patient education for inpatients. This instruction can cover a wide range of areas from pre-operative assistance⁴ to how to get out of a hospital bed with a leg in a cast.

Other types of inpatient educational activities include patients meeting with professional staff members on a one-to-one teaching basis,⁵ attending physical or occupational therapy

¹Collen et al., "Kaiser-Permanente."

²"Patient Education System."

³Margaret Pohl, "A Study of the Teaching Activities of the Nursing Practitioner" (Ph.D. dissertation, Columbia University, 1963), p. 9; Redman, Process, p. 117.

⁴Alexander et al.; Carole Ayers and Linda Walton, "A Guide for the Pre-Operative Visit," AORN Journal 19 (February 1974): 413-18; Linderman, "Nursing Intervention."

⁵Elizabeth Bernheimer and Linda Clever, The Team Approach to Patient Education: One Hospital's Experience in Diabetes (Atlanta: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education,



sessions, meeting with the hospital social worker to discuss a personal concern,¹ attending formal classes,² listening to telephone taped messages,³ viewing videotape on bedside television sets,⁴ and having a volunteer who had a similar illness stop in to explain how he or she coped with the illness.⁵

Not all of the above-mentioned activities may be regarded as educational ones by either the patient or the health care personnel; yet they involve both teaching and learning by the parties involved. These types of activities may also be parts of a formal patient education program, or may happen informally as part of what is considered regular hospital routine.

The majority of the formal patient education activities for inpatients are focused primarily on patients with chronic illnesses.⁶

1977), p. 11; Donald F. Besta, "New Services Generate Teaching Role," Hospitals 47 (March 1, 1973), 46; Anne Jernigan, "Diabetics Need to Know More About Diet," Hospitals 45 (February 16, 1971): 100-102.

¹Field.

²Kelsey and Beamer, pp. 513-14; "Making the Patient a Part of Patient Care"; Monteiro, p. 27.

³Bartlett, Johnston, and Meyer.

⁴Horwitz.

⁵Breckon, "Hospital Health Education."

⁶American Hospital Association, "Patient Education Project"; Susan Jane Peters, "A Survey of Health Education Programs in Selected Hospitals in the United States With a Proposed Model for a Comprehensive Health Education Program in a Hospital Setting" (Ph.D. dissertation, Southern Illinois University, 1974), p. 88; U.S. Department of Health, Education, and Welfare, Patient Education Workshop.



The diseases that account for the majority of the programs include diabetes, ostomy, mastectomy, and heart problems. Two other very popular forms of hospital education for inpatients are those for patients who will undergo surgery and those for maternity patients and their husbands.¹

Linkages Between Hospital-Based Programs

There appears to be a lack of linkages, at least on a formal basis, between patient education programs for the three types of clientele that hospitals serve. This is especially important in the transition of a hospitalized patient to an out-patient status. The follow-up of the educational activities provided by the hospital and the continuation of needed activities is not well organized.

Some formal patient education programs encourage patients to continue coming to the educational activities after being discharged.² Other programs allow for informal communications if the person has a specific educational need related to the illness.³ Still other programs, through the hospital social service or discharge planning department, refer the patient to the Visiting Nurse's Association or their local homemakers' service for follow-up and

¹American Hospital Association, "Patient Education Project"; Peters, p. 88.

²Diggins; Estes; Kelsey and Beamer.

³Diggins.



further activity. Some patients receive no follow-up service, other than visits with their physician.

Establishing better linkages between the inpatient hospital education services and the services needed for patients once they have left the hospital is an area that needs further study.

Content of Patient Education Activities for Inpatients

The areas for patient education are wide and varied. They include topics such as orientation to the hospital, explanation of the diagnosis and treatment of the health problem, and learning about independent living skills and appropriate community resources. Most patients are not involved in all of the content areas, but only a few specific to their health problem.

Orientation to Hospital Facilities and Services

This area is covered in a number of ways from the handing out of printed materials to patients and their families to having nurses on the individual floors explain the various hospital services.¹ Volunteers also are relied upon quite heavily to provide this type of information for patients.

Explanation of the Diagnosis of the Health Problem

This area is primarily dealt with by the physician, many times prior to the patient being admitted to the hospital. The

¹Simmons, "Overview of Patient Education," p. 24.



extent of this explanation differs depending on the physician's style of working with patients, the patient, and the type of illness.¹

Explanation of the Treatment for the Health Problem

This area also is primarily dealt with by the physician, many times prior to hospitalization, and varies in its nature and completeness.² In some cases nurses and other allied health personnel are charged with giving part of the explanation. In most cases, however, they will not give out this type of information on their own initiative unless instructed to do so by the physician.³ This is changing, though, with the advent of more formalized patient education programs. One of the components of formal programs includes either full or partial explanation of the medical treatment.⁴ This is illustrated by the growing number of formal pre- and post-operative patient education programs.⁵

¹D. G. Pocock, "Teaching Patients--Why and How?" Southern Medicine 62 (February 1974): 9; Lois Pratt, Arthur Seligmann, and George Reader, "Physicians' Views on the Level of Medical Information Among Patients," American Journal of Public Health 47 (October 1957): 1279-80.

²Pocock, p. 10.

³Dale C. Levine and June P. Fiedler, "Fears, Facts, and Fantasies About Pre- and Post-Operative Care," Nursing Outlook 18 (February 1970): 28.

⁴U.S. Department of Health, Education, and Welfare, Patient Education Workshop, pp. 81-88.

⁵American Hospital Association, "Patient Education Project."

Teaching of the Medical Management of the Health Problem

Medical management of his/her own illness by the patient includes items such as learning about medications,¹ the management of medical apparatus such as a catheter for ostomy patients,² dietary instructions,³ needed self-examinations to watch for recurring medical problems such as breast cancer, and physical exercise so muscles will not become atrophied. These topics are usually taught from a more technical standpoint and are the ones most often included in formal hospital programs. A variety of professional health personnel including nurses, occupational therapists, physical therapists, pharmacists, dieticians and, at times, physicians are involved in the teaching of these topic areas.

Assisting Patients to Learn or Relearn Self-Care, Independent Living Skills

The educational goals of this area include having patients relearn to walk, talk, eat, read, write, manage household activities, and, in some cases, job skills. Though this involves the relearning of technical type skills, the patient must also deal

¹Besta.

²U.S. Department of Health, Education, and Welfare, Patient Education Workshop, pp. 91-95; Fralic, pp. 34-36.

³U.S. Department of Health, Education, and Welfare, Patient Education Workshop, pp. 62-68.



with various emotional problems¹ resulting from loss of bodily functions. This area is usually covered in a formal manner. It involves activities that are planned by the professional staff and are usually carried out only on a prescription from the doctor. Physical therapists, occupational therapists, speech therapists, and nurses are the primary teachers in this area.

Teaching Patients and Their Families
About Short- and Long-Term Life Style
Changes Due to the Health Problem

This area involves helping the patients and their families understand the various types of changes necessitated by the nature of the health problem. This includes things such as reducing daily activities, exercise programs, change in dietary habits, the stopping of smoking and drinking, and change in or termination of some recreational interests. These topics are covered most often in formal patient education programs. It is especially common for heart patients,² diabetics,³ and people with respiratory conditions. Nurses and physicians tend to be the primary teachers in this

¹Franklin C. Shontz, The Psychological Aspects of Physical Illness and Disability (New York: Macmillan Publishing Co., 1975); James F. Garrett and Edna S. Levine, Rehabilitation Practices With the Physically Disabled (New York: Columbia University Press, 1973).

²"Cardiac Education Teaching Manual" (Urbana, Illinois: Cardiac Education Section, Patient Service of Carle Foundation Hospital and Carle Clinic Association, 1976); Joy Duncan, Ardith Granbouche, and Ginevra Moody, "A Program for the Teaching of Cardiovascular Patients," Heart and Lung 2 (July-August 1973): 508-11; Fralic, p. 36.

³Estes; Fralic, pp. 33-34.



area with some involvement by health educators in the formal programs.

The three previous categories cannot always be separated because teaching of one area may involve two or all of them simultaneously.

Educating Patients and Their Families About Appropriate Community Resources

This area involves providing information on resources such as the visiting nurses service, extended care facilities, outpatient hospital services, and related home health services. The completeness of this kind of patient education depends on the degree to which the hospital program has been formally developed and the amount of time hospital personnel have to spend with the patients and/or their families. Instruction has traditionally been done by the hospital social worker. In smaller community hospitals the information might be provided by a staff nurse, a physician, or a public health nurse. This particular content area has not been extensively reported in the patient education literature.

Teaching About the Financial Management of the Health Problem

This subject has also not been stressed in the patient education literature. Yet it is a topic, with the continued rising cost of medical care, that needs to be addressed more fully. Traditionally, hospital social workers have counseled with patients and their families when help was requested in this area.



Teaching of General Preventive Activities

This area includes such tasks as the teaching of all women patients how to do breast self-examinations or teaching all patients the importance of a well-balanced diet. The coverage of general preventive health topics does not appear to be a prevalent one in hospital programs for inpatients, nor does there seem to be any great push to organize such programs.

Not all patients learn about all of the content areas in the list. Some may never receive education about any of them; others receive information in only one or two of the categories; and still others may be exposed to educational activities in all of the content areas.

Roles of Professional Staff, Patients, and Families of Patients in Hospital-Based Inpatient Education Programs

As outlined in the section on inpatient hospital activities and the content areas covered, almost all professional hospital staff members, frequently with the exception of hospital administrators, are involved in either formal or informal inpatient educational activities. Physicians, nurses, dietitians, pharmacists, social workers, occupational therapists, physical therapists, and speech therapists teach patients and, at times, their families. The newest member of the allied health care team to join the hospital staff in this endeavor is the health or patient educator. Until recently in hospital settings, the functions now performed



by this person were usually incorporated as part of a traditional staff role, often that of a nurse, and even now one is not likely to be hired as a patient educator unless he/she has had background in that more traditional area.¹

With the expanding development of more formal patient education programs for hospitalized patients, many questions have been raised as to what the roles of the patient educator as well as other hospital professional personnel should be in those programs. Who should be involved in the teaching activities of which topic area? Who should do the planning and evaluation of programs? Who should have the administrative responsibility for programs? The literature outlines numerous functions for each role but differences among authors demonstrate a definite lack of agreement on who should be doing what.

Physician's Roles

The majority of studies state that the physician should be involved in patient education programs for hospital inpatients. People working in the field tend to agree with this general principle. The type of involvement, however, varies greatly.

Physicians themselves have not, for the most part, given much input into what they think their role should be as educators of inpatients in a hospital setting. One physician states that

¹Marle K. Moran and Elizabeth Parris, "Patient Education Coordination in Greenville, S.C. Hospitals," Public Health Reports 9 (May-June 1976): 275; Estes.



The responsibility of all patient education emanates from the doctor; and this responsibility can and should be shared and delegated in part to staff residents, nurses of head nurse stature, dietitians, and others in allied services.¹

A similar opinion is given by two other physicians that the physician should remain directly in control of his patients' education and prescribe its content, though "he should not attempt to do it all himself."² Dr. Etzwiler³ describes patient education programs that use a team in an interdisciplinary approach to patient education with the physician being a member of that team. Dr. Robert Canfield⁴ of Columbia University's College of Physicians and Surgeons does not see a clearer role definition coming from physicians in this area until medical schools change some of their basic teaching goals and the ways they teach students.

Other types of health care personnel agree with the roles of physicians as directors of patient education teams,⁵ as members of those teams,⁶ and as the prescribers for specific patient education programs.⁷ Additional roles seen by others include viewing

¹Alt, p. 68.

²Jamplis, p. 96; "Roundtable/Patient Education."

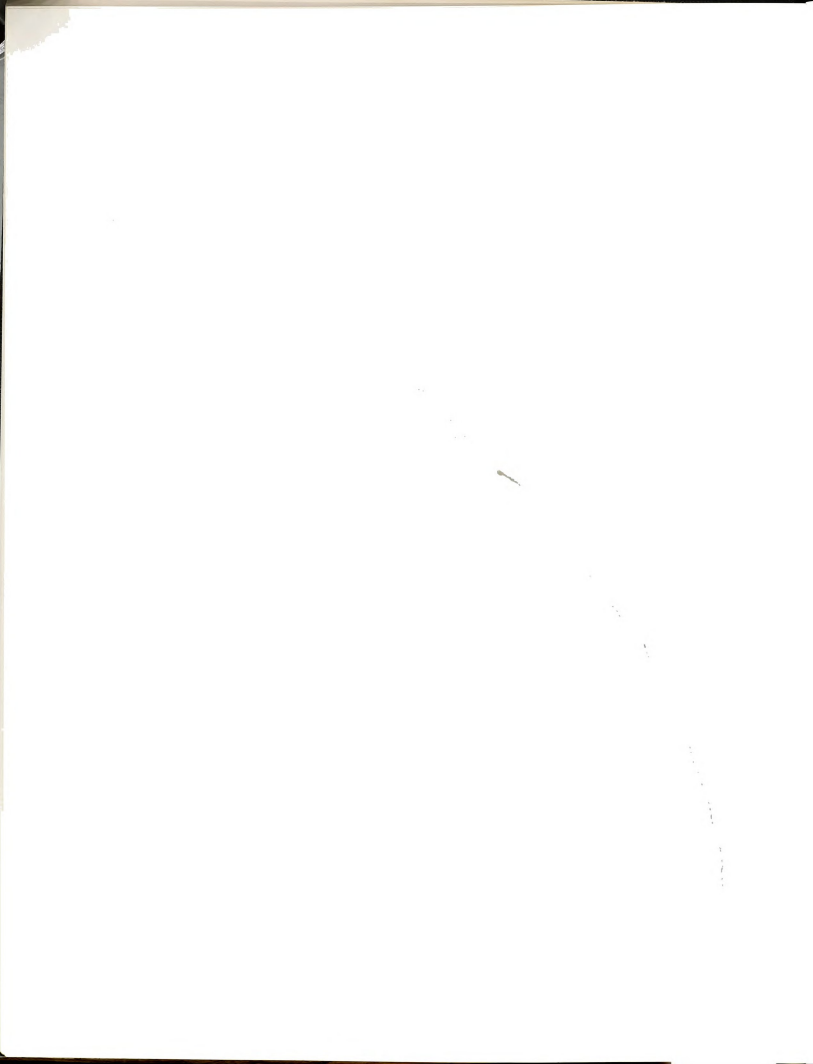
³Etzwiler, "Current Status."

⁴Canfield, pp. 85-86.

⁵Shaw, p. 99; Vega, p. 79.

⁶Field, pp. 179-81; American Hospital Association, Strategies; Ulrich, pp. 105-107; Walter J. McNerney, "The Missing Links in Health Services," Journal of Medical Education 50 (January 1975): 19.

⁷Bernheimer and Clever, Team Approach, p. 8; Diggins; Scott Simonds, "Health Education and Medical Care: Focus on the Patient,"



the physician as the teacher,¹ and as administrator to develop and coordinate the educational programs.²

Nurse's Roles

Teaching has long been considered a part of the nurse's role.³ A national study of nurses conducted by Margaret Pohl⁴ confirms this view. The majority of respondents to her study, which included all kinds of nursing personnel, felt ". . . that teaching is a responsibility of nursing practitioners, that they enjoy teaching and want to teach, and that teaching is as important as other aspects of their work."⁵

The nurse's role in hospital formal patient education programs has been discussed widely in the nursing literature and by nursing personnel. The nurse is seen first as the primary teacher of patients.⁶ A second role assigned to the nurse is leader of a

Health Education Monograph (San Francisco: Society for Public Health, 1963), No. 16, p. 38; U.S. Department of Health, Education, and Welfare, Patient Education Workshop.

¹Burton.

²Shaw, p. 99.

³Redman, Process, pp. 1-5; Virginia Streeter, "The Nurse's Responsibility for Teaching Patients," American Journal of Nursing 53 (July 1953): 118.

⁴Pohl, "Study of Teaching Activities."

⁵Ibid., p. 9.

⁶Roselle Denison Collins, "Problem Solving: A Tool for Patients Too," American Journal of Nursing 7 (July 1968): 1483; DeCicco, pp. 30-32; Anne Gusfa, Virginia Christoff, and Lorraine Headley, "Patient Teaching: One Approach," Supervisor Nurse 6



multidisciplinary patient education program.¹ A third role is being a member of an interdisciplinary patient education team.² The nurse is also seen as the chief administrator of all patient education programs.³ To fulfill the patient educator role some hospitals require further education by the nurse in health education or a related field. The general consensus from the nursing literature is that nurses do have and should continue to assume a major leadership role in hospital patient education programs.⁴

Other types of health care professionals also identify the roles that nurses should play in formal hospital patient education programs. For the most part they center on the nurse's role as being that of a teacher,⁵ a member of an interdisciplinary patient education team,⁶ or as administrator of the patient education team.⁷

(December 1975): 17; Eleanor C. Lambertson, "Nurses Must Be Teachers and Must Know These Principles," Modern Hospital 110 (February 1968): 126; Monteiro, p. 26; Pender; Pohl, Teaching Functions, p. 9; Joan Royle, "Coronary Patients and Their Families Receive Incomplete Care," Canadian Nurse 69 (February 1973): 3135.

¹Redman, Process, pp. 218-20.

²Howard A. Rusk, "Rehabilitation Belongs in the General Hospital," American Journal of Nursing 62 (September 1962): 62-63; Redman, Process, pp. 218-20.

³Estes; Moran and Parris, p. 275.

⁴Fralic, p. 30; Redman, Process.

⁵Field, p. 185.

⁶Alt, p. 78; Etzwiler, "Current Status"; Vega, p. 79; Ulrich, p. 104.

⁷American Hospital Association, Strategies in Patient Education, p. 29.



Allied Health Professional's Role

The allied health professional provides mostly supporting roles in hospital patient education programs. They function primarily as individual teachers of patients¹ and members of interdisciplinary patient education teams.²

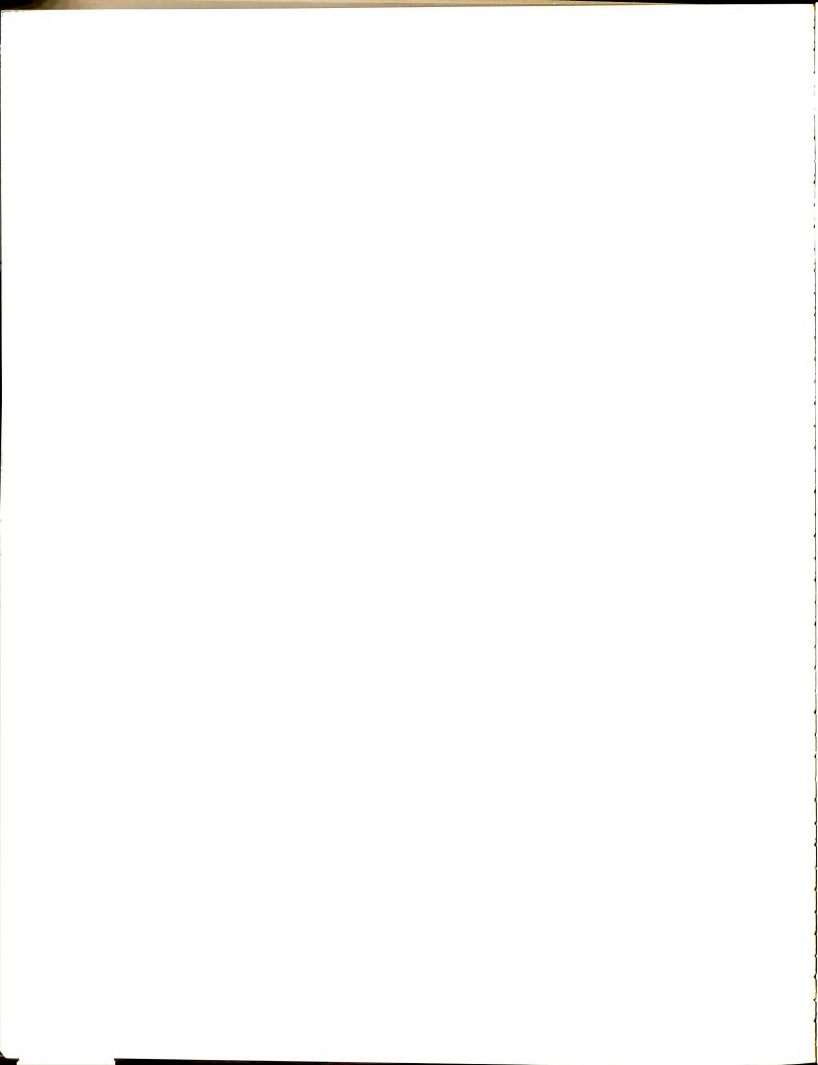
Hospital Administrator's Role

Hospital administrators perform two primary roles in patient education programs. The first is general policy making, usually conducted at the higher levels of the hospital hierarchy. The hospital's executive director may appoint a committee with titles such as the Patient Education Policy Committee, the Patient Teaching Committee, or the Health Education Committee³ to undertake the policy development function; or may prefer to work out such policy with members of the hospital's Board of Trustees.

¹Besta, p. 146; Gary Greiner, "The Pharmacist's Role in Patient Discharge Planning," American Journal of Hospital Pharmacists 29 (January 1972): 72-76; Marianne Ivey, Vonne Tso, and Stanan Tso, "Communication Techniques for Patient Instruction," American Journal of Hospital Pharmacists 32 (August 1976): 828; Jernigan, "Diabetics," p. 93.

²Elaine Cue, "The Hospital Pharmacist's Role in Health Education," American Journal of Hospital Pharmacy 28 (September 1971): 697-99; Field, pp. 182-92; M. Jinks, "The Hospital Pharmacist in an Interdisciplinary Inpatient Teaching Program," American Journal of Hospital Pharmacists 31 (June 1974): 569-73; Sister Rosita Schiller, "The Dietitian's Changing Role," Hospitals 47 (December 1, 1973): 97-122; Bernheimer and Clever, Team Approach, p. 7.

³U.S. Department of Health, Education, and Welfare, Patient Education Workshop, pp. 72-76.



Second, in some hospitals full- or part-time administrators are appointed to the position of Patient or Health Education Director or Coordinator. The administrators of formal patient education programs have varying professional backgrounds as alluded to earlier. They may be physicians, nurses, health educators, social workers, dietitians, physical therapists, or occupational therapists.¹ In practice, a nurse most often fills this specific administrative position.²

Patient's Role

Health care professionals view the patient's role in formal hospital patient education programs in a number of ways. Some see the patient's role as being an active participant in all phases of the program, from needs assessment through evaluation.³ This type of role implies that the patient must take on part of the responsibility for regaining and maintaining his/her own health.⁴

¹American Hospital Association, Strategies in Patient Education, p. 29.

²American Hospital Association, "Patient Education Project"; Simmons, "Overview of Patient Education," p. 21.

³Collins, p. 1483; Donnell Etzwiler, "The Contract for Health Care (editorial)," Journal of the American Medical Association 224 (May 14, 1973): 1034; Rosemary Monaco, Linda Salfen, and John S. Spratt, "The Patient as an Education Participant in Health Care," Missouri Medicine 69 (December 1972): 932; Shontz, pp. 51-56; Ulrich, p. 105.

⁴Etzwiler, "Contract."

Others see the patient as an active participant only in the implementation stage of the formal patient education program.¹ In such cases programs are pre-planned for the patient and follow a fairly specified routine.

A third way that the patient is viewed is as a passive recipient of educational information.² Such a role is present in programs or parts of programs which include handing out of pamphlets or check lists that patients should follow once they are discharged. This latter area tends to be a trait more of non-formal patient education activities than of formal ones.

Family Members' Roles

Family members are seen by professionals as important in the patient education process³ since illness of one member of the family affects others in the family as well.⁴

The family's role, however, has not been well defined. It ranges from being learners to be helped to cope with the patient's illness and the changes that illness has brought, to making them an adjunct part of the patient education team.⁵ It is a very

¹Linderman, p. 516; U.S. Department of Health, Education, and Welfare, Patient Education Workshop, pp. 81-88.

²Laurel A. Copp, "The Waiting Room--A Health Teaching Site," Nursing Outlook 19 (July 1971): 481-83.

³Anne Eardley, Frances Davis, and John Wakefield, "Health Education by Chance," International Journal of Health Education 18 (1975): 22; C. Hopkins, "Patient Education: A Part of Quality Health Care," Journal of Arkansas Medical Society 71 (December 1974): 231-32; Kelsey and Beamer, p. 513.

⁴Field, pp. 207-15.



complicated area due to the many different parties involved, from children to grandparents, the varied capacities and needs of family members themselves, and the range of emotions and attitudes family members have toward the patient and his/her illness.

Constraints to the Development and Implementation of Patient Education Activities

There are a number of constraints that tend to prevent the development and implementation of hospital patient education activities. These may include the lack of acceptance of patient education by professionals,¹ especially physicians, lack of staff competence to do patient education,² lack of staff time to do patient education,³ cost of patient education,⁴ lack of necessary facilities and equipment,⁵ lack of good resource material,⁶ and lack of third

¹Bernheimer and Clever, Team Approach, p. 1; Etzwiler et al., p. 36; Jamplis, p. 94; U.S. Department of Defense, Veterans' Administration Medical District 15, "Orientation Conference on Patient Education" (Ann Arbor: n.p., April 29, 1975) (Mimeographed).

²Meg Doolittle, "Making Patient Education a Reality," Cross-Reference 5 (June 1975): 4; U.S. Department of Defense, "Orientation Conference"; Elizabeth Hahn Winslow, "The Role of the Nurse in Patient Education Focus: The Cardiac Patient," The Nursing Clinics of North America 11 (June 1976): 217.

³Alexander et al., p. 405; U.S. Department of Defense, "Orientation Conference"; Winslow, p. 217.

⁴Bernheimer and Clever, Team Approach, p. 1; Estes; Etzwiler et al., p. 36; Peters, p. 111.

⁵U.S. Department of Defense, "Orientation Conference."

⁶Estes; Skaling.



party payments for patient education.¹ These constraints need to be taken into account and worked through in order to insure the success of a patient education program.

Need for Further Study

The review of the literature has demonstrated a variety of needs for further study in patient education. Among the questions it raises are the following:

1. Should patient education programs include both formal and informal patient education activities? If so, how can they be combined?
2. How important is patient education as a component of adequate health care, in the opinion of most health care professionals?
3. What roles should the various health care professionals have in the planning, implementation, and evaluation of patient education?
4. What roles should patients and their families have in the planning, implementation, and evaluation of patient education?
5. What content areas should be included in patient education programs?
6. What are the best methods for teaching patients?
7. What constitutes an effective patient education program?

¹Jamplis, p. 94.



8. How can patient education programs be made more cost-effective? How can hospitals determine cost-effectiveness?
9. What are the factors that inhibit the development and implementation of patient education programs?
10. Should patient education activities be individualized for each patient? If so, how?
11. Do patients and the general public want to become more actively involved in their own health care?
12. What should be the role of the hospital in patient education?
13. Is it feasible to develop formal patient education programs, especially in the smaller hospitals?
14. To whom should formal patient education programs be directed (i.e., all patients, patients with only certain kinds of illnesses)?
15. Should there be a unified, comprehensive patient education program including hospitals and other community agencies (i.e., schools, health groups, physicians' offices)?
16. How can health care professionals most effectively be trained or retrained to carry out patient education activities?

The literature addresses some of these question areas, but in varying degrees of depth. The literature that is available

comes from three principal sources: public health education, nursing, and hospital management literature, and most of it is written by people with either nursing or public health education backgrounds. There is especially a lack of material on patient education from the perspective of physicians, allied health professionals, and adult educators.

Task Assumed in This Study

This study has sought answers to some of the questions raised in the previous section. The study contains an analysis of opinions of hospital professionals (physicians, nurses, administrators, allied health professionals, and patient education staff toward hospital inpatient education. The study has sought judgments of professional workers in Maine hospitals concerning the following areas:

1. Importance of patient education for adequate health care.
2. The scope of hospital inpatient education.
3. Content areas.
4. Roles of professionals in the planning, implementation, and evaluation of patient education.
5. Roles of patients and their families in the planning, implementation, and evaluation of patient education activities.
6. Role of hospital in follow-up of discharged patients who need further patient education.

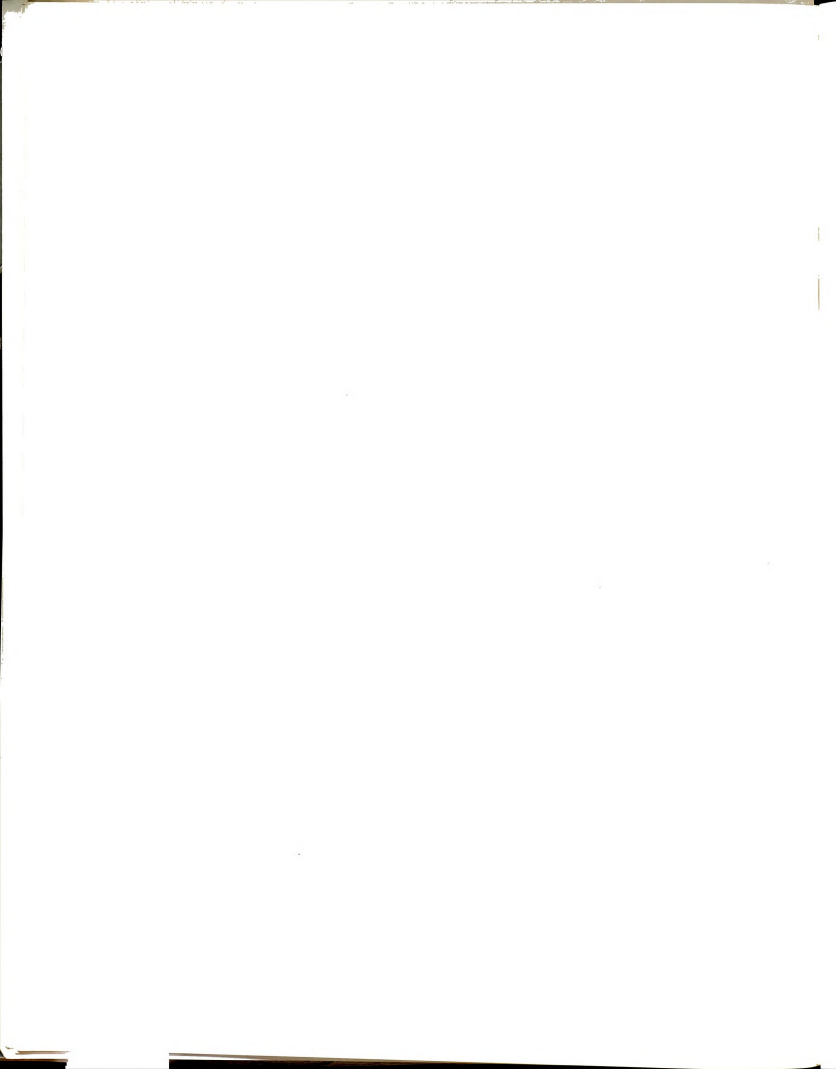
7. Constraints to the development and implementation of patient education activities.
8. Feasibility of the development or expansion of formal patient education programs.

The review of literature helped in formulating the study. First, it helped to define the parameters of the study. The literature identified three major segments of hospital patient education, including community health education, out-patient education, and inpatient education. The investigator chose inpatient education as the area for this research.

Second, the review assisted the investigator in determining which professional hospital staff should be included in the study. The literature stressed the importance of having physicians, nurses, allied health professionals, administrators, and designated patient educators involved in the development and implementation of patient education programs. These groups therefore were chosen to be included in the study.

Third, the review helped to identify what specific objectives the study should include. The objectives were chosen because of a lack of data in the literature on certain aspects of patient education.

Fourth, the review assisted in the development and administration of the questionnaire. It helped to put the questions into the language and context of the hospital health care providers.



Fifth, the review provided a foundation for a comprehensive conception of patient education by including its history, its importance in the health care field, and the patient education process.

CHAPTER III

METHODOLOGY

The general procedure used in this study to achieve the purpose described in chapters one and two was survey research. A mail survey was sent to health care professionals working in Maine community hospitals to ascertain their opinions about patient education for hospital inpatients. Responses to the questionnaire served as the data base for the analyses of this study.

Chapter three is divided into the following sections:

1. Objectives of the study
2. Endorsements for the study
3. Pre-survey
4. Sample
5. How sample was chosen
6. Instrument
7. Administration of instrument
8. Display and analysis of data

Objectives of the Study

The specific objectives the study addressed are outlined below. The term hospital professionals refers to the five categories of hospital professional personnel referred to in chapter one of this study. The term sub-group refers to each of these



five categories as individual professions. The specific objectives were:

1. a. To ascertain whether hospital professionals collectively believe patient education is an important component of adequate inpatient care.
- b. To ascertain whether each professional sub-group believes patient education is an important component of adequate inpatient care.
- c. To ascertain whether there are differences of belief among sub-groups on whether patient education is an important component of adequate inpatient care.
2. a. To ascertain how hospital professionals collectively define the type of patient education for hospital inpatients.
- b. To ascertain how each professional sub-group defines the type of patient education for hospital inpatients.
- c. To ascertain whether there are differences among the sub-groups in the definitions of the type of patient education for hospital inpatients.
3. a. To ascertain which patient education content areas hospital professionals collectively believe are appropriate for inclusion in hospital programs of patient education.
- b. To ascertain which patient education content areas each professional sub-group believes are appropriate for inclusion in hospital programs of patient education.



- c. To ascertain whether there are differences among the sub-groups in the content areas believed to be appropriate for inclusion in hospital programs of patient education.
- 4. a. To ascertain how hospital professionals collectively define the overall roles of professionals in planning, conducting, and evaluating patient education.
- b. To ascertain how each professional sub-group defines its role and the roles of other professional sub-groups in planning, conducting, and evaluating patient education.
- c. To ascertain whether there are differences among the sub-groups in the roles that they have defined for themselves and other professional sub-groups.
- 5. a. To ascertain how hospital professionals collectively define the role(s) of former patients in planning, conducting, and evaluating patient education.
- b. To ascertain how each professional sub-group defines the role(s) of former patients in planning, conducting, and evaluating patient education.
- c. To ascertain whether there are differences among the sub-groups in the role(s) that they define for former patients.
- 6. a. To ascertain how hospital professionals collectively define the role(s) of the families of present and former patients in planning, conducting, and evaluating patient education.
- b. To ascertain how each professional sub-group defines the role(s) of the families of present and former patients

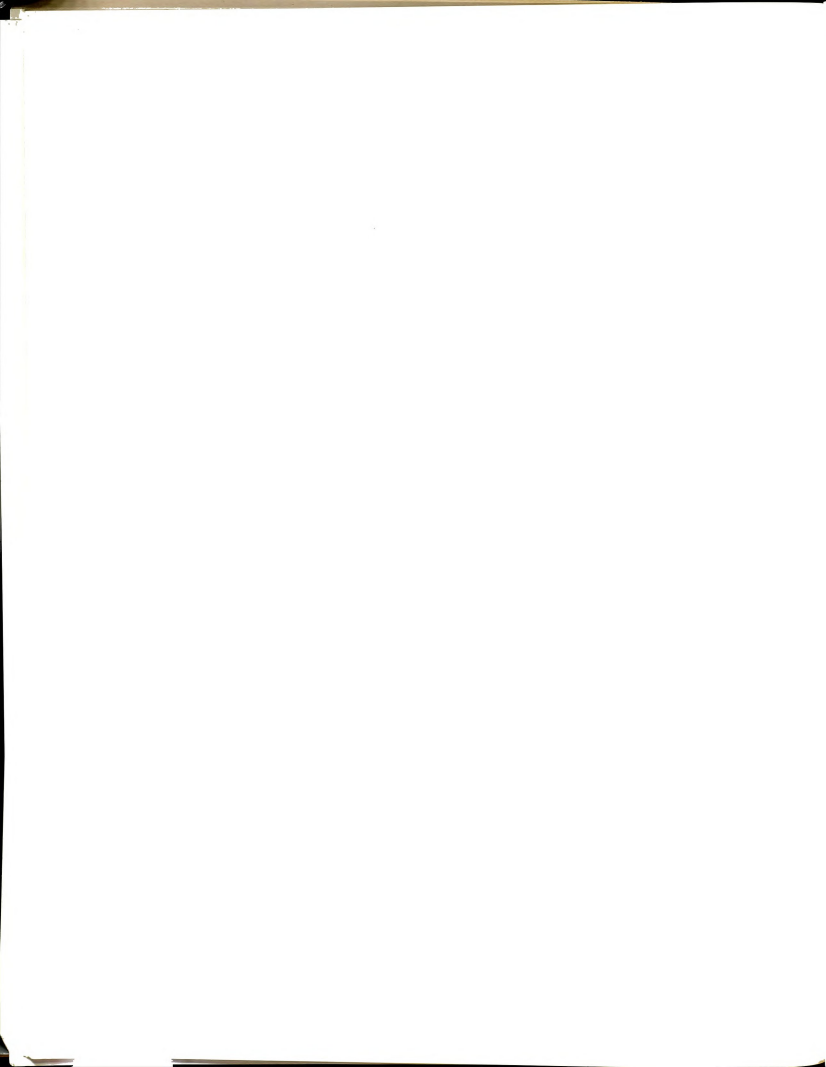


in planning, conducting, and evaluating patient education.

- c. To ascertain whether there are differences among the sub-groups in the role(s) they define for families of present and former patients.
7. a. To ascertain how hospital professionals collectively define the hospital's role in the follow-up of discharged patients who need further educational services.
- b. To ascertain how each professional sub-group defines the hospital's role in the follow-up of discharged patients who need further educational services.
 - c. To ascertain whether there are differences among the sub-groups in the role(s) they define for hospitals in the follow-up of discharged patients who need further educational services.
8. a. To ascertain what the respondents collectively identify as the constraints inhibiting development and implementation of hospital patient education activities.
- b. To ascertain what each of the individual sub-groups identifies as the constraints inhibiting development and implementation of hospital patient education activities.
 - c. To ascertain whether there are differences among the sub-groups in the constraints they identify as inhibiting development and implementation of hospital patient education programs.



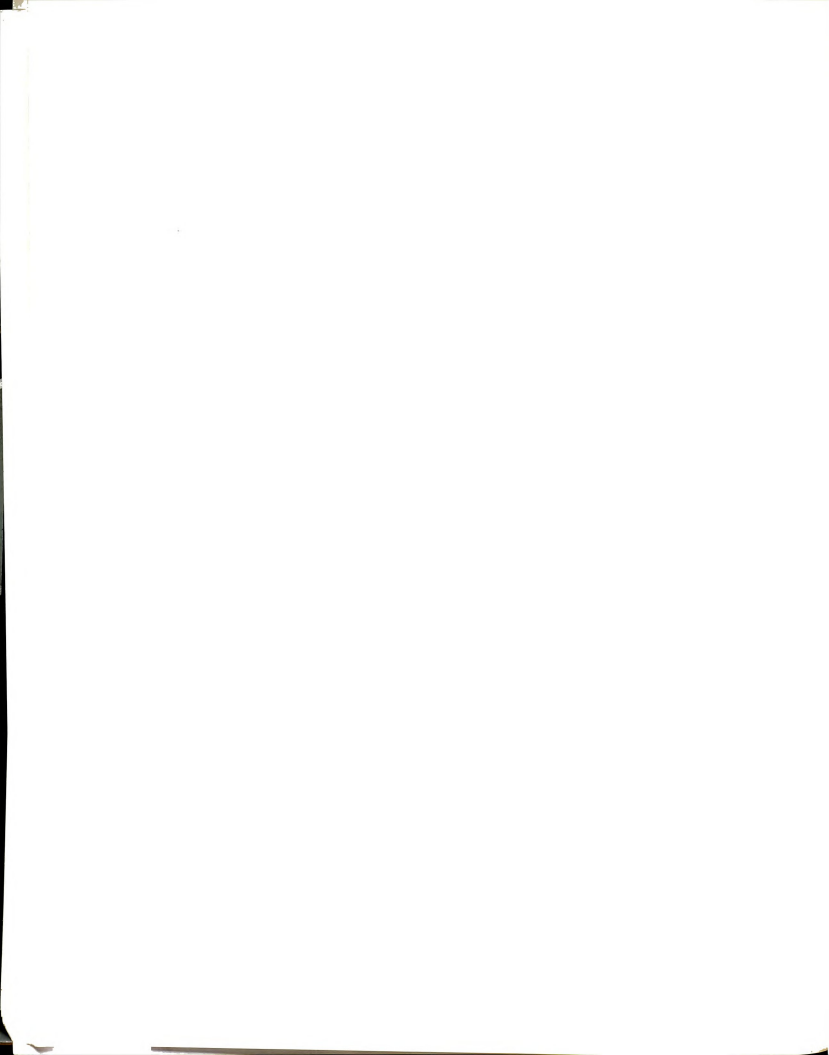
9. a. To ascertain whether hospital professionals collectively believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
- b. To ascertain whether each professional sub-group believes there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
- c. To ascertain whether there are differences of opinion among sub-groups on whether there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
10. a. To determine which major illness categories pose, in the judgment of hospital professionals collectively, the greatest need for formal patient education programs.
- b. To determine which major illness categories pose, in the judgment of each professional sub-group, the greatest need for formal patient education programs.
- c. To ascertain whether there are differences of judgment among sub-groups on which major illness categories pose the greatest need for formal patient education programs.
11. To ascertain the relationship between hospital size and variance in respondents' answers to the following question areas:
 - a. Which patient education content areas hospital professionals collectively believe are appropriate for inclusion in hospital programs of inpatient education.



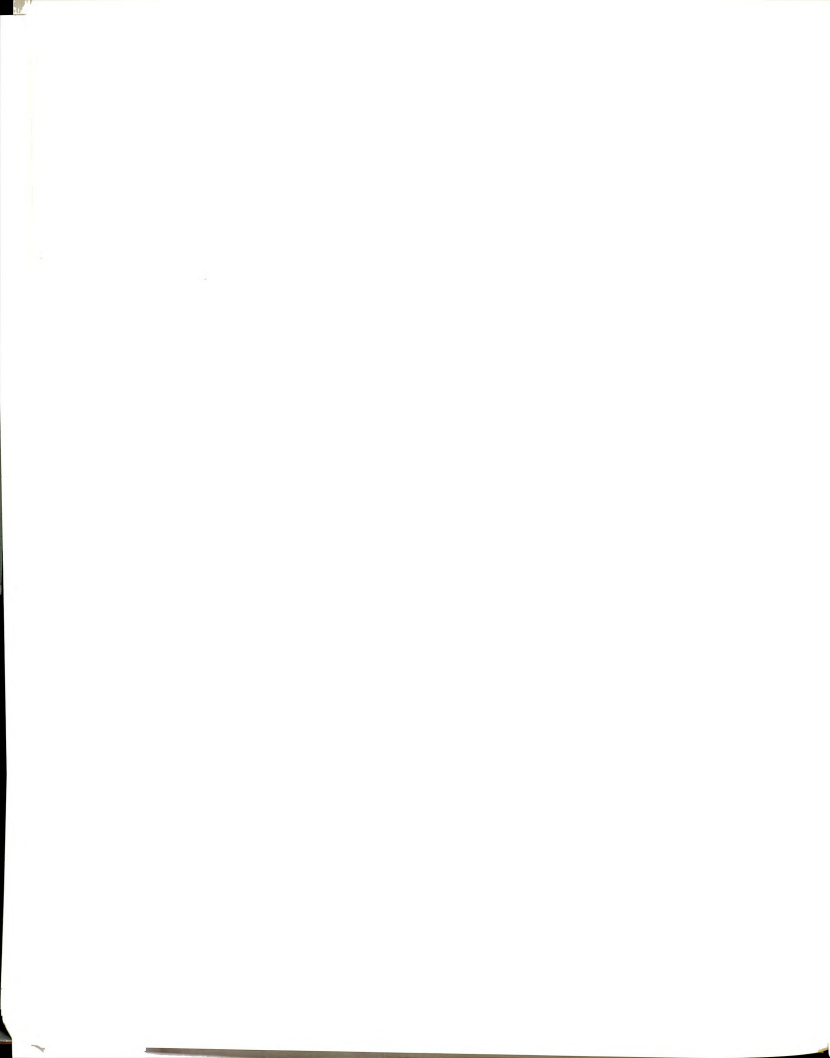
- b. Which patient education content areas each professional sub-group believes are appropriate for inclusion in hospital programs of inpatient education.
 - c. How professionals collectively define the overall role of professionals in the planning and conducting of patient education.
 - d. How each professional sub-group defines its own role and the roles of other professional sub-groups in planning and conducting of patient education.
 - e. Whether hospital professionals collectively believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
 - f. Whether each professional sub-group believes there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
12. To ascertain the relationship between the existence of operating formal patient education programs in hospitals and variance in the respondents' answers to the following question areas:
- a. Which patient education content areas hospital professionals collectively believe to be appropriate for inclusion in hospital programs of inpatient education.
 - b. Which patient education content areas each professional sub-group believes to be appropriate for inclusion in hospital programs of inpatient education.



- c. How professionals collectively define the overall role of professionals in planning and conducting of patient education.
 - d. How each professional sub-group defines its own role and the roles of other professional sub-groups in planning and conducting of patient education.
 - e. Whether hospital professionals collectively believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
 - f. Whether each professional sub-group believes there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
13. To ascertain the relationship between hospital professionals' experience with formal patient education programs and variance in their answers to the following question areas:
- a. Which patient education content areas they collectively believe to be appropriate for inclusion in hospital programs of inpatient education.
 - b. Which patient education content areas they, by professional sub-groups, believe to be appropriate for inclusion in hospital programs of inpatient education.
 - c. How they collectively define the overall role of professionals in planning and conducting of patient education.
 - d. How they, by professional sub-groups, define their own roles and the roles of other professionals in planning and conducting of patient education.



- e. Whether they collectively believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
 - f. Whether they, as professional sub-groups, believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.
14. To ascertain the relationship between the amount of training in patient education and/or related areas (e.g., education methods, health education, adult education) respondents report and variance in their answers to the following question areas:
- a. Which patient education content areas they collectively believe to be appropriate for inclusion in hospital programs in inpatient education.
 - b. Which patient education content areas they, by professional sub-groups, believe to be appropriate for inclusion in hospital programs of inpatient education.
 - c. How they collectively describe the overall role of professionals in the planning and conducting of patient education.
 - d. How they, by sub-groups, define their own roles and the roles of other professionals in the planning and conducting of patient education.
 - e. Whether they collectively believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.



- f. Whether they, as professional sub-groups, believe there is a need to initiate or expand formal patient education programs in their hospitals for inpatients.

Endorsements for the Study

Various groups and individuals in Maine hospitals and the health education community provided endorsement and assistance for this study. This was sought for four primary reasons. The first was to gain access to statistical materials and other types of data on the hospitals. This material was needed to both determine and carry out the sampling procedures. The second reason was to have assistance in the development and formative review of the questionnaire. The third was to help assure a better return rate on the mail questionnaire. Fourth, the data generated from the study will be disseminated to these and similar interested parties.

Specific endorsements for the study were obtained from the following associations and groups:

1. Research and Education Trust of the Maine Hospital Association.
2. Maine Health Education Resource Center of the University of Maine at Farmington.
3. Maine Medical Association.

Pre-Survey

A pre-survey of hospital administrators in fifty-one Maine community hospitals was conducted by telephone. The purpose of this pre-survey was threefold:

1. to determine the number of professional personnel by categorical groups who worked in Maine community hospitals;
2. to determine which hospitals had operating patient education programs;
3. to obtain names of hospital personnel who were actively involved in patient education programs.

For the purpose of the pre-survey, professional hospital personnel included the following groups:

Physicians--Physicians (M.D.'s and D.O.'s) who were employed by and/or had active staff privileges at Maine community hospitals.

Nurses--Registered nurses and licensed practical nurses who were employed either full- or part-time in community hospitals in Maine. (Only nurses who worked twenty hours a week or more were included in the final survey.)

Hospital Administrators--The chief executive officer of each community hospital in Maine.

Allied Health Professionals--Physical therapists, occupational therapists, dietitians, pharmacists, social workers, and speech therapists who were employed either full- or part-time by Maine community hospitals.

Patient Education Staff--Staff of Maine community hospitals who were employed either full- or part-time as either coordinators (directors) of patient education programs or patient teachers.



A hospital was considered to have a formal patient education program if it had in operation one or more planned patient education programs with written goals and objectives for its inpatient population.

The pre-survey was conducted by telephone by the investigator. Since Maine hospitals receive numerous mail questionnaires, personnel from the Research and Education Trust of the Maine Hospital Association advised that the pre-survey be done via telephone. Also the types of data needed necessitated communicating with two or three departments in some hospitals and this was better facilitated on the telephone.

Prior to the telephone call a letter from the Research and Education Trust was sent to the chief executive officer in each hospital indicating that the investigator for this study would be calling and for what purpose. The specific questions on the pre-survey telephone questionnaire relating to patient education were adapted from the American Hospital Association's Survey Form on Inpatient Hospital Education Programs.¹ A copy of the letter sent to each hospital and the telephone questionnaire form can be found in Appendix A.

All hospitals in Maine, a total of fifty-one, officially listed as community hospitals were contacted. Forty-nine hospitals responded to the telephone pre-survey. One of the forty-nine

¹American Hospital Association, "Survey Form on Inpatient Education Programs" (Chicago: American Hospital Association, 1975).



respondents was found to be not a community hospital but a long-term health care facility. Thus the total of Maine community hospitals comprising the population for the study was forty-eight.

Data from the pre-survey indicating the total number of professional personnel found to be working in the professional categories included in the study in Maine hospitals was as shown in Table 1. There was a total of 6,299 professionals working in the 48 Maine community hospitals as of March 1977. The largest number of professionals, 2,610, worked in hospitals with over 200 beds, followed by 1,706 professionals in the 50-99 bed hospitals, 1,299 professionals in the 100-199 bed hospitals, and 684 professionals in the 0-49 bed hospitals. A detailed breakdown by individual hospitals of all personnel can be found in Appendix B, Summary of the Pre-Survey Results.

Data indicating whether or not Maine community hospitals in various size categories had formal patient education programs established or in the planning stages are presented in Table 2. Twenty of the hospitals had established formal patient education programs; eight hospitals were in the process of developing formal programs; and the remaining twenty hospitals did not have formal programs. A more complete summary of the patient education portion of the pre-survey can be found in Appendix B.

Following the telephone pre-survey a follow-up letter was sent to the chief executive officer in each hospital. The letter thanked each executive for his/her participation in the pre-survey



Table 1.--Numbers of professional personnel in Maine community hospitals by professional category and size of hospital as of March 1977.

Hospital Size	Number of Hospitals	Physicians ^a	Nurses	Allied Health Prof.	Patient Education Staff	Hospital Administrators	Total
0-49 beds	19	160	465	34	6	19	684
50-99 beds	17	331	1277	73	8	17	1706
100-199 beds	7	384	852	54	2	7	1299
200 beds and over	5	587	1848	156	14	5	2610
Totals	48	1462	4442	317	30	48	6299

^aThe total number of physicians reported does not represent an actual individual count of physicians as many physicians, especially in urban areas, have active staff privileges at more than one hospital.



Table 2.--Distribution of patient education programs in Maine community hospitals by size of hospital and stage of development as of March 1977.

Hospital Size	Hospitals With Established Formal Patient Education Programs		Hospitals in the Planning Stage of Developing Formal Patient Education Programs		Hospitals With No Formal Patient Education Programs	
	Number	Percentage of All Hospitals	Number	Percentage of All Hospitals	Number	Percentage of All Hospitals
0-49 beds	7	15	0	0	12	25
50-99 beds	8	17	5	10	4	8
100-199 beds	1	2	3	6	3	6
200 beds and over	4	8	0	0	1	2
Totals	20	42	8	16	20	42

and for the information provided. Sample copies of the letters that were sent are included in Appendix B.

Sample

The primary data for the study were generated from a mail questionnaire survey. The questionnaire was sent to a random sample of professionals identified through the pre-survey as working in Maine community hospitals. The five groups of professionals surveyed were as described both in chapter one and in the pre-survey section of this chapter.

The community hospitals in Maine were stratified into four size categories according to number of beds. In addition to stratifying the hospitals by size, the hospitals were also clustered within those strata by whether or not they had formal patient education programs. This ensured that hospitals with and without programs were selected for the study.

Twenty-four hospitals, one-half of which had patient education programs and one-half of which did not, and in numbers as nearly as possible proportional to the number in each size category, were chosen through a random number table for inclusion in the study. Hospitals in the process of planning programs were included in the group of hospitals which did not presently have formal operating programs. Distribution of the population and the survey group by hospital size and whether the hospital had formal patient education programs is displayed in Table 3.

Table 3.--Number of hospitals in the population, in the survey group, and from which responses were received by hospital size and whether the hospital had a formal patient education program.

Hospital Size	Number of Hospitals in Population		Number of Hospitals Chosen for the Survey Group		Number of Hospitals From Which Responses Were Received	
	With Formal Patient Education Programs	Without Formal Patient Education Programs	With Formal Patient Education Programs	Without Formal Patient Education Programs	With Formal Patient Education Programs	Without Formal Patient Education Programs
0-49 beds	7	12	3	6	3	6
50-99 beds	8	9	4	4	4	4
100-199 beds	1	6	1	3	1	3
200 beds and over	4	1	2	1	1	0
Total	20	28	10	14	9	13

t

n

f

R

c

i

r

w

h

n

o

t

s

o

o

o

e

o

p

o

p

t

Five of the hospitals originally chosen declined to participate in the study. Four of these hospitals could not release names of their employees due to hospital policy. Lists of employees from the fifth hospital, though promised, were never received. Replacements for three of the five hospitals were found, again chosen through a random number table. Two of the hospitals, both in the over 200 bed size, could not be replaced. There was no replacement hospital available for one of those hospitals as it was the only over 200 bed community hospital in Maine that did not have a formal patient education program. The second hospital could not be replaced due to the personnel policies of the remaining over 200 bed hospitals which did not allow names of their employees to be released. The total number of hospitals included in the study thus became twenty-two, with all size categories except that of over 200 beds proportionately represented.¹

All of the professionals, except for the nurses, in each of the selected hospitals were surveyed. One-third of the nurses employed by the selected hospitals were chosen by a random table of numbers for inclusion in the study. Due to the low numbers of patient education staff and the nature of the study, all members of this sub-group in Maine, including those in non-selected hospitals, were included in the survey. Table 4 describes the distribution of professional workers included in the survey by

¹See Appendix C for a list of participating hospitals.

Table 4.--Number of professional workers included in the survey by professional group, size of hospital and whether or not the hospital had a formal patient education program.

Professional Group	Size of Hospital							
	0-49 Beds (N = 9)		50-99 Beds (N = 8)		100-199 Beds (N = 4)		200 Beds & Over (N = 1)	
	With Formal Patient Education Program	Without Formal Patient Education Program	With Formal Patient Education Program	Without Formal Patient Education Program	With Formal Patient Education Program	Without Formal Patient Education Program	With Formal Patient Education Program	Without Formal Patient Education Program
Physicians	22	43	68	60	116	81	227	--
Nurses	27	33	71	65	41	59	194	--
Allied Health Professionals	5	6	19	16	12	9	82	--
Patient Educa- tion Staff ^a	6	--	8	--	1	1	14	--
Hospital Administrators	3	6	4	4	3	1	1	-
Totals	63	88	170	145	173	151	518	0
							924	384

^aPatient education staff were not limited to the 22 selected hospitals; all persons in this professional category from any Maine community hospitals were included in the survey.

P

P

T

C

T

S

H

C

T

t

v

f

C

e

d

o

w

p

s

professional group, size of hospital, and whether or not the hospital had a formal patient education program.

The lists of professionals were obtained by sending a letter to the chief executive officer of each hospital chosen, outlining the study and asking for cooperation in the study.¹ The letter was followed up by a telephone call from the investigator. As stated above, lists were provided for all except two hospitals.

Instrument

The survey instrument was a mailed questionnaire. It consisted mostly of closed ended, multiple choice type questions.² The questions were developed based on information obtained from the literature reviewed, outlines of operating programs and interviews with people actively involved in the patient education field.³ The questions focused on the importance of patient education; roles of professionals, patients and families of patients; evaluation; program content and organization; and feasibility of developing patient education programs. There were also questions on the respondents' professional background, their experience with formal patient education, and their attendance at educational programs in or related to patient education. The instrument was six pages in length and professionally printed on yellow paper.

¹See Appendix C for a copy of the letter.

²See Appendix D for a copy of the instrument.

³See Appendix F for a list of the people consulted.

t

p

r

s

r

M

R

M

P

o

(

Ma

Ec

De

Ma

So

we

mu

ho

se

po

ma

in

A team of individuals reviewed the preliminary draft of the survey instrument for content and face validity. After the pre-testing of the instrument it was revised and the same team reviewed it again. The team represented both the kind of professional people who received the instrument and specialists in survey research. The reviewers included: (1) Dr. William Bristol, M.D., Medical Care Development, Augusta, Maine; (2) Mrs. Lois Estes, R.N., Director of Inservice and Patient Education, Eastern Maine Medical Center; (3) Mr. Larry Nanney, Director of Long Range Planning, Mid-Maine Medical Center; (4) Ms. Ann Spencer, Director of Occupational Therapy, Eastern Maine Medical Center; (5) Mr. Michael Skaling, Director, Project RISE, Waterville, Maine; (6) Dr. John Roser, Executive Director, Maine Health Education Resource Center; (7) Dr. Louis Ploch, Professor, Department of Agricultural and Resource Economics, University of Maine at Orono; and (8) Dr. Kenneth Hayes, Director, Social Science Research Institute, University of Maine at Orono. Changes were made in the instrument according to their recommendations.

The pre-test of the instrument was done with a Maine community hospital that had not been chosen as part of the group of hospitals to be surveyed. This hospital had on its staff representatives of all of the professional groups that were in the population. A total of fifty-seven people, which is approximately 5 percent of the number in the surveyed group, were included in the pre-test group.



Administration of Instrument

The survey instrument was sent through the mail to all professionals chosen to be part of the study. A return self-addressed stamped envelope was included with each questionnaire. The return envelopes were pre-coded to indicate the size of hospital, whether or not the hospital had a formal patient education program, and to whom it had been sent.

A different cover letter was used for each professional group. The hospital administrators' cover letter was from the investigator, as she had had numerous contacts with this group concerning the proposed study. The cover letter to physicians was on stationery of the Maine Health Education Resource Center (HERC) of the University of Maine at Farmington and was signed by Dr. Richard Chamberlin. Dr. Chamberlin, a physician, was a member of the Advisory Board of HERC and the medical advisor to Maine's Professional Standards Review Organization for physicians. The cover letter for nurses and patient education staff was also on HERC stationery and was signed by Dr. John Roser, the executive director of that organization. The cover letter to the allied health professionals was on stationery from the Research and Education Trust of the Maine Hospital Association. It was signed by Douglas Kramer, Program Coordinator of the Research and Education Trust. Copies of the cover letters are included in Appendix D.

Three separate mailings were sent. The first mailing included the survey instrument, cover letter, and a self-addressed



stamped envelope. The second mailing consisted of a reminder postcard. It was sent three weeks after the first mailing to those who had not returned the survey form. The coding system permitted this determination to be made. The third mailing consisted of a second cover letter, with another copy of the survey instrument and return envelope. This mailing was sent two weeks after sending the follow-up postcard and only to those who had not returned the survey form. Follow-up cards and letters were signed for each sub-group by the same person who had signed the original cover letters. Copies of the follow-up postcards and letters can be found in Appendix E.

Display and Analysis of Data

The data generated from the mail survey are displayed and analyzed in the following chapter. The display shows how all professionals, collectively and by each professional sub-group, responded to each question. The first analysis included both an examination of how each sub-group responded and a comparison among the sub-groups to determine if there were differences among sub-groups in the way that they responded to each of the questions.

Further analyses investigated the responses to selected questions in relation to four additional variables. Two of the variables related directly to the employing institution (size and whether or not the hospital had a formal patient education program). The other two variables centered on the background of the professional staff (their experience and training in patient



education). Three question areas (content, roles of the professionals and feasibility of developing or expanding formal patient education programs) were the focus for these analyses.

Data on the first variable, the size of the hospital, were analyzed to determine if differences in the ways respondents answered the questions were correlated with the size of the hospitals where they worked/practiced. The hospital size was divided into four categories: (1) 1-49 beds, (2) 50-99 beds, (3) 100-199 beds, and (4) 200 beds and over. As only one over 200 bed hospital was included in the study, the investigator has little confidence that the opinions of professionals in that size category are generalizable.

Data on the second variable, whether the hospital had an operating formal patient education program, were obtained from the pre-survey reports.¹ They were analyzed to determine if there were relationships between the ways respondents answered the questions and whether their employing hospitals had formal patient education programs.

Data on the third variable, whether or not professionals had had experience with formal patient education programs, were obtained from the general information section in the questionnaire. Experience with formal patient education programs included present or past involvement with such programs. This third analysis determined if there were relationships between the

¹See Appendix B, Summary of Pre-Survey Results.



ways respondents answered the questions and whether or not they had had some involvement with formal patient education programs.

Data on the fourth variable, whether professionals had had special training in patient education or related educational areas (e.g., adult education, educational theory and method, health education) were also obtained from the general information section of the questionnaire. This fourth analysis determined if there were relationships between the way respondents answered the questions and whether or not they had had some training in patient education or related educational areas.

The three professional sub-groups included in these four analyses, except for the one involving hospital size, were physicians, nurses, and allied health professionals. The responses of the two other professional sub-groups, patient education staff and hospital administrators, were examined but because of the group's small sample sizes meaningful statistical analysis was not possible. The responses of the allied health professionals were also not fully analyzed in relation to hospital size. This was due to the very small number of those workers in hospitals, especially those under 50 bed capacity.

The data analyses were done using the Statistical Package for the Social Sciences at the University of Maine Computing and Processing Service. The description of how all professionals collectively and how each sub-group responded to the questions was done in simple percentages. Chi square tests of independence were used to ascertain whether there were relationships between



the various factors and the variance in respondents' answers to chosen questions. In most cases a significance level of .05 was used in the chi square analyses.

The findings and the interpretations of the data are presented in chapter four. The data are presented in several ways. First a display shows how all professionals, collectively and by sub-group, responded to each question concerning patient education. The data are then analyzed to ascertain the relationship between professional sub-groups in their judgments on each question. Finally, the data are analyzed to ascertain how responses varied in three of the questions in relation to four other variable factors (size of hospital, whether the hospital had a formal patient education program, experience of respondents with formal patient education programs, and respondents' training in patient education). This is done both with and without regard to professional classification.

A summary of the study, the conclusions, and the implications for research and practice follow in chapter five.



CHAPTER IV

RESULTS OF THE STUDY

Chapter four includes a description of the respondents and the major findings of the study. The major findings include the opinions of both the total respondent group and each professional sub-group on issues relating to the organization, development, and implementation of patient education for hospital inpatients. The chapter is divided into six sections: (1) respondents; (2) ratings of importance of patient education and selected content areas; (3) roles deemed appropriate for health care professionals, patients, and families of patients in the planning and conducting of patient education activities; (4) ascribed responsibility for evaluation of patient education; (5) judgments about organization of patient education; and (6) judgments as to feasibility of developing or expanding patient education programs.

Respondents

The respondents are described by: (1) professional group, (2) size of hospital where they practiced, (3) whether they practiced in a hospital that had a formal patient education program, (4) their involvement in patient education activities, and (5) their previous attendance at classes on patient education or related educational areas.



The data on professional groups, size of hospital, and whether or not each hospital had a formal patient education program were obtained from available records and from the pre-survey as presented in chapter three. They were precoded and combined with data from the questionnaire. The data on professional background, respondents' involvement in patient education activities, and respondents' previous study in patient education or related educational areas were obtained from the general information section of the questionnaire.

One thousand, three hundred and eight questionnaires were sent in the original mailing. Sixteen of these were returned as not deliverable. Of the 1292 presumed to have been delivered, 762 were returned, for a total return rate of 59%. Of the returns, 720 were usable, for a usable return rate of 56%. These data are displayed in Table 5.

Table 5.--Questionnaires mailed and returned by number and percentage.

	Number	Percent
Mailed	1308	100
Not delivered	16	1
Presumed delivered	1292	99
Returned	762	59
Not usable	42	3
Usable	720	56



The forty-two non-usable questionnaires were returned without the requested data. Twenty-two were returned incomplete with no explanation. Twenty were returned incomplete with one of the following reasons given: (1) do not have the time to complete, (2) do not work with hospital inpatients, (3) do not work/practice in the hospital, or (4) questionnaire too complex. Non-respondents included persons from whom there were no replies and those whose questionnaires were received after the closing date. The closing date was July 15, 1977, eight weeks after the original mailing (May 22, 1977).

Basic data for this investigation, except as otherwise specified, came from the 720 usable questionnaires which represented 56% of those contacted and 13% of the overall population of professionals in Maine community hospitals.

The numbers of usable responses as a percentage of either populations or numbers surveyed across the five professional groups were not equal. They did, however, provide reasonably proportional representation for all five groups. The patient education staff and hospital administrators had the highest response rates, 87% and 82% respectively, of those surveyed. These were followed by the allied health professionals (69%), nurses (58%), and physicians (49%).

Physicians, with an estimated population of 1325, were represented in the study by 298 respondents (22% of their population) and constituted 41.3% of the respondent group. Nurses, with an estimated population of 3835, were represented by 278 respondents (7% of their population) and constituted 38.6% of the respondent group. Allied health professionals, estimated to number 328, were



represented by 100 respondents (30% of their population) and constituted 13.9% of the respondent group. Hospital administrators, a much smaller population (50), were represented by 18 respondents (36% of their population) and comprised 2.5% of the respondent group. Because the patient education staff from all community hospitals in the state (30 in total) were included in the survey, the 26 respondents comprised 87% of the population. However, they constituted only 3.6% of the respondent group.

In sum, the final sample, comprised of 720 respondents, represented approximately one-eighth (12.9%) of the health care professionals in Maine community hospitals. The largest professional sub-groups, physicians and nurses, comprised the largest portions of the responding sample; hospital administrators and allied health professionals had representation roughly proportional to their populations; and patient education staff, though represented much more heavily in relation to their small population, comprised the next to smallest portion of the final sample. Data on respondents in each professional sub-group as a percentage of the population, of those surveyed, and of the final sample of 720 respondents, are presented in Table 6.

Both in hospitals with formal patient education programs and in those without programs, numbers of respondents were closely proportional to numbers in practice in each of the several bed-size hospitals. The 50 to 99 bed hospitals, both those with and those without formal patient education programs, were slightly over



Table 6.--Numbers and percentages of persons in professional sub-groups in Maine community hospitals and the percentages of all professional workers, questionnaire recipients, and questionnaire respondents represented by each.

Professional Group	Population ^a		Questionnaire Recipients		Questionnaire Respondents		
	Number	Percent of all Professionals	Number	Percent of Population All Recipients	Number	Percent of Recipients	Percent of Population Respondents
Physicians	1325	23.8	612	46.2	298	49	22.0
Nurses	3825	68.9	483	12.6	278	58	--
Allied health professionals	328	5.9	145	44.2	100	69	30.0
Patient education staff	30	.5	30	100.0	26	87	87.0
Hospital administrators	50	.9	22	44.0	18	82	36.0
Totals	5568	100.0	1292	23.2	720	56	12.9
							99.9

^aThe population of professional workers in Maine community hospitals by professional sub-groups was estimated by the investigator. The estimates were based on data from the pre-survey of Maine hospitals completed by the investigator in March of 1977.

represented, while hospitals with 100-199 beds were slightly under represented. Data are presented in Table 7.

Table 8 presents data on distribution and level of respondents' involvement in both formal and informal patient education activities. The patient education staff were the most active in formal patient education programs for inpatients with 88.5% of the respondents reporting very active or somewhat active involvement. The allied health professionals displayed the second highest rate of involvement with 43.4%, followed by the physicians (33.5%), hospital administrators (31.3%), and nurses (26.5%).

All of the responding groups described themselves as more active in informal patient education activities than in formal ones. One hundred percent of the patient education staff reported "very active" or "somewhat active" involvement in informal patient education. Of the nurses 79.7% described themselves as involved there, followed closely by allied health professionals at 78.1%. Sixty-eight percent of the physicians and 35.3% of the hospital administrators reported themselves involved in informal patient education activities.

A large percentage of patient education staff indicated they had attended programs or classes on patient teaching (72%) and/or on topics related to patient education (82.6%). Approximately one-third of each of the remaining groups, except for administrators, had previously attended classes or programs on or related to patient education. The data concerning respondents' previous



Table 7.--Percentages of professionals and of respondents who practiced in hospitals with and without formal patient education programs by hospital size.

Size of Hospital	Practiced in Hospitals			
	With Formal Patient Education Programs		Without Formal Patient Education Programs	
	Professionals	Respondents	Professionals	Respondents
1-49 beds	3.4	3.8	10.7	11.6
50-99 beds	9.2	11.7	19.1	21.9
100-199 beds	9.2	7.5	20.2	16.5
200 beds and over	28.2	27.0	--	--



Table 8.--Percentage of each professional sub-group involved and levels of their involvement in formal and informal patient education activities for hospital inpatients.

Professional Sub-Groups	Formal Patient Education Activities			Informal Patient Education Activities		
	Very Active	Somewhat Active	Not Active	Very Active	Somewhat Active	Not Active
Physicians	9.3	24.2	66.5	31.6	36.4	32.0
Nurses	5.5	12.0	73.5	21.8	57.9	20.3
Allied health professionals	15.6	27.8	56.7	33.3	44.8	21.9
Patient education staff	42.3	46.2	11.5	53.8	46.2	.0
Hospital administrators	.0	31.3	68.0	5.9	29.4	64.7
Total respondent group	9.8	24.5	65.7	28.1	46.2	25.7



involvement in programs or classes on patient education or related areas are found in Table 9.

The types of programs or classes on patient education and related areas attended by respondents covered a wide variety of topics and had many formats. The topic areas most often listed were diabetes, cardiac rehabilitation, ostomy care, prenatal care, and patient teaching. The types of formats included college courses, television courses, hospital staff meetings, conferences, workshops, pre-professional medical training, audio-tapes, and hospital classes.

In summary, the final sample included 720 respondents, representing approximately one-eighth (12.9%) of the health care professionals in Maine community hospitals. Physicians (41.3%) and nurses (38.6%) comprised the largest portions of the responding sample, followed by allied health professionals (13.9%), patient education staff (3.6%), and hospital administrators (2.5%). Both in hospitals with formal patient education programs and in those without programs, numbers of respondents were closely proportional to numbers in practice in each of the several bed-size hospitals.

All respondents had more involvement in informal than formal patient education programs. Patient education staff had the most involvement in both formal and informal programs. Patient education staff also had most often attended programs on or related to patient education.



Table 9.--Percentage of respondents by professional sub-groups who had previously attended programs or classes on or related to patient education.

	Physicians	Nurses	Allied Health Professionals	Patient Education Staff	Hospital Administrators	Total of All Groups
Programs or classes on patient education	28.8	28.0	31.9	72.0	31.3	30.4
Programs or classes related to patient education	25.5	30.6	31.9	82.6	18.8	30.1



Rating of Importance of Patient Education
and Selected Content Areas

This section describes both the respondents' views on the general importance of patient education as a component of patient care and the importance of eight selected content areas as elements of a hospital's patient education program.

General Importance of
Patient Education

A large proportion (79%) of the total respondent group believed patient education to be an extremely important component of patient care for hospital inpatients. As shown in Table 10, 44% believed it to be extremely important for all patients, while 35% believed it to be extremely important for some patients.

Most physicians rated patient education as an important component of care for hospital patients, but not all of them did so. Approximately two-thirds of them believed patient education to be extremely important (30.7% for all patients, and 36.9% for some patients). Another one-fourth of the physicians believed it to be of moderate importance, but 4.5% believed it was either of little importance or undesirable. Three percent indicated that they did not know.

Nurses were more fully agreed about its importance. Eighty-six percent of them believed patient education to be an extremely important component of patient care; 55.1% believed it to be extremely important for all, and 30.4% extremely important for some. Approximately 12% of the nurses believed it to be of moderate



Table 10.--Percentage of respondents by professional sub-groups and total respondent group who accorded selected levels of importance to patient education for hospital inpatients.

Level of Importance	Physicians N=287	Nurses N=276	Allied Health Professionals N=100	Patient Education Staff N=26	Hospital Administrators N=18	Total Respondent Group N=707
Extremely important for all	30.3	55.1	44.0	76.9	44.4	43.9
Extremely important for some	36.9	30.4	43.0	19.2	38.9	34.7
Moderately important for all	12.9	8.7	11.0	3.8	16.7	10.8
Moderately important for some	12.2	3.6	1.0	.0	.0	6.5
Of little importance	3.5	.7	.0	.0	.0	1.7
Undesirable	1.0	.0	.0	.0	.0	.4
Don't know	3.1	1.4	1.0	.0	.0	2.0



importance, with less than 1% indicating patient education was of little importance. None believed it to be undesirable.

The patient education staff indicated overwhelmingly (96.1%) that patient education was an extremely important component of patient care. Seventy-seven percent of them believed it to be extremely important and 4% believed it to be moderately important for all patients, while 19% believed it to be extremely important for some patients.

Allied health professionals and hospital administrators had very similar responses. Approximately four-fifths of them believed patient education to be an extremely important component of patient care for hospital inpatients. Two-fifths of these groups believed it to be extremely important for all patients and two-fifths of them extremely important for some patients. Another 12% of allied health professionals and 16.7% of hospital administrators believed patient education was moderately important as a component of patient care.

Physicians showed the lowest percentage of respondents who believed patient education to be an extremely important component of patient care. Fewer than one-third of them rated it so for all patients and slightly more than one-third rated it so for some patients. Another one-fourth rated it as moderately important. One percent even rated it as undesirable and 3.5% saw it as of little importance for all patients. In contrast, more than three-fourths of patient education staff believed it to be extremely important for all patients, and nearly one-fifth rated it so for some patients.



Only one patient education staff member rated it as moderately important; and none gave it a lower rating.

Importance of Selected Content Areas

A large number of the total respondent group, as indicated in Table 11, believed all but one of eight selected content areas to be extremely important for inclusion in hospital inpatient education activities. Approximately four-fifths of the respondents indicated the following content areas to be extremely important and more than 94% judged them to be at least moderately important: (1) explanation of diagnosis and treatment (79.4% and 94.4%); (2) teaching patients to administer own treatment (86.1% and 97.9%); and (3) teaching patients self-care independent living skills (85.3% and 98%). Seventy-two percent of the total respondents indicated teaching about short- and long-term life style adjustments to be extremely important and another 24% rated it moderately important. Approximately 66% indicated that teaching about appropriate community resources and general preventive medicine were extremely important and another 31.4% and 27.8%, respectively, rated each area as moderately important. Fifty-six percent indicated teaching about financial management of the health problem to be extremely important and another 35.5% rated it moderately important.

Fifty-four percent of the total respondents rated one content area, orientation to hospital facilities and services, as only moderately important but another 28.2% rated it extremely important. Sixteen percent believed this area to be of little or no importance.



Table 11.--Percentage of total respondent group who indicated that specific content areas are important for inclusion in hospital patient education programs for inpatients.

Content Areas	Of No Importance	Of Little Importance	Moderately Important	Extremely Important
Teaching patient to administer own treatment	.6	.9	11.8	86.1
Teaching patient self-care independent living skills	.4	1.0	12.7	85.3
Explanation of diagnosis & treatment of health problem	2.4	2.5	15.0	79.4
Teaching about short & long term life style adjustments	.4	2.6	24.0	72.1
Teaching of general preventive medicine	1.3	6.0	27.8	68.8
Teaching about appropriate community resources	.3	2.2	31.4	65.5
Teaching about financial management of health problem	.7	4.8	35.5	55.9
Orientation to hospital facilities & services	2.6	13.7	54.0	28.2



Very few respondents rated any of the other areas as being of little or no importance.

In general, the five professional groups tended to agree as to the level of importance for each content area. Nurses and allied health professionals seemed to be in especially close agreement. There was, however, some minor variance in ratings of importance of these areas among the other groups.

Physicians and hospital administrators were not in full agreement with the other three professional sub-groups. A majority of physicians and hospital administrators rated only five out of the eight content areas as extremely important. These areas were explanation of diagnosis and treatment, teaching patients to administer their own treatment, teaching about short- and long-term life style adjustments, teaching patients self-care independent living skills, and teaching about appropriate community resources. Almost consistently a lesser percentage of physicians and hospital administrators than of nurses, allied health professionals, and patient education staff rated the content areas as extremely important, while a greater percentage rated them to be of little or no importance.

A greater percentage of patient education staff than of the other professional groups rated all content areas, except one, to be extremely important. Five out of the eight content areas were rated by over 90% of patient education staff as extremely important for inclusion in hospital programs of patient education.



Detailed data describing how each professional group saw the importance of each content area are given in Tables G1-G5 in Appendix G.

Further analyses were done to investigate differences in these ratings of importance of content areas within the total respondent group and within three of the professional groups in relation to several variables. The three professional groups were the larger groups and those who showed larger differences in ratings, namely physicians, nurses, and allied health professionals. The variables were size of hospital, whether hospital had a formal patient education program, whether respondents had participated in special training for patient education, and whether they had experience in patient education.

Only with the allied health professionals was there a significant correlation between size of hospital and ratings of importance of one of the selected content areas. Twenty-two percent more of the allied health professionals who practiced in hospitals with over 100 beds than of those in hospitals with under 100 beds believed the inclusion of teaching patients about life style adjustment to be extremely important. When both the moderately important and extremely important ratings were tabulated together, statistically significant correlations were not noted. Size of hospital seems not to have been a major factor in relation to respondent ratings of importance of content areas in patient education.



For only two groups, physicians and allied health professionals, was a positive relationship demonstrated between ratings of importance of selected content areas and whether the hospital in which they practiced had a formal patient education program. About 10% fewer of the physicians in hospitals with formal patient education programs than of those in hospitals without such programs believed one content area (orientation to hospital facilities and programs) to be of little or no importance. Approximately 17% more of the allied health professionals in hospitals with programs than of those in hospitals without programs believed it was extremely important to include the teaching of short- and long-term life style adjustments. Again, when both the moderately important and extremely important ratings were tabulated together, no statistically significant correlations were noted. Professionals' ratings of importance of various areas of content in patient education seemed to bear little relationship to the presence or absence of formal patient education programs in hospitals where they practiced.

In two of the professional groups there were apparent positive relationships between the respondents' previous attendance at educational programs on or related to patient education and their ratings of importance of selected content areas. As illustrated in Figure 1, approximately 10% more of the nurses who had previously attended programs than of those who had not believed the teaching of the patients to administer their own treatment to be an extremely important content area. Likewise, a much greater percentage (20%) of allied health professionals who had previously attended programs



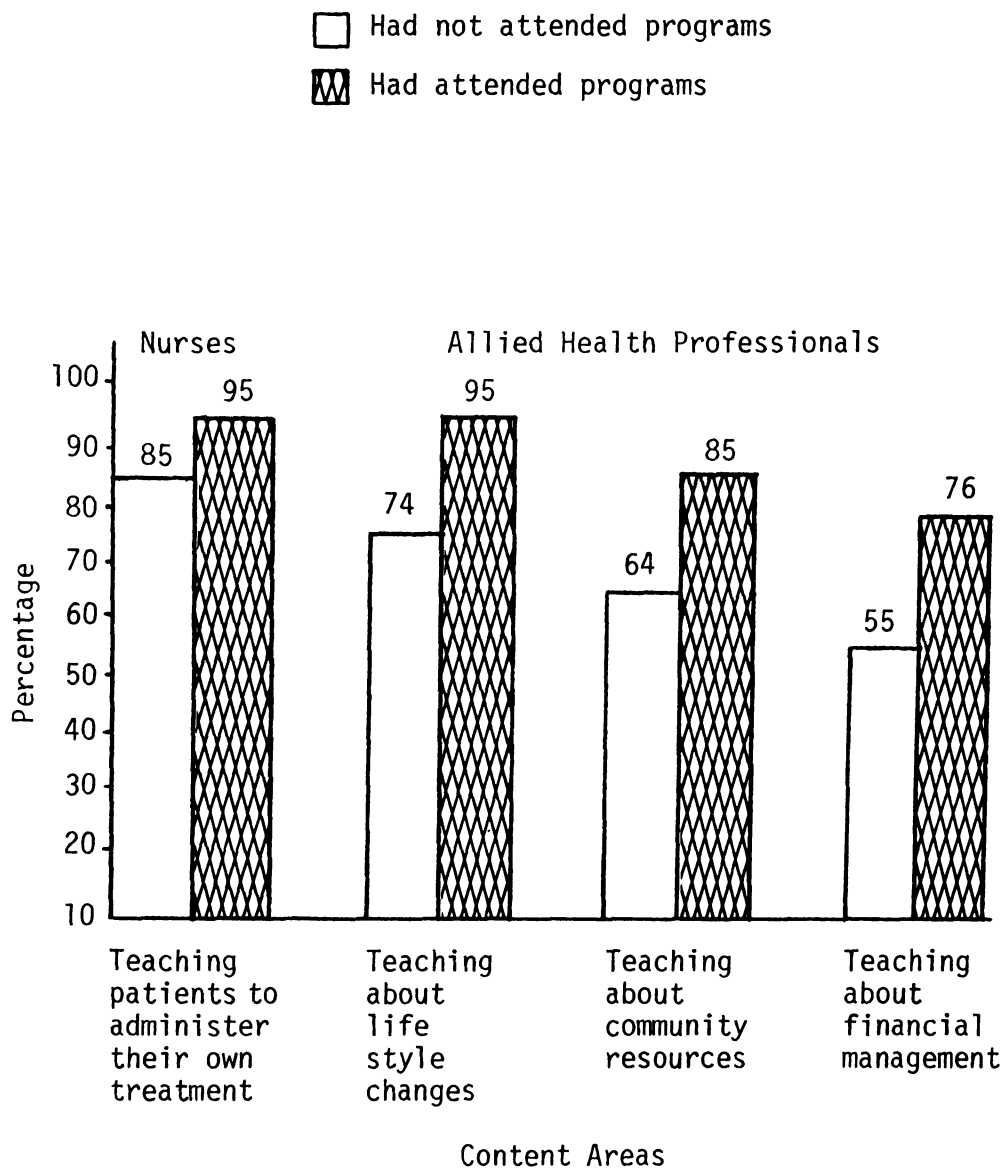


Figure 1.--Percentage of nurses and allied health professionals who had and who had not had special training in patient education who rated selected content areas as extremely important.



than of those who had not believed the teaching of three content areas (life style adjustments, community resources, and financial management of the health problem) to be extremely important. When both the moderately important and extremely important ratings were tabulated together, no statistically significant correlations were noted. One must wonder, of course, whether participation in special training tends to heighten the ratings of importance, or whether persons who believe patient education is important are more likely to seek out special training. Whichever is the case, there appears to be a relationship between the two.

A positive relationship was also demonstrated between ratings of importance by the total respondent group and by each of three professional groups and their experience or lack of experience with formal patient education programs. In four of the nine content areas, orientation to hospital facilities and services, teaching self-care skills, teaching about community resources, and teaching about financial management (as illustrated in Figure 2), a greater percentage of all respondents who had experience than of those who did not rated the content areas as extremely important. No statistically significant relationship was demonstrated between the variables when the ratings of both moderately and extremely important were taken into account.

In each of the three professional groups a greater percentage of those who had experience with formal programs than of those who did not also believed specified content areas to be extremely important to include in hospital patient education programs.



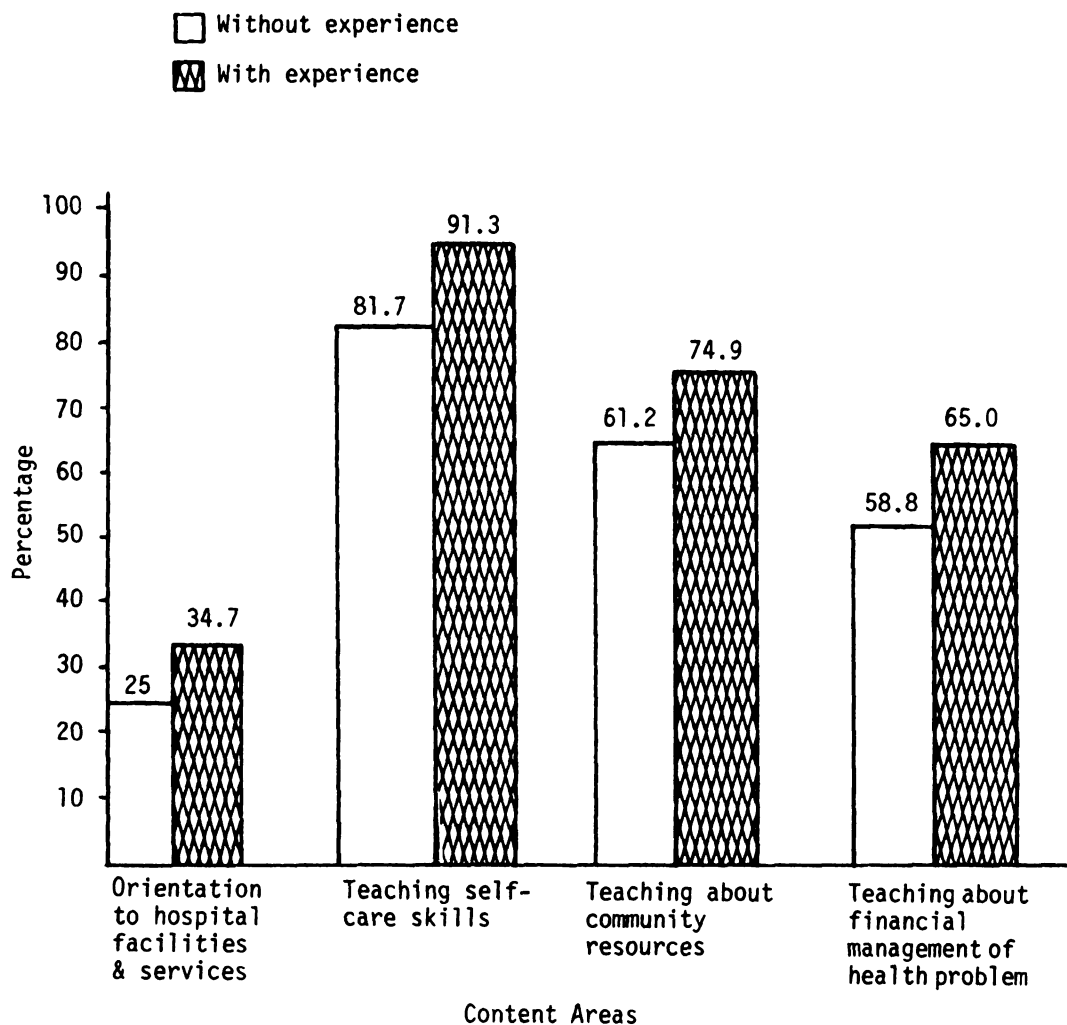


Figure 2.--Percentage of the total respondent group who had and did not have experience with formal patient education programs who rated selected content areas as extremely important.



As illustrated in Figure 3, about 14% more of the physicians with experience than of those without gave "very important" ratings to three content areas, namely orientation to hospital facilities and services, teaching self-care independent living skills, and teaching about community resources. Fifteen percent more of the nurses did so in one content area (teaching about community resources). Approximately 20% more of the allied health professionals gave such ratings in three content areas, namely explanation of diagnosis and treatment, teaching about financial management, and teaching general preventive medicine. Again, like the total respondent group, no statistically significant relationship was demonstrated between the variables when the ratings of both moderately and extremely important were taken into account.

In summary, professionals overwhelmingly agreed that patient education is an important component of patient care. Thirty-five percent of the total respondent group believed patient education to be extremely important and another 6.5% believed it to be moderately important for some patients, and 44% extremely important and another 10.8% moderately important for all patients. A variety of content areas were judged by professionals to be appropriate to include in hospital patient education programs. All professionals rated the most important areas as teaching patients to administer their own treatment (86.1% extremely important and 11.8% moderately important), teaching patients self-care independent living skills (85.3% extremely important and 12.7% moderately important), and explanation of diagnosis and treatment of the health



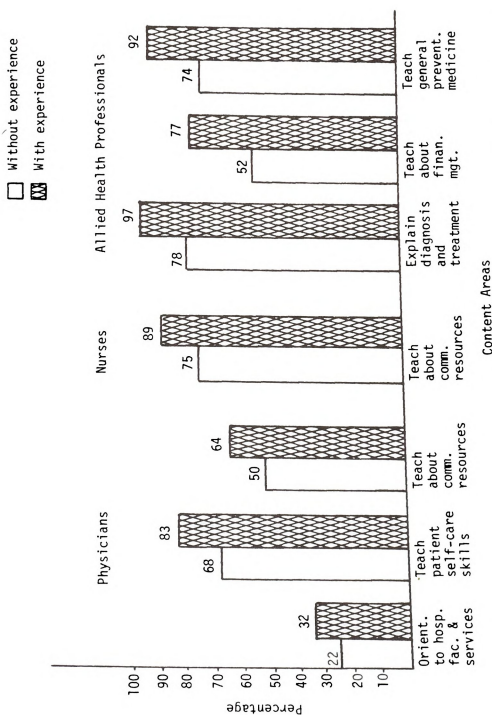


Figure 3.--Percentage of physicians, nurses, and allied health professionals who had and did not have experience with formal patient education programs who rated selected content areas as extremely important.



problem (79.4% extremely important and 15% moderately important). Every one of the selected topics was judged to be at least moderately important by more than 80% of all respondents.

Roles Deemed Appropriate for Health Care
Professionals, Patients, and Families of
Patients in the Planning and Conducting
of Patient Education Activities

This section describes the roles deemed appropriate for themselves and each other by patient education staff, physicians, nurses, allied health professionals, and hospital administrators, and the role they believe to be appropriate for patients and families of patients in the planning and conducting of hospital patient education activities for inpatients.

Respondents were asked to identify the primary and supportive responsibilities that each professional group should have in selected patient education content areas. Each health care professional group's role is described in three primary ways: (1) how the total respondent group defines the role, (2) how the professional group defines its own role, and (3) how the other four professional groups define the role of that professional.

Each sub-section on the roles of health care professionals contains a report of further analyses of responses of the total respondent group and of the three largest professional groups, physicians, nurses, and allied health professionals, in relation to four other variables: (1) size of hospital, (2) whether or not the respondents' hospitals had operating formal patient education



programs, (3) the respondents' previous attendance at programs on or related to patient education, and (4) the respondents' experience with formal patient education programs. Relationships were reported only when the variances in respondents' opinions concerning role were noted in at least one-third of the selected patient education content areas.

The respondents' opinions on whether or not the patients and the families of patients should be included in the planning and conducting of patient education activities are also reported.

Role Deemed Appropriate for
Patient Education Staff

Primary role.--Approximately 36% of the total respondent group, as shown in Table 12, judged that patient education staff should have primary responsibility for planning, and 30% judged that they should have primary responsibility for conducting patient education activities. In each of the selected content areas, the patient education staff's role was defined, especially by the patient education staff themselves, more as planner than as conductor of patient education activities. In one content area (orientation to hospital facilities and services), however, a majority (approximately 58%) of respondents judged that patient education staff should have primary responsibility for both planning and conducting the activities.

In comparing how the small group of patient education staff defined their own role with the way other professional groups defined the patient education staff role, it appears that a much larger

Table 12.--Percentage of patient education staff members who judged that their own professional role should include primary responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and of the total respondent group who judged that patient education staff should have such primary responsibilities.

Content Area	Function	Patient Education Staff N=26	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Hospital Administrators N=18	4 Groups Collectively N=637	
Orientation to hospital facilities and services	Planning	69.3	44.3	69.3	74.5	55.6	59.5	60.6
	Conducting	54.3	55.0	54.3	65.6	44.4	56.0	56.2
Explanation of diagnosis	Planning	46.2	14.7	22.9	23.7	11.1	19.3	20.3
	Conducting	20.0	12.5	12.2	9.4	11.1	11.9	12.3
Explanation of treatment	Planning	53.8	15.6	23.2	26.8	22.2	20.7	21.9
	Conducting	20.1	13.1	16.6	12.2	11.1	14.6	14.8
Teaching patients to administer own treatment	Planning	68.0	16.1	34.3	36.7	33.3	27.5	29.0
	Conducting	32.0	17.8	25.4	20.6	27.8	20.7	16.6
Teaching self-care independent living skills	Planning	61.5	29.2	45.5	37.1	55.6	37.8	38.5
	Conducting	28.0	32.3	33.3	21.1	41.2	31.1	30.9



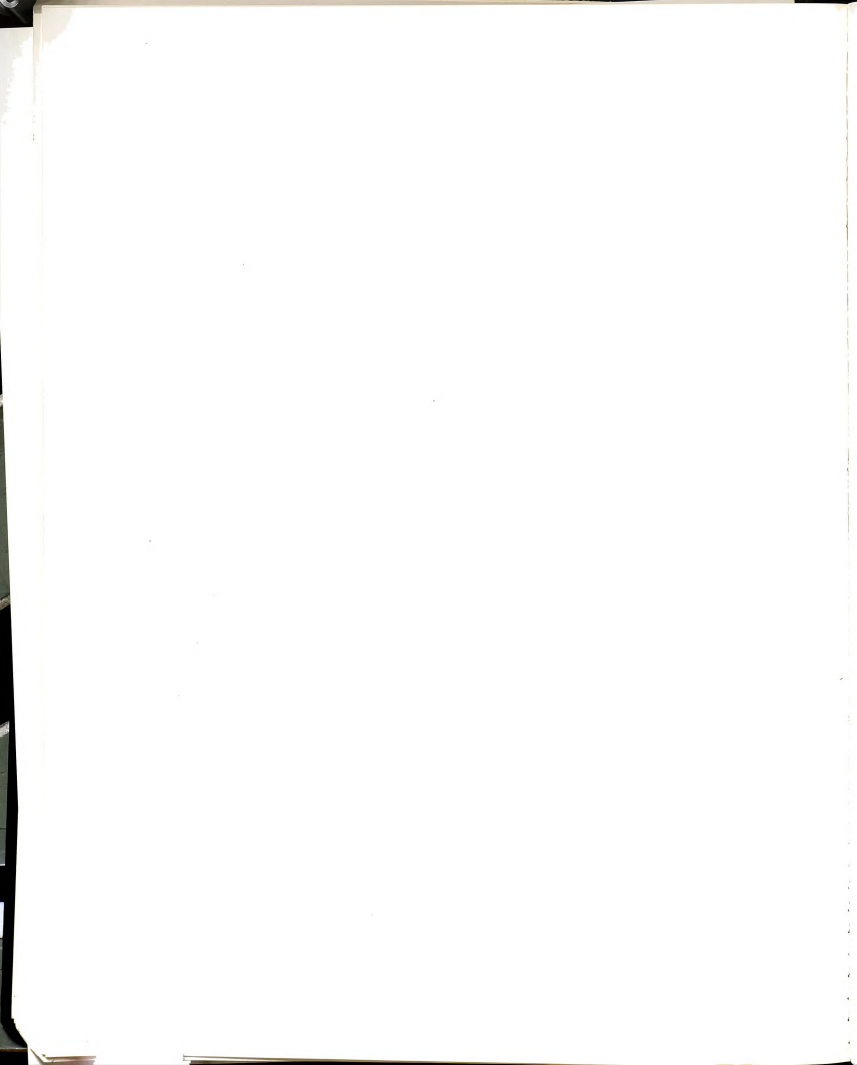
Table 12.--Continued.

Content Area	Function	Patient Education Staff N=26	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Hospital Adminis- trators N=18	4 Groups Collectively N=637	
Teaching long- and short-term life style adjustment	Planning	60.0	28.9	45.7	36.7	55.6	37.6	38.5
	Conducting	24.0	30.6	36.0	24.7	33.3	31.9	31.6
Teaching about community resources	Planning	60.0	37.4	46.1	42.3	61.1	42.3	42.9
	Conducting	24.0	39.8	37.3	35.4	44.4	38.0	37.4
Teaching about financial management of health problem	Planning	44.0	37.2	38.8	42.6	41.2	38.6	38.6
	Conducting	16.0	40.2	34.4	35.5	47.1	37.2	36.4
Teaching of general preventive medicine	Planning	68.0	31.0	38.9	38.1	50.0	35.9	37.2
	Conducting	40.0	33.1	33.3	34.0	44.4	33.6	33.9
Mean over nine areas	Planning	59.0	28.3	40.5	39.8	42.9	35.5	36.4
	Conducting	28.6	30.5	31.4	28.7	33.9	30.6	30.0



percentage of patient educators believed they should have primary responsibility for planning programs, but a slightly smaller percentage believed they should have primary responsibility for conducting them. Fifty-nine percent of patient education staff members indicated that they should have primary responsibility for planning patient education activities in the nine content areas, while 28.6% indicated they should have primary responsibility for conducting such activities. Nearly 70% of them believed that they should have primary responsibility for planning orientation to hospital facilities and services, planning for teaching patients to administer their own treatment, and planning for teaching of general preventive medicine. In contrast, there was only one content area, orienting patients to hospital facilities and services, in which a majority (54.3%) of them believed they should have primary responsibility for conducting the activities.

The other four groups were not in full agreement with patient education staff about the role of patient education staff. Physicians had the greatest differences of opinion. Fewer than one-third of them judged that patient education staff should have primary responsibility for planning and conducting patient education activities in general. Only about one-sixth of them believed that patient education staff should have primary responsibility for planning and conducting explanations of diagnosis and treatment and for teaching patients to administer their own treatment. In only one activity, conducting orientation to hospital facilities



and services, did a majority (55%) of physicians ascribe primary responsibility to patient education staff.

With respect to planning, less than one-half as large a percentage of physicians as of patient education staff, in general, ascribed primary responsibility to patient education staff. Though the percentages varied, this difference was significant and consistent across all nine content areas.

With respect to primary responsibility for conducting patient education, however, the differences between physicians and patient education staff were not nearly as great, nor were they all in the same direction. In three content areas: teaching long- and short-term life style adjustment, teaching about community resources, and teaching about financial management, significantly larger percentages of physicians than of patient education staff ascribed primary responsibility to patient education staff.

It appears that many physicians saw an important role for patient education staff but that their definition of that role was different from the role definition patient education staff described for themselves.

Nurses, allied health professionals, and hospital administrators were in close agreement among themselves, but in less close agreement with patient education staff and physicians about responsibilities of patient education staff for planning. Approximately 40% of them judged that patient education staff should have overall primary responsibility for planning of patient education activities.



About 30% of them, a percentage very similar to that of physicians and patient education staff themselves, believed that in general the patient education staff should have primary responsibility for conducting patient education activities. In one area, orientation to hospital facilities and services, a clear majority of the nurses, allied health professionals, and hospital administrators agreed with most physicians and most patient education staff that patient education staff should have primary responsibility for planning and conducting the activity. Fifty-five to sixty percent of hospital administrators also believed that patient education staff should have primary responsibility for the planning of five of the nine content areas. But as was true of physicians, nurses, and allied health professionals, a very small percentage of the administrators believed that patient education staff should have primary responsibility for either planning or conducting explanations of diagnosis and treatment.

Patient education staff defined roles for themselves that were different from roles defined for them by the other four professional groups. A much larger percentage of patient education staff (59%) than of the four other professional sub-groups collectively (35.5%) believed they should have primary responsibility for planning patient education activities. This difference was apparent in all but two of the nine content areas specified.

Although the percentages of patient education staff and the other four sub-groups were about equal concerning the overall primary responsibility for conducting patient education activities,

there were some differences noted in four of the content areas. In two of those areas (explanation of diagnosis and treatment and teaching patients to administer their own treatment), approximately 10% more of the patient education staff indicated they should have primary responsibility than did the other sub-groups. In two other areas (teaching about community resources and financial management of the health problem), a larger percentage of the other four professional groups collectively than of the patient education staff believed patient educators should have primary responsibility for conducting those activities.

It should be noted that consistently a smaller percentage of physicians than of the other sub-groups judged that patient education staff should have primary responsibility for planning and conducting patient education activities.

There was very little relationship between definitions of patient education staff's role by any of the groups and either of two factors: (1) whether the respondents practiced in hospitals with formal patient education programs, or (2) the respondents' previous attendance at programs on or related to patient education.

A partial relationship was demonstrated between hospital size and nurses' responses concerning the primary responsibility of patient education staff. About 15% fewer of the nurses who worked in the hospital with over 200 beds than of those in hospitals with under 200 beds judged that the patient education staff should have primary responsibility for planning patient education activities in five content areas as illustrated in Figure 4. No other

100
90
80
70
Percentage
60
50
40
30
20
10

Fig

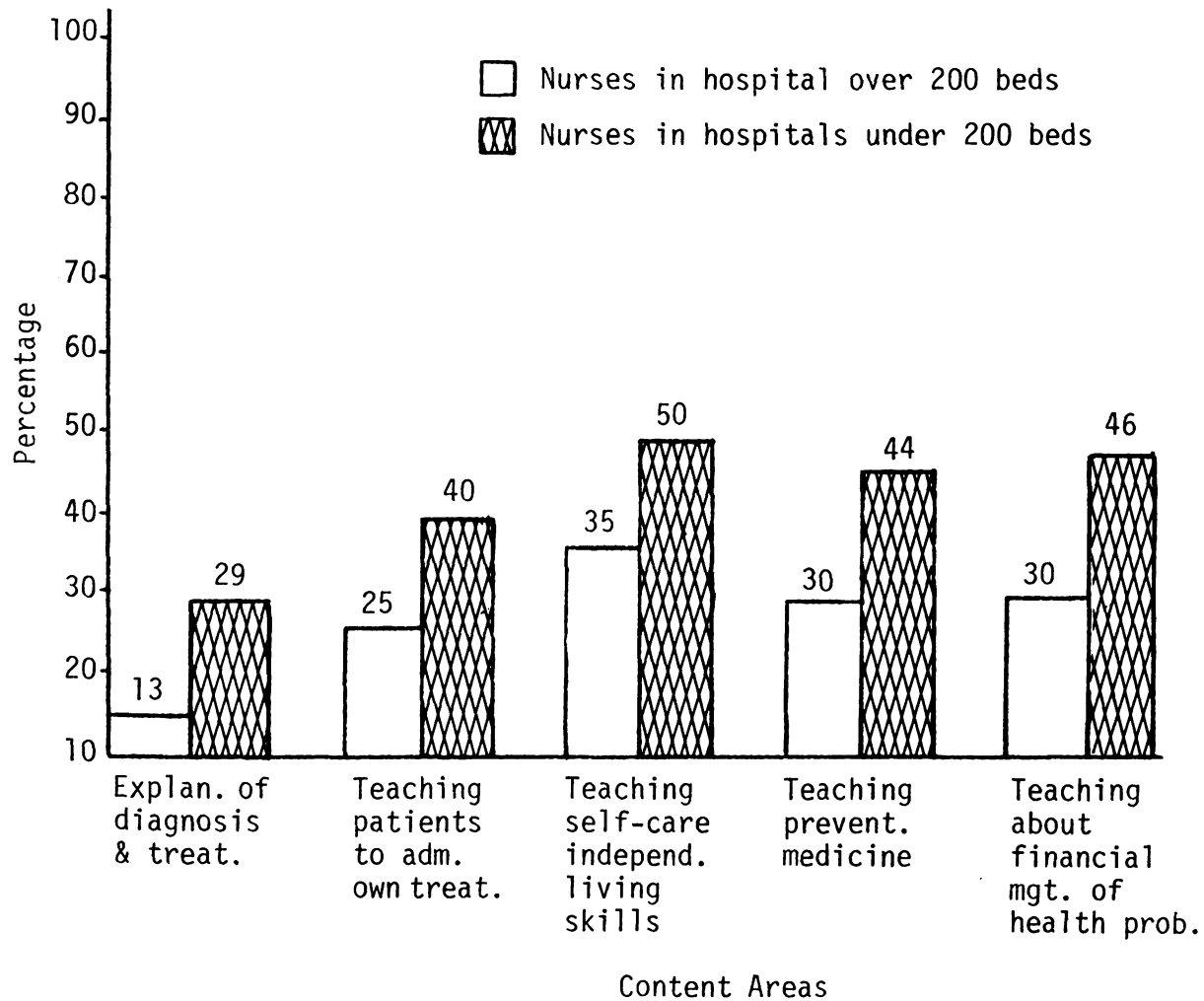
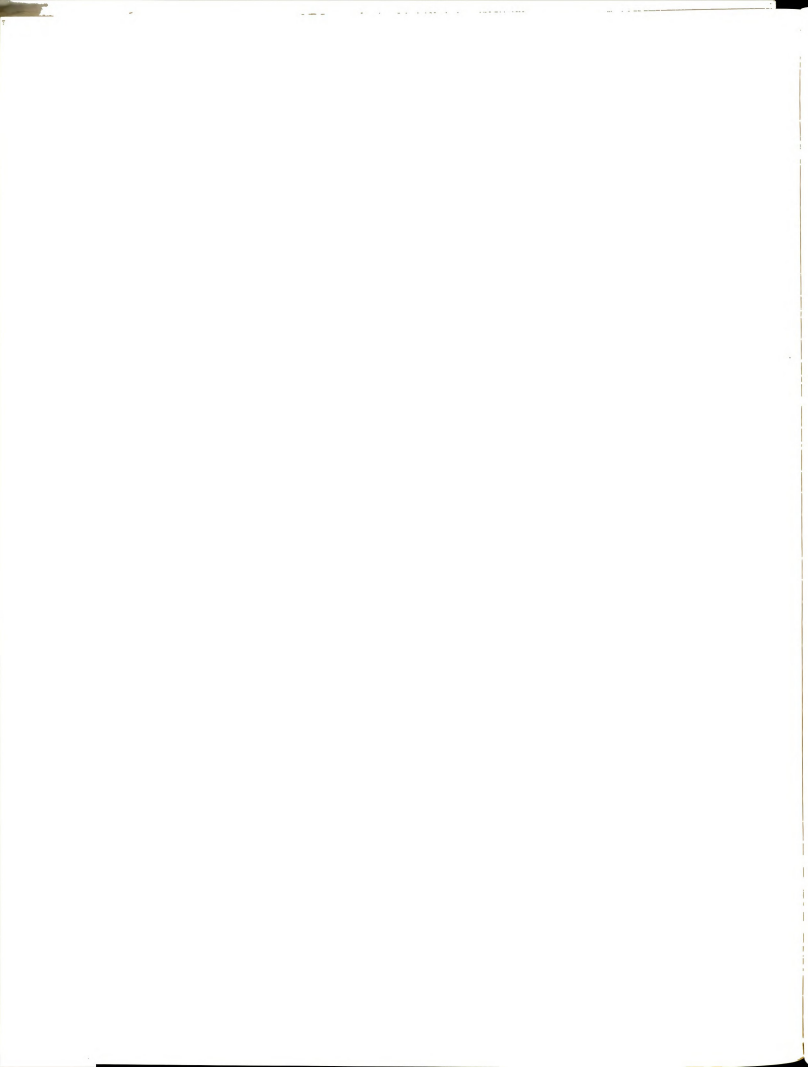


Figure 4.--Mean percentage of nurses by hospital size who judged that patient education staff should have primary responsibility for planning patient education activities in selected content areas.

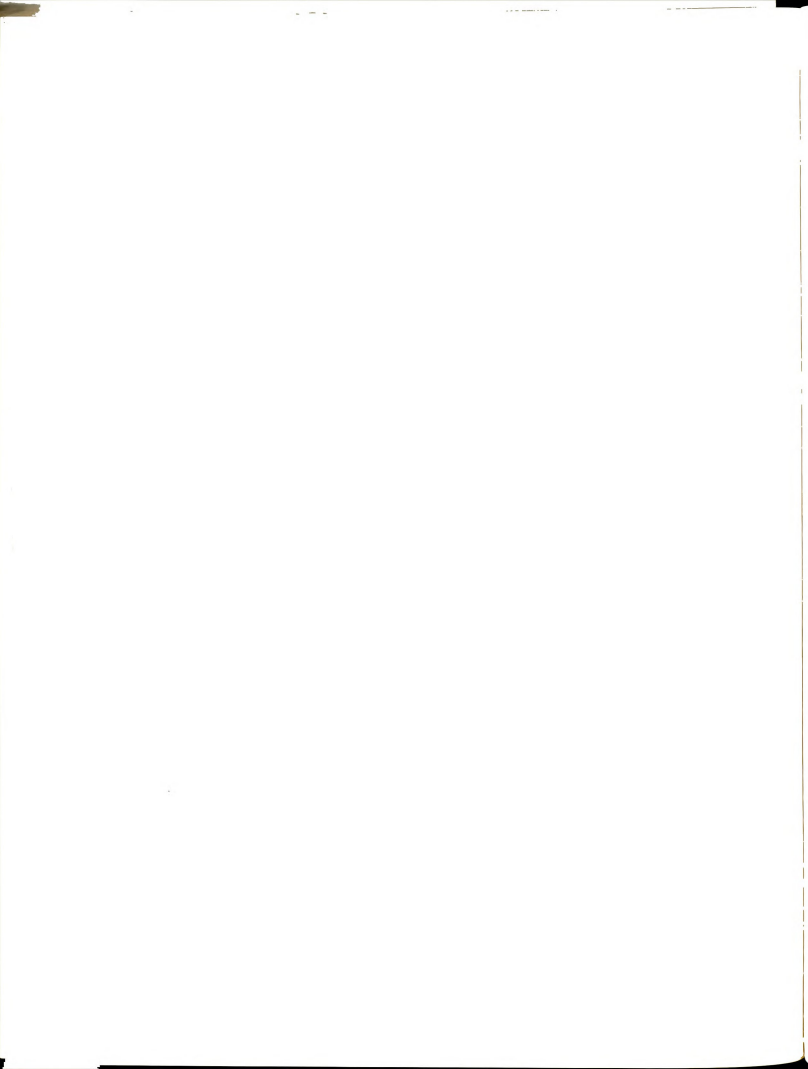


significant relationships appeared to exist between size of hospital and definitions of role for patient education staff.

There was also a relationship, as illustrated in Figure 5, between the respondents' experience with formal patient education programs and answers of the total respondent group concerning the primary role of patient education staff in the planning of patient education activities in three content areas. In each of the three content areas about 10% more of respondents who had experience with formal patient education programs than of those who did not judged that patient education staff should have primary responsibility for planning. No other significant relationships appeared to exist between respondents' experience with formal patient education programs and their responses concerning responsibilities of patient education staff for planning or conducting patient education activities.

Supportive role.--A relatively small percentage of the total respondent group judged, as indicated in Table 13, that patient education staff should have supportive roles in planning (15.8%) and conducting (17.2%) patient education activities.

The small group of patient education staff viewed their supportive responsibilities somewhat differently than did the other four groups. Nearly one-fifth of them judged that their professional role should include supportive responsibility for planning. This was in reasonably close agreement, overall, with the other groups. However, more than twice as large a percentage (35%) of patient education staff as of the other four groups collectively



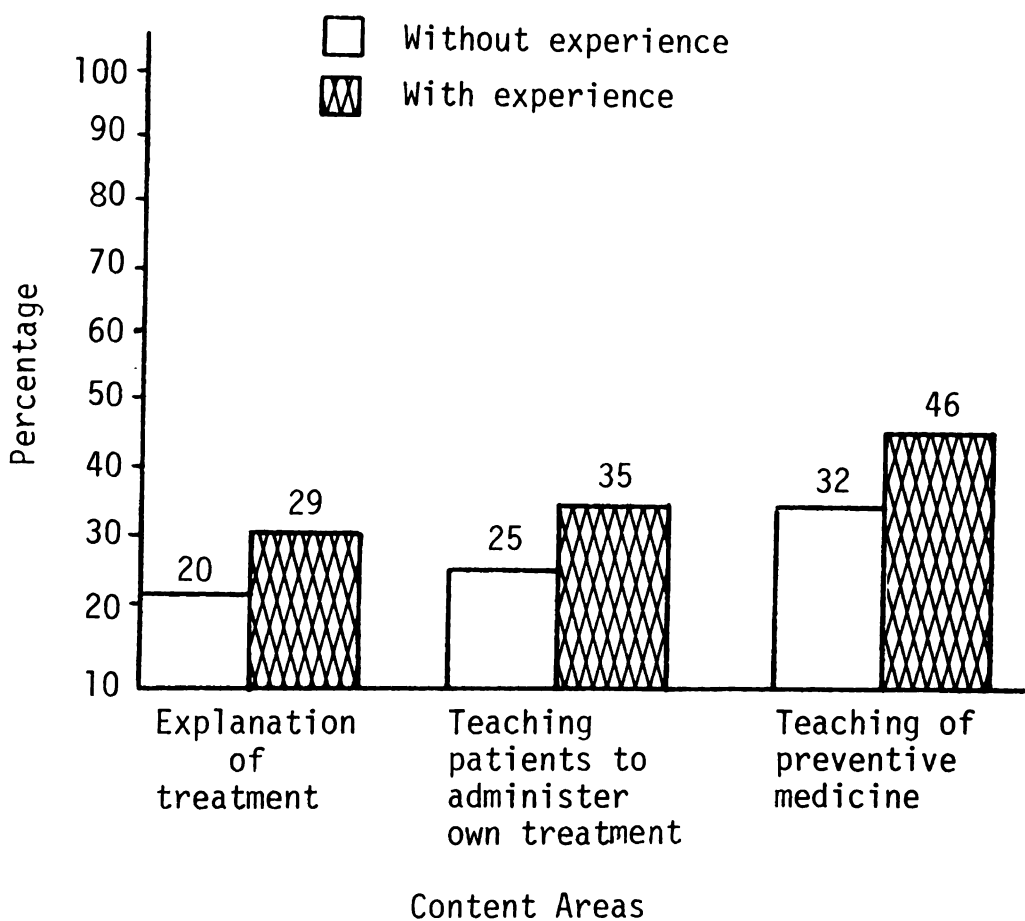


Figure 5.--Percentage of total respondent group who had or did not have experience with formal patient education programs who judged that the patient education staff should have primary responsibility for planning patient education activities in selected content areas.

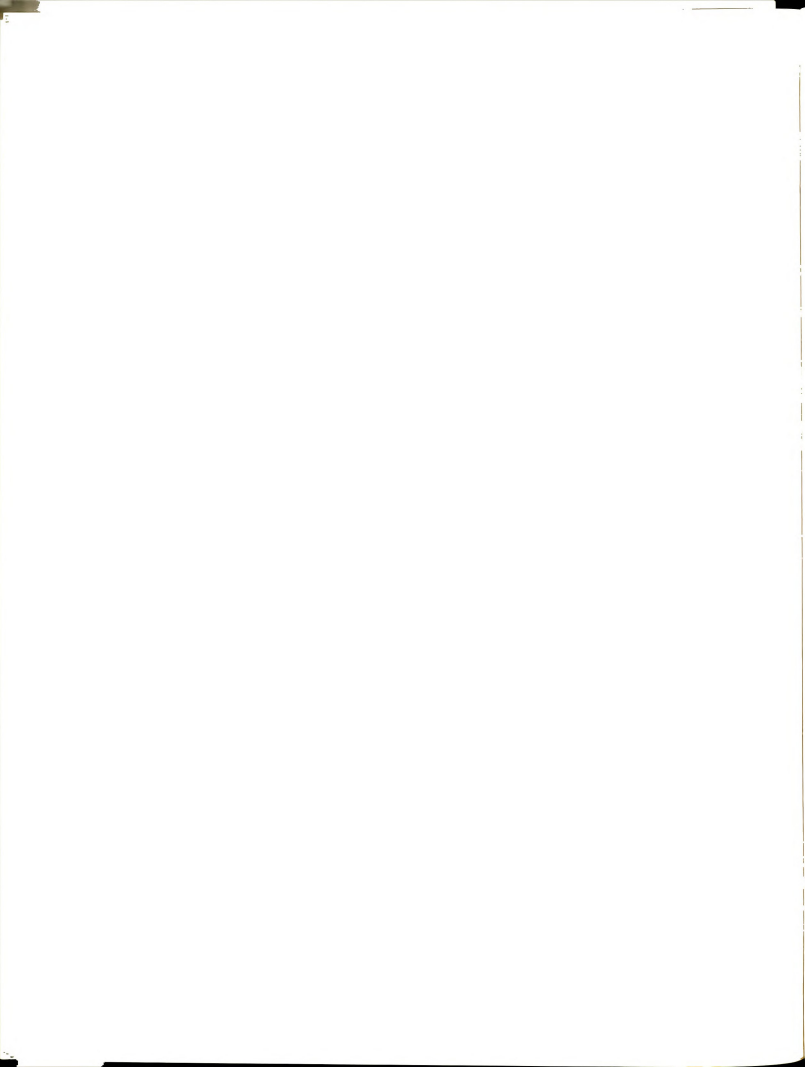


Table 13.--Percentage of patient education staff members who judged that their own professional role should include supportive responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that patient education staff should have such supportive responsibilities.

Content Area	Function	Patient Education Staff N=26	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Hospital Administrators N=18	4 Groups Collectively N=637	
Orientation to hospital facilities and services	Planning	.0	21.0	13.1	11.2	11.1	15.9	15.3
	Conducting	15.4	11.6	11.7	9.4	11.1	11.3	11.4
Explanation of diagnosis	Planning	19.2	15.8	12.0	18.6	22.2	14.9	15.1
	Conducting	36.0	16.4	13.7	21.9	11.1	16.1	16.8
Explanation of treatment	Planning	19.2	15.3	12.0	15.5	11.1	13.9	14.1
	Conducting	36.0	17.3	14.7	18.4	16.7	16.4	17.2
Teaching patients to administer own treatment	Planning	12.0	18.3	15.3	15.3	22.2	16.7	16.6
	Conducting	32.0	15.9	17.8	17.5	16.7	17.9	18.5
Teaching self-care independent living skills	Planning	19.2	15.8	8.6	13.4	5.6	12.1	12.4
	Conducting	40.0	13.8	14.7	14.7	17.6	14.5	15.5

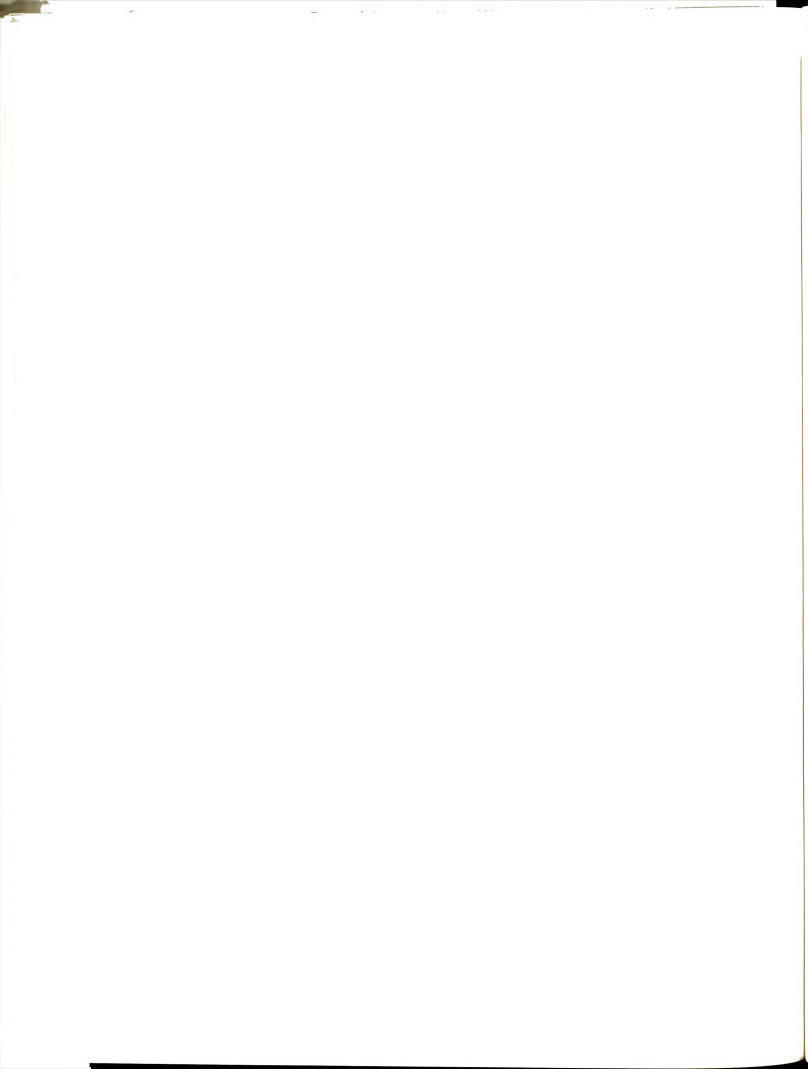
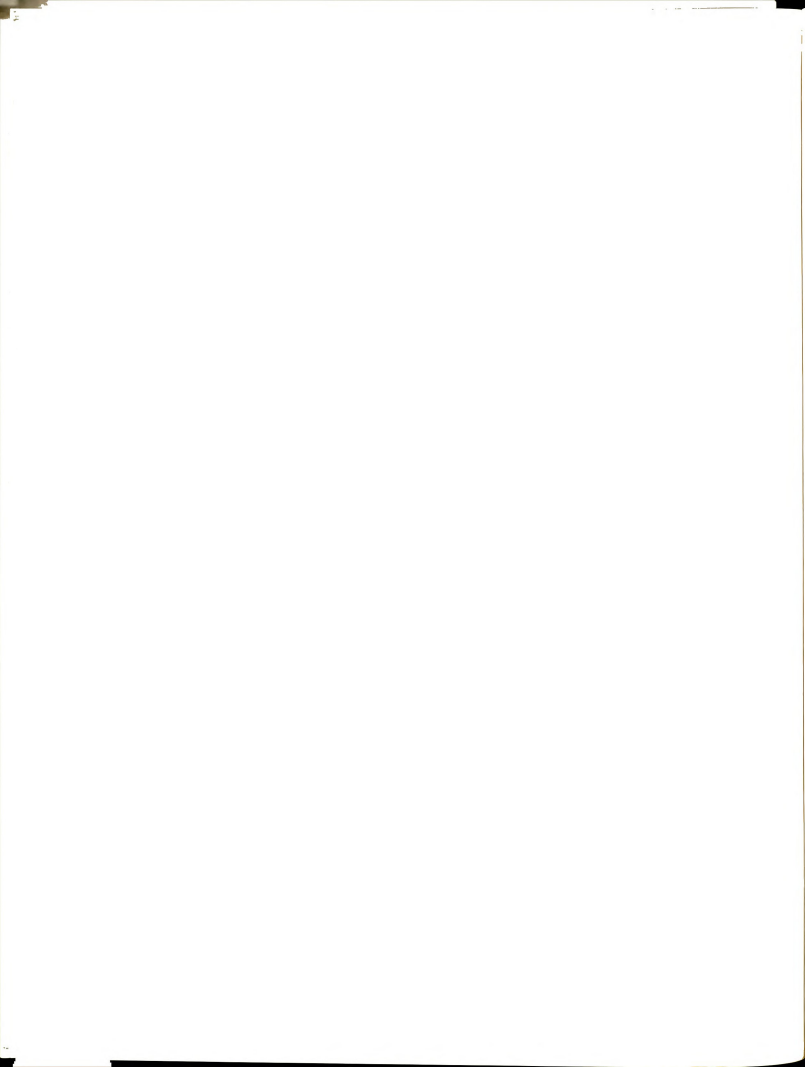


Table 13.--Continued.

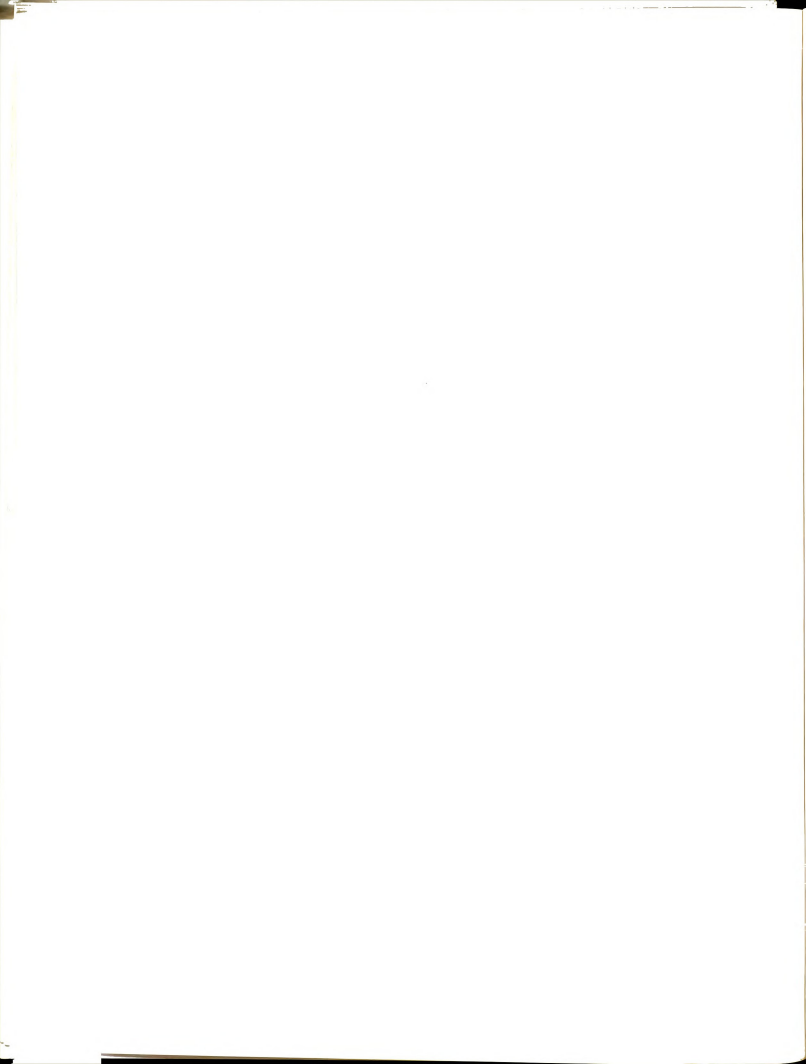
Content Area	Function	Patient Education Staff N=26	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Hospital Administrators N=18	4 Groups Collectively N=637	
Teaching long- and short-term life style adjustment	Planning	24.0	19.9	13.1	17.3	11.1	16.5	16.8
	Conducting	40.0	18.0	18.2	25.8	27.8	19.5	20.3
Teaching about community resources	Planning	20.0	18.3	14.6	21.6	11.1	17.1	17.2
	Conducting	36.0	16.5	17.3	15.6	27.8	16.9	17.6
Teaching about financial management of health problem	Planning	40.0	17.6	19.6	22.3	23.5	19.4	20.2
	Conducting	52.0	15.6	23.2	22.6	23.5	19.9	21.2
Teaching of general preventive medicine	Planning	16.0	13.9	13.6	15.1	22.2	14.1	14.2
	Conducting	28.0	13.9	18.6	14.9	5.6	15.7	16.1
Mean over nine areas	Planning	18.4	17.3	13.5	16.7	15.6	15.6	15.8
	Conducting	35.0	15.4	16.7	17.9	17.5	16.5	17.2



(16.5%) believed their role should include a supportive responsibility for the conducting of patient education activities. This difference was apparent in all but one of the nine content areas. In only one content area, teaching about the financial management of the health problem, did a large percentage (52%) of patient education staff believe they should have a supportive role for conducting the activity.

With respect to planning, patient education staff and the other four professional groups differed principally in two of the content areas. A greater percentage (40%) of patient education staff than of the other four professional groups collectively (19.4%) believed that patient education staff should have a supportive role in planning in the area of financial management of the health problem. The opposite was true for planning of orientation to hospital facilities and services. None of the patient education staff believed that their role should be a supportive one in that area, while 15.9% of the other four groups believed that patient education staff should play a supportive role there. That is the area, it should be recalled, in which a majority of all groups, including physicians and patient education staff, ascribed primary responsibility to patient education staff.

There was very little relationship between the variance in the respondents' judgments concerning the supportive role of patient education staff and whether the respondents practiced in hospitals with or without patient education programs, or whether

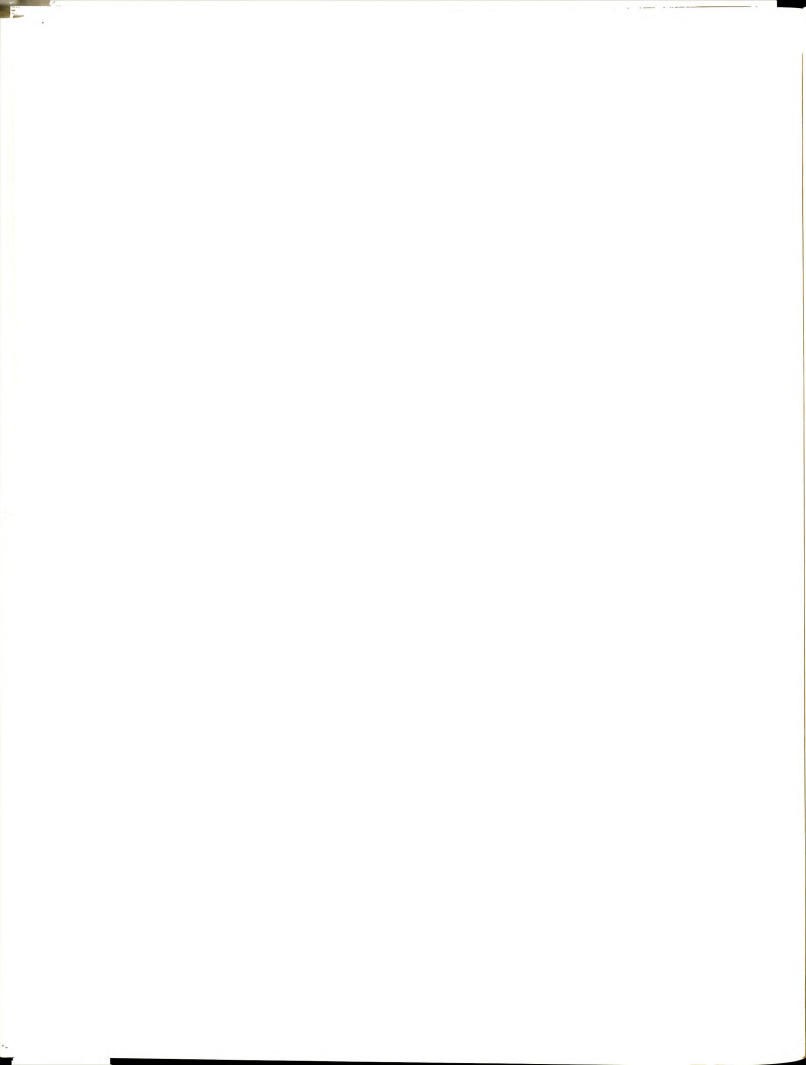


or not respondents had experience with formal patient education programs.

Nurses' responses concerning supportive responsibilities of patient education staff varied in relationship to the two remaining variables, size of hospital and previous training in patient education. As illustrated in Figure 6, a greater percentage of nurses in hospitals with 50 to 199 beds believed that the patient education staff should have a supportive role than did those in the hospital with over 200 beds or those with under 50 beds. This was seen in their ratings of both planning and conducting functions in three of the nine content areas.

There was also a relationship shown between whether the nurses had previously attended programs on or related to patient education and variance in the nurses' answers concerning the supportive responsibility of the patient education staff. As illustrated in Figure 7, about twice as many of the nurses who had previously attended these programs as of those who had not believed that patient education staff should have a supportive role in planning for two content areas, orientation to hospital facilities and services and teaching life style adjustments, and in conducting in two other areas, explanation of diagnosis and explanation of treatment.

In summary, patient education staff were believed by nearly two-fifths of professionals in other groups to have primary responsibility for the overall planning of patient education activities, and by nearly one-third of them to have primary responsibility for conducting such activities. They were seen by about one-sixth of



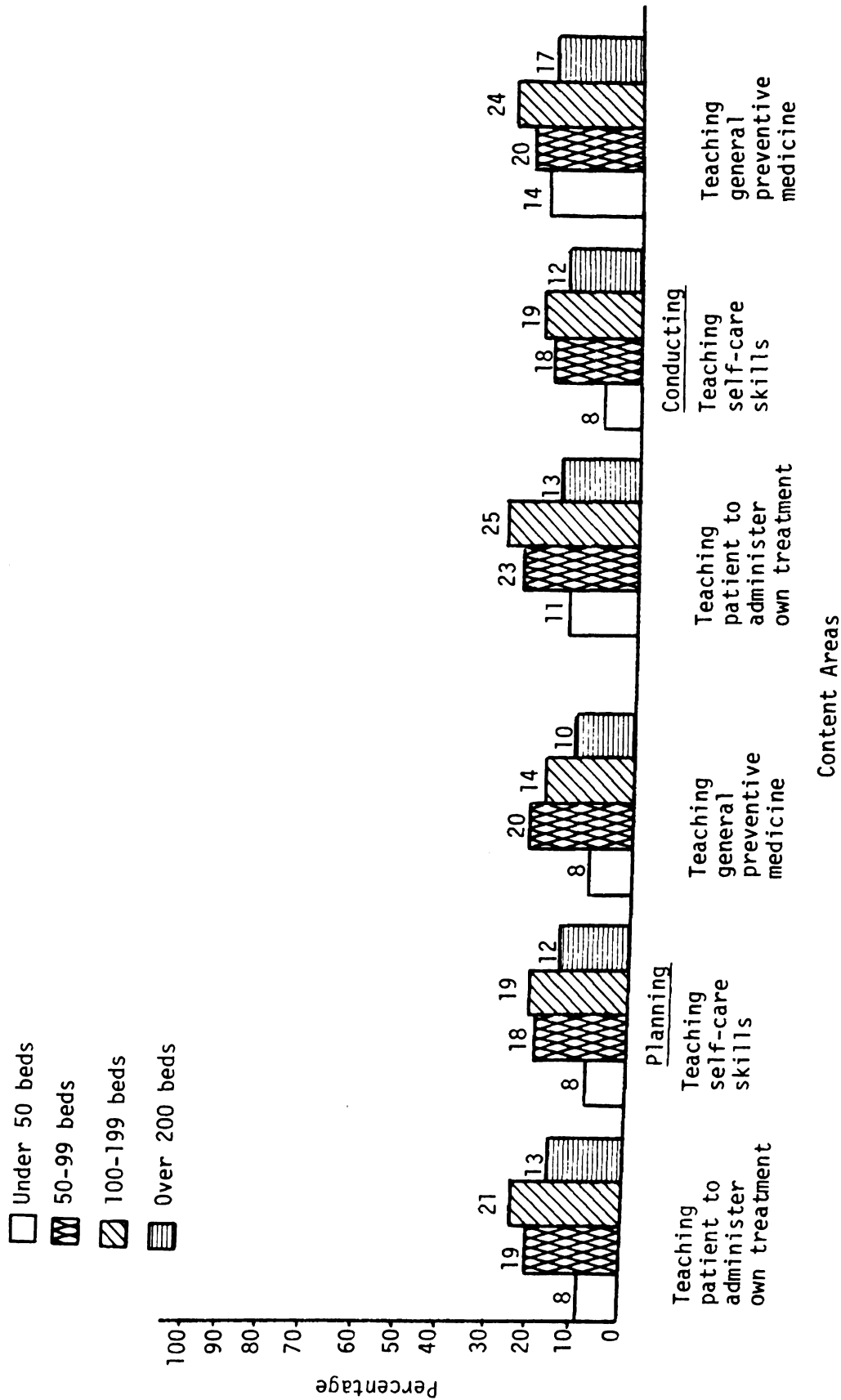
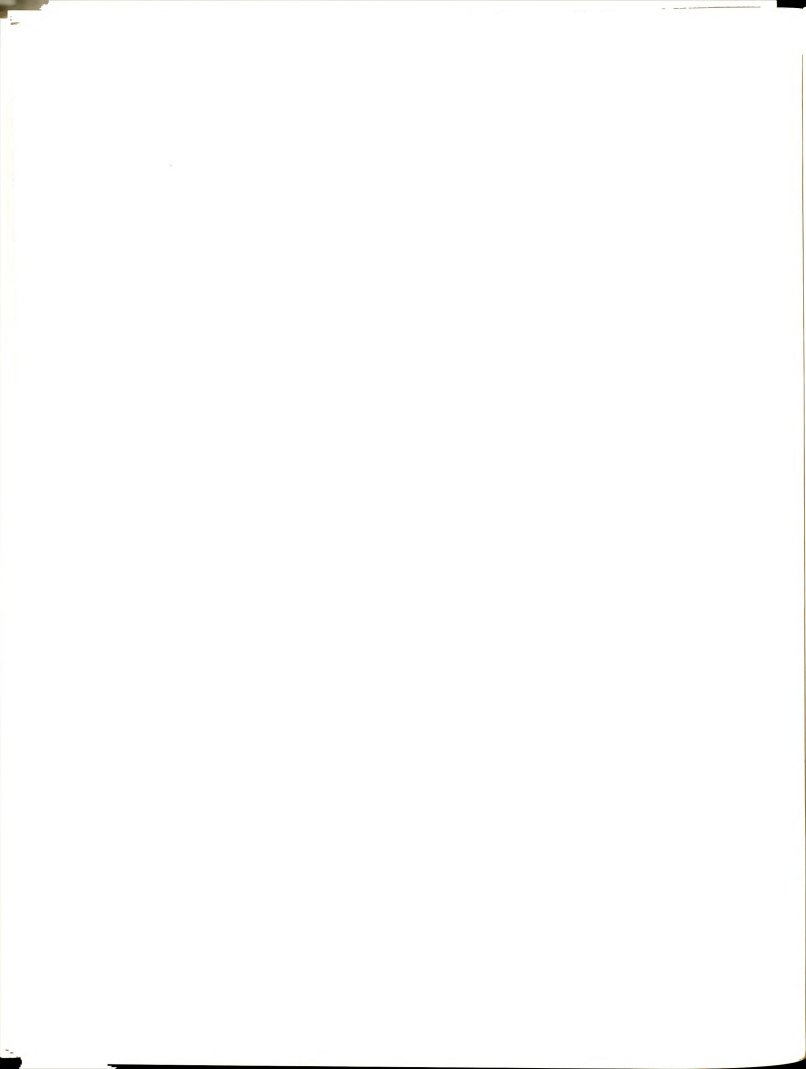


Figure 6.--Percentage of nurses by hospital size who judged that patient education staff should have supportive responsibility for planning and conducting patient education activities in selected content areas.



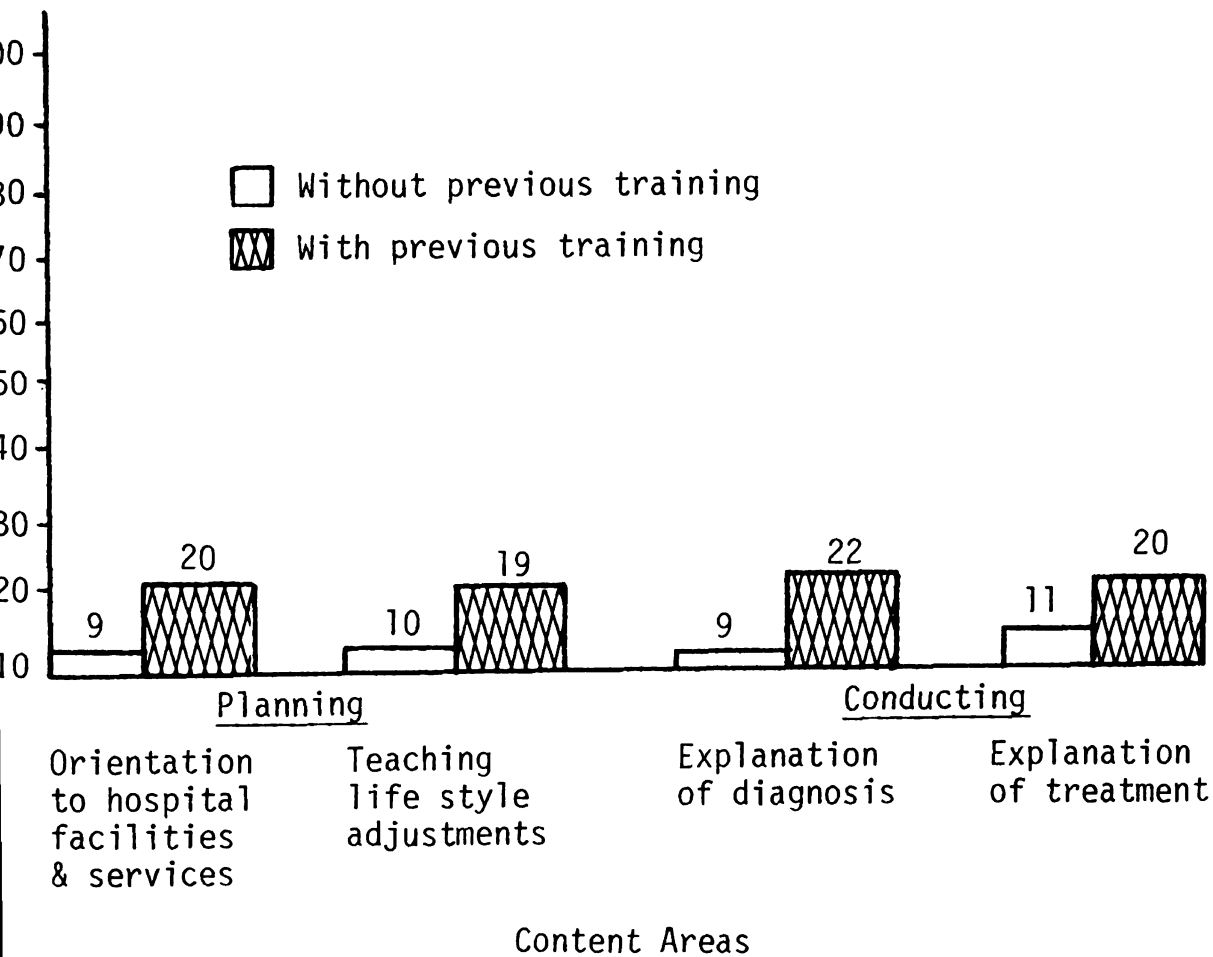
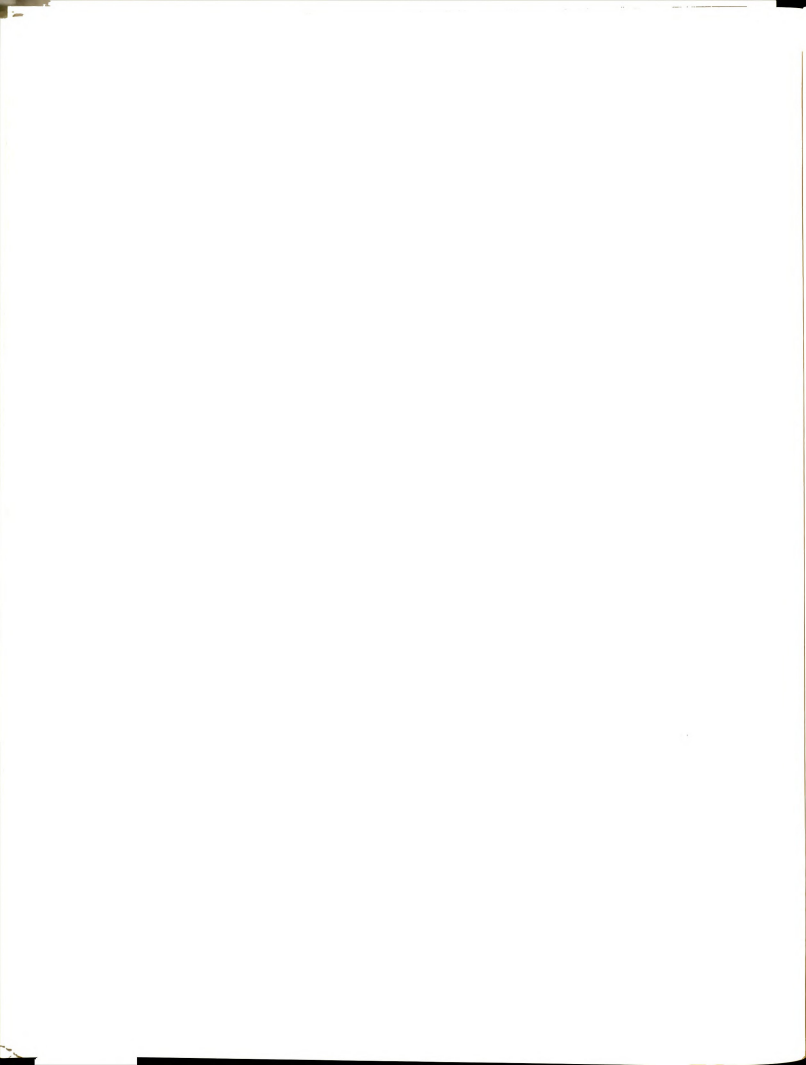


Figure 7.--Percentage of nurses who had and had not previously attended programs on or related to patient education that judged patient education staff should have supportive responsibility for planning or conducting patient education activities in selected content areas.



those in other professional groups as having major supportive roles in both planning and conducting patient education. In only one content area, orientation to hospital facilities and services, were patient education staff believed by a majority of those in other professional groups to have primary responsibility for both planning and conducting programs. Three-fifths of the patient educators themselves believed they should have primary responsibility for planning programs, but only 26.6% believed they should have primary responsibility for conducting them.

The greatest differences of opinion concerning the role of the patient education staff were between the physicians and patient education staff. The percentage of physicians believing that primary responsibility for planning patient education programs should reside with the patient education staff was only half as large as the percentage of patient education staff who believed they should have such responsibility.

The percentages of persons in all groups including physicians who ascribed patient education staff primary responsibility for conducting patient education programs were very similar, ranging only from 28.6% to 33.9%.

Roles Deemed Appropriate for Physicians

Primary role.--Approximately one-third of the total respondent group, as shown in Table 14, judged that physicians should have primary responsibility in the planning of patient education activities for hospital inpatients. One-fourth of the group believed that

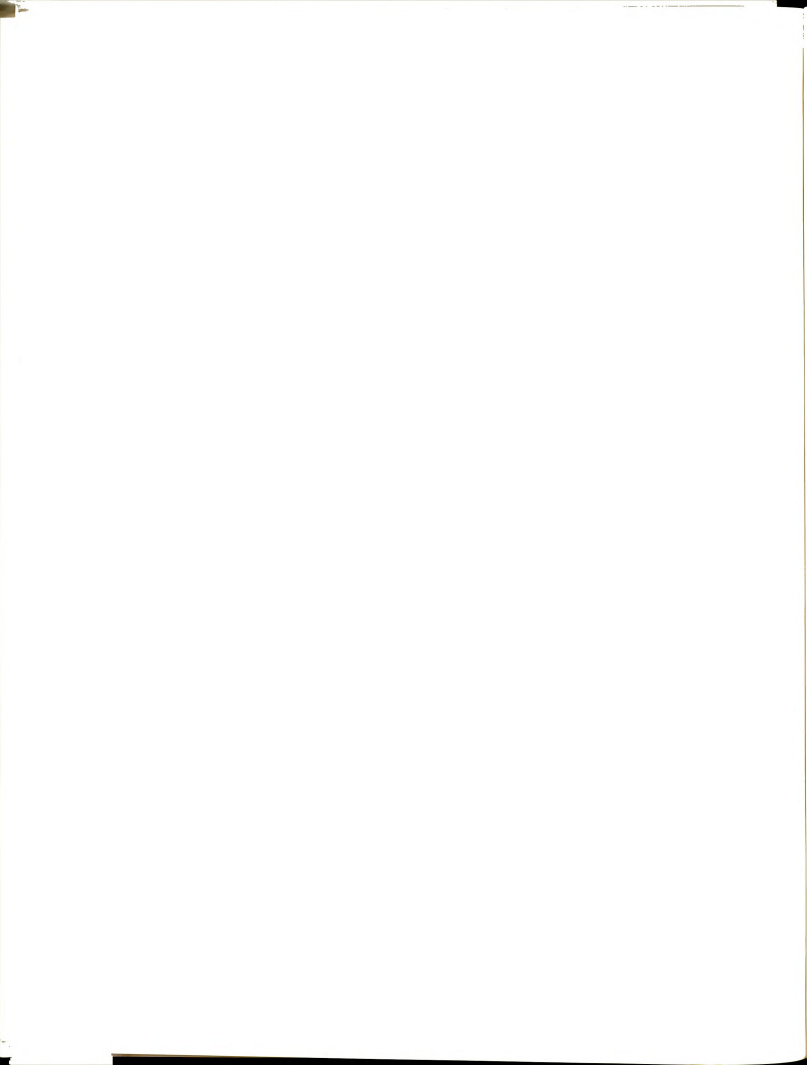
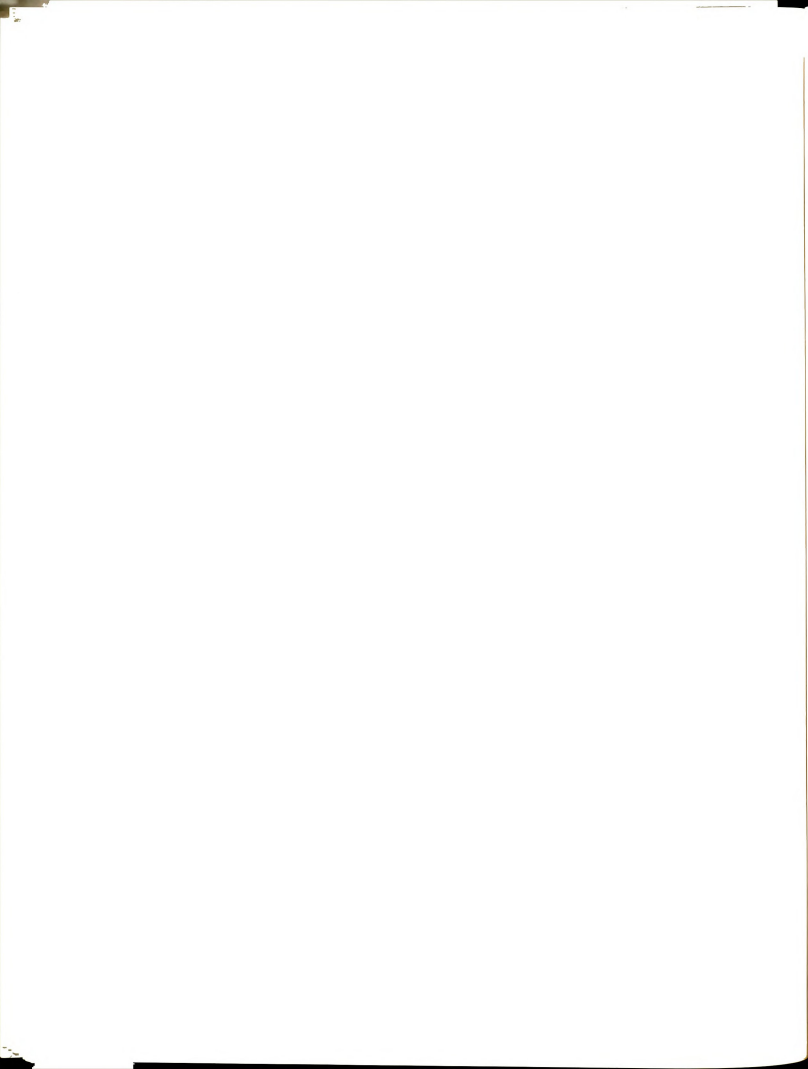
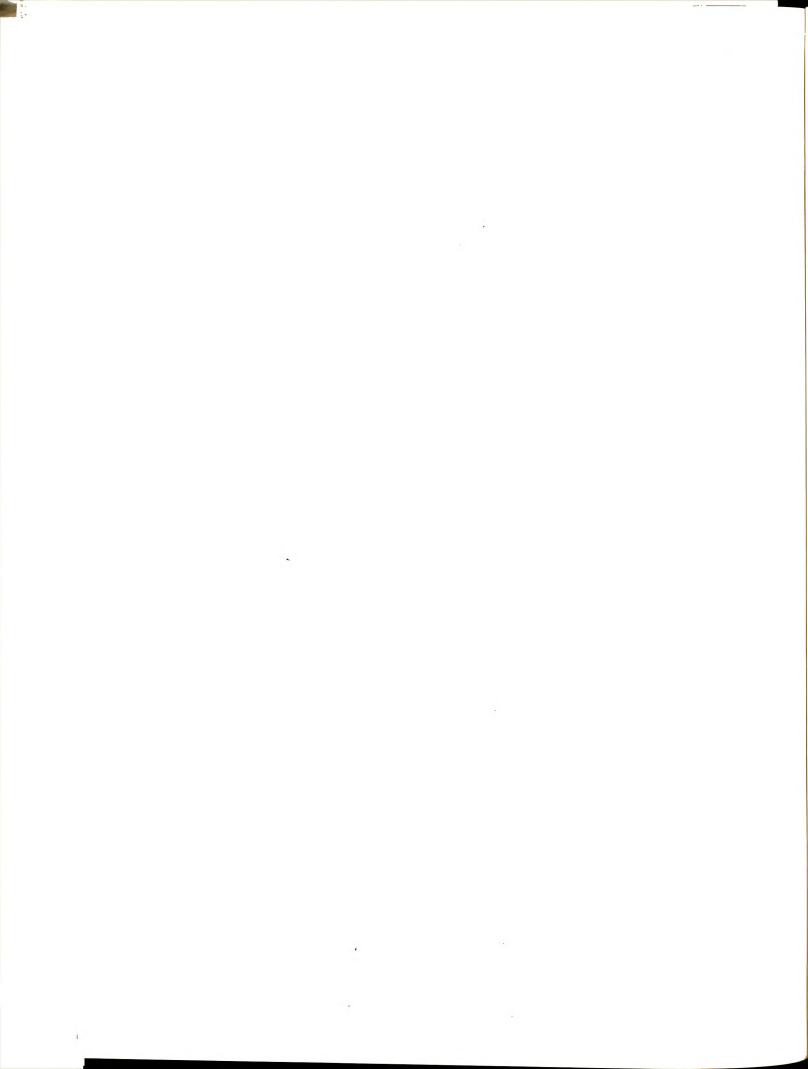


Table 14.--Percentage of physicians who judged that their own professional role should include primary responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that physicians should have such primary responsibilities.

Content Area	Function	Physicians N=259	Other Professional Groups					Total Respondent Group N=663
			Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=404	
Orientation to hospital facilities and services	Planning	15.4	5.6	7.2	15.4	11.1	6.8	10.1
	Conducting	5.8	4.9	5.1	.0	5.6	4.6	5.1
Explanation of diagnosis	Planning	82.9	76.2	81.4	92.3	100.0	79.5	80.8
	Conducting	78.6	75.6	83.7	92.3	94.4	79.4	79.1
Explanation of treatment	Planning	81.1	75.3	69.4	80.8	77.8	74.5	77.1
	Conducting	75.0	67.8	64.9	76.9	94.4	68.9	71.3
Teaching patients to administer own treatment	Planning	54.4	27.4	38.8	32.0	44.4	30.9	40.1
	Conducting	22.6	7.1	11.3	11.5	22.2	9.0	14.3
Teaching self-care independent living skills	Planning	31.4	9.7	17.7	30.8	27.8	13.9	20.7
	Conducting	8.9	3.4	5.2	12.0	5.6	4.4	6.1



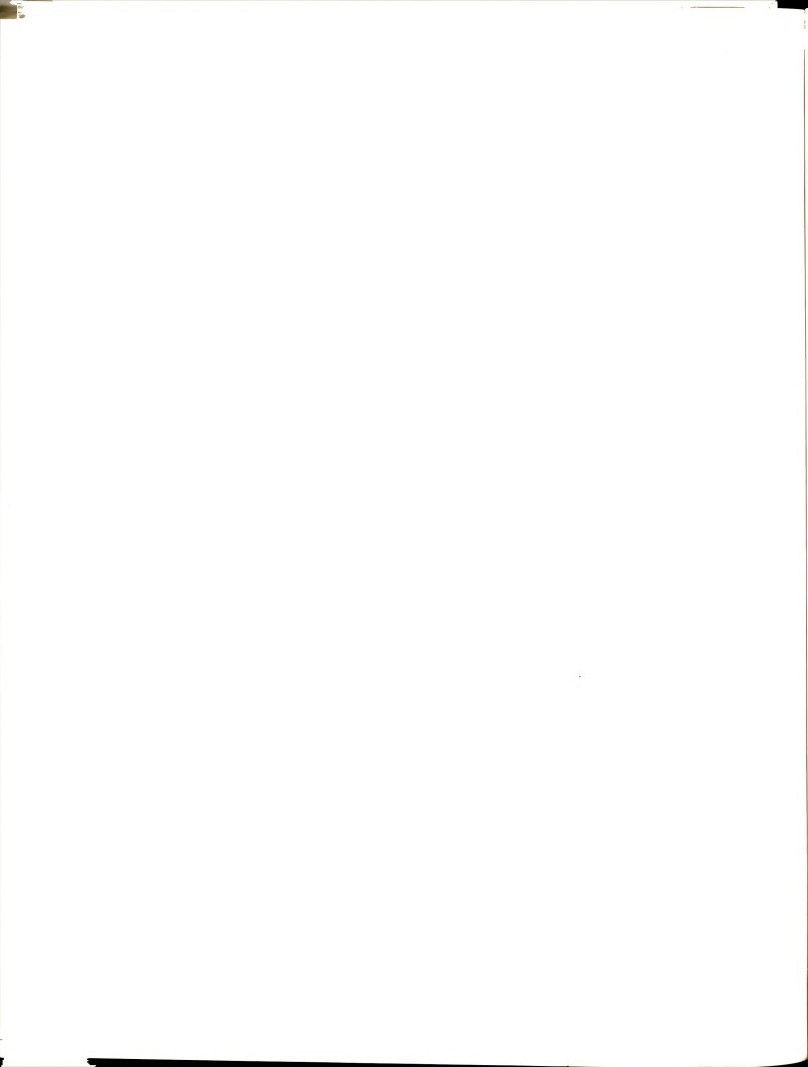
Content Area	Function	Physicians N=259	Other Professional Groups					Total Respondent Group N=663
			Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=404	
Teaching long- and short-term life style adjustment	Planning	37.7	16.5	20.6	32.0	27.8	19.1	26.2
	Conducting	14.8	4.9	6.1	16.0	11.1	6.4	9.6
Teaching about community resources	Planning	17.9	9.9	18.6	8.0	16.7	12.3	14.5
	Conducting	5.4	3.4	4.1	4.0	11.1	4.2	4.7
Teaching about financial management of health problem	Planning	9.0	3.1	10.8	8.0	5.9	5.6	6.9
	Conducting	4.4	2.0	7.4	4.0	.0	3.5	3.9
Teaching of general preventive medicine	Planning	64.3	47.9	63.3	56.0	66.7	53.1	57.2
	Conducting	39.1	27.0	35.1	52.0	55.6	31.9	34.6
Mean over nine areas	Planning	43.8	30.2	36.4	39.5	38.9	32.8	37.3
	Conducting	28.3	21.8	24.8	29.9	33.3	23.6	25.4



Physicians should have primary responsibility in the conducting of those activities. An especially large percentage (70 to 80%) of respondents in the five groups believed that physicians should have primary responsibility in both the planning and conducting of those areas of patient education involving explanation of diagnosis and general treatment for the health problem. A smaller but still major percentage (57.2%) believed that physicians should have primary responsibility for planning the teaching of general preventive medicine to inpatients.

Among the large group of physicians themselves, 43.8% judged that they should have primary responsibility for planning of patient education activities, in general, while 28.3% indicated that they should have primary responsibility for conducting those activities. An especially large percentage of physicians believed that they should have primary responsibility for four areas: both planning and conducting explanation of the diagnosis (82.9% and 78.6%, respectively), both planning and conducting explanation of the treatment (81.1% and 75%, respectively), planning for the teaching of general preventive medicine (64.3%), and planning for the teaching of patients to administer their own treatment (54.4%).

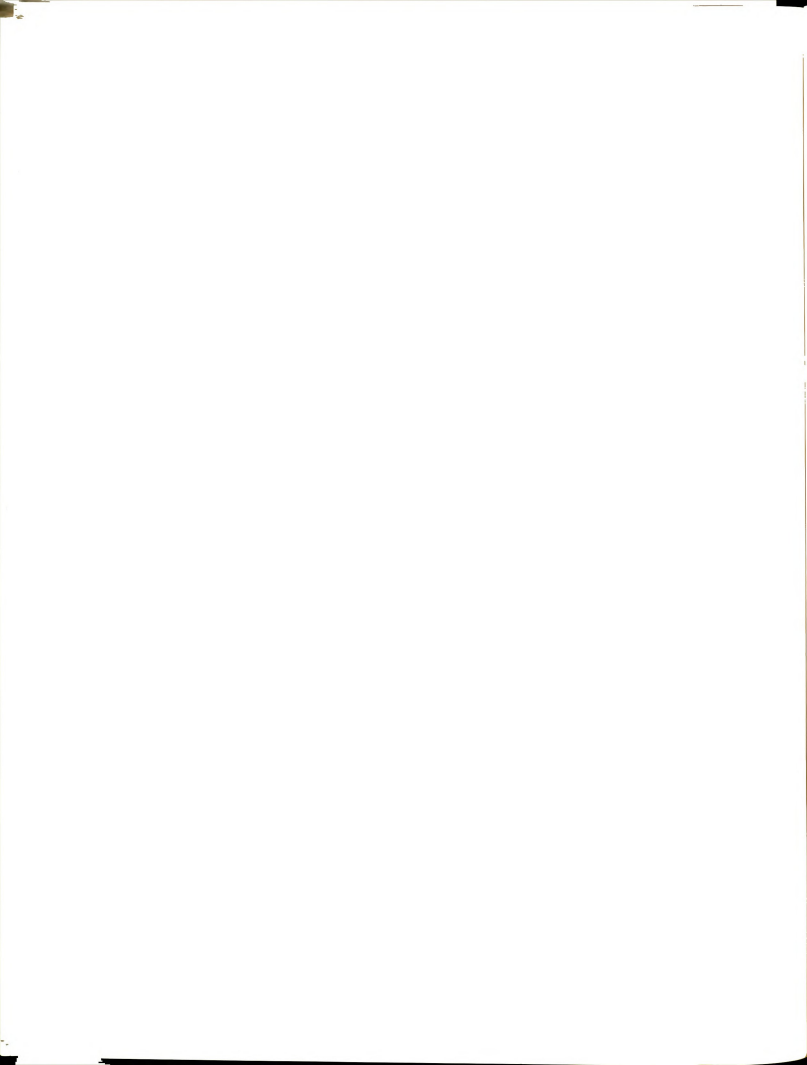
The judgments of the four other professional groups concerning the primary role of physicians in the planning of patient education activities were very similar within three of the four areas. In other areas there was not such strong agreement. Overall approximately one-third of respondents in the four groups, as compared to 43.8% of the physicians, believed that physicians should have primary



responsibility for planning of patient education activities. A somewhat lesser percentage of the nurses (21.8%) and allied health professionals (24.8%) and very similar percentages of patient education staff (29.9%) and hospital administrators (33.3%), as compared with 28.3% of physicians themselves, believed that physicians should have primary responsibility overall for conducting patient education activities.

Differences among the four groups, and between them and physicians, were noted in several specific areas. Principal differences appeared between nurses and physicians. A smaller percentage of nurses than of physicians, in every case, believed that physicians should have primary responsibility for planning and conducting patient education. The differences seem not to be significant in the four areas mentioned above. However, for five of the nine areas the percentage of nurses ascribing primary responsibility for planning to physicians is less than half of the percentage of physicians doing so. Similarly, in four of the content areas, the percentage of nurses ascribing primary responsibility to physicians for conducting patient education activities is less than half the percentage of physicians doing so.

Physicians defined roles for themselves that were different from roles defined for them by the other four professional groups. Approximately 10% more of the physicians (43.8%) than of the other professional groups collectively (32.8%) judged that their role should include primary responsibility for the planning of patient education activities. The major differences of opinion can be seen



in three of the content areas (teaching patients to administer own treatment, self-care independent living skills, and long- and short-term life style adjustments).

Although overall the physicians and the other four professional groups had similar beliefs about the primary responsibility of physicians in conducting of patient education activities, they did differ somewhat in one content area. Almost a fourth of the physicians judged they should have primary responsibility for conducting the teaching of patients to administer their own treatment, while only one-tenth of the other four professional groups responded in that way.

There was very little relationship between variance in definitions of the physician's role by any of the groups and either of two factors: the size of hospital where respondents practiced or whether the respondents practiced in hospitals with or without patient education programs.

A relationship was demonstrated between respondents' experience with formal patient education programs and variances in the total respondent group's and physicians' responses concerning the primary responsibility of physicians. A somewhat greater percentage of the total respondent group, as illustrated in Figure 8, who had experience with formal patient education programs than of those who did not judged that physicians should have a primary role in the planning of four of the content areas, namely explanation of diagnosis, teaching of self-care skills, teaching of life style changes, and teaching about community resources.



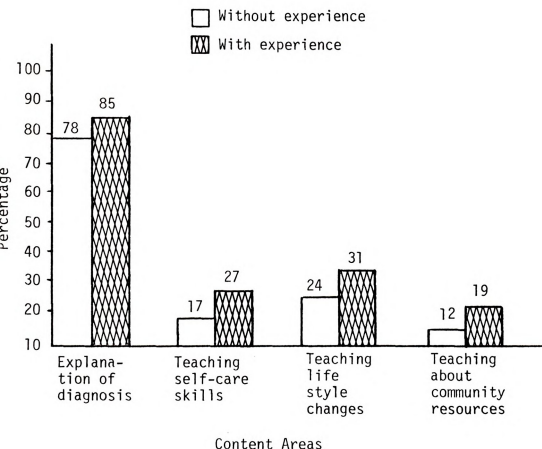
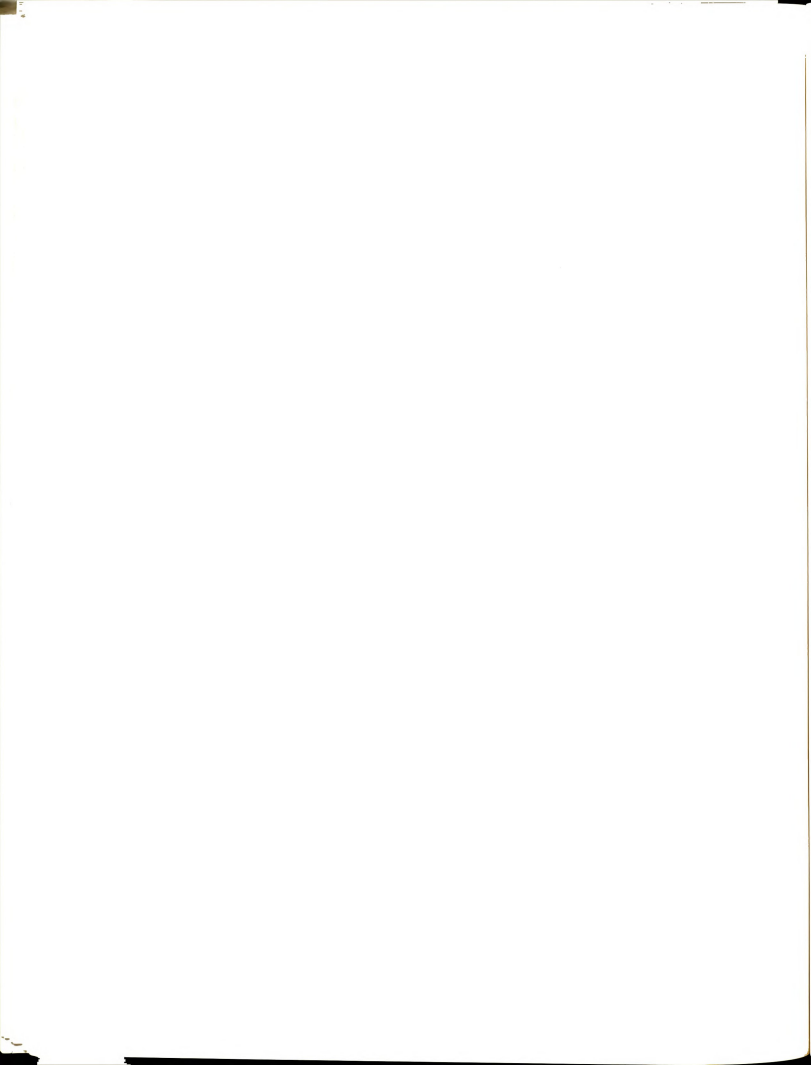


Figure 8.--Percentage of total respondent group with and without experience in formal patient education programs who judged that physicians should have primary responsibility for planning of patient education activities in selected content areas.



About 14% more of the total respondent groups with experience than of those without also believed that physicians should have primary responsibility for conducting one of the content areas, the teaching of preventive medicine.

A greater percentage of physicians, as illustrated in Figure 9, with experience in formal patient education programs than of those without such experience judged that they should have primary responsibility for planning three content areas (teaching patients to administer their own treatment, teaching life style adjustments, and teaching about community resources) and conducting of three content areas (teaching patients self-care skills, teaching life style adjustments, and teaching general preventive medicine). No other statistically significant relationships appeared to exist between the respondents' experience with patient education and their definitions of role for physicians.

There was also a relationship, as shown in Figure 10, between the physicians' previous attendance at programs on or related to patient education and their answers concerning their own primary role in patient education. Approximately 14% more of the physicians who had attended programs than of those who had not judged that they should have primary responsibility for three of the content areas, namely planning the teaching of self-care skills, planning the teaching about community resources, and conducting the teaching of preventive medicine. No other statistically significant relationships appeared to exist between respondents' previous attendance at programs on or related to patient education and their responses

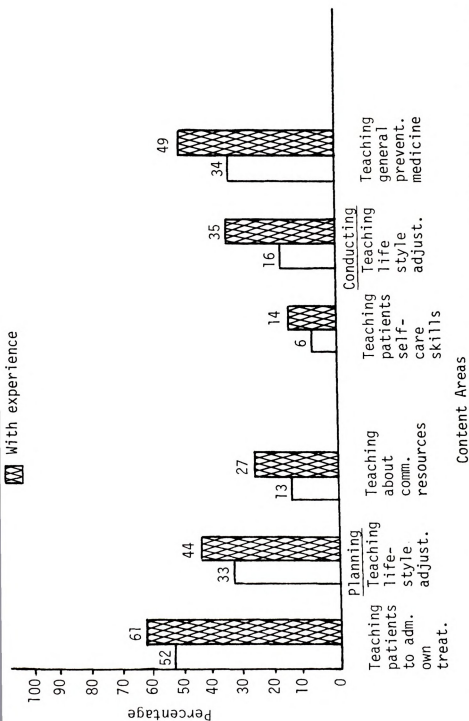


Figure 9.--Percentage of physicians with and without experience in formal patient education programs who judged that their own role should include primary responsibility for both planning and conducting of patient education activities in selected content areas.



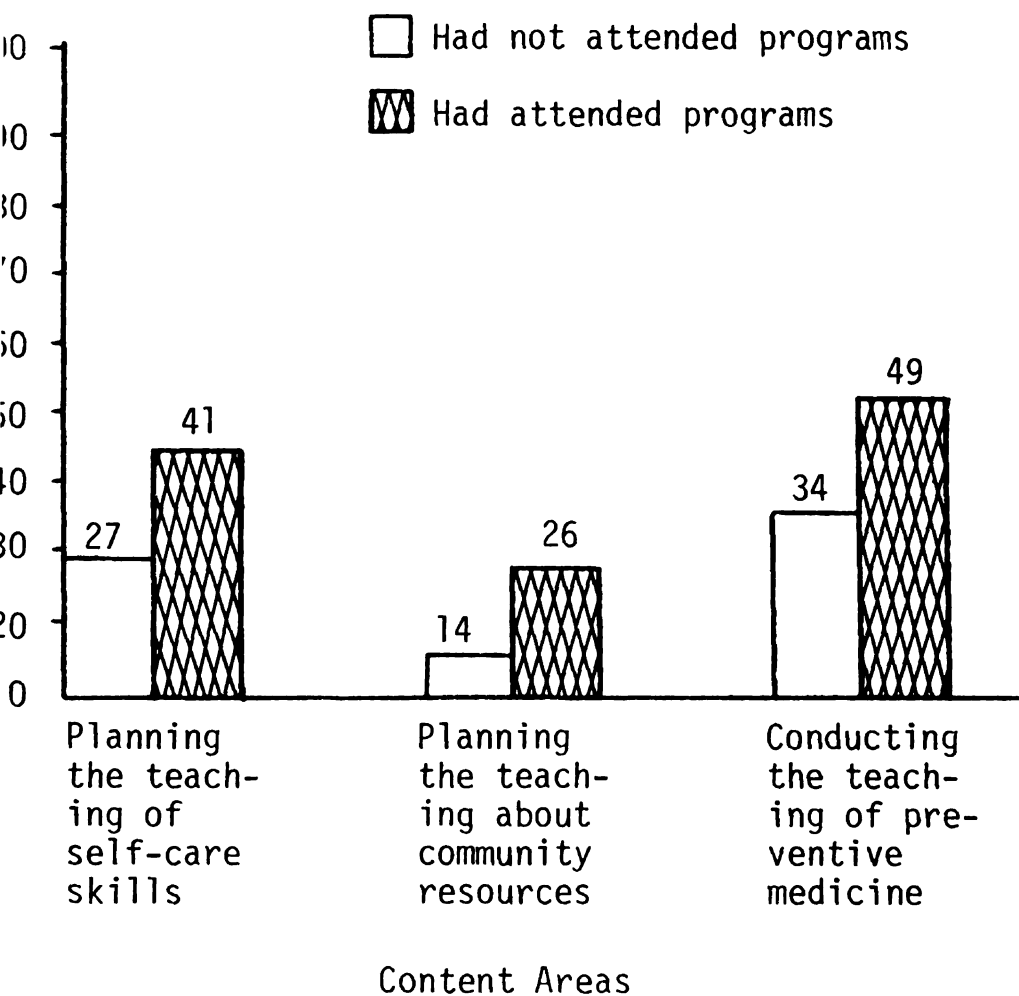


Figure 10.--Percentage of physicians who had and who had not attended programs on or related to patient education who judged that their own role should include primary responsibility for patient education activities in selected content areas.

erning responsibilities of physicians for planning or conducting patient education activities.

Supportive role.--Only a small percentage of the total respondent group, as shown in Table 15, judged that physicians should have supportive roles in planning and conducting patient education activities for hospital inpatients. Twelve point five percent believed they should have supportive responsibility for planning and 18.2% believed they should have such responsibility for conducting patient education activities.

Among the large group of physicians themselves, only 13% believed that they should have supportive responsibility for planning and 18.2% judged that they should have supportive responsibility for conducting patient education activities. The largest percentage of respondents (26.7%) believed they should have a supportive role in teaching residents to administer their own treatment.

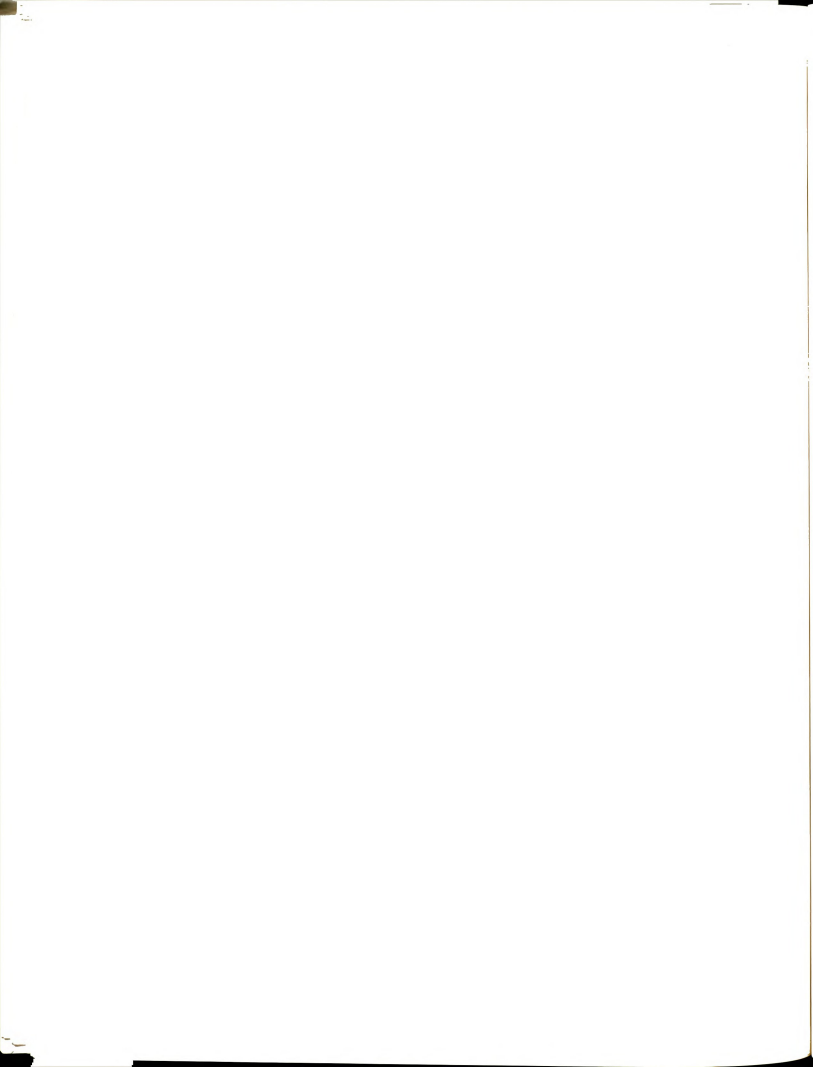
The judgments of the four other professional groups concerning the supportive role of the physicians in both the planning and conducting of patient education activities were very similar to those of the physicians. Twelve point one percent of the other respondents believed physicians should have a supportive responsibility for planning and 14% believed they should have such responsibility for conducting patient education activities.

There was no statistically significant relationship between respondents' judgments concerning the supportive role of the physicians and the size of hospital where they practiced, or whether they

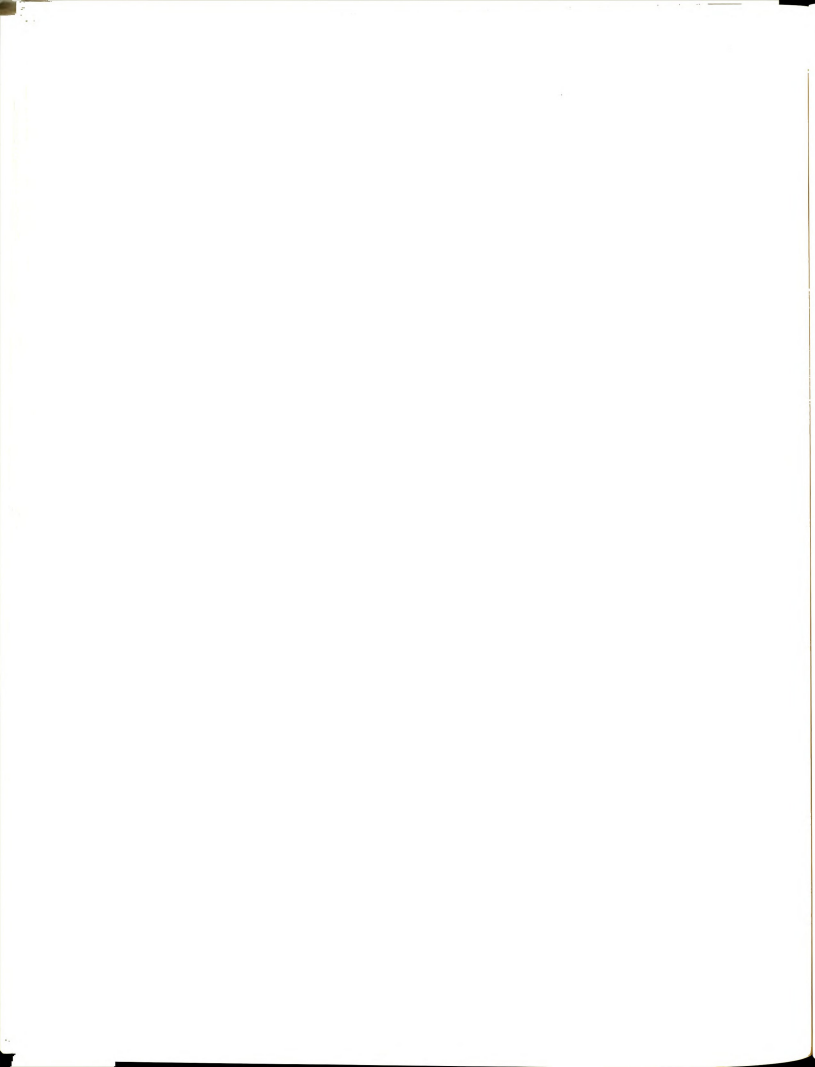


Table 15.--Percentage of physicians who judged that their own professional role should include supportive responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that physicians should have such secondary responsibilities.

Content Area	Function	Physicians N=259	Other Professional Groups					Total Respondent Group N=663
			Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=404	
Orientation to hospital facilities and services	Planning	17.0	14.6	13.4	23.1	16.7	14.8	15.6
	Conducting	18.5	10.9	13.3	23.1	16.7	12.7	14.9
Explanation of diagnosis	Planning	8.2	7.9	7.2	3.8	.0	7.1	7.5
	Conducting	8.2	6.5	7.1	3.8	5.6	6.4	7.1
Explanation of treatment	Planning	7.6	7.5	9.2	11.5	11.1	8.3	8.0
	Conducting	9.8	10.2	7.2	15.4	.0	9.3	9.5
Teaching patients to administer own treatment	Planning	13.7	12.9	13.3	12.0	16.7	13.5	13.6
	Conducting	26.8	18.7	23.7	23.1	33.3	21.1	23.3
Teaching self-care independent living skills	Planning	12.6	10.9	15.6	19.2	11.1	12.4	12.5
	Conducting	21.2	13.6	18.6	24.0	22.2	15.9	18.0



Content Area	Function	Physicians N=259	Other Professional Groups					Total Respondent Group N=663
			Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=404	
Teaching long- and short-term life style adjustment	Planning	15.5	11.5	18.6	16.0	22.2	14.1	14.6
	Conducting	21.4	14.3	24.5	20.0	22.2	17.6	19.1
Teaching about community resources	Planning	14.3	9.5	9.3	36.0	11.1	11.4	12.5
	Conducting	19.8	12.5	18.6	28.0	16.7	15.2	17.0
Teaching about financial management of health problem	Planning	15.5	14.8	12.9	24.0	23.5	15.4	15.5
	Conducting	16.1	14.5	14.9	28.0	35.3	16.4	16.3
Teaching of general preventive medicine	Planning	13.0	10.7	13.3	24.0	11.1	12.1	12.4
	Conducting	21.8	16.9	24.7	20.0	16.7	18.7	19.9
Mean over nine areas	Planning	13.0	11.1	12.5	18.8	13.7	12.1	12.5
	Conducting	18.2	13.1	17.0	20.6	18.7	14.8	16.1



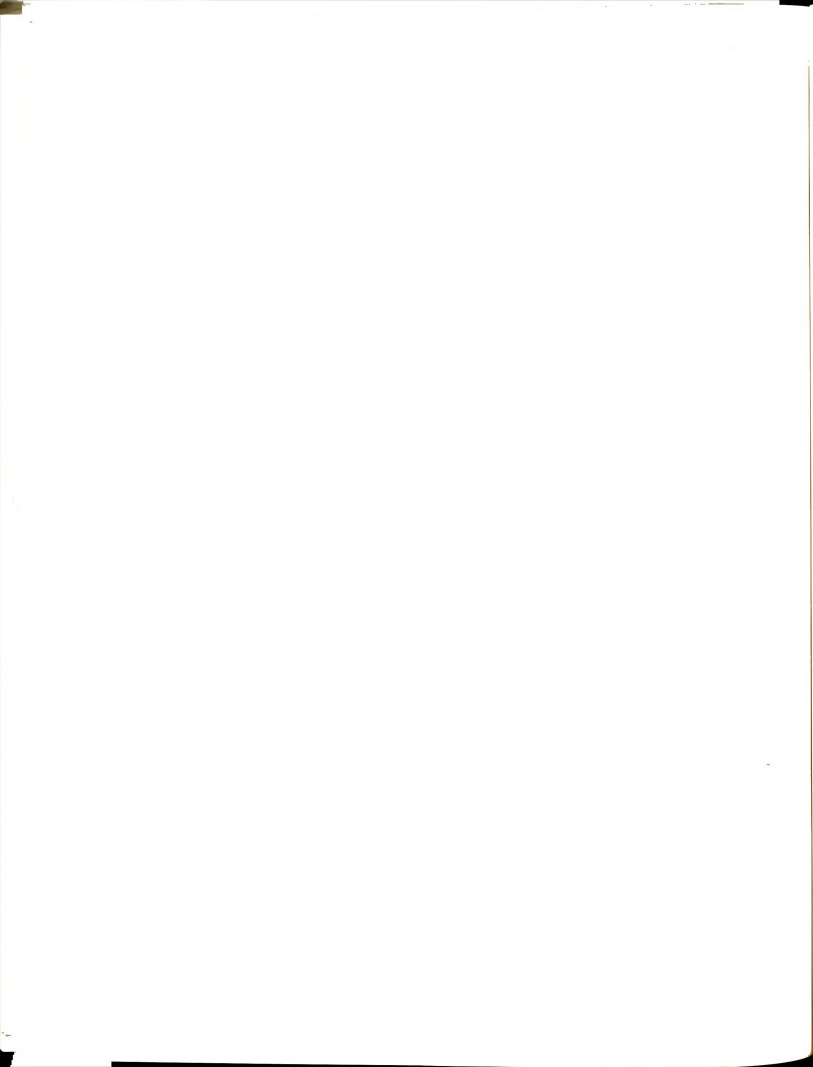
practiced in hospitals with or in hospitals without patient education programs.

A statistically significant correlation was demonstrated between the respondents' experience with formal patient education programs and their responses concerning that role. This relationship was seen in the responses of the total respondent group, the physicians, and the nurses, but not in those of the allied health professionals.

Approximately 9% more of the respondents, as illustrated in Figure 11, who had experience with formal patient education programs than of those who did not have such experience judged that physicians should have supportive responsibility for planning patient education activities in seven of the nine content areas, and 11% believed they should have supportive responsibility for conducting activities in six content areas.

A greater percentage of the physicians who had experience with formal patient education programs than of those who did not have such experience believed that they should have a supportive role in patient education activities. This was especially so in the conducting of patient education activities as pictured in Figure 12. From 13% to 19% more of the physicians with experience than of those without judged that they should have supportive responsibility for five of the nine content areas.

A somewhat greater percentage of the nurses, as illustrated in Figure 13, who had experience in formal patient education programs than of those who did not also judged that physicians should have a



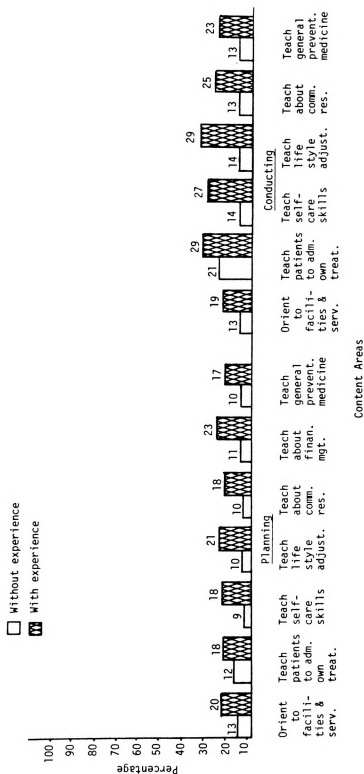
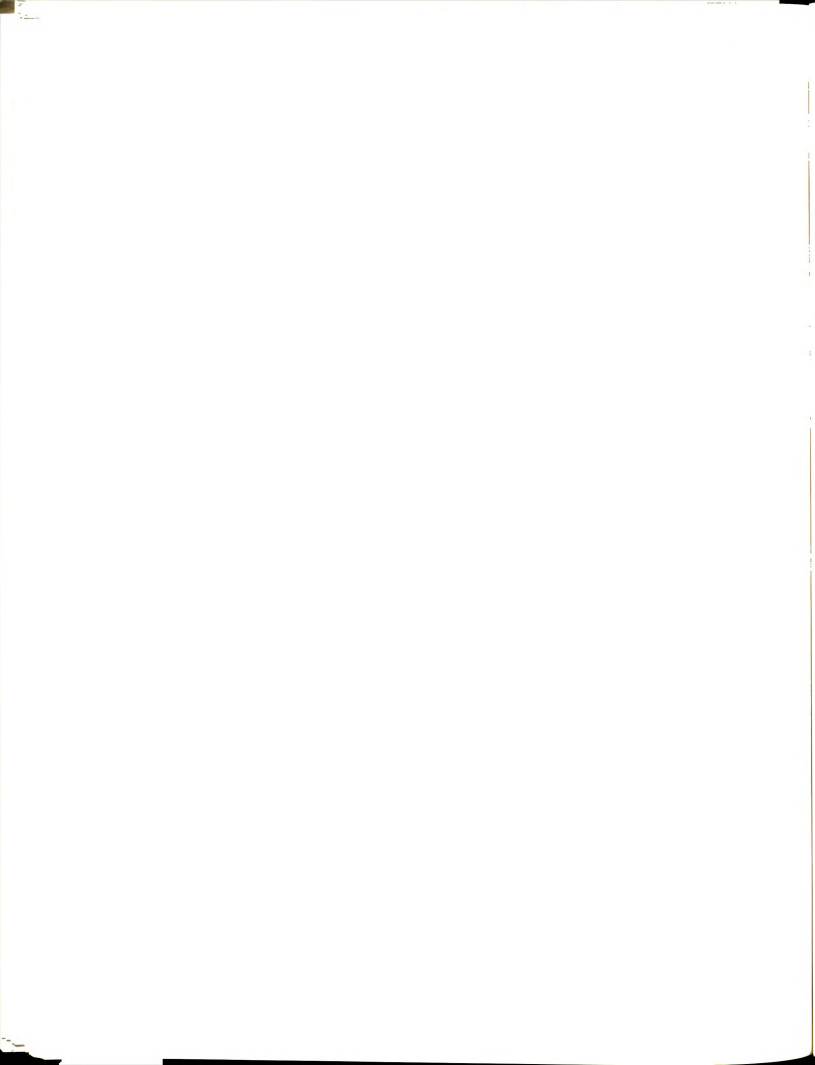


Figure 11.--Percentage of total respondent group with and without experience in formal patient education programs who judged that physicians should have supportive responsibility for planning and conducting patient education activities in selected content areas.



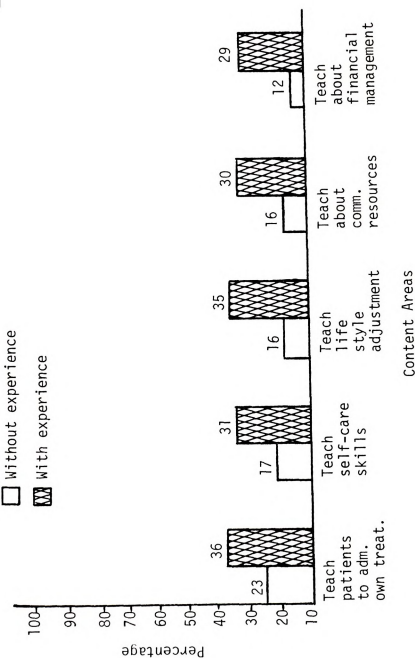
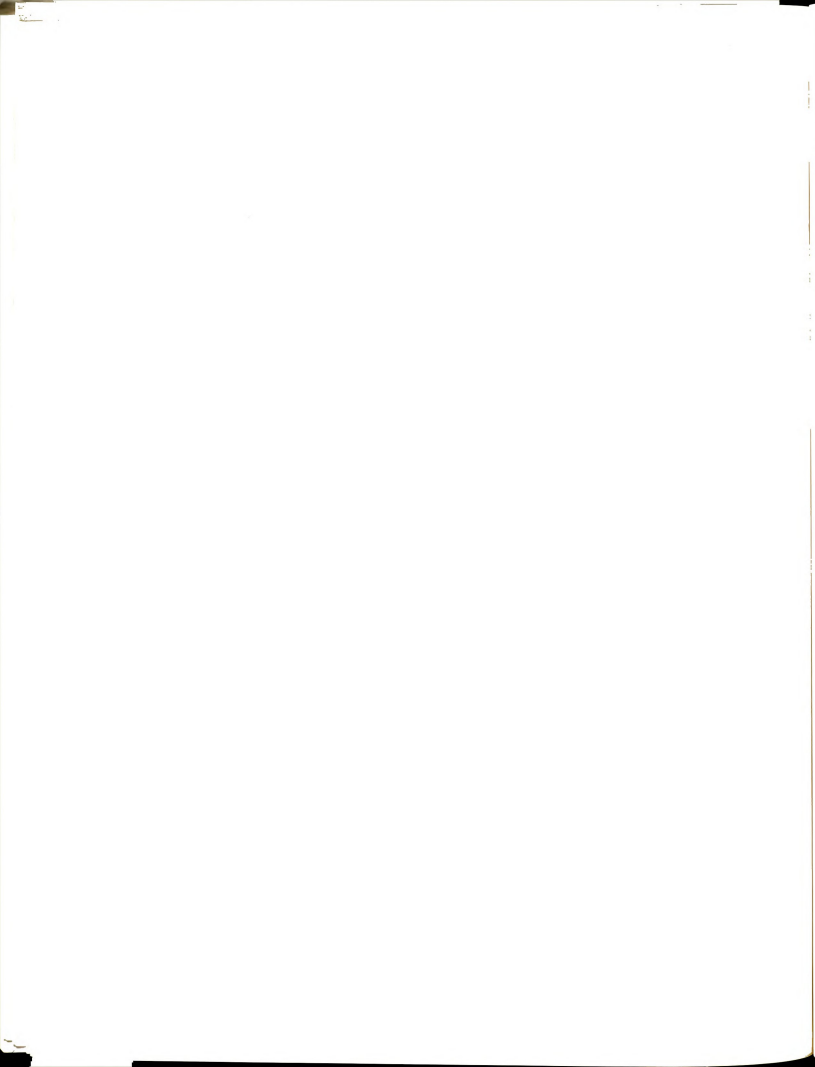


Figure 12.--Percentage of physicians with and without experience in formal patient education programs who judged that their role should include supportive responsibility for conducting patient education activities in selected content areas.



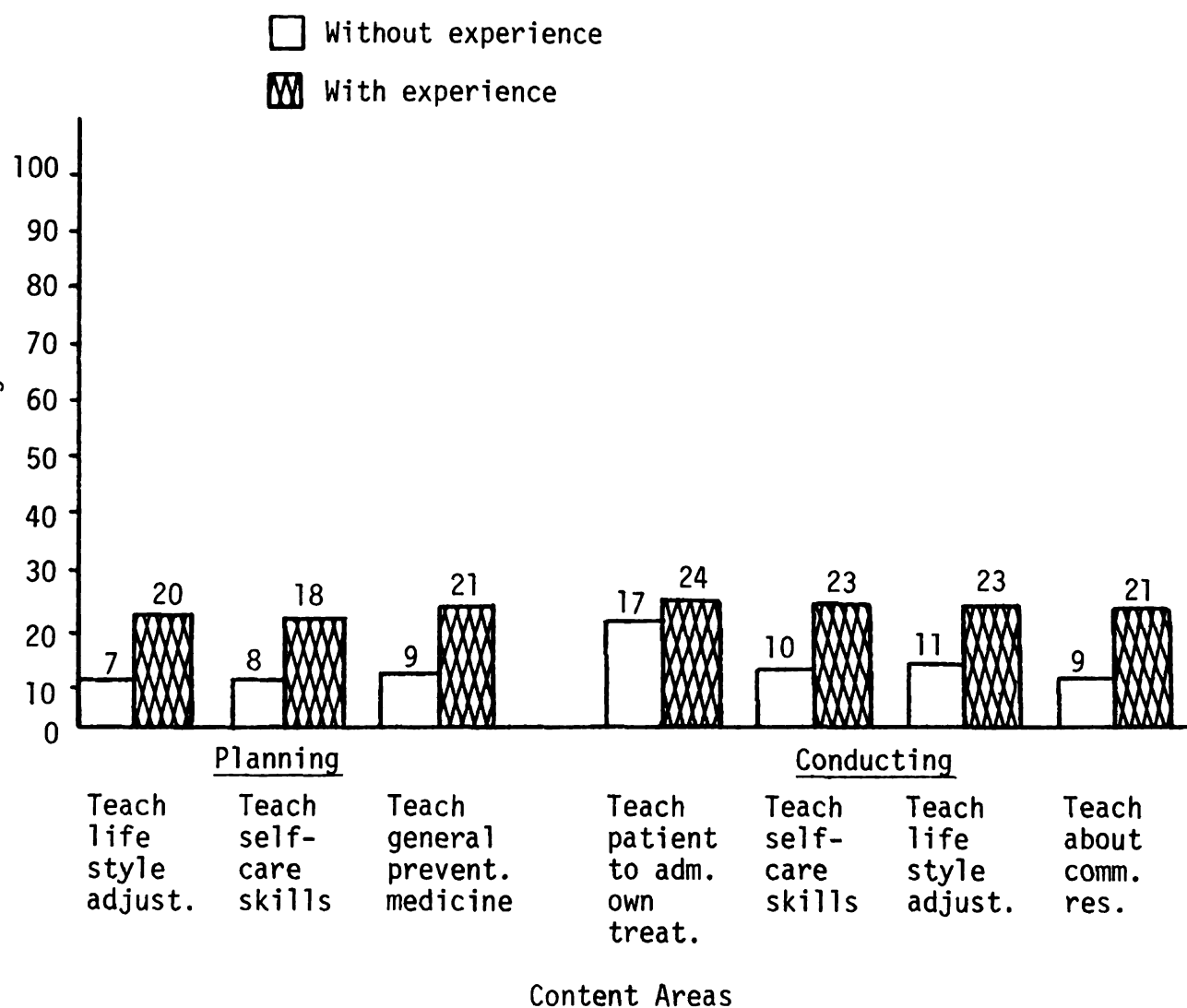
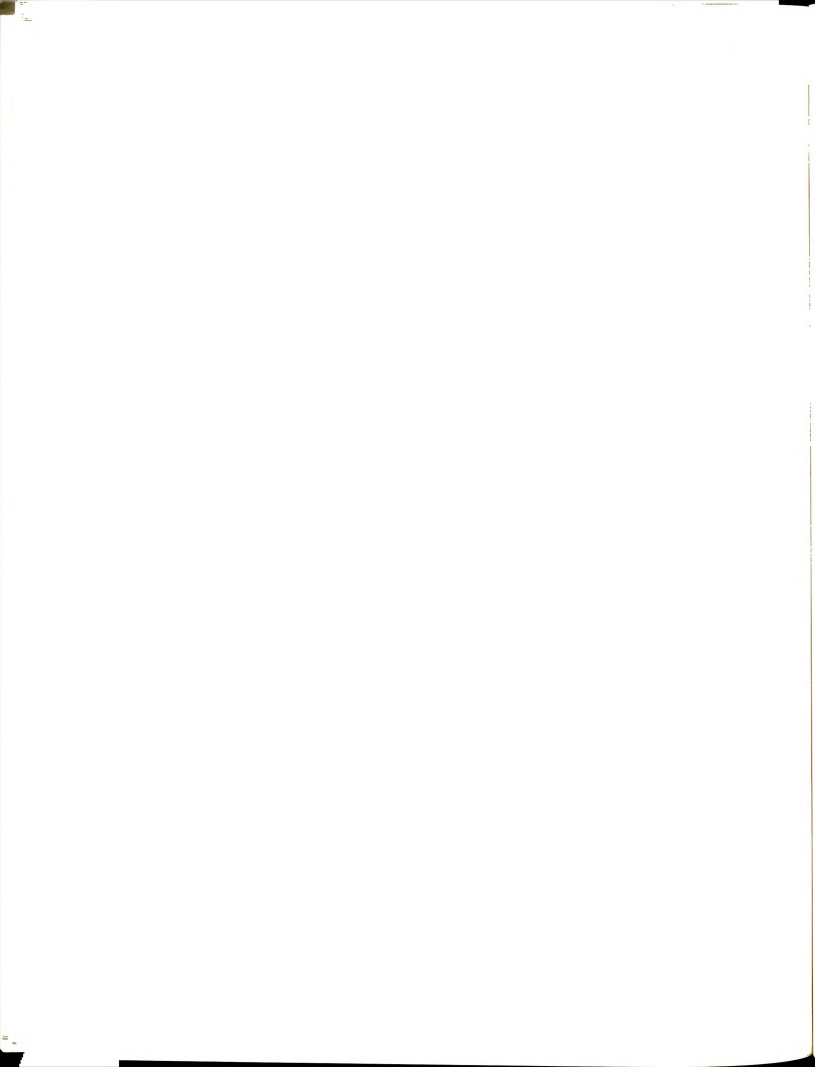


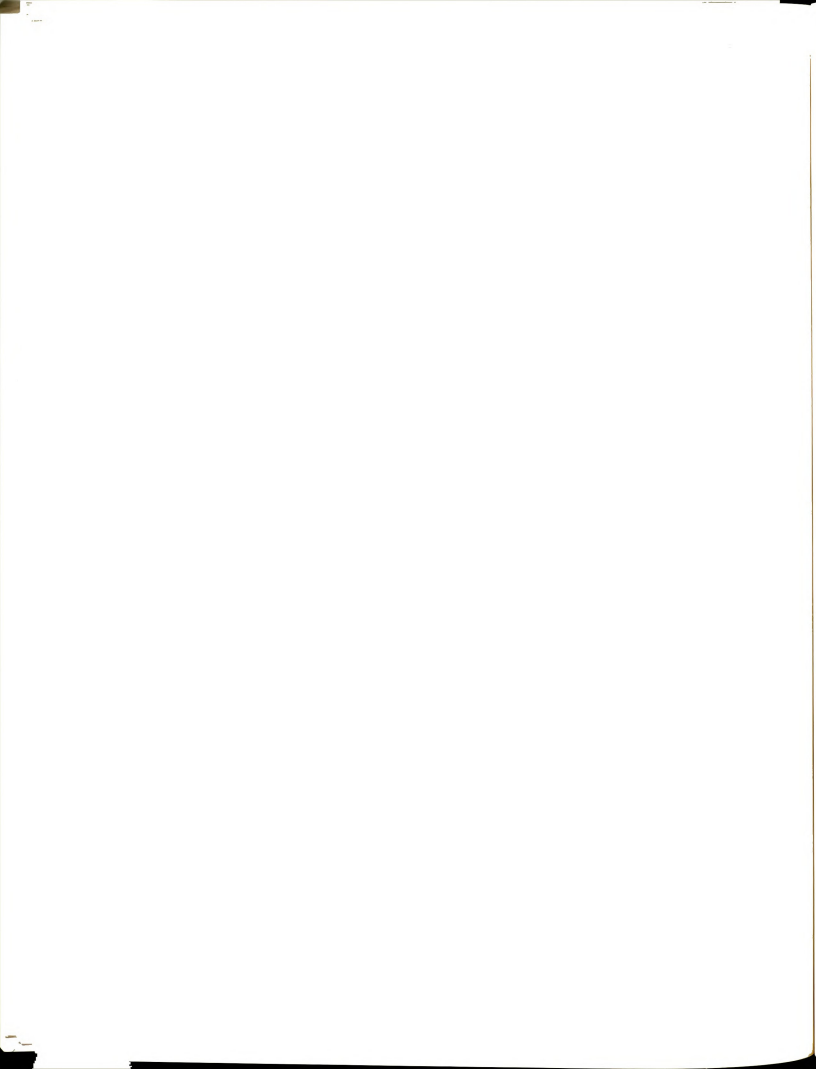
Figure 13.--Percentage of nurses with and without experience in formal patient education programs who judged that physicians should have supportive responsibility for planning and conducting patient education activities in selected content areas.



supportive role in planning and conducting patient education activities. Approximately twice as many nurses with experience than of those without experience had this opinion about physicians' supportive role for planning in three of the content areas and for conducting four of them.

Only within the total respondent group, as shown in Figure 1, was there a statistically significant relationship between whether the respondents had attended educational programs on or related to patient education and their responses concerning the supportive role of physicians. A somewhat greater percentage (approximately 8% more) of all respondents who had attended programs than of those who had not judged that physicians should have a supportive role in the conducting of patient education in three of the nine content areas, namely orientation to hospital facilities and services, teaching about community resources, and teaching financial management. When the sub-groups were analyzed individually, no statistically significant relationships appeared to exist between respondents' previous attendance at educational programs on or related to patient education and their responses concerning responsibilities of physicians for planning and conducting patient education activities.

In summary, physicians were believed by nearly one-third of professionals in other groups to have primary responsibility for the overall planning of patient education activities, and by nearly three-fourth of them to have primary responsibility for conducting such activities. They were seen by somewhat more than one-tenth of those in other professional groups as having major roles in both



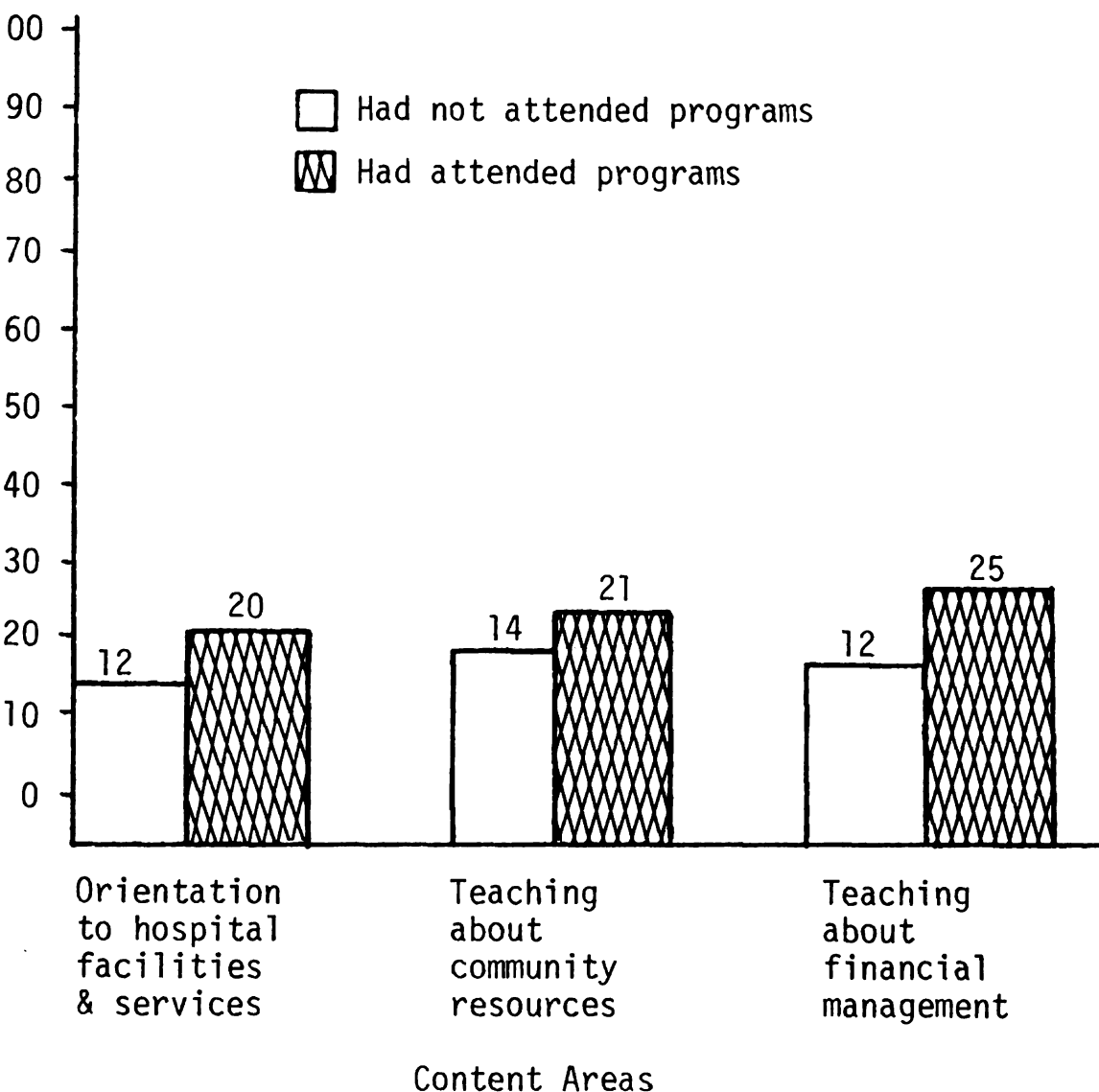


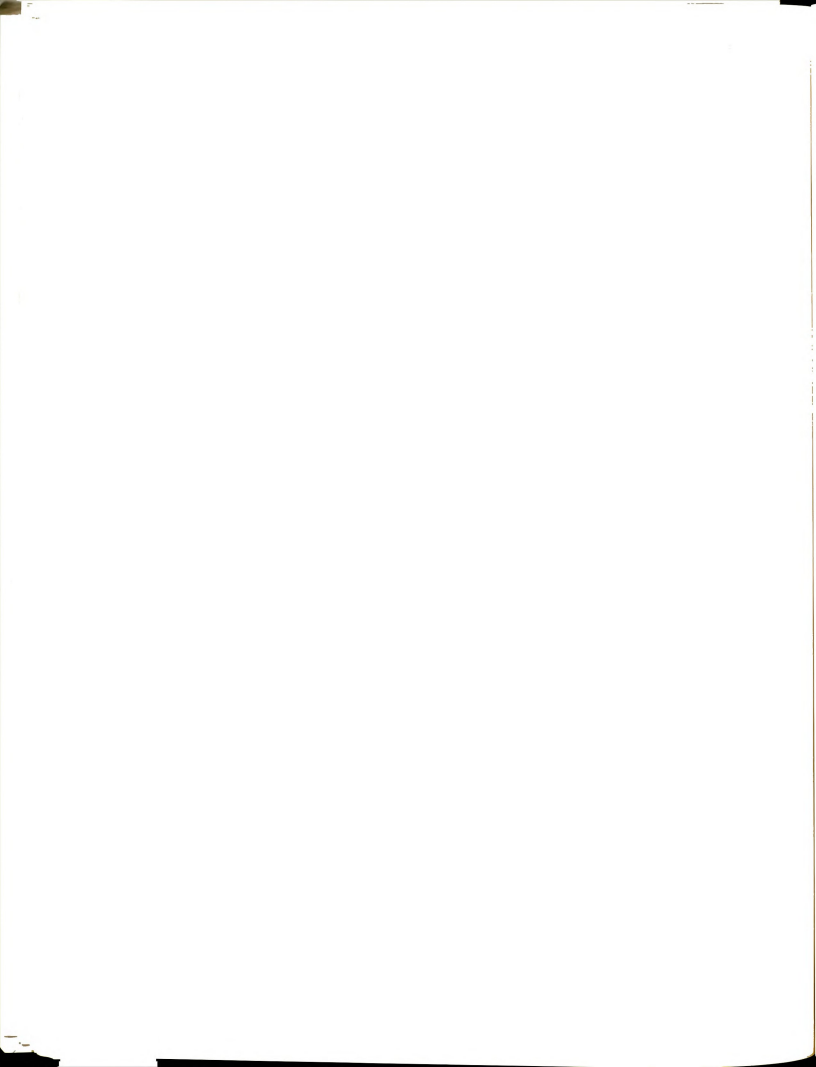
Figure 14.--Percentage of total respondent group who had and had not attended programs on or related to patient education who judged that the physician's role should include supportive responsibility for conducting patient education activities in selected content areas.



ning and conducting of patient education. In two content areas, explanation of diagnosis and explanation of treatment, physicians were ascribed by a large majority of those in other professional groups to have primary responsibility for both planning and conducting the activities. They were also believed by these professional groups to have primary responsibility for planning the teaching of general preventive medicine.

Over two-fifths of the physicians themselves believed they should have primary responsibility for planning programs, but only 30% believed they should have primary responsibility for conducting them. The physicians' opinions concerning their responsibility for the planning and conducting of the explanation of diagnosis and treatment and the conducting of general preventive medicine were similar to the opinions of the other four groups. Physicians believed they should have primary responsibility for the planning of teaching patients to administer their own treatment.

The greatest differences of opinion concerning the role of physicians were between the nurses and the physicians. The percentage of nurses believing that primary responsibility for planning and conducting patient education programs should reside with physicians was only half as large as the percentage of physicians who believed they should have such responsibility in at least half the content areas.



Roles Deemed Appropriate for Nurses

Primary role.--Approximately one-fourth of the total respondent group, as shown in Table 16, judged that nurses should have primary responsibility for planning patient education activities. About a third of the group believed they should have primary responsibility for conducting those activities. In one content area, teaching patients to administer their own treatment, a much larger percentage (69%) of the total respondent group judged that nurses should have primary responsibility for conducting patient education.

In defining their own role, about 30% of the nurses judged that they should have primary responsibility for planning, while 37% indicated that they should have primary responsibility for conducting patient education activities. About half of the nurses believed they should have primary responsibility in three areas: both planning and conducting the teaching of self-care independent living skills, planning for teaching patients to administer their own treatment, and conducting the teaching of general preventive medicine. Almost three-fourths of the nurses judged that they should have primary responsibility for conducting the teaching of patients to administer their own treatment.

Of the other four groups, allied health professionals and hospital administrators were most nearly in agreement with the nurses about the overall role of the nurses. About 22% of the allied health professionals and 27% of the hospital administrators believed that nurses should have overall primary responsibility for planning patient education activities, and approximately 30% of

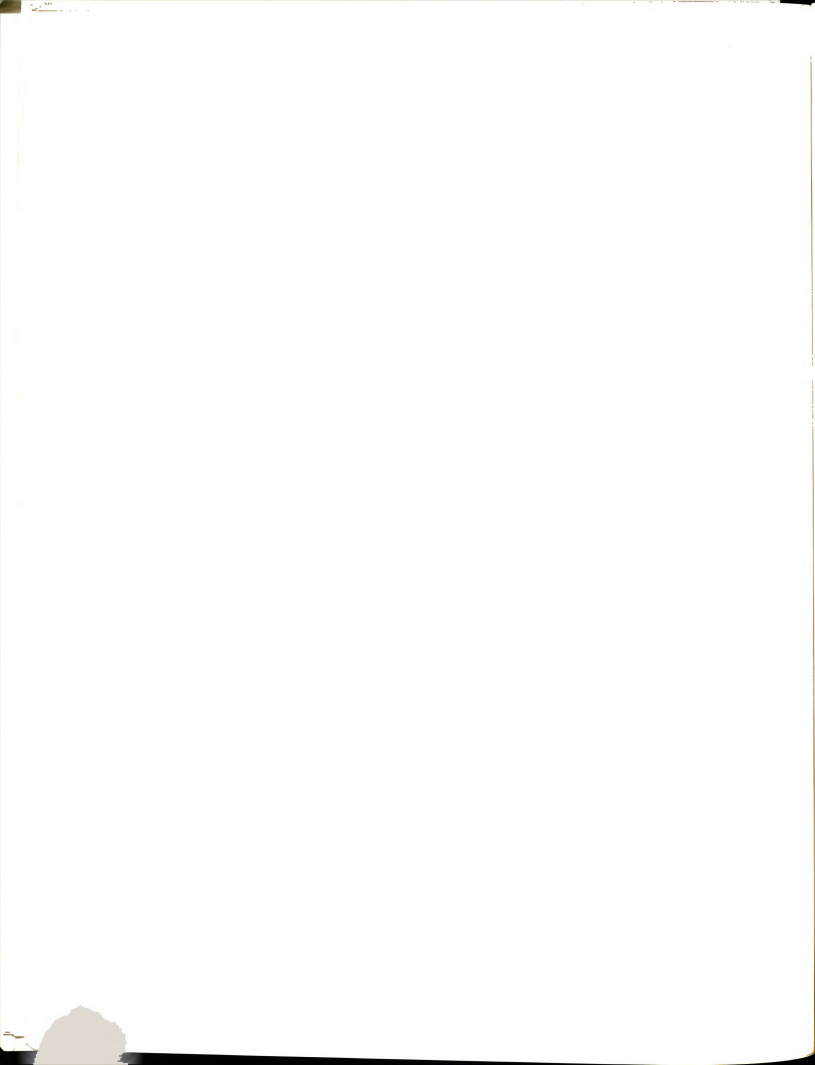


Table 16.--Percentage of nurses who judged that their professional role should include primary responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that nurses should have such primary responsibilities.

Content Area	Function	Nurses N=263	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=400	
Orientation to hospital facilities and services	Planning	20.7	14.2	13.3	30.8	38.9	16.3	18.0
	Conducting	40.1	23.6	28.1	64.0	61.1	29.4	33.6
Explanation of diagnosis	Planning	15.0	10.9	12.4	34.6	27.8	13.4	14.1
	Conducting	18.1	13.3	12.4	30.8	16.7	14.2	15.8
Explanation of treatment	Planning	23.1	12.3	23.7	44.0	33.3	17.8	19.9
	Conducting	29.1	17.4	24.5	52.0	27.8	21.6	24.6
Teaching patients to administer own treatment	Planning	56.0	25.8	40.8	56.0	50.0	41.4	47.2
	Conducting	73.8	32.8	64.9	69.2	77.8	65.9	69.0
Teaching self-care independent living skills	Planning	48.5	25.8	35.4	50.0	44.4	30.4	37.6
	Conducting	54.5	32.8	45.3	69.2	55.6	39.5	45.5

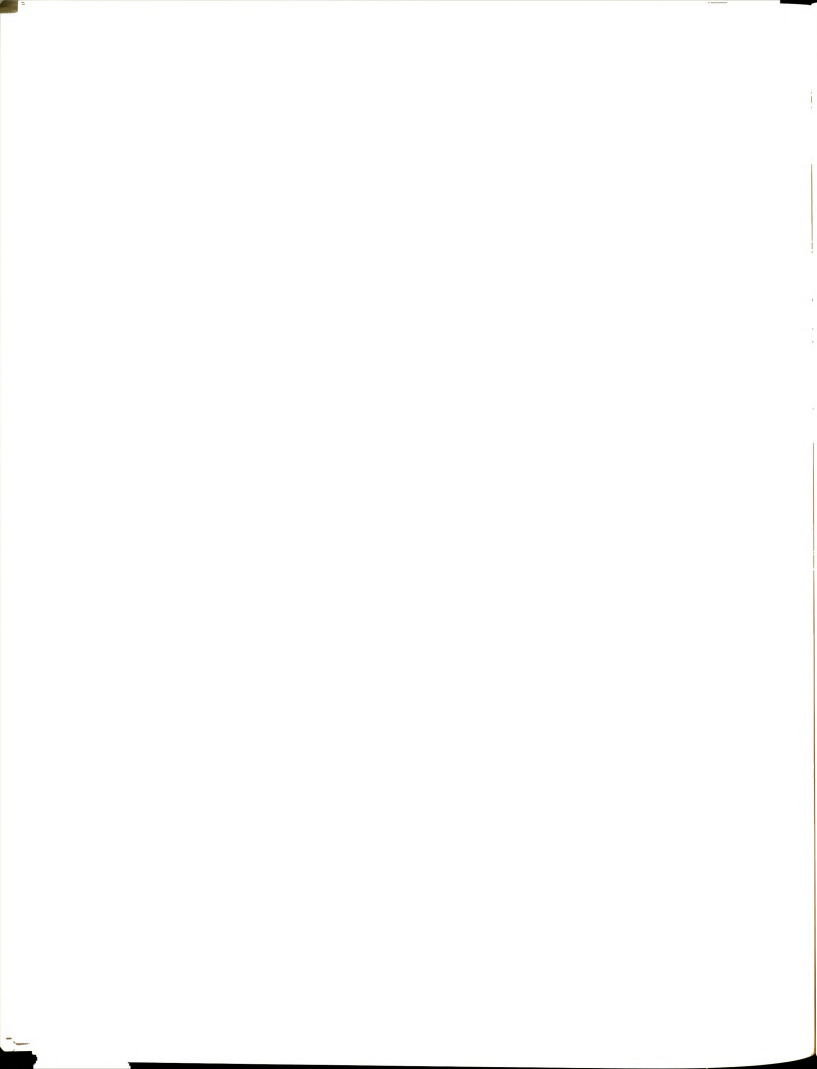


Table 16.--Continued.

Content Area	Function	Nurses N=263	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=400	
Teaching long- and short-term life style adjustment	Planning	27.1	12.5	16.3	45.8	16.7	15.5	20.1
	Conducting	35.6	18.4	24.5	68.0	22.2	23.1	28.1
Teaching about community resources	Planning	19.0	8.6	16.5	32.0	11.1	12.0	14.8
	Conducting	20.4	13.0	18.6	37.5	.0	15.2	17.2
Teaching about financial management of health problem	Planning	8.0	2.0	8.5	12.0	.0	4.1	5.7
	Conducting	6.0	2.0	9.7	8.0	.0	4.2	4.9
Teaching of general preventive medicine	Planning	40.0	19.9	29.6	48.0	23.5	24.4	30.7
	Conducting	56.1	30.2	39.2	80.0	22.2	35.5	43.8
Mean over nine areas	Planning	29.7	14.7	21.8	39.2	27.3	19.4	23.1
	Conducting	37.0	20.4	29.7	53.2	31.5	27.6	31.4

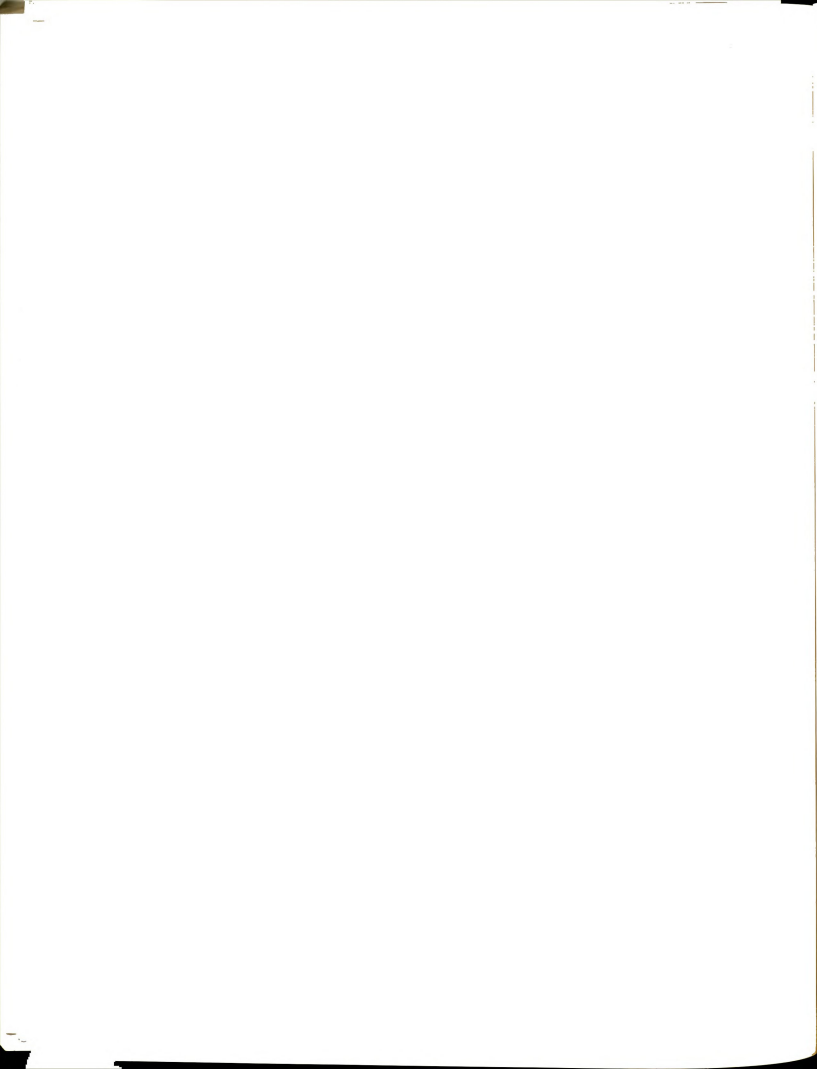


Both groups believed they should have such responsibility for conducting those activities. Like the nurses, a large percentage of both the allied health professionals (64.9%) and hospital administrators (77.8%) judged that nurses should have primary responsibility for conducting the teaching of patients to administer their own treatment. The two groups' opinions differed slightly from those of the nurses concerning some of the other content areas, but no major differences were apparent.

The principal differences of opinion appeared between the physicians and the nurses, and between the patient education staff and the nurses.

Only about 15% of the physicians, as compared to 29.7% of the nurses, judged that nurses should have overall primary responsibility for planning of patient education activities and only 20% of the physicians, in comparison to 37% of the nurses, judged that nurses should have overall primary responsibility for conducting those activities. In none of the specified content areas did a majority of physicians believe that nurses should have primary responsibility for either planning or conducting patient education.

With respect to planning within the selected content areas, less than one-half as large a percentage of physicians as of nurses, in general, ascribed primary responsibility to the nurses. Although the percentages varied, this difference was significant and consistent across all of the nine content areas.



With respect to primary responsibility for conducting patient education in the selected content areas, the differences between physicians and nurses were similar to those related to planning, though even greater difference existed for one of the content areas, teaching patients to administer their own treatment.

It appears that physicians do not see a very important primary role for nurses, especially in the planning of patient education activities.

Approximately 40% of the patient education staff judged that nurses should have primary responsibility for planning patient education activities and about half judged that they should have such responsibility for conducting those activities. An especially large percentage of patient education staff (80%) believed that nurses should have primary responsibility for conducting the teaching of preventive medicine, while from 64% to 69% believed that they should have primary responsibility for conducting teaching in four additional areas: orientation to hospital facilities and services, teaching patients to administer their own treatment, teaching patients self-care independent living skills, and teaching long- and short-term life style adjustments. Close to half of the patient education staff also believed that nurses should have primary responsibility for conducting the explanation of treatment and for planning in three other areas: teaching patients to administer their own treatment, teaching self-care independent living skills, and teaching of general preventive medicine.



With respect to planning, patient education staff believed nurses should have a greater responsibility than did the nurses for six of the nine content areas. The differences were most apparent in the planning for conducting of explanation of diagnosis and treatment, where about twice as large a percentage of patient education staff as of nurses ascribed primary responsibility to the nurses.

With respect to primary responsibility for conducting patient education, the differences were somewhat greater. In general, the patient education staff ascribed a greater primary responsibility to the nurses than did the nurses themselves. Although the percentages varied, these differences were significant and consistent for eight of the nine content areas. In the ninth area, teaching patients to administer their own treatment, patient education staff and nurses were in very close agreement.

It appears that patient education staff saw an important role for nurses, and that their definition of that role was more primary than the role nurses defined for themselves.

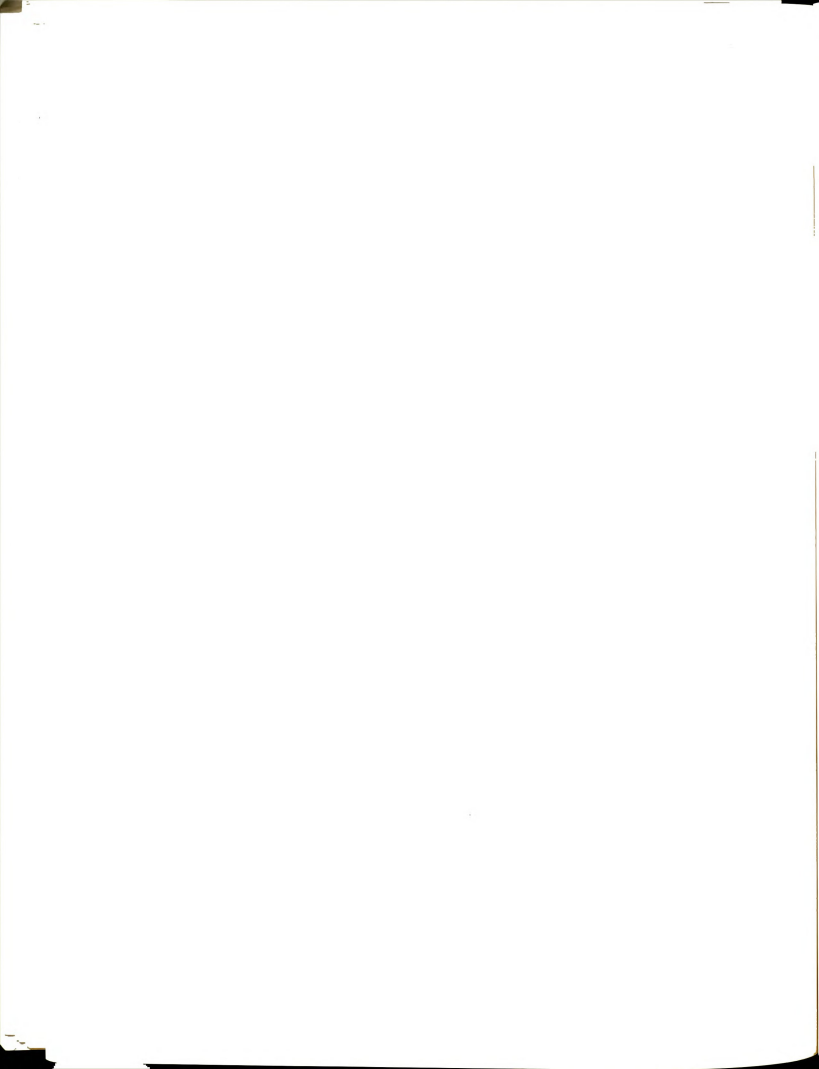
In summary, nurses defined roles for themselves that were different from roles defined for them by the other four professional groups, especially those defined by physicians and the patient education staff. Approximately 10% more of the nurses than of the other four professional groups collectively judged that they should have an overall primary responsibility for both planning and conducting of patient education activities. Their major differences of opinion were seen in three of the content areas (teaching self-care independent living skills, long- and short-term



life style adjustments, and general preventive medicine). A much greater percentage of nurses than of physicians believed they should have primary responsibility for both the planning and conducting of patient education activities. In contrast, a much lesser percentage of nurses than of patient education staff had this opinion, especially in relationship to the conducting of patient education activities.

There was very little relationship between definitions of the primary role of the nurse by any of the groups and three of the factors: (1) the size of hospital there they practiced, (2) whether they practiced in hospitals with or without patient education programs, or (3) whether they had attended educational programs on or related to patient education.

There was a significant relationship demonstrated between the respondents' experience with formal patient education programs and their answers concerning the nurses' role. This was seen in the responses of the total respondent group, physicians, nurses, and allied health professionals. About 13% more of the total respondents, as illustrated in Figure 15, who had experience with formal patient education programs than of those who did not have such experience judged that nurses should have primary responsibility for both planning and conducting patient education activities. This was apparent in all content areas for planning patient education activities and in all but one of the content areas for conducting those activities.



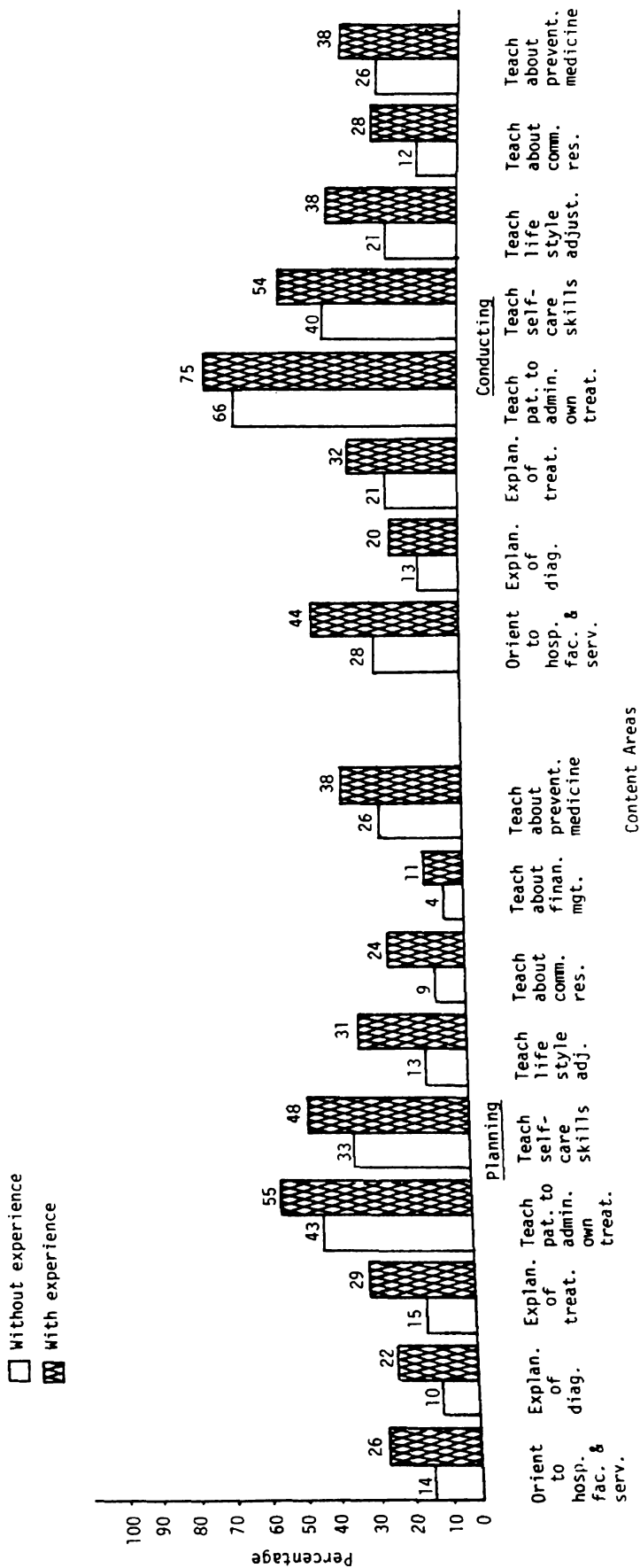


Figure 15.--Percentage of total respondent group with and without experience in formal patient education programs who judged that nurses should have supportive responsibility for planning and conducting patient education activities in selected content areas.



A much larger percentage of the nurses who had experience with formal patient education programs than of those who did not have such experience judged that their own role should include primary responsibility for both planning and conducting patient education activities. As shown in Figure 16, approximately 26% more of the nurses with than of those without experience believed they should have a primary role in planning, and 20% more of those with than of those without experience believed that they should have a primary role in conducting patient education activities. The differences of opinion among the nurses were especially apparent in regard to planning for teaching patients self-care skills and life style adjustment, and to conducting of teaching patients self-care skills.

As shown in Figure 17, a somewhat greater percentage of physicians (approximately 9% more) with experience in formal patient education programs than of those without such experience judged that nurses should have primary responsibility for planning patient education activities in five of the nine content areas. No differences in opinion among the physicians were noted concerning the nurses' primary role in the conducting of the activities in relationship to this variable.

Approximately 11% more of the allied health professionals, as illustrated in Figure 18, with experience than of those without judged that nurses should have primary responsibility for planning three of the nine content areas, and 16% more of those with experience judged that nurses should have primary responsibility in



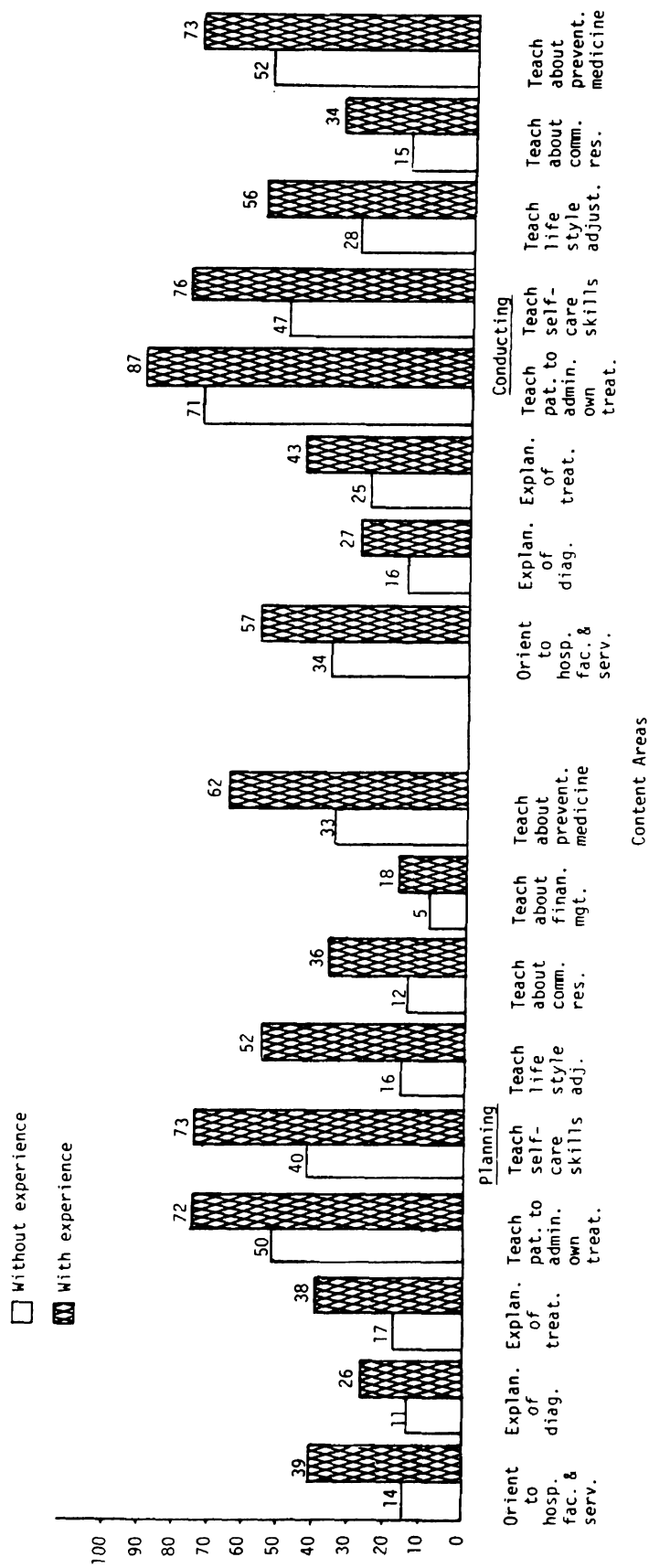


Figure 16.--Percentage of nurses with and without experience in formal patient education programs who judged that their role should include primary responsibility for planning and conducting patient education activities in selected content areas.



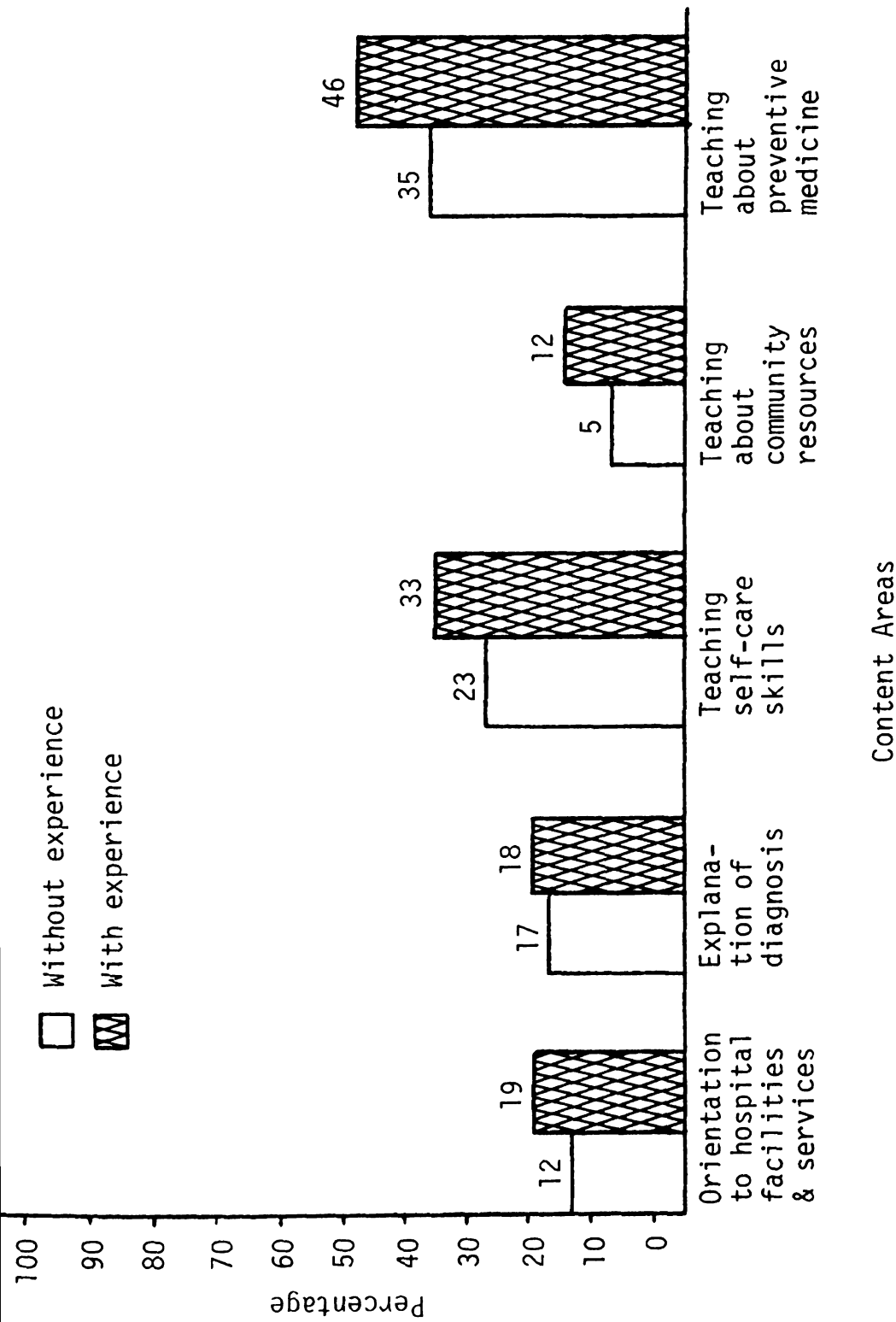


Figure 17.--Percentage of physicians with and without experience in patient education programs who judged that nurses should have primary responsibility for planning patient education activities in selected content areas.



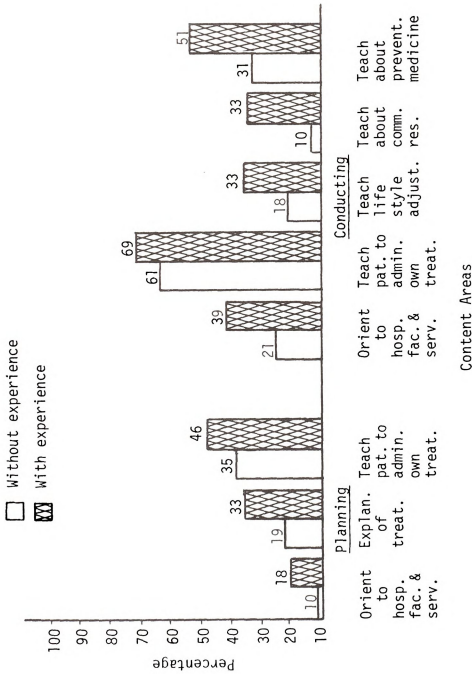


Figure 18.--Percentage of allied health professionals with and without experience in patient education programs who judged that nurses should have primary responsibility for planning and conducting patient education activities in selected content areas.



conducting five of the nine content areas. The differences were especially apparent in regard to conducting of two of the content areas, teaching about community resources and preventive medicine.

Supportive role.--Approximately one-third of the total respondent group, as illustrated in Table 17, judged that nurses should have an overall supportive responsibility for both planning and conducting patient education activities. In two of the content areas, explanation of diagnosis and explanation of treatment, about half of the group believed that nurses should have a supportive role in both planning and conducting those activities.

In defining their own role, 39% of the nurses believed they should have an overall supportive responsibility for planning patient education activities and 36.6% of them believed they should have an overall supportive responsibility for conducting those activities. Over half of them believed they should have supportive responsibility for both planning and conducting patient education activities in two content areas, explanation of the diagnosis and explanation of the treatment of the health problem. The largest percentage (67.6%) believed they should have a supportive role for conducting the explanation of the diagnosis.

The other four professional groups for the most part were in agreement with the nurses about the supportive role of the nurses in both the planning and conducting of patient education activities. Approximately one-third of each of the groups, except for hospital administrators, believed that nurses should have supportive



Table 17.--Percentage of nurses who judged that their professional role should include supportive responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that nurses should have such supportive responsibilities.

Content Area	Function	Nurses N=263	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=400	
Orientation to hospital facilities and services	Planning	39.5	28.1	29.6	53.8	33.3	30.3	33.9
	Conducting	37.8	27.1	32.3	24.0	22.2	27.9	31.8
Explanation of diagnosis	Planning	57.9	45.1	50.5	42.3	38.9	46.3	50.8
	Conducting	67.6	48.4	56.7	53.8	72.2	52.1	58.2
Explanation of treatment	Planning	53.0	45.0	45.4	44.0	55.6	45.8	48.7
	Conducting	56.7	46.9	52.0	44.0	72.2	49.5	52.3
Teaching patients to administer own treatment	Planning	28.0	37.6	32.7	36.0	44.4	36.5	33.1
	Conducting	18.0	21.8	19.6	26.9	22.2	21.4	20.1
Teaching self-care independent living skills	Planning	27.2	33.1	33.3	34.6	44.4	33.7	31.1
	Conducting	25.4	30.1	29.5	30.8	33.3	30.0	28.1

Table 17.--Continued.

Content Area	Function	Nurses N=263	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	4 Groups Collectively N=400	
Teaching long- and short-term life style adjustment	Planning	30.8	23.4	31.6	25.0	44.4	26.7	28.4
	Conducting	31.1	23.9	29.6	20.0	44.4	26.3	28.2
Teaching about community resources	Planning	29.1	22.7	21.6	32.0	33.3	23.8	25.9
	Conducting	35.3	22.1	25.8	37.5	44.4	25.1	29.1
Teaching about financial management of health problem	Planning	24.5	14.8	17.0	32.0	41.2	17.7	20.4
	Conducting	30.1	16.0	20.4	40.0	41.2	19.9	23.9
Teaching of general preventive medicine	Planning	35.1	38.2	34.7	36.0	41.2	37.4	36.5
	Conducting	27.7	32.3	34.0	12.0	55.6	32.7	30.6
Mean over nine areas	Planning	39.0	32.0	32.9	37.3	36.9	33.1	34.3
	Conducting	36.6	29.8	32.9	32.1	45.3	31.7	33.6



responsibility for both planning and conducting patient education. A greater percentage of hospital administrators (45%) judged that nurses should have primary responsibility for conducting the activities. Consistently the largest percentage of each of the four groups believed that nurses should have supportive responsibility for both planning and conducting the explanation of the diagnosis and of the treatment of the health problem.

About half of the patient education staff also judged that nurses should have supportive responsibility for planning the orientation to hospital facilities and services, while about half of the hospital administrators judged that nurses should have supportive responsibility for conducting the teaching of general preventive medicine.

The nurses and the four other professional groups differed somewhat in opinion in two of the content areas. A greater percentage of the nurses (67.6%) than of the other four professional groups collectively (52.1%) judged that they should have supportive responsibility for conducting the explanation of the diagnosis. Similarly a greater percentage (10% more) of nurses than of the other four groups believed they should have supportive responsibility for both planning and conducting the orientation to hospital facilities and services.

There was very little relationship between the respondents' judgments concerning the supportive role of the nurses and the size of hospital where they practiced, or whether they had attended educational programs on or related to patient education.

A partial relationship was demonstrated between nurses' responses concerning the supportive responsibility of the nurse and whether they practiced in hospitals with or without formal patient education programs. No statistically significant relationship appeared to exist between the answers of the total respondent group, physicians, or allied health professionals and this variable.

A greater percentage of the nurses, as illustrated in Figure 19, who worked in hospitals with formal patient education programs than of those who did not judged that their role should include supportive responsibility for planning and conducting patient education activities. This was especially so in regard to planning. Approximately 13% more of the nurses who worked in hospitals with formal programs than of those who worked in hospitals without such programs believed that they should have this supportive role in planning five of the nine content areas.

A significant relationship was also demonstrated between the experience professionals had with formal patient education programs and their responses concerning the supportive role of the nurses. This relationship was apparent primarily in the responses of the nurses, but also in those of the physicians and allied health professionals.

As pictured in Figure 20, approximately 12% fewer of nurses who had experience with formal patient education than of those who did not believed they should have supportive responsibility for planning in four content areas and conducting in two areas. In an additional two content areas about 15% more of the nurses with than



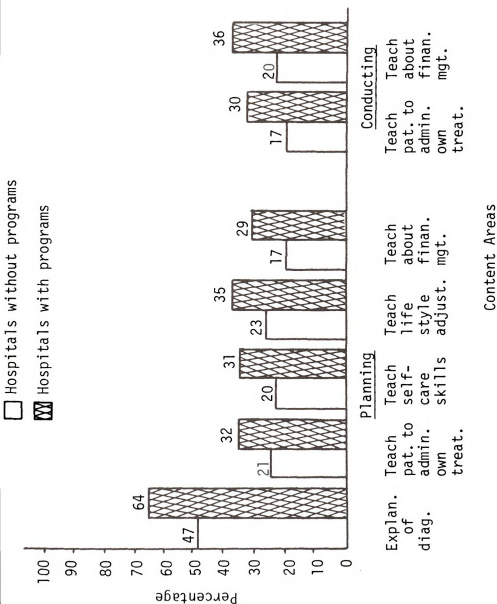


Figure 19.--Percentage of nurses who worked in hospitals with and without formal patient education programs who judged that their role should include responsibility for the planning and conducting of patient education activities in selected content areas.

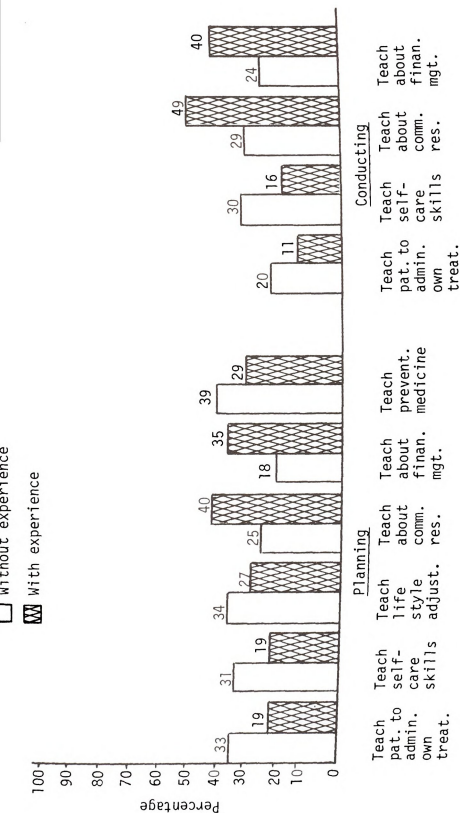


Figure 20.--Percentage of nurses with experience and without experience in patient education programs who judged that their role should include supportive responsibility for planning and conducting patient education activities in selected content areas.

of those without experience judged that their role should include this supportive responsibility for both planning and conducting those activities.

As shown in Figure 21, about 10% more of the physicians with experience in formal patient education programs than of those without judged that nurses should have primary responsibility for planning four of the nine content areas.

As illustrated in Figure 22, approximately 16% more of the allied health professionals who had experience with formal patient education programs than of those who did not judged that nurses should have supportive responsibility for planning four of the nine content areas and conducting five of the nine areas. This was especially so in conducting the teaching about life style adjustments and community resources.

In summary, nurses were believed by nearly one-fifth of professionals in other groups to have primary responsibility for the overall planning of patient education activities, and by over one-fourth of them to have primary responsibility for conducting such activities. They were seen by about one-third of those in other professional groups as having major supportive roles in both planning and conducting programs. About 30% of the nurses themselves believed they should have primary responsibility for planning programs and 37% believed they should have primary responsibility for conducting them.

The greatest differences of opinion concerning the role of the nurses were between the physicians and the nurses and the patient education staff and the nurses. In general, the percentage of

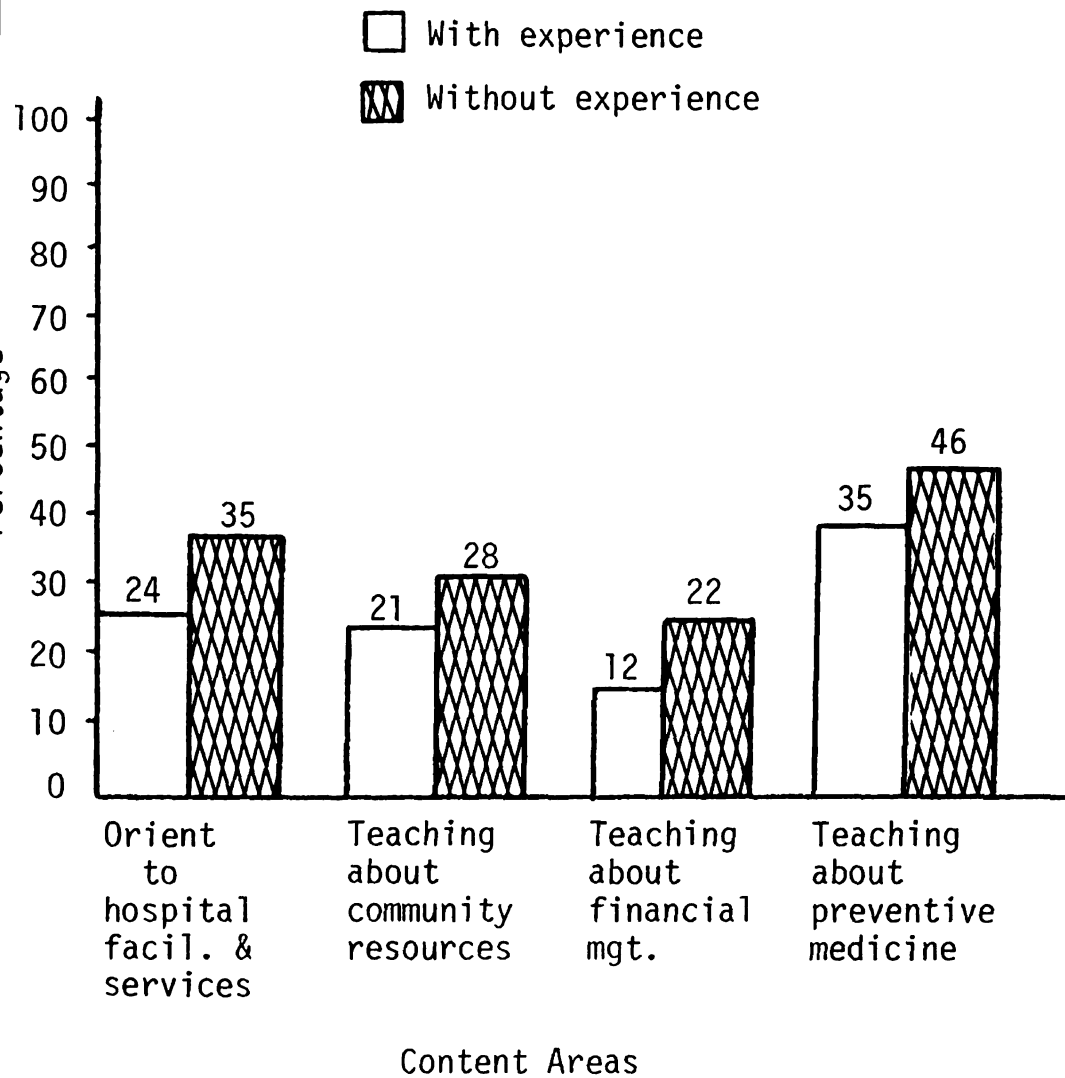


Figure 21.--Percentage of physicians with and without experience with formal patient education programs who judged that nurses should have supportive responsibility for planning of selected content areas.



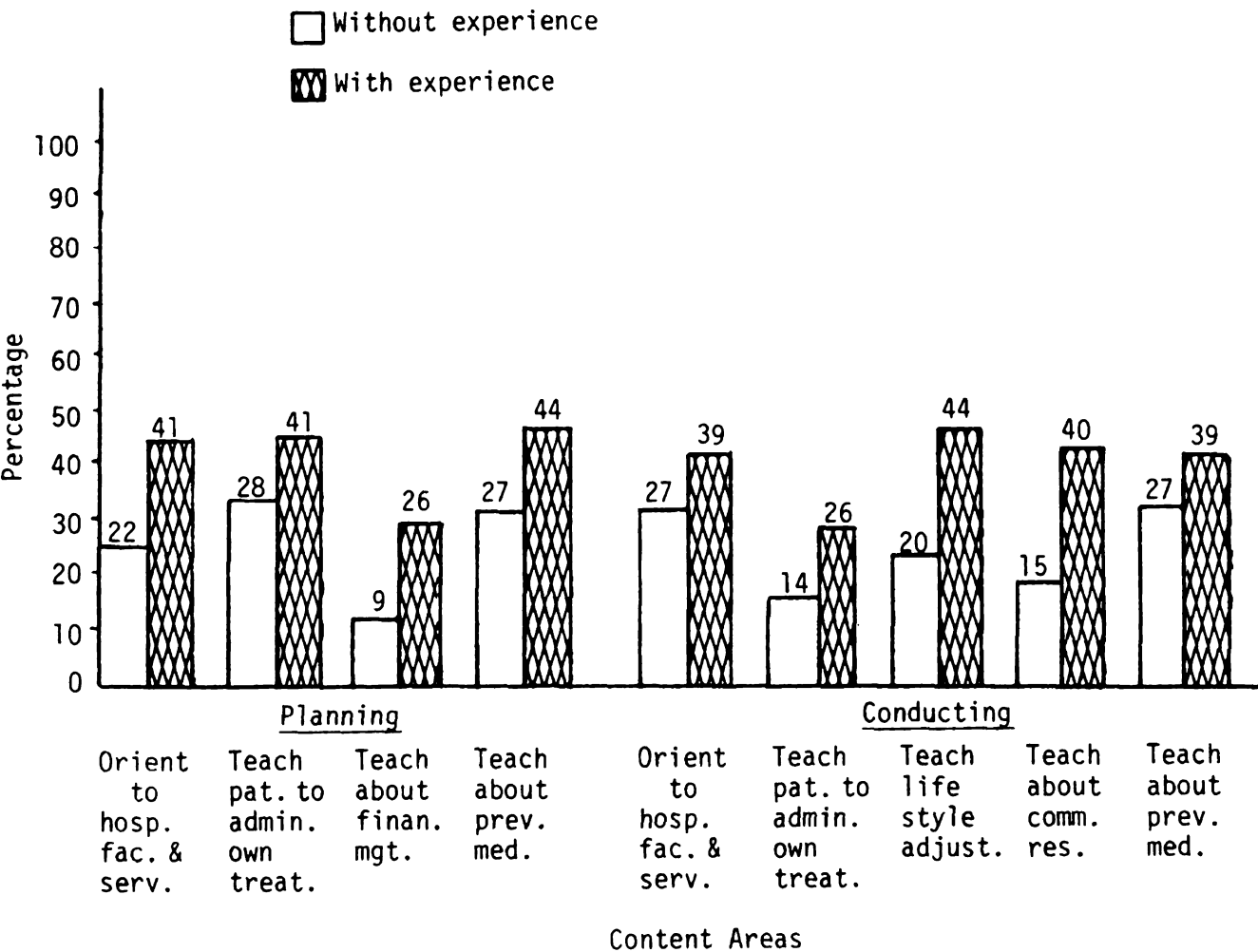


Figure 22.--Percentage of allied health professionals with and without experience who judged that nurses should have supportive responsibility for planning and conducting patient education activities in selected content areas.

physicians believing that primary responsibility for planning and conducting patient education should reside with nurses was only half as large as the percentage of nurses who believed they should have such responsibility. In contrast, a much greater percentage of patient education staff than of nurses believed that nurses should have primary responsibility for both planning and conducting patient education activities.

Roles Deemed Appropriate for Allied Health Professionals

Primary role.--About 30% of the total respondent group, as shown in Table 18, judged that allied health professionals should have primary responsibility for planning and conducting patient education activities. More than half of all respondents believed that allied health professionals should have primary responsibility for planning and conducting teaching about long- and short-term life style adjustments, teaching about community resources, and teaching about financial management of the illness.

In comparing how the allied health professionals defined their own roles with the way other groups defined allied health professional staff roles, it appears that a somewhat larger percentage (about 12% more) of the allied health professionals believed they should, in general, have primary responsibility for both planning and conducting patient education programs. Thirty-seven percent of the allied health professionals, as compared with 25.5% of all other respondents, indicated that they should have primary responsibility for planning, while 41.6% of them, as compared to 29.6% of all other

Table 18.--Percentage of allied health professionals who judged that their professional role should include primary responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that allied health professionals should have such primary responsibilities.

Content Area	Function	Allied Health Professionals N=97	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Patient Education Staff N=26	Hospital Administrators N=18	4 Groups Collectively N=566	
Orientation to hospital facilities and services	Planning	7.3	12.7	8.0	8.0	16.7	10.5	10.1
	Conducting	17.5	19.2	11.4	15.4	11.1	15.1	15.4
Explanation of diagnosis	Planning	15.8	5.2	5.0	8.3	5.6	5.4	6.9
	Conducting	9.3	6.6	5.0	3.8	.0	5.7	6.2
Explanation of treatment	Planning	19.8	6.6	5.7	19.2	5.6	6.7	8.5
	Conducting	16.3	8.3	5.7	11.5	5.9	7.1	8.5
Teaching patients to administer own treatment	Planning	28.6	12.1	10.8	12.0	16.7	11.7	14.2
	Conducting	40.2	16.9	12.4	23.1	16.7	15.0	18.6
Teaching self-care independent living skills	Planning	53.6	40.0	27.5	23.1	27.8	33.0	36.0
	Conducting	45.3	32.8	54.5	69.2	55.6	39.1	42.7



Table 18.---Percentage of allied health professionals who judged that their professional role should include primary responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that allied health professionals should have such primary responsibilities.

Content Area	Function	Allied Health Professionals N=97	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Patient Education Staff N=26	Hospital Administrators N=18	4 Groups Collectively N=566	
Orientation to hospital facilities and services	Planning	7.3	12.7	8.0	8.0	16.7	10.5	10.1
	Conducting	17.5	19.2	11.4	15.4	11.1	15.1	15.4
Explanation of diagnosis	Planning	15.8	5.2	5.0	8.3	5.6	5.4	6.9
	Conducting	9.3	6.6	5.0	3.8	.0	5.7	6.2
Explanation of treatment	Planning	19.8	6.6	5.7	19.2	5.6	6.7	8.5
	Conducting	16.3	8.3	5.7	11.5	5.9	7.1	8.5
Teaching patients to administer own treatment	Planning	28.6	12.1	10.8	12.0	16.7	11.7	14.2
	Conducting	40.2	16.9	12.4	23.1	16.7	15.0	18.6
Teaching self-care independent living skills	Planning	53.6	40.0	27.5	23.1	27.8	33.0	36.0
	Conducting	45.3	32.8	54.5	69.2	55.6	39.1	42.7



Table 18.--Continued.

Content Area	Function	Allied Health Professionals N=97	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Patient Education Staff N=26	Hospital Administrators N=18	4 Groups Collectively N=566	
Teaching long- and short-term life style adjustment	Planning	63.3	45.1	41.4	41.7	38.9	43.2	46.2
	Conducting	78.6	59.5	47.7	56.0	66.7	54.1	57.7
Teaching about community resources	Planning	61.9	52.8	52.3	64.0	50.0	53.0	54.2
	Conducting	70.1	56.3	54.4	68.0	66.7	56.4	58.4
Teaching about financial management of health problem	Planning	57.4	45.2	52.9	76.0	35.3	50.0	51.1
	Conducting	64.9	48.8	54.2	84.0	41.2	52.7	54.5
Teaching of general preventive medicine	Planning	26.0	15.6	14.2	29.2	23.5	16.0	17.5
	Conducting	32.0	23.1	17.2	40.0	35.3	21.3	22.9
Mean over nine areas	Planning	37.0	26.1	24.2	31.3	24.5	25.5	27.2
	Conducting	41.6	30.2	29.2	41.2	33.2	29.6	31.7



respondents, indicated they should have primary responsibility for conducting patient education activities.

Over half of the allied health professionals believed they should have primary responsibility for planning for the teaching of self-care independent living skills (53.6%), long- and short-term life style adjustments (63.3%), community resources (61.9%), and financial management of the health problem (57.4%). A somewhat larger percentage of them believed they also should have primary responsibility for conducting three of these four activities: teaching of long- and short-term life style adjustments (78.6%), teaching about community resources (70.1%), and teaching about financial management of the health problem (64.9%).

The judgments of three of the other professional groups concerning the overall primary role of allied health professionals in the planning and conducting of patient education activities were very similar. Approximately one-fourth of the physicians, nurses, and hospital administrators, as compared to 37% of the allied health professionals, believed that allied health professionals should have primary responsibilities for planning patient education activities. Close to one-third of the physicians, nurses, and hospital administrators, as compared to 41% of the allied health professionals, indicated that allied health professionals should have primary responsibility for conducting those activities.

The patient education staff were more in agreement with the allied health professionals. Thirty-one percent of the patient education staff indicated that allied health professionals should



have primary responsibility for planning patient education activities and an almost identical 41% indicated that they should have primary responsibility for conducting them.

At least half of each of the groups agreed that allied health professionals should have primary responsibility for both planning and conducting of teaching about community resources. The groups differed somewhat in their beliefs concerning the role of the allied health professionals in the other content areas. The major differences of opinion were between the patient education staff and the other groups. This was especially apparent in the teaching of self-care independent living skills and teaching about financial management of the health problems, where a much larger (approximately 30% larger) percentage of patient education staff than of the other groups indicated that allied health professionals should have primary responsibility for conducting those activities.

In summary, allied health professionals defined roles for themselves that were moderately different from roles defined for them by the other four professional groups. As mentioned earlier, approximately 12% more of the allied health professionals than of the other four professional groups collectively believed their professional role should include primary responsibility for both planning and conducting patient education activities. These differences of opinion were apparent in eight of the nine content areas. The differences in percentages were especially large in regard to planning and conducting the teaching of long- and short-term life style adjustments. About 63% of the allied health professionals

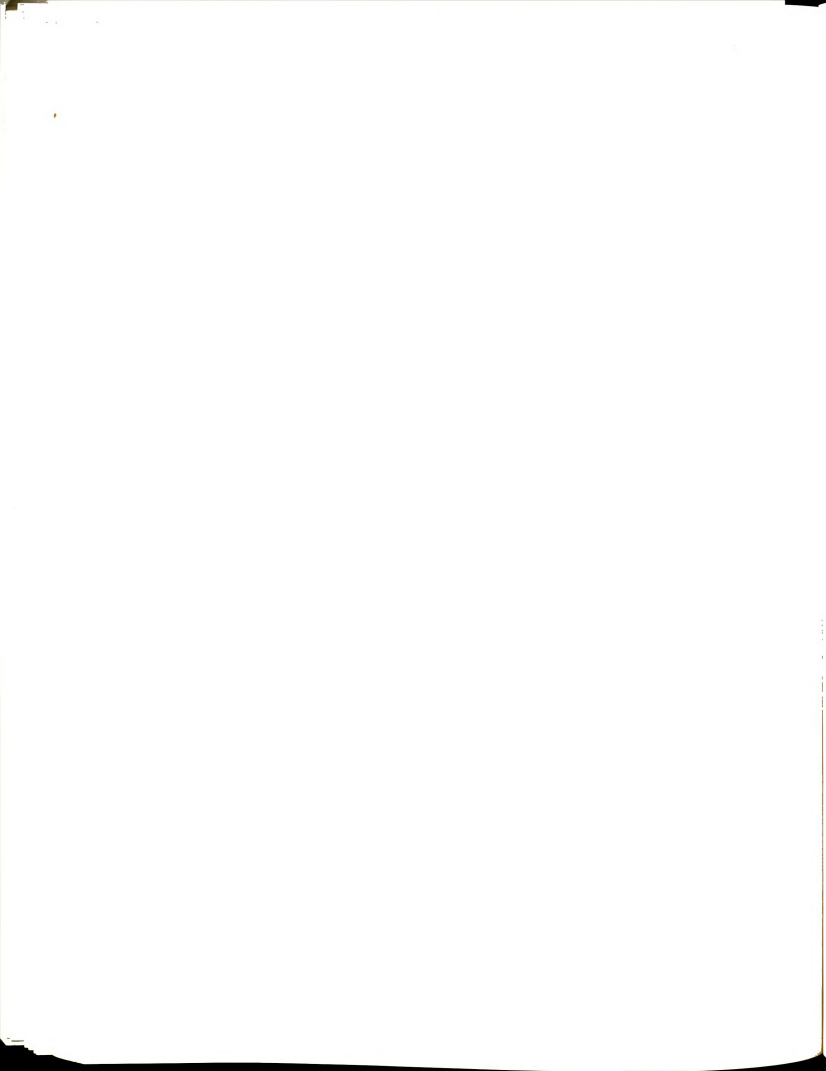


indicated they should have primary responsibility for planning that activity, while only 43.2% of the other four professional groups collectively indicated this. In conducting that activity 78.6% of the allied health professionals indicated they should have primary responsibility, while only 54.1% of the other four groups indicated allied health professionals should have this responsibility.

Patient education staff were more in agreement than were the other three professional groups with the allied health professionals. This was especially so in regard to conducting patient education activities.

There was very little relationship between definitions of the allied health professionals' role by any of the groups and the following three factors: (1) the size of the hospital where professionals practiced, (2) whether they had experience with formal patient education programs, or (3) whether they had attended educational programs on or related to patient education.

There was a relationship, as illustrated in Figure 23, between whether respondents practiced in hospitals with formal patient education programs and answers of the allied health professionals concerning the primary role of the allied health professionals. A greater percentage (20%) of allied health professionals who worked in hospitals with programs than of those who did not judged that they should have primary responsibility for planning for teaching about financial management. In three content areas, namely orientation to facilities and services, teaching life style adjustments, and teaching about financial management, about 15% more of



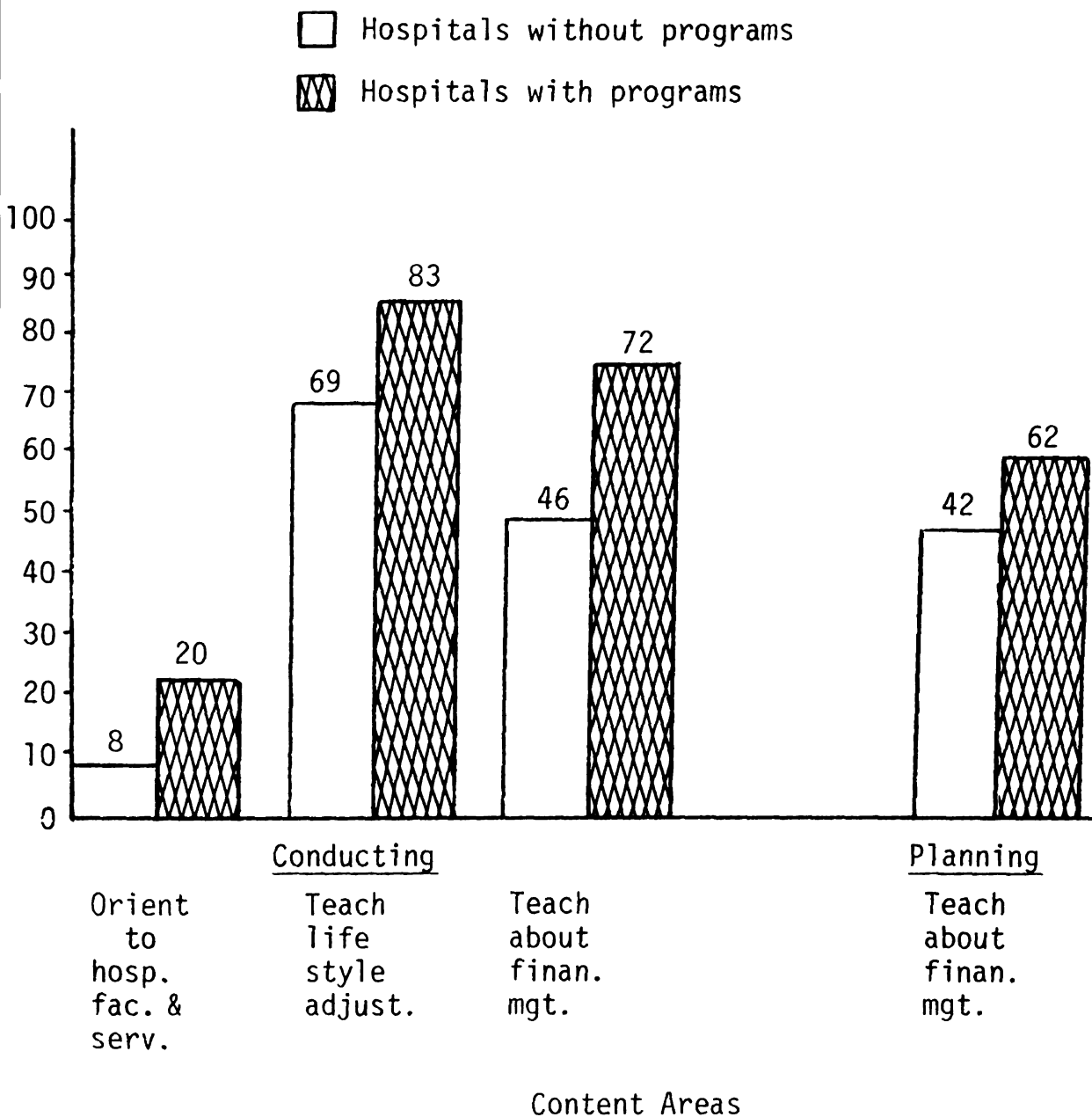


Figure 23.--Percentage of allied health professionals who worked in hospitals with and without patient education programs who judged that their professional role should include the responsibility for planning and conducting patient education activities in selected content areas.



this same group indicated they should have primary responsibility for conducting those activities. No other significant relationships appeared to exist between whether respondents practiced in hospitals with or without formal patient education programs and their responses concerning responsibilities of allied health staff for planning or conducting patient education activities.

Supportive role.--Slightly over one-fourth of the total respondent group, as shown in Table 19, judged that allied health professionals should have supportive responsibility for planning and conducting patient education. In none of the content areas did a large percentage of the total respondent group believe that allied health professionals should have a supportive role, though 20 to 37% of all respondents indicated this group should have supportive responsibility in each of the content areas. Approximately one-fourth of the allied health professionals themselves also judged that their professional role should include supportive responsibility for planning and conducting patient education activities.

Physicians, nurses, and hospital administrators had similar opinions about the supportive role of the allied health professionals in both planning and conducting patient education activities and were in agreement with the allied health professionals' own judgments. Between 25 and 33% of each of the three groups believed they should have supportive responsibility for both planning and conducting patient education activities.



Table 19.--Percentage of allied health professionals who judged that their professional role should include supportive responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that allied health professionals should have such supportive responsibilities.

Content Area	Function	Allied Health Professionals N=97	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Patient Education Staff N=26	Hospital Administrators N=18	4 Groups Collectively N=566	
Orientation to hospital facilities and services	Planning	34.4	26.2	27.4	48.0	38.9	28.1	29.0
	Conducting	34.0	27.7	34.1	42.3	61.1	32.4	32.6
Explanation of diagnosis	Planning	25.3	19.5	17.6	29.2	33.3	19.4	20.2
	Conducting	29.9	22.6	21.1	38.5	22.2	22.4	23.5
Explanation of treatment	Planning	26.0	19.7	18.9	30.8	22.2	19.8	20.7
	Conducting	36.7	22.7	22.8	38.5	23.5	23.3	25.3
Teaching patients to administer own treatment	Planning	34.7	24.7	31.6	64.0	38.9	29.9	30.6
	Conducting	36.1	30.5	41.9	53.8	50.0	37.2	37.0
Teaching self-care independent living skills	Planning	26.8	31.2	38.1	65.4	38.9	36.1	34.8
	Conducting	29.5	30.1	25.4	30.8	33.3	36.3	34.6



Table 19.--Continued.

Content Area	Function	Allied Health Professionals N=97	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Patient Education Staff N=26	Hospital Administrators N=18	4 Groups Collectively N=566	
Teaching long- and short-term life style adjustment	Planning	21.4	31.8	32.0	50.0	44.4	32.8	31.1
	Conducting	11.2	23.7	33.1	40.0	22.2	28.6	26.1
Teaching about community resources	Planning	23.7	25.6	28.4	28.0	27.8	27.0	26.4
	Conducting	18.6	21.9	31.2	28.0	27.8	26.5	25.3
Teaching about financial management of health problem	Planning	22.3	21.2	23.6	16.0	29.4	22.2	22.2
	Conducting	13.8	20.2	25.4	12.0	29.4	22.4	21.1
Teaching of general preventive medicine	Planning	28.1	26.6	23.8	37.5	23.5	25.6	25.9
	Conducting	24.7	25.9	28.9	24.0	17.6	26.8	26.5
Mean over nine areas	Planning	27.0	25.2	26.8	41.0	33.0	26.8	26.8
	Conducting	26.0	25.0	29.3	34.2	32.0	28.3	28.0



Among the patient education staff a slightly higher percentage accorded supporting roles to the allied health professionals. About 41% of the patient education staff indicated that allied health professionals should have supportive responsibility for planning and 34.2% indicated that they should have such responsibility for conducting patient education activities. The largest percentage of patient education staff (65%) believed that allied health professionals should have supportive responsibility for the planning of both teaching patients to administer their own treatment and self-care independent living skills. About half of the patient education staff also believed the allied health professionals should have supportive responsibility for planning the orientation to hospital facilities and services, and the teaching of long- and short-term life style adjustments.

It appears that patient education staff were more inclined to define a supportive role for allied health professionals, especially in the area of planning patient education activities, than were the allied health professionals themselves or members of the other three professional groups.

The judgments of the four other professional groups collectively and the allied health professionals themselves were very similar concerning the supportive role of the allied health professionals in patient education. In only three of the content areas did their opinions differ greatly. Approximately 13% more of allied health professionals than of the other four professional groups collectively indicated that they should have supportive



responsibility for planning patient education activities relating to the explanation of the treatment procedures. Just the reverse is true in two other content areas (planning and teaching of self-care independent living skills and long- and short-term life style adjustments) where 10% more of the other four professional groups collectively than of allied health professionals believed they should have a supportive role.

There was very little apparent relationship between definitions of allied health professionals' role by any of the groups and either of two factors: (1) the size of the hospital where professionals practiced or (2) whether they had previously attended educational programs on or related to patient education.

Only for the allied health professionals, as shown in Figure 24, was there a statistically significant relationship demonstrated between their responses concerning the supportive role of allied health professionals and whether they practiced in hospitals with or without formal patient education programs. In three of the nine selected content areas about 17% fewer of the allied health professionals who worked in hospitals with patient education programs than of those who worked in hospitals without programs believed that their role should include supportive responsibility for conducting those activities (orientation to hospital facilities and services, teaching patients to administer their own treatment, and teaching of life style adjustment).

There was a relationship between respondents' experience with formal patient education programs and the answers of respondents



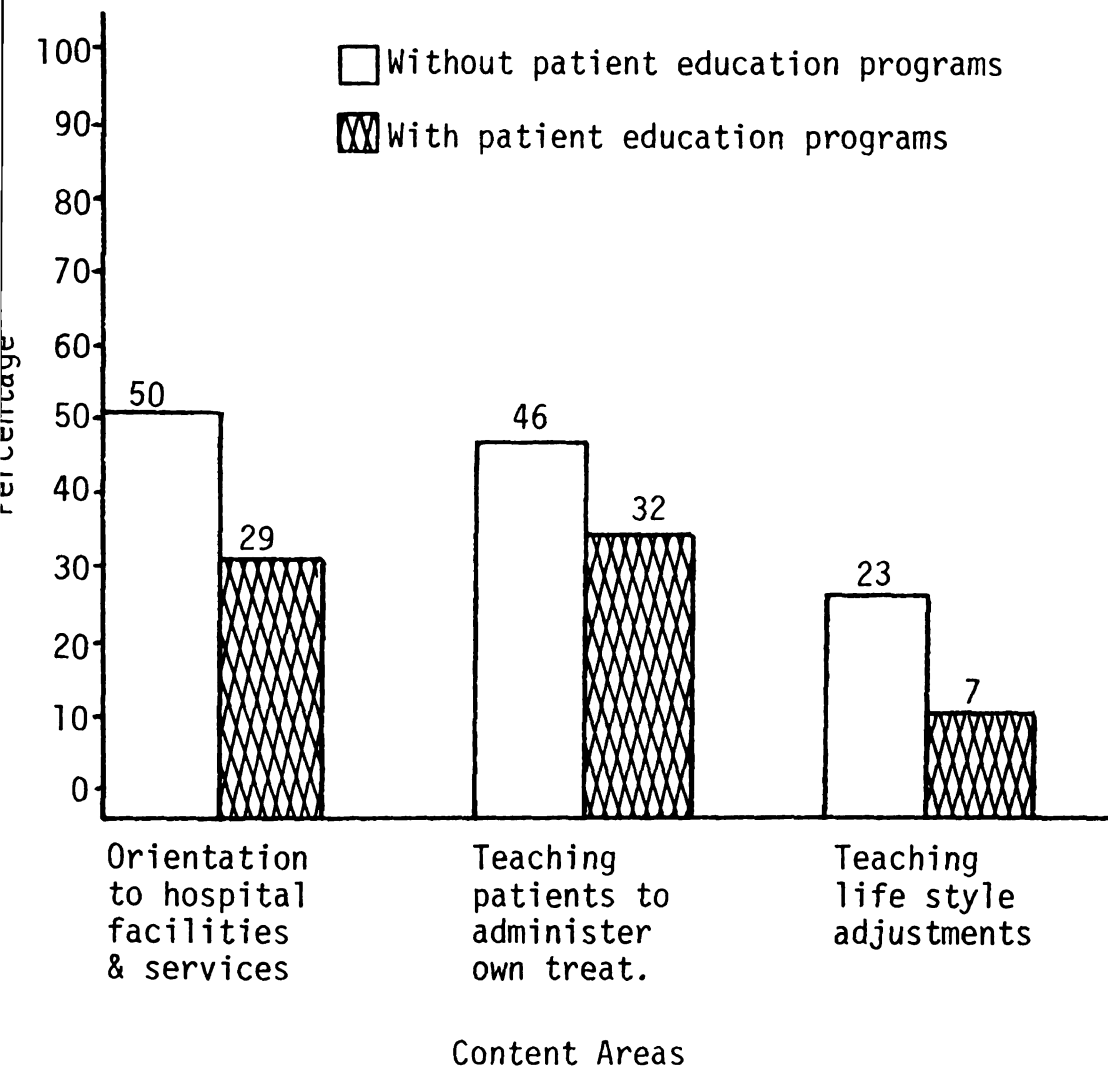


Figure 24.--Percentage of allied health professionals who worked in hospitals with and without patient education programs who judged that allied health professionals should have supportive responsibility for conducting patient education activities in selected content areas.

concerning the supportive role of allied health professionals. As illustrated in Figure 25, about 7% more of the total respondent group with experience than of those without experience believed that allied health professionals should have supportive responsibility for both planning and conducting teaching of patients to administer their own treatment. In two additional content areas (teaching self-care skills and teaching about community resources), approximately 8% more believed they should have supportive responsibility for planning and in two other content areas (explanation of diagnosis and of treatment) 10% and 9%, respectively, believed they should have such responsibility for conducting patient education activities.

Approximately 17% more of the allied health professionals, as illustrated in Figure 26, who had experience with formal patient education programs than of those who did not, judged that their role should include supportive responsibility for planning in three content areas (explanation of treatment, teaching patients to administer their own treatment, and teaching of financial management) and 25% more of them believed that they should have such responsibility for conducting in three areas (explanation of diagnosis, explanation of treatment, and teaching patients to administer their own treatment).

A greater percentage of the nurses, as shown in Figure 27, with experience than of those without it also believed that allied health professionals should have supportive responsibility for planning and conducting patient education activities in selected content



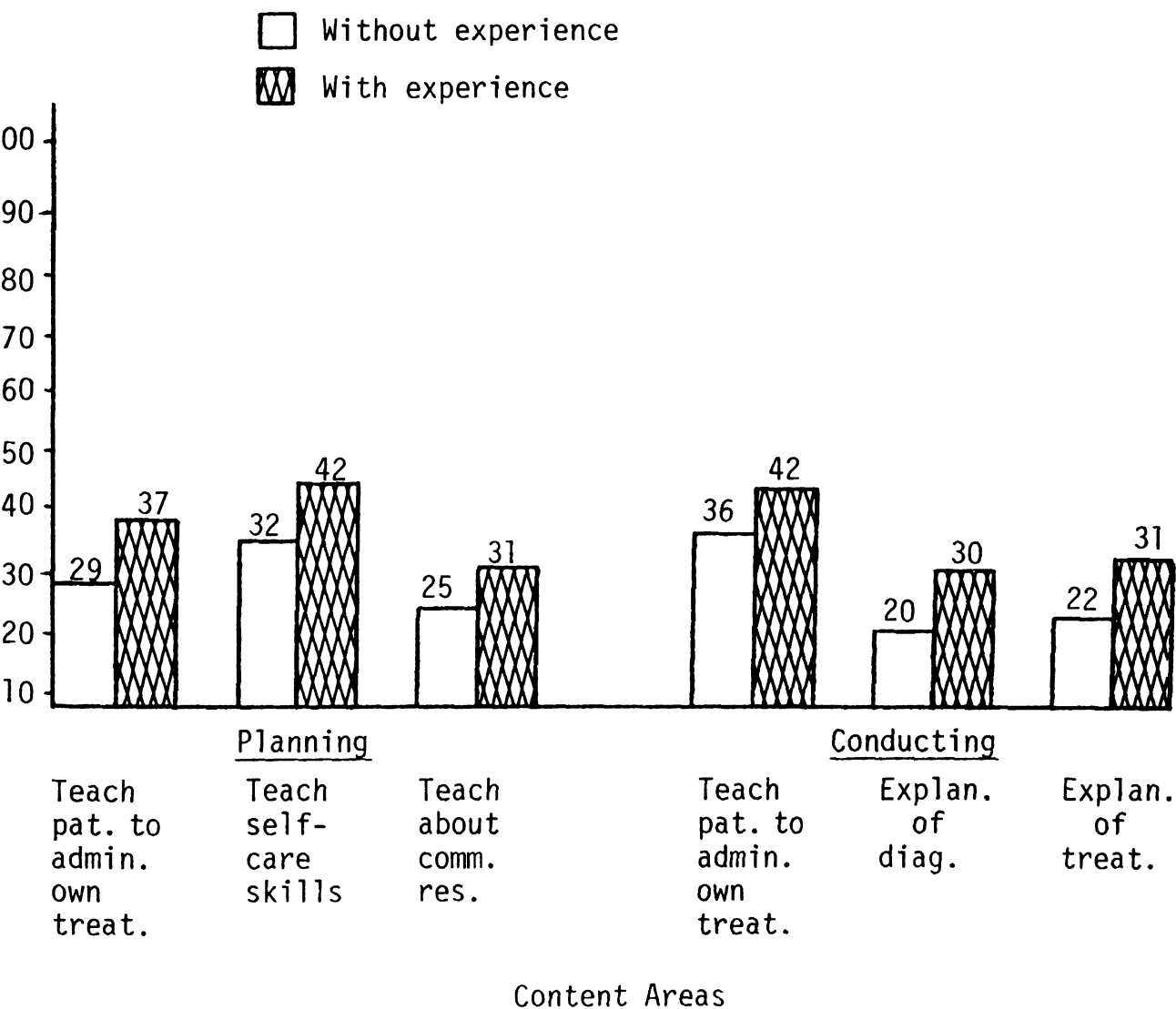
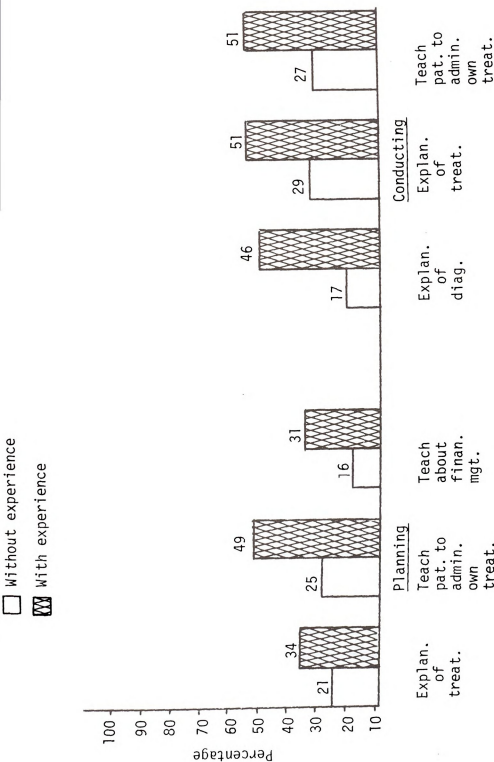


Figure 25.--Percentage of total respondent group with and without experience in formal patient education programs who judged that allied health professionals should have supportive responsibility for planning and conducting patient education activities in selected content areas.





Content Areas

Figure 26.--Percentage of allied health professionals with and without experience in formal patient education who judged that their role should include a supportive responsibility for the planning and conducting of patient education activities in selected content areas.

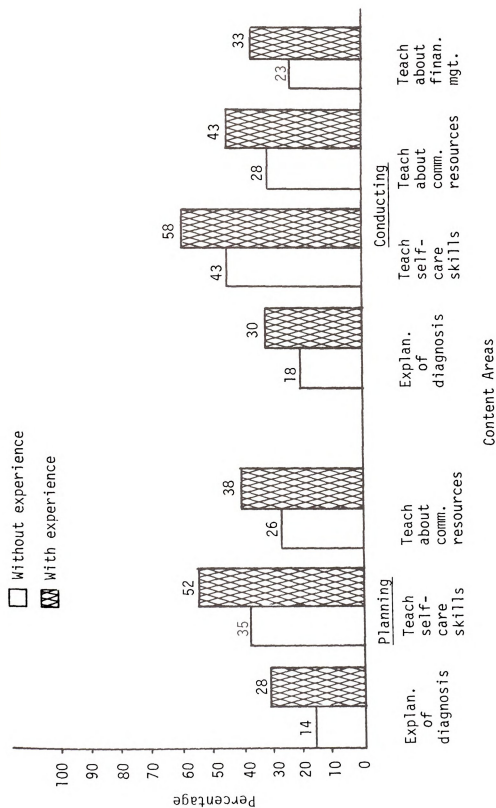
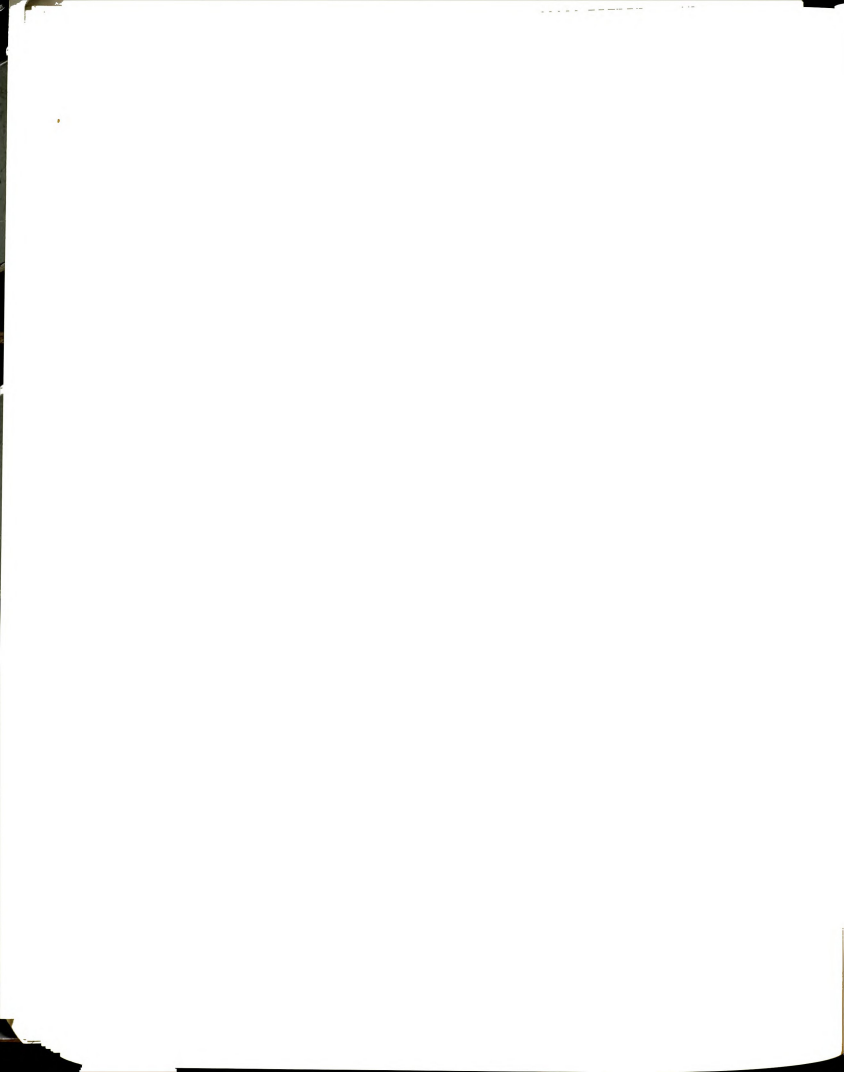


Figure 27.--Percentage of nurses with and without experience in formal patient education programs who judged that allied health professionals should have supportive responsibility for the planning and conducting of patient education activities in selected content areas.

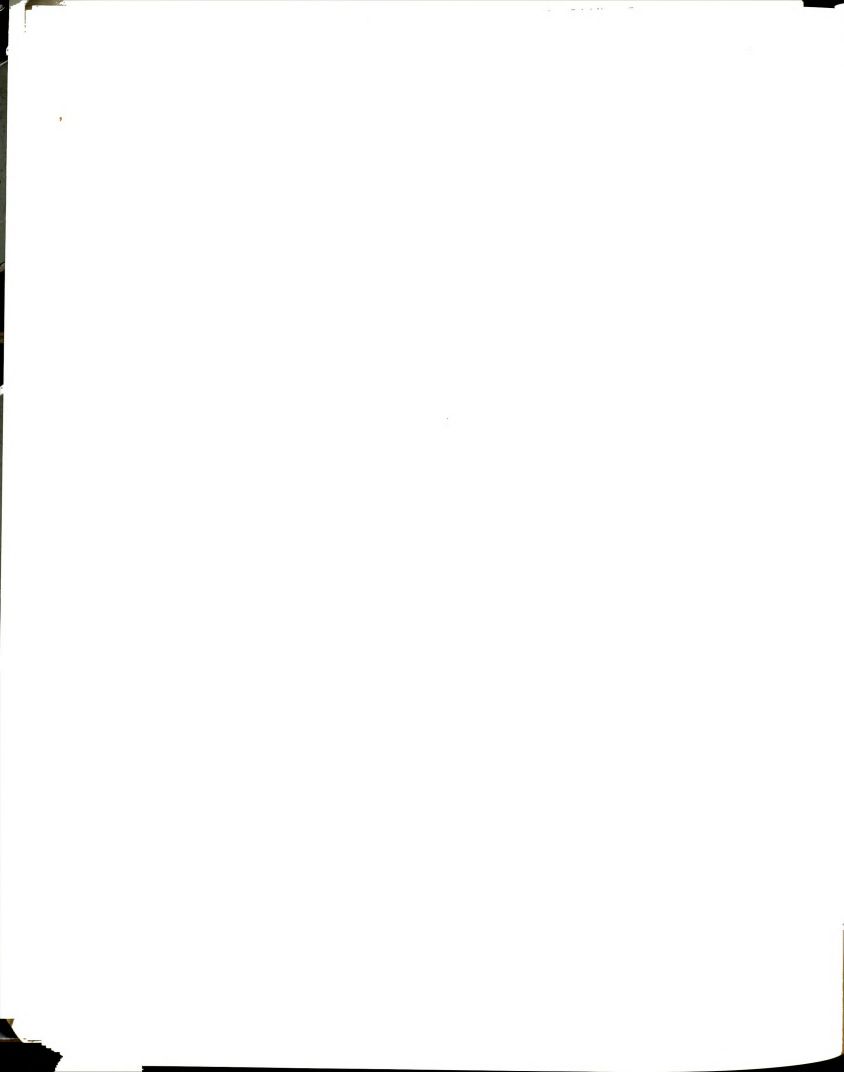


areas. Approximately 14% more of them judged that allied health professionals should have supportive responsibility for both planning and conducting the explanation of diagnosis, teaching self-care skills, and teaching about community resources, and for just conducting the teaching about financial management of the health problem.

No statistically significant relationships appeared to exist between the physicians' experience with formal patient education programs and their responses concerning responsibilities of allied health professionals for planning or conducting patient education activities.

In summary, allied health professionals were believed by just over one-fourth of professionals in other groups to have primary responsibility for the overall planning and conducting of patient education activities. Thirty-seven percent of the allied health professionals themselves believed they should have primary responsibility for planning programs and 41.6% believed they should have primary responsibility for conducting them. Allied health professionals were seen by about one-fourth of all professional groups, including themselves, as having major supportive roles in both planning and conducting patient education.

Allied health professionals believed more frequently than did physicians, nurses, and hospital administrators that their professional role should include primary responsibility for both planning and conducting patient education activities. They were in close agreement with all other professional groups concerning their supportive responsibilities in both planning and conducting.



Patient education staff more frequently than the other three professional groups accorded allied health professionals responsibility for patient education.

Roles Deemed Appropriate for Hospital Administrators

Primary roles.--In general, as shown in Table 20, a very small percentage of all professional groups judged that hospital administrators should have primary responsibility for planning and conducting patient education activities. Only 6% of the total respondent group believed hospital administrators should have primary responsibility for planning, and 3.1% believed they should have such responsibility for conducting these activities. In all but two of the content areas, less than 5% of the respondents judged that they should have primary responsibility. In the two areas, planning the orientation to hospital facilities and services (24.1%) and planning and conducting the teaching about financial management of the health problem (19.2%), slightly larger portions of the several groups, including the administrators themselves, believed that hospital administrators share primary responsibility.

The small group of hospital administrators very much mirrored the responses of the total respondent group. Overall, 9.4% of the hospital administrators indicated they should have primary responsibility for planning and 4.4% indicated they should have it for conducting patient education activities. The largest percentage of administrators judged that their role should include planning (44.4%) and conducting (16.7%) of orientation to hospital

Table 20.--Percentage of hospital administrators who judged that their professional role should include primary responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that hospital administrators should have such primary responsibilities.

Content Area	Function	Hospital Adminis- trators N=18	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	4 Groups Collectively N=645	
Orientation to hospital facilities and services	Planning Conducting	44.4 16.7	30.9 10.9	16.1 5.4	24.5 7.1	26.9 3.8	23.6 7.8	24.1 8.0
Explanation of diagnosis	Planning Conducting	.0 .0	1.9 .8	1.9 .4	1.0 1.0	.0 .0	1.7 .6	1.6 .6
Explanation of treatment	Planning Conducting	.0 .0	1.2 .8	.7 .0	2.0 1.0	.0 .0	1.1 .5	1.0 .5
Teaching patients to administer own treatment	Planning Conducting	.0 .0	.8 .4	.7 .7	1.0 .0	.0 .0	.8 .5	.7 .4
Teaching self-care independent living skills	Planning Conducting	.0 .0	1.2 1.6	.0 .0	1.0 .0	.0 .0	.6 .6	.6 .6

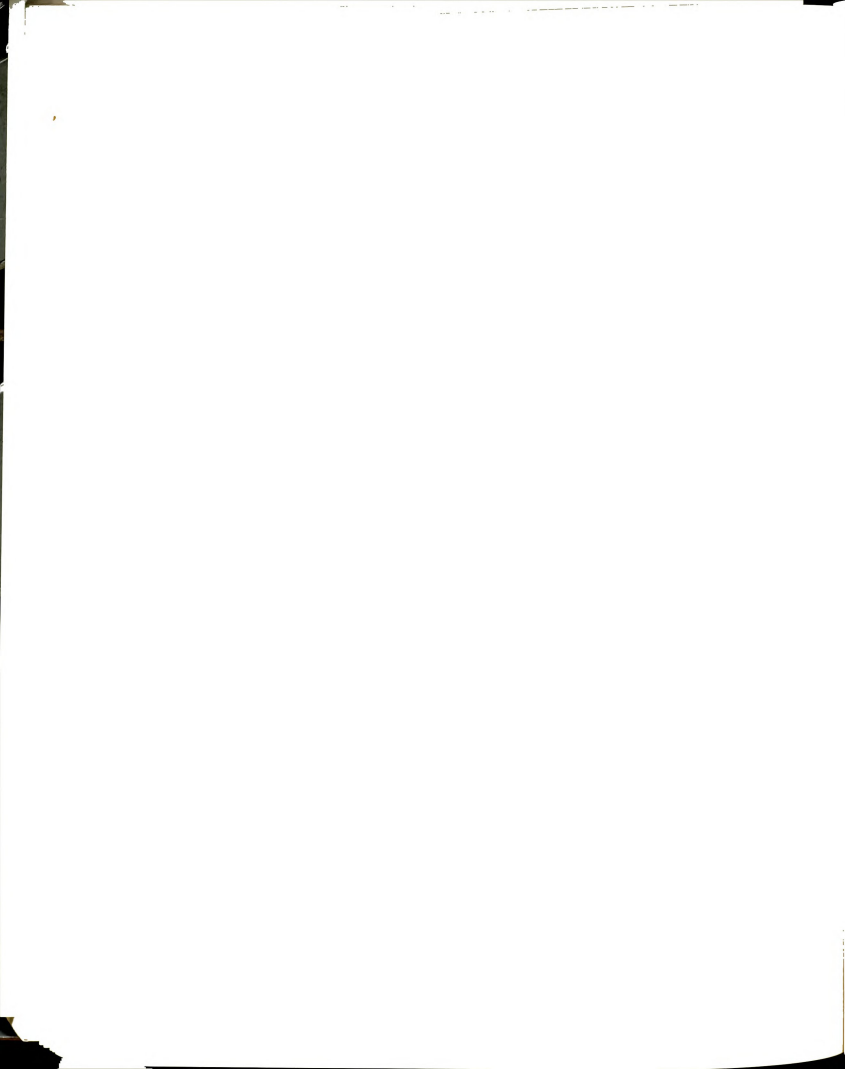


Table 20.--Continued.

Content Area	Function	Hospital Adminis- trators N=18	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	4 Groups Collectively N=645	
Teaching long- and short-term life style adjustment	Planning	.0	2.0	.4	1.0	.0	1.1	1.0
	Conducting	.0	1.6	.0	.0	.0	.6	.6
Teaching about community resources	Planning	5.6	5.1	2.2	3.1	4.0	3.6	3.6
	Conducting	.0	3.6	1.2	1.1	.0	2.1	2.0
Teaching about financial management of health problem	Planning	29.4	23.6	16.8	14.9	12.0	18.9	19.2
	Conducting	17.6	18.8	12.4	11.0	4.0	14.4	14.4
Teaching of general preventive medicine	Planning	5.6	2.1	2.3	4.1	4.0	2.5	2.6
	Conducting	5.6	1.6	1.1	1.0	.0	1.3	1.4
Mean over nine areas	Planning	9.4	7.6	4.5	5.7	5.2	5.9	6.0
	Conducting	4.4	4.5	2.4	2.5	.9	3.1	3.1



facilities and services and planning (29.4%) and teaching (17.6%) about the financial management of the health problem. None of the hospital administrators believed their role should include primary responsibility for five of the nine content areas, and only one or two of them claimed any responsibility in the remaining areas.

The four other professional groups were in full agreement with hospital administrators about the overall role of hospital administrators in patient education. They did, however, differ somewhat with respect to the two content areas on which the administrators saw a role for themselves. Only about half as large a percentage of the other four professional groups collectively judged that the administrators' role should include primary responsibility for both the planning and conducting of orientation to hospital facilities and services and only about two-thirds as large a percentage judged that it should include primary responsibility for planning the teaching about financial management of the health problem.

There was very little or no relationship between definitions of hospital administrators' role by any of the groups and any of the four other variables: (1) the size of the hospital where professionals practiced, (2) whether the hospital where they practiced had a formal patient education program, (3) whether the respondents had experience with formal patient education programs, and (4) whether they had previously attended educational programs on or related to patient education.

Supportive role.--Less than 10% of the total respondent

group, as shown in Table 21, judged that hospital administrators should have overall supportive responsibility for planning and conducting patient education activities. In none of the content areas did more than 17% believe they should have this supportive role.

The small group of hospital administrators viewed their supportive role somewhat differently than did the other groups, except for patient education staff. Approximately 16% of them judged that their professional role should include supportive responsibility for both planning and conducting patient education activities. The largest percentage of them, about one-third, indicated that their role should include supportive responsibility for both planning and conducting teaching about the financial management of the health problem.

Physicians, nurses, and allied health professionals were not in full agreement with hospital administrators concerning the overall supportive role of hospital administrators. Less than 10% of each of the groups, as compared to 16% of the hospital administrators themselves, indicated that hospital administrators should have overall supportive responsibility. Their differences of opinion were especially apparent in the content area on teaching about the financial management of the health problem.

Patient education staff and hospital administrators had very similar opinions concerning the overall supportive role of the hospital administrators. They differed modestly in two of the content

Table 21.--Percentage of hospital administrators who judged that their professional role should include supportive responsibility for planning and conducting patient education in nine selected content areas and percentages of four other professional groups and the total respondent group who judged that hospital administrators should have such supportive responsibilities.

Content Area	Function	Hospital Administrators N=18	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	4 Groups Collectively N=645	
Orientation to hospital facilities and services	Planning Conducting	22.2 16.7	17.6 19.4	15.0 11.5	17.3 19.4	26.9 26.9	16.7 16.4	16.9 16.4
Explanation of diagnosis	Planning Conducting	16.7 16.7	7.4 6.7	7.9 7.3	7.2 7.3	12.2 16.0	8.0 7.4	8.2 7.6
Explanation of treatment	Planning Conducting	16.7 16.7	6.6 6.2	6.4 6.2	6.1 7.1	19.2 15.4	6.9 6.7	7.2 6.9
Teaching patients to administer own treatment	Planning Conducting	11.1 11.1	6.4 6.1	7.5 6.7	7.1 8.2	16.0 11.5	7.3 6.8	7.4 4.0
Teaching self-care independent living skills	Planning Conducting	11.1 11.1	6.6 5.5	7.8 7.3	7.2 8.5	15.4 11.5	7.5 6.9	7.6 7.0

Table 21.--Continued.

Content Area	Function	Hospital Adminis- trators N=18	Other Professional Groups					Total Respondent Group N=663
			Physicians N=259	Nurses N=263	Allied Health Professionals N=97	Patient Education Staff N=26	4 Groups Collectively N=645	
Teaching long- and short-term life style adjustment	Planning Conducting	11.1 11.1	7.0 6.2	8.2 7.2	8.2 8.2	16.0 12.0	8.0 7.1	8.1 7.2
Teaching about community resources	Planning Conducting	22.2 16.7	8.7 8.8	8.6 7.3	7.2 8.4	16.0 12.5	8.7 8.2	9.0 8.5
Teaching about financial management of health problem	Planning Conducting	29.4 35.3	16.4 17.6	11.8 11.2	10.6 14.3	16.0 20.0	13.6 14.7	14.0 15.2
Teaching of general preventive medicine	Planning Conducting	11.1 11.1	7.4 6.5	8.7 8.0	8.2 9.3	20.0 24.0	8.5 8.2	8.6 8.2
Mean over nine areas	Planning Conducting	16.8 16.3	9.3 9.3	9.1 8.0	8.8 10.0	18.3 16.6	9.5 9.2	9.7 9.0

areas (teaching about financial management of the health problem and general preventive medicine).

There was very little relationship between definitions of hospital administrators' role by any of the groups and either of two factors: (1) whether they practiced in hospitals with or without formal patient education programs and (2) whether they had previously attended educational programs on or related to patient education.

A very modest relationship was demonstrated between hospital size and physicians' responses concerning the supportive responsibility of hospital administrators. In regard to planning in five content areas, 1% or less of the physicians who practiced in hospitals with 1-49 beds or 100-199 beds believed that hospital administrators should have supportive responsibility. In hospitals with 50-99 beds about 6% of physicians believed this and in hospitals with over 200 beds 12% believed it. No other statistically significant relationships appeared to exist between size of hospital and definitions of role for hospital administrators.

There was also a relationship between respondents' experience with formal patient education programs and answers of the total respondent group and the allied health professionals concerning the supportive role of hospital administrators in patient education. Approximately 5% more of the total respondent group, as illustrated in Figure 28, who had experience than of those who did not have experience judged that hospital administrators should have supportive responsibility for both planning and conducting patient education

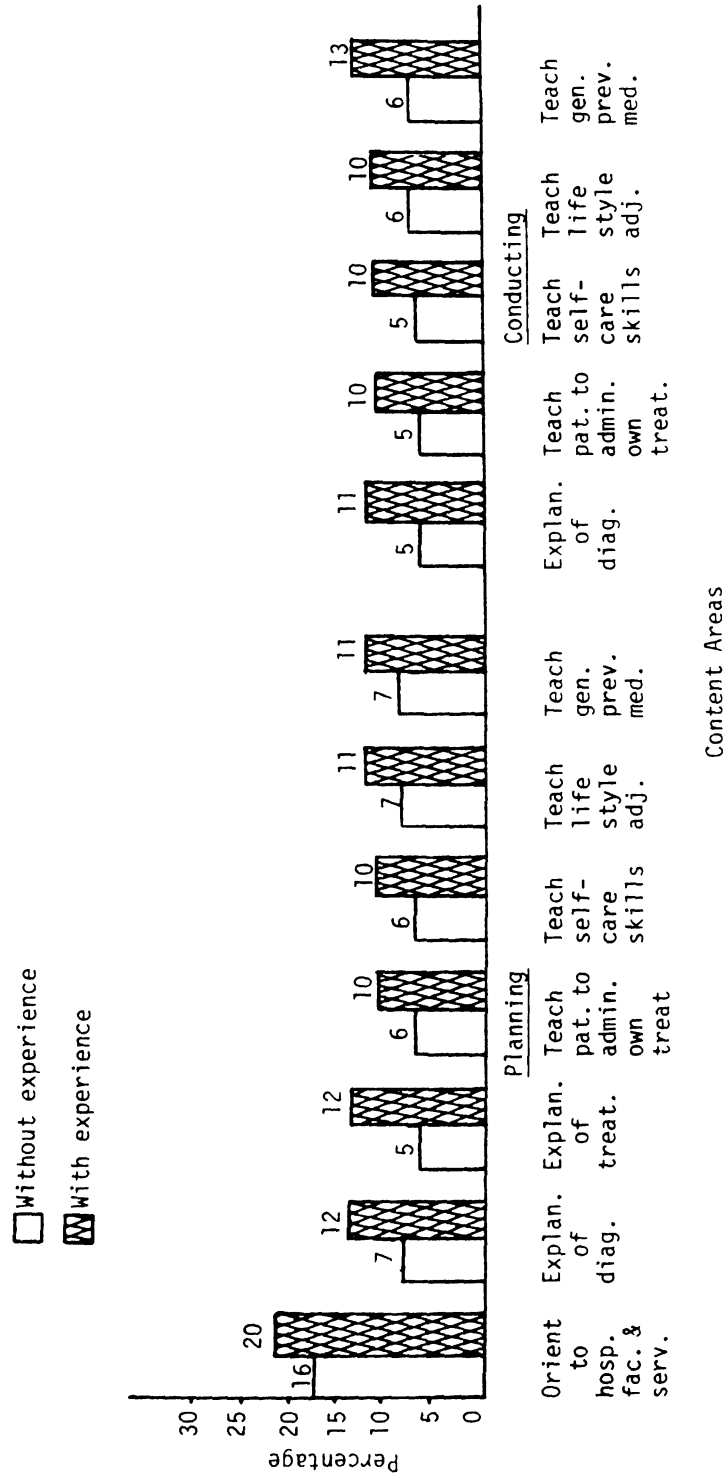


Figure 28.--Percentage of the total respondent group with and without experience in formal patient education programs who judged that hospital administrators should have supportive responsibility for planning and conducting of patient education activities in selected content areas.



activities. This was apparent in regard to planning in seven and in regard to conducting in five of the selected content areas.

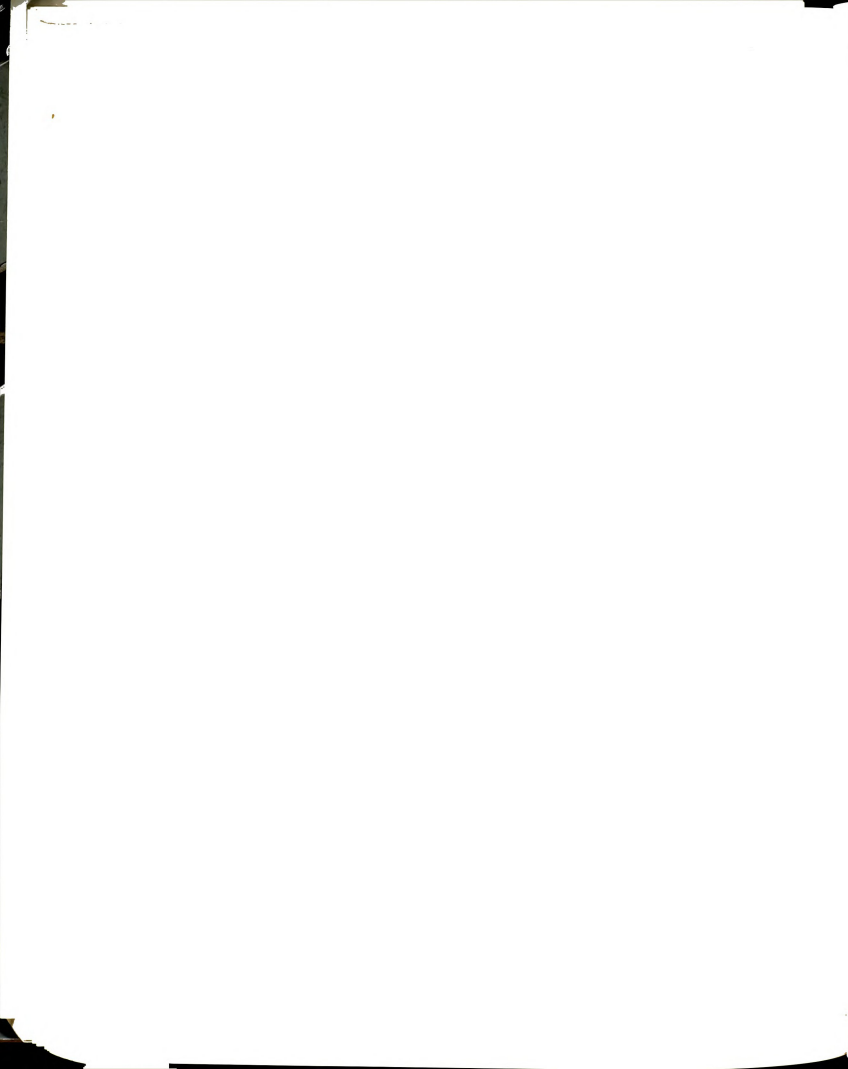
About 12% more of the allied health professionals, as shown in Figure 29, with experience than of those without experience indicated that hospital administrators should have supportive responsibility for planning teaching patients life style adjustment and for both planning and conducting the explanation of treatment and teaching of preventive medicine.

No other significant relationships appeared to exist between respondents' experience with formal patient education programs and their responses concerning responsibilities of hospital administrators for planning or conducting patient education activities.

In summary, hospital administrators were believed by less than 10% of each of the professional groups, including hospital administrators themselves, to have overall primary responsibility for either planning or conducting patient education activities. They were also seen by less than 10% of the physicians, nurses, and allied health professionals and about 16% of the patient education staff and hospital administrators themselves as having supportive roles in planning and conducting of those activities. No major differences of opinion were apparent among the groups.

Roles Deemed Appropriate for Former Patients

Approximately one-third (32.5%) of the total respondent group, as shown in Table 22, believed that former patients should



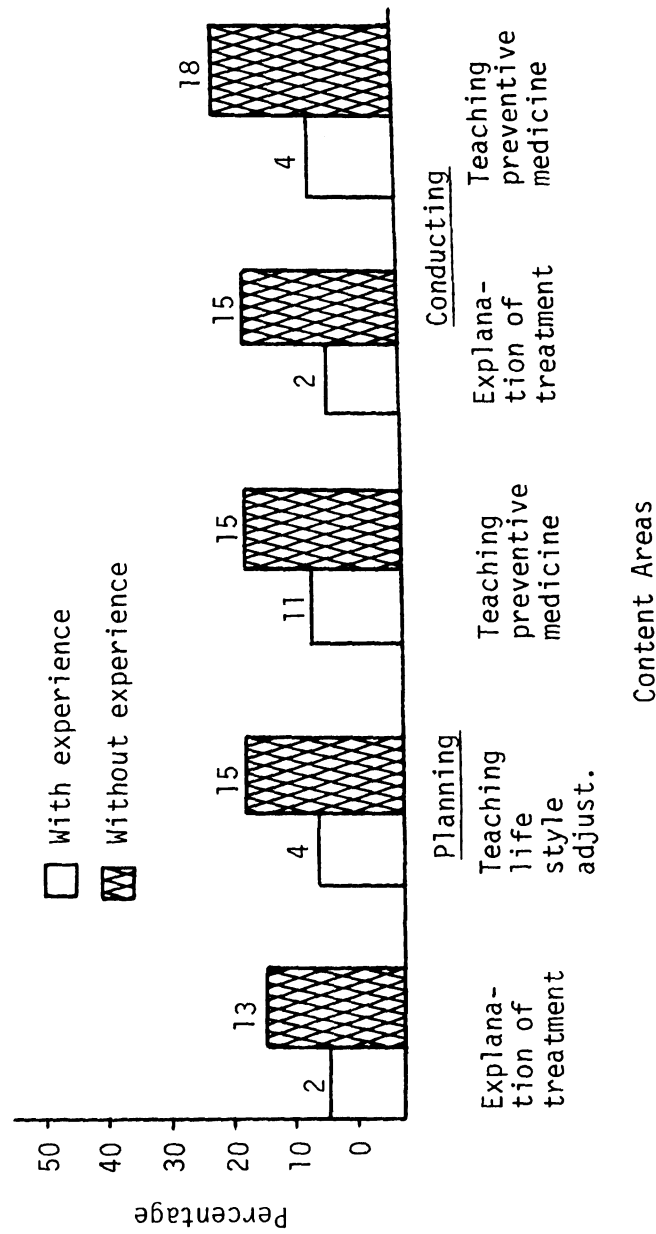


Figure 29.--Percentage of allied health professionals with and without experience in formal patient education programs who judged that hospital administrators should have supportive responsibility for planning and conducting of patient education activities in selected content areas.

be involved in planning patient education activities and 22.5% believed they should be involved in conducting those activities for hospital inpatients. Over half of these professionals believed that the involvement of former patients should depend on the health problem.

Table 22.--Percentage of respondents by professional group and for the total respondent group who believed that former patients should have a role in the planning and conducting of patient education activities.

Professional Group	Definitely Should Be Involved		Involvement Should Depend on Health Problem	
	Planning	Conducting	Planning	Conducting
Physicians N = 262	22.8	14.6	55.9	58.1
Nurses N = 268	38.7	29.6	53.9	58.4
Allied Health Professionals N = 97	39.2	26.5	51.5	52.0
Patient Education Staff N = 26	53.8	23.1	38.5	61.5
Hospital Administrators N = 18	23.5	11.8	58.8	58.8
Total Respondent Group N = 670	32.5	22.5	54.1	57.7

39

in

of

ac

ha

st

co

p

t

e

(

h

More than half (53.8%) of the patient education staff, 39.2% of the allied health professionals, and 38.7% of the nurses indicated that former patients should be involved in the planning of patient education activities. A smaller percentage of hospital administrators (23.5%) and physicians (22.8%) indicated this. Over half of each of these groups, except for the patient education staff (38.5%), indicated that involvement in planning patient education by former patients should depend on the health problem.

Approximately one-fourth of the nurses (29.6%), allied health professionals (26.5%), and patient education staff (23.1%) indicated that former patients should be involved in the conducting of patient education activities. Again a smaller percentage of physicians (14.6%) and hospital administrators (11.8%) indicated this. Over half of each of the professional groups indicated that involvement in conducting patient education by former patients should depend on the health problem.

In general a lesser percentage of physicians and hospital administrators than of other professional groups believed that former patients should be involved in planning and conducting patient education activities, regardless of the health problem. In contrast, a greater percentage of patient education staff than of all other groups believed that former patients should be involved, regardless of the health problem, in planning patient education activities.

Roles Deemed Appropriate for
Families of Present and
Former Patients

Nearly one-third (29.0%) of the total respondent group, as illustrated in Table 23, believed that families of present and former patients should be involved in planning patient education activities and 22% believed they should be involved in conducting those activities. About half (47.5%) of these professionals believed that involvement of such families in planning should depend on the health problem.

Table 23.--Percentage of respondents by professional group and for the total respondent group who believed families of present and former patients should have a role in planning and conducting of patient education activities.

Professional Group	Definitely Should Be Involved		Involvement Should Depend on Health Problem	
	Planning	Conducting	Planning	Conducting
Physicians N = 260	20.4	14.6	45.4	48.8
Nurses N = 268	36.8	31.1	46.8	49.8
Allied Health Professionals N = 95	31.6	18.9	48.4	46.3
Patient Education Staff N = 25	36.0	16.0	60.0	68.0
Hospital Administrators N = 16	12.5	12.5	62.5	62.5
Total Respondent Group N = 664	29.0	22.0	47.5	49.9

sion

fam

ning

cial

From

pla

hea

(18

ton

she

th

gr

by

o

a

p

p

t

p

About one-third of the nurses (36.8%), allied health professionals (31.6%), and patient education staff (36.0%) indicated that families of present and former patients should be involved in planning patient education activities. A smaller percentage of physicians (20.4%) and hospital administrators (12.5%) indicated this. From 45% to 63% of these same groups indicated that involvement in planning patient education by such families should depend on the health problem.

Fewer of the physicians (14.6%), allied health professionals (18.9%), patient education staff (16.0%), and hospital administrators (12.5%) indicated that families of present and former patients should be involved in conducting patient education activities. Of the nurses, 31.1% indicated this. From 46% to 68% of each of the groups indicated that involvement in conducting patient education by such families should depend on the health problem.

In general a somewhat lesser percentage of physicians than of most other professional groups believed that families of present and former patients should be involved in planning and conducting patient education activities. Conversely, a greater percentage of patient education staff than of most of the professional groups believed in the involvement of families of present and former patients.

In summary, a large percentage of professionals believed that former patients and families of present and former patients should be involved in both planning and conducting patient education activities. However, the involvement of both groups should be

dependent, for the most part, on the health problem of the patient. The patient education staff reacted the most favorably to the inclusion of these groups.

Ascribed Responsibility for Evaluation of
Patient Education Activities

Over half of the total respondent group, as shown in Table 24, believed that a variety of people and agencies should have a role in the evaluation of patient education activities. The groups included physicians, nurses, allied health professionals, patient education staff, patients and/or their families, and community home health agencies. The largest percentage of the total group indicated that patients and/or their families (76.3%) and physicians (68.8%) should be involved in evaluating programs.

Of the physicians, 71.6% and 64.8%, respectively, believed that they themselves and patients and/or their families should have a role in evaluating patient education activities. Somewhat lesser percentages of them believed that patient education staff (54%), allied health professionals (47.9%), nurses (45.2%), and community health agencies (36.9%) should have such a role. Only 21.1% would include hospital administrators in the evaluation.

A large percentage (84.8%) of the nurses indicated that patients and/or their families should have a role in the evaluation process. Approximately 70% of the nurses believed that both they themselves and physicians should have a role. A large number of them also saw a role for patient education staff (64.3%), allied health professionals (58.4%), and community home health agencies (56.2%).



Table 24.--Percentage of respondents by professional group and for the total respondent group who indicated that specific groups or agencies should have a role in evaluating patient education programs for hospital inpatients.

Group or Agency	Sub-Groups					Total Respondent Group N=671
	Physicians N=261	Nurses N=269	Allied Health Professionals N=98	Patient Education Staff N=26	Hospital Adminis- trators N=17	
Physicians	71.6	67.2	60.2	80.8	94.1	68.8
Nurses	45.2	70.6	50.0	88.5	76.5	57.8
Allied health professionals	47.9	58.4	71.4	65.4	52.9	56.3
Patient educa- tion staff	54.0	64.3	67.3	84.6	70.6	61.5
Hospital administrators	21.1	18.6	30.6	42.3	52.9	23.0
Patients and/or their families	64.8	84.8	76.5	92.3	94.1	76.3
Community home health agencies	36.9	56.2	57.1	76.9	58.8	49.7

Only
trat

sion
own
edu
pat
hea
hos

th
ed
be
nu
an
Ho

b
h
t
(
a
l

Only 18.1% of the nurses saw a role here for hospital administrators.

Approximately three-fourths of the allied health professionals believed that both patients and/or their families and their own professional group should have a role in evaluating patient education activities. A large number of them also saw a role for patient education staff (67.3%), physicians (60.2%), community home health agencies (57.1%), and nurses (50%). Only 30.6% would include hospital administrators.

A very large percentage of patient education staff believed that patients and their families (92.3%), nurses (88.5%), patient education staff themselves (84.6%), and physicians (80.8%) should be involved in evaluating patient education activities. A large number also believed that community home health agencies (76.9%) and allied health professionals (65.4%) should also have a role. Hospital administrators would be included by 42.3% of them.

An overwhelming majority of hospital administrators (94.1%) believed both physicians and patients and/or their families should have a role in the evaluation process. A somewhat lesser percentage believed that nurses (76.5%) and patient education staff (70.6%) should have a role. Approximately half of the hospital administrators also believed that community health agencies, hospital administrators themselves, and allied health professionals should also be involved in the evaluation.

Professional sub-groups were not in complete agreement as to who should have a role in the evaluation of patient education

ac

an

ph

fa

le

si

ha

be

sh

fo

be

si

th

ce

z

f

i

c

t

i

r

activities. A much greater percentage of patient education staff and hospital administrators than of other groups believed that physicians, nurses, patient education staff, patients and/or their families, and community home health agencies should have a role. A lesser percentage of the physicians than of the other groups consistently believed that all parties, except for themselves, should have a role in evaluating patient education activities.

In summary, the largest percentage of the professionals believed that patients and their families (76%) and physicians (68%) should have a role in evaluating patient education activities. Except for the physicians, a large percentage of the professionals also believed that nurses, patient education staff, allied health professionals, and community home health agencies should be involved in the process. Hospital administrators were included by lesser percentages of each of the groups.

Judgments About Organization of Patient Education Activities

This section describes five issues relating to the organization of patient education for hospital inpatients. Respondents first indicated what type of patient education activities, formal or informal, they would include within hospital patient education programs. Second, they indicated which categories of health problems they would choose first to develop organized patient education activities. The third issue focused on was the respondents' opinions on whether the hospital, community agencies, or a combination of the two should have the responsibility for providing needed

educ

on t

ment

on w

for

Type

Tabl

shou

educ

shou

prin

cons

tio

the

tha

opi

org

ti

of

an

(c

educational services for discharged patients. The fourth centered on the factors that impede or prevent the development and implementation of patient education programs. The fifth issue focused on was who should coordinate organized patient education programs for inpatients.

Types of Patient Education Activities

About 80% of the total respondent group, as shown in Table 25, judged that patient education for hospital inpatients should consist of an intentional combination of formal and informal educational activities. About 12% believed that the activities should be principally informal, while 8% believed they should be principally formal.

Most physicians (70%) agreed that patient education should consist of an intentional combination of formal and informal educational activities. However, one-fifth of the physicians judged that the activities should be principally informal, and one-tenth judged that they should be principally formal.

Nurses and allied health professionals shared similar opinions concerning how patient education activities should be organized. Approximately 85% judged that there should be an intentional combination of formal and informal activities. Only about 8% of each group believed the activities should be principally informal and 6 to 8% indicated that they should be principally formal.

An overwhelming percentage of patient education staff (92.3%) and hospital administrators (94.4%) judged that patient



Table 25.--Percentage of respondents by professional group and for the total respondent group who judged that patient education activities should be principally formal, principally informal, or an intentional combination of formal and informal activities.

Types of Activities	Physicians N=273	Nurses N=268	Allied Health Professionals N=97	Patient Education Staff N=26	Hospital Adminis- trators N=18	Total Respondent Group N=682
Principally informal	20.1	7.5	8.2	3.8	.0	12.4
Principally formal	10.3	6.0	8.2	3.8	5.6	8.0
Intentional combination of formal and informal	69.6	86.6	83.5	92.3	94.4	79.6

e

i

p

s

b

o

s

i

o

p

t

(

t

b

C

P

E

P

r

r

education should consist of an intentional combination of formal and informal activities. No hospital administrator and only a very small percentage (3.8%) of patient education staff believed the activities should be principally informal. A very small percentage (4.6%) of both groups believed the activities should be principally formal ones.

Physicians' opinions differed the most from the other professional groups on how patient education activities should be organized. More than twice the percentage of physicians as compared to other groups judged that patient education activities should be principally informal, and a moderately larger percentage judged that they should be principally formal. The majority of physicians (69.6%), however, agreed with the other groups (83.5% to 94.4%) that patient education programs should include an intentional combination of both formal and informal activities.

Categories of Health Problems Which
Professionals Would Choose First for
Developing Organized Patient Education
Programs for Hospital Inpatients

The findings concerning which health problem areas should receive priority in the development of organized or formal patient education programs are presented in Table 26. Respondents were asked to choose, out of a list of twenty health problem areas, the five areas which they would choose first for developing programs.

The largest percentage of the total respondent group chose the following five health problems: (1) diabetes (67.7%), (2) cardiac (58.6%), (3) cancer--general (45.1%), (4) hypertension

Table 26.--Percentage of respondents by professional group and for the total respondent group who indicated selected health problem areas as ones which they would choose first for developing organized patient education programs.

Health Problem Area	Total Respondent Group N=641	Physicians N=248	Nurses N=257	Allied Health Professionals N=92	Patient Education Staff N=26	Hospital Administrators N=18
Diabetes	61.7	62.7	64.0	53.3	76.9	77.8
Cardiac	58.6	52.6	59.6	69.6	69.2	61.1
Cancer	45.1	44.0	50.2	40.9	30.8	27.8
Hypertension	40.2	43.9	36.9	35.9	42.3	56.6
Alcoholism & drug	39.7	45.2	42.0	28.0	11.5	27.8
Pre- & post-natal	29.9	27.8	28.8	34.1	38.5	41.2
Stroke	28.7	26.1	27.7	35.1	26.9	50.0
Ostomy	28.3	28.2	28.0	29.0	25.0	22.2
Pulmonary disease	28.1	33.9	23.4	25.0	24.0	33.3
Pre- & post-operative care	27.7	15.9	39.4	19.6	50.0	23.5
Personal health habits	26.3	35.1	21.3	19.4	23.1	22.2
Mental health	24.0	23.9	23.2	26.7	26.9	23.5
Mastectomy	13.1	9.9	15.2	14.0	15.4	16.7
Arthritis	12.6	15.9	5.6	20.4	4.0	7.8
Spinal cord injuries	9.2	8.2	10.4	12.0	.0	.0
Orthopedic disease & injuries	7.6	6.7	5.7	15.1	3.8	5.9
Kidney	5.6	3.3	6.7	11.2	.0	.0
Gastrointestinal disease	5.2	4.1	6.6	4.4	4.0	5.9
Speech & hearing	4.3	4.4	5.3	12.0	3.8	.0
Vision	1.4	1.2	1.5	1.1	3.8	.0

(4)

on

he

an

ea

ch

co

co

g

o

t

a

(

t

c

(40.2%), and (5) alcohol and drug dependency (39.7%). At least one-fourth of the respondents also indicated that programs in mental health, ostomy care, personal health habits (e.g., smoking), pre- and post-natal care, pre- and post-operative care, pulmonary disease, and stroke should be among the first to be included.

The largest percentage of all of the professional groups chose diabetes and cardiac-related illnesses as the highest priority categories in which they would first develop organized patient education programs. There were differences of opinions among the groups concerning the other priority areas. Ten additional categories of health problems were indicated by one-fourth or more of most of the professional groups as ones which should be included. These areas were: (1) cancer (all groups); (2) hypertension (all groups); (3) alcoholism and drug abuse (nurses, physicians, allied health professionals, and hospital administrators); (4) pre- and post-natal care (all groups); (5) stroke (all groups); (6) ostomy care (all groups); (7) pulmonary disease (physicians, allied health professionals, and hospital administrators); (8) pre- and post-operative care (nurses and patient education staff); (9) personal health habits (physicians); and (10) mental health (allied health professionals and patient education staff).

As outlined above, professional groups responded somewhat differently concerning which five priority categories they would first choose to develop organized patient education programs. Patient education staff and hospital administrators in contrast to the other three professional groups exhibited the greatest differences of

opinions. A much lower percentage (only 11.5%) of patient education staff than of the other four professional groups chose alcoholism and drug abuse as one of the top five categories. In contrast, a much higher percentage of the patient education staff (50%) indicated pre- and post-operative care within their top five choices. A much larger percentage of the hospital administrators (50%) than of the other four professional groups indicated stroke as one of their top five choices.

Ascribed Responsibility of Hospital
and Community Agencies for
Discharged Patients Who Need
Further Educational Services

The majority of the respondent group (59.4%), as shown in Table 27, believed that both hospital and community agencies should provide needed educational services for discharged patients. A large percentage of professionals (39.9%), though, believed that patients should principally be referred to appropriate community agencies upon discharge. A very small percentage (1.2%) believed that principally the hospital should provide these services. The professional groups for the most part were in agreement with each other concerning this issue.

Factors Believed to Impede or Prevent
the Development and Implementation of
Patient Education Activities for
Hospital Inpatients

A large number of the total responding group, as shown in Table 28, believed that the following factors tend to impede or

Table 27.--Percentage of respondents by professional group and for the total respondent group who identified principal responsibility for educational services to discharged patients with hospitals and with other community agencies.

Responsible Organization	Physicians N=253	Nurses N=256	Allied Health Professionals N=99	Patient Education Staff N=26	Hospital Administrators N=17	Total Respondent Group N=660
Hospital continue services	2.8	.4	.0	.0	.0	1.2
Refer patients to community agencies	43.1	37.0	36.4	34.6	29.4	39.4
Combination of both hospital and community agencies	54.2	62.3	63.6	65.4	70.6	59.4

Table 28. --Percentage of respondents by professional group and for the total respondent group who
have participated in patient education activities for the past 12 months.

Table 28.--Percentage of respondents by professional group and for the total respondent group who believed the development and implementation of patient education activities for hospital inpatients were impeded or prevented by designated factors.

Factors	Total Respondent Group N=634	Physicians N=232	Nurses N=269	Allied Health Professionals N=92	Patient Education Staff N=25	Hospital Adminis- trators N=16
Lack of staff time	79.6	70.0	88.3	80.2	65.4	100.0
Lack of identified staff to coordinate	66.7	60.4	71.8	69.5	53.8	80.0
Lack of third-party payments for patient ed.	50.0	59.8	39.9	50.0	44.0	75.0
Cost of patient education	49.7	53.8	45.6	52.1	23.1	88.2
Lack of necessary equipment & facilities	45.6	45.1	48.0	43.0	20.0	68.0
Lack of necessary resource materials	43.7	45.9	46.1	38.6	16.0	47.1
Lack of staff interest	40.5	43.5	41.4	37.4	29.2	17.6
Lack of staff competence	36.4	31.6	42.9	28.6	38.5	52.9
Lack of acceptance by physicians	36.3	29.1	40.7	35.2	53.8	53.3
Lack of acceptance by hospital administrator	27.9	18.8	37.2	29.0	20.8	25.0
Lack of patient interest	24.5	28.1	23.5	18.9	24.0	25.0
Lack of acceptance by nurses	13.7	10.5	16.0	8.8	18.6	13.3
Lack of acceptance by allied health prof.	11.5	18.8	18.5	4.5	4.2	6.7

pr

ac

st

th

(4

of

ci

ed

ne

to

ac

(7

pr

e

t

a

prevent the development and implementation of patient education activities: (1) lack of staff time (80%), (2) lack of identified staff to coordinate patient education activities (67%), (3) lack of third-party payments for patient education activities (51%), and (4) cost of patient education activities (50%). Approximately 40% of these same professionals believed lack of acceptance by physicians of patient education; lack of staff competence to do patient education; lack of staff interest in patient education; and lack of necessary facilities, equipment, and resource materials to be factors. About one-third of the professionals believed that lack of acceptance by hospital administrators was a factor.

A majority of the physicians agreed that lack of staff time (70%), lack of identified staff to coordinate (60.4%), lack of third-party payments for patient education (59.8%), and cost of patient education (53.8%) were factors. Approximately 45% also believed that lack of necessary facilities, equipment, and resource materials and lack of staff interest were factors.

A large percentage of the nurses (88.3%) believed lack of staff time and a lack of identified staff (71.8%) to be factors that can impede or prevent the development and implementation of patient education activities. Forty-five to forty-eight percent of the nurses believed cost of patient education and a lack of necessary equipment, facilities, and resource materials to be factors. Approximately two-fifths of the nurses also saw lack of staff interest and competence, lack of acceptance by hospital administrators and

phys

as

als

les

din

juc

be

sa

ta

th

br

t

p

c

physicians, and lack of third-party payments for patient education as factors.

A large percentage of the allied health professionals (80.2%) also agreed that lack of staff time was a factor, while a somewhat lesser percentage (69.5%) believed lack of identified staff to coordinate was a factor. About half of the allied health professionals judged lack of third-party payments and cost of patient education to be factors. Somewhat over one-third of them believed lack of necessary resource materials, lack of staff interest, and lack of acceptance by physicians to be factors.

Sixty-five percent of the patient education staff agreed that the lack of staff time was a factor. About half of them believed lack of identified staff to coordinate and lack of acceptance by physicians to be factors. Approximately two-fifths of the patient education staff saw lack of third-party payments and staff competence as factors.

All of the hospital administrators agreed that lack of staff time was a factor. A large percentage of them judged that the cost of patient education (88.2%), lack of identified staff to coordinate (80%), lack of third-party payments (75%), and lack of necessary facilities and equipment (68%) were factors. About half of the hospital administrators believed lack of necessary resource materials, staff competence, and acceptance by physicians to be factors.

Professional groups had somewhat differing opinions concerning the factors that can impede or prevent the development and implementation of patient education programs. A smaller percentage

of

lac

tie

tha

as

ton

pat

gro

Coc

Pa

men

pro

ju

or

be

pr

gr

Th

in

pr

th

in

of patient education staff than of most other professional groups saw lack of third-party payments, cost, lack of equipment and facilities, or lack of necessary resources as impediments. More frequently than other groups they saw lack of acceptance by physicians and nurses as the problem. A much greater percentage of hospital administrators than of the other groups saw numerous impediments. They, like patient education staff, more frequently than the other professional groups believed that lack of acceptance by physicians was a factor.

Coordination of Organized Patient Education Programs

The respondents were asked to indicate which hospital department was best equipped to coordinate an organized patient education program. Half of the total respondent group, as shown in Table 29, judged that a separate education department could best coordinate an organized patient education program. Approximately 30% of them believed that nursing was the best department to coordinate such a program.

The professional groups were in general agreement. Each group judged that a separate education department would be best. The second highest percentage of each of the professional groups indicated that the nursing department could best coordinate such programs. The nurses indicated a slightly stronger preference for the nursing department; conversely, the allied health professionals indicated a weaker preference.

Table 29.--Percentage of respondents by professional group and for the total respondent group who judged that organized patient education programs could best be coordinated in designated departments of hospitals.

Hospital Department	Physicians N=246	Nurses N=265	Allied Health Professionals N=94	Patient Education Staff N=26	Hospital Administrators N=17	Total Respondent Group N=648
Education	46.3	47.2	60.6	57.7	52.9	49.5
Nursing	26.0	38.5	12.8	26.9	29.4	29.3
Personnel	.8	.4	3.2	.0	.0	.9
Social services	14.6	7.5	10.6	.0	17.6	10.6
Other	12.2	6.4	12.8	15.4	.0	9.7

S

m

o

O

m

Pl

ac

ph

sh

ci

si

ac

mc

pi

ij

g

a

c

tr

c

s

r

Summary

In summary, a large percentage of professionals (approximately 80%) believed that patient education programs should consist of an intentional combination of formal and informal activities. Only 12% of them believed the activities should be principally formal, while 8% believed that they should be principally informal. Physicians differed the most on how they believed patient education activities should be organized. At least twice the percentage of physicians as of other groups judged that patient education activities should be principally formal. While a smaller percentage of physicians than of other groups believed that such programs should consist of an intentional combination of both informal and formal activities, a majority of them agreed that such a combination was most appropriate.

Diabetes and cardiac-related illnesses were chosen by the professionals as the two health problem areas with highest priority in organizing patient education programs. Other priority categories given by the professional groups included cancer, hypertension, alcohol and drug abuse, pre- and post-natal care, stroke, ostomy care, pre- and post-operative care, personal health habits, and mental health.

A majority of the professionals (about 59%) agreed that a combination of the hospital and appropriate community agencies should have the responsibility for providing further educational services to hospital inpatients following discharge. There was a large minority (about 39%), however, who indicated that only the

community agencies should have responsibility for further educational services needed by discharged patients.

Lack of staff time and a person to coordinate patient education activities were given by the professionals as the two major factors that impede or inhibit the development and implementation of organized patient education programs. Other factors also agreed upon by a large number of professionals included cost of patient education, lack of third-party payments, and lack of acceptance by physicians. The professional groups responded somewhat differently as to which factors inhibit the development and implementation of organized patient education programs. The patient education staff and hospital administrators exhibited the greatest differences of opinion from the other groups.

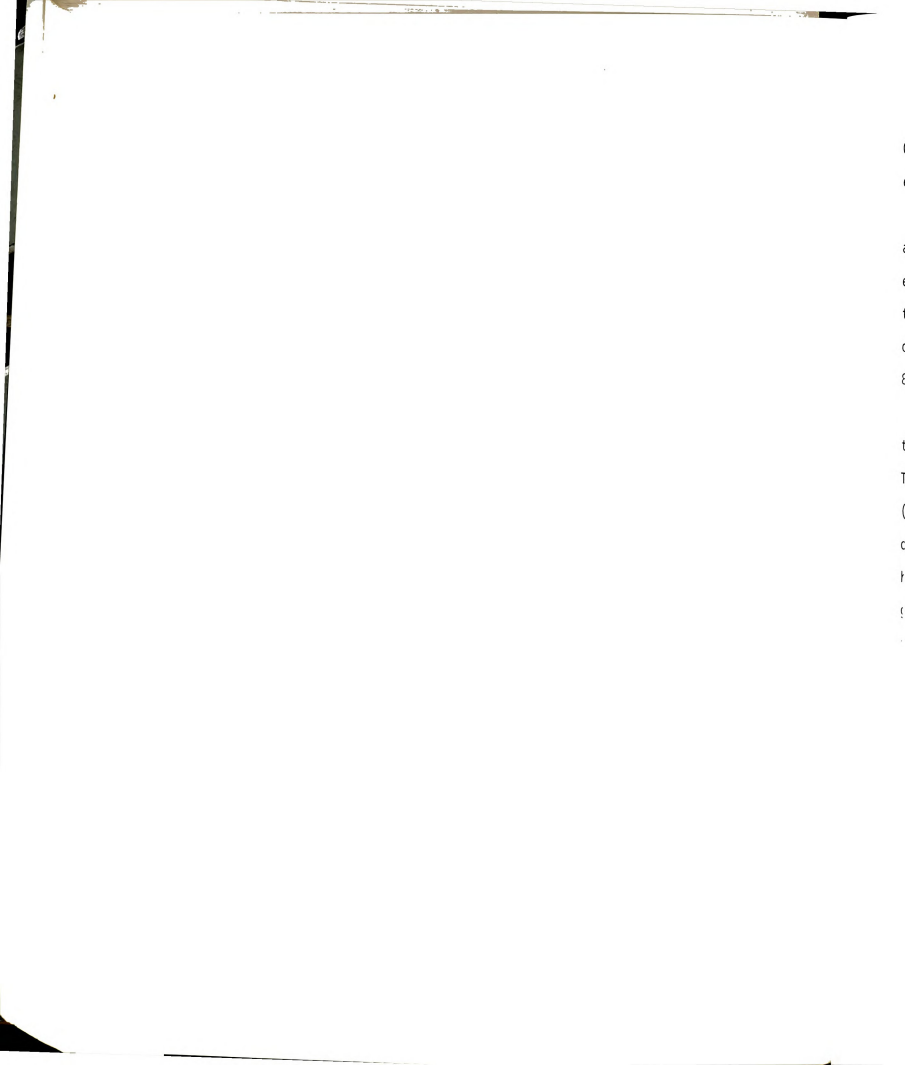
About half of the professionals believed that a separate educational department would be the best department to coordinate an organized patient education program. A minority, however, of all of the professional groups except the allied health professionals indicated that the nursing department would be better able to do this.

Judgments as to Feasibility of Developing
or Expanding Organized Patient
Education Programs

Approximately three-fourths of the total respondent group, as shown in Table 30, believed that it was feasible to develop or expand organized patient education programs in their hospitals.

Table 30.--Percentage of respondents by professional group and for the total respondent group who indicated the feasibility of developing or expanding organized patient education programs in their hospitals.

Feasibility	Physicians N=257	Nurses N=265	Allied Health Professionals N=97	Patient Education Staff N=25	Hospital Adminis- trators N=17	Total Respondent Group N=661
Yes	72.4	84.5	71.1	100.0	64.7	78.0
No	8.9	5.7	7.2	0.0	11.8	7.1
Uncertain	18.7	9.8	21.6	0.0	23.5	14.9



Only 7.1% believed these types of programs could not be developed or expanded, while 15% were uncertain.

Although physicians, allied health professionals, and hospital administrators were not quite as positive as the nurses and patient education staff, all groups agreed that it would be feasible. More than 70% of the physicians and allied health professionals and 64.7% of the hospital administrators believed it was feasible, as did 84.5% of the nurses and 100% of the patient education staff.

Professionals who responded "no" or "uncertain" to this question were asked to explain briefly the rationale for their answers. The reasons most often given by all professional groups were: (1) lack of funds to support patient education programs, (2) lack of staff to do patient education, (3) lack of knowledge concerning hospital's patient education activities or hospital operations in general, (4) the small size of the hospital, and (5) lack of staff interest in patient education. Physicians noted two additional factors: (1) lack of proven cost-effectiveness of patient education and (2) that patient education was the physician's responsibility. Nurses also noted two other factors: (1) lack of staff training in patient education and (2) patient education was a low priority of the hospital's administration.

Further analyses were done to investigate differences in judgments of the professionals on the feasibility of developing or expanding patient education programs. These analyses were done within the total respondent group and within three of the professional groups in relation to several variables: size of hospital,

who

re:

ca

Th

sh

an

Fi

pl

tl

t

c

s

p

c

c

whether the hospital had a formal patient education program, whether respondents had participated in specific training for patient education, and whether they had experience with patient education. The three professional groups were the larger groups and those who showed larger differences in ratings, namely physicians, nurses, and allied health professionals.

The total respondent group (see Figure 30), nurses (see Figure 31), and allied health professionals (see Figure 32) who practiced within the larger hospitals were more in agreement than those in smaller hospitals with the premise that it was feasible to develop or expand formal patient education programs. The physicians demonstrated no major variance in their responses in relationship to the size of the hospital where they practiced. Size of hospital seems to be a significant factor in relationship to respondents' judgments of the feasibility of expanding organized patient education programs.

For only one of the groups, allied health professionals, was there a significant relationship between their judgments concerning the feasibility of developing or expanding organized patient education programs and whether the hospital in which they practiced had a formal patient education program. Approximately 30% more of the allied health professionals, as illustrated in Figure 33, in hospitals with formal patient education programs than of those in hospitals without programs judged that development or expansion was feasible.



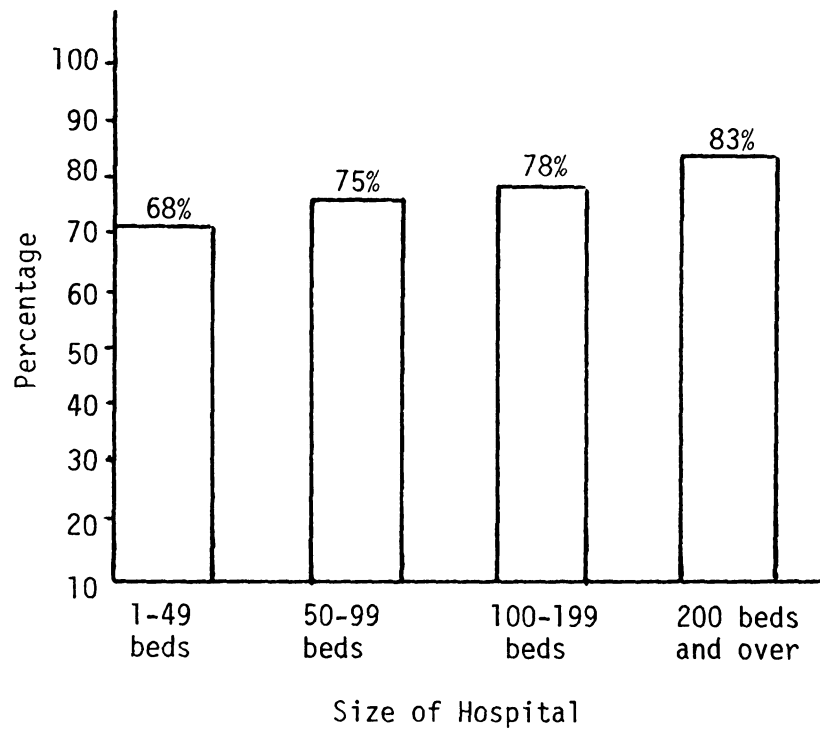


Figure 30.--Percentage of total respondents by hospital size who believed it was feasible to develop or expand formal patient education programs.

Percentage

F

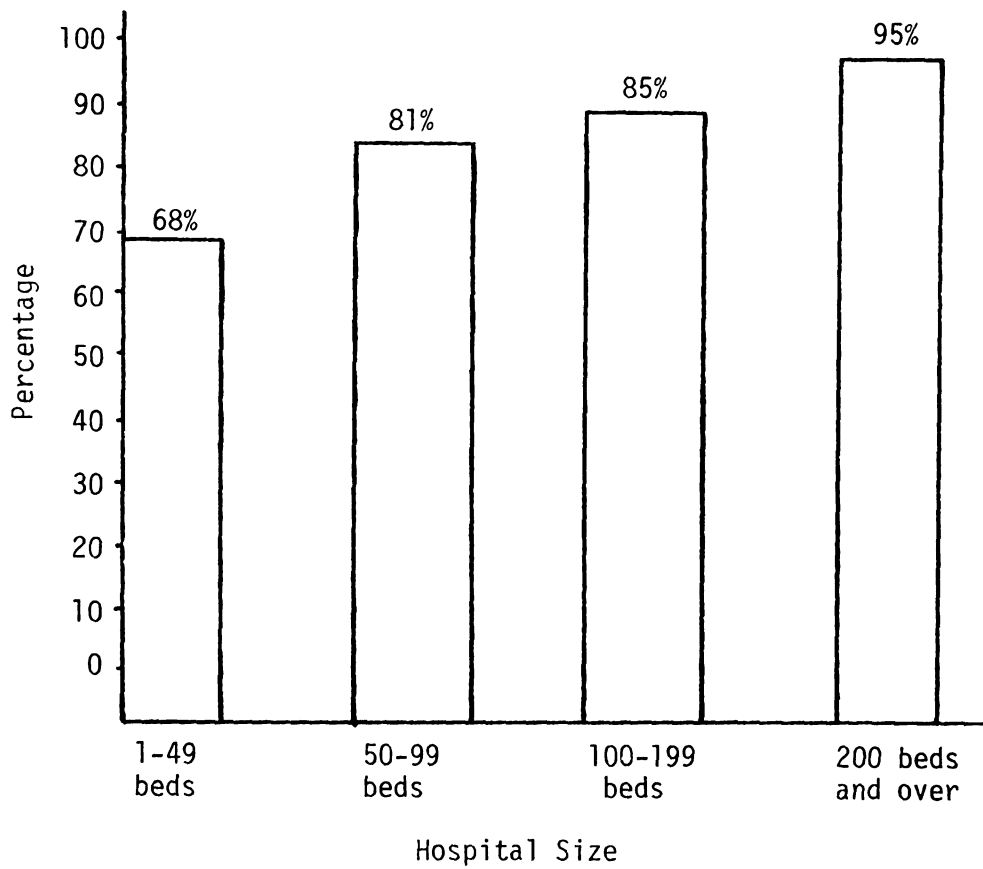


Figure 31.--Percentage of nurses by hospital size who believed it was feasible to develop or expand formal patient education programs.



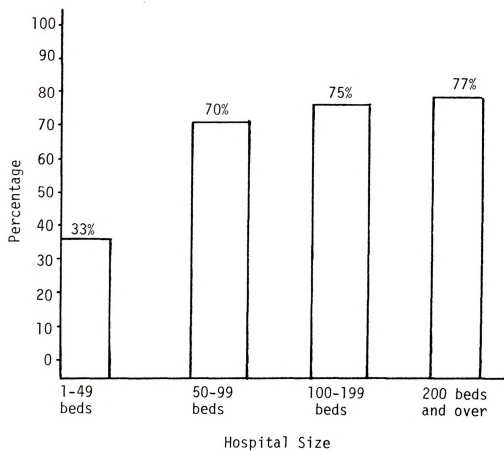


Figure 32.--Percentage of allied health professionals by hospital size who believed it was feasible to develop or expand formal patient education programs.



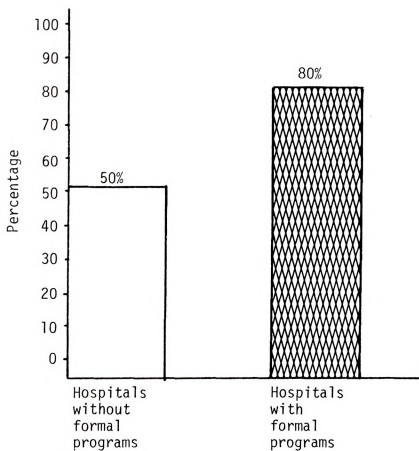


Figure 33.--Percentage of allied health professionals who worked in hospitals with and without formal patient education programs who judged that it was feasible to develop or expand formal patient education programs.



There were also apparent significant correlations between both the respondents' experience with formal patient education programs and their attendance at educational programs on or related to patient education and their judgments concerning the feasibility of developing or expanding formal patient education programs. About 10% more of the total respondent group (as illustrated in Figure 34) who had experience in formal patient education programs and (as illustrated in Figure 35) of those who had previously attended educational programs related to patient education indicated that it was feasible either to develop or expand formal patient education programs.

Physicians were the only sub-group who demonstrated a positive relationship between their judgments on the feasibility of developing or expanding organized patient education programs and their experience with formal patient education programs. As shown in Figure 36, approximately 16% more of the physicians who had experience with formal patient education than of those who did not believed it was feasible to develop or expand such programs.

In summary, a large percentage of professionals believed it was feasible to either develop or expand formal patient education programs in their hospitals. Higher percentages of patient education staff and nurses than of physicians, allied health professionals, and hospital administrators believed development or expansion to be feasible. There were apparent significant correlations between the size of hospital where respondents practiced, respondents' experience with formal patient education programs, and respondents'



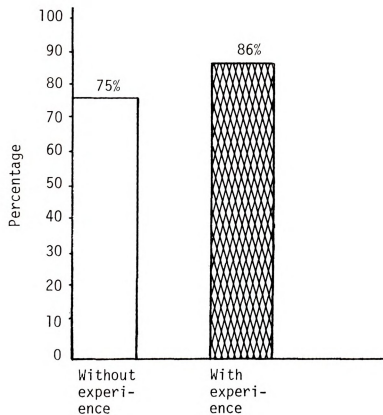


Figure 34.--Percentage of total respondent group with and without experience in formal patient education programs who indicated that it was feasible to develop formal patient education programs in their hospitals.



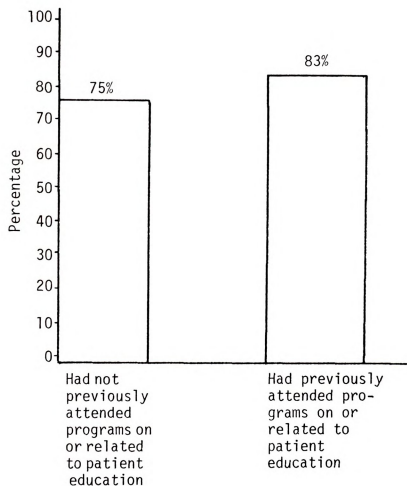


Figure 35.--Percentage of total respondent group who had and had not previously attended programs on or related to patient education who indicated that it was feasible to develop formal patient education programs in their hospitals.



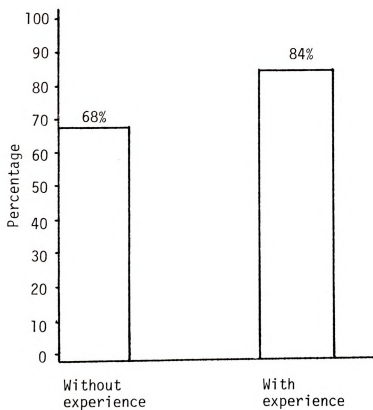
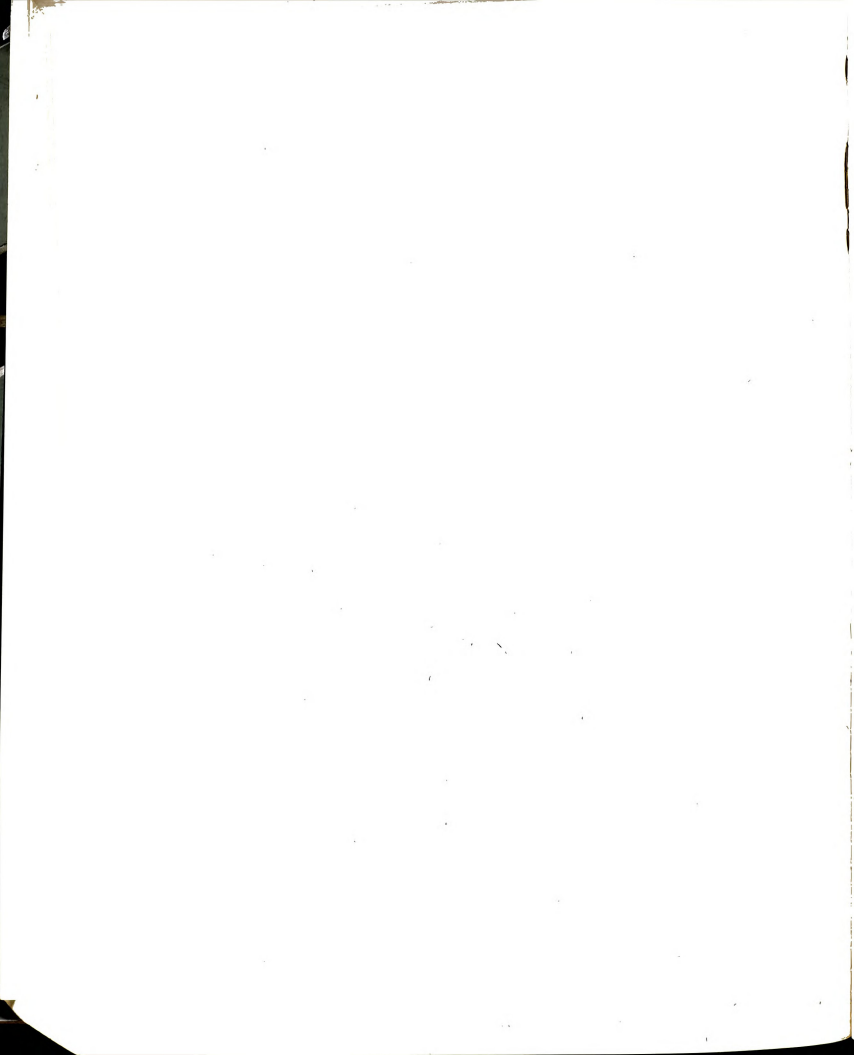


Figure 36.--Percentage of physicians with and of those without experience in formal patient education who indicated that it was feasible to develop formal patient education programs in their hospitals.



attendance at educational programs and their judgments concerning the feasibility of developing or expanding formal patient education programs.

In this chapter the findings of the study have been reported. They have been summarized section by section. An overall summary of findings is incorporated in the next chapter.



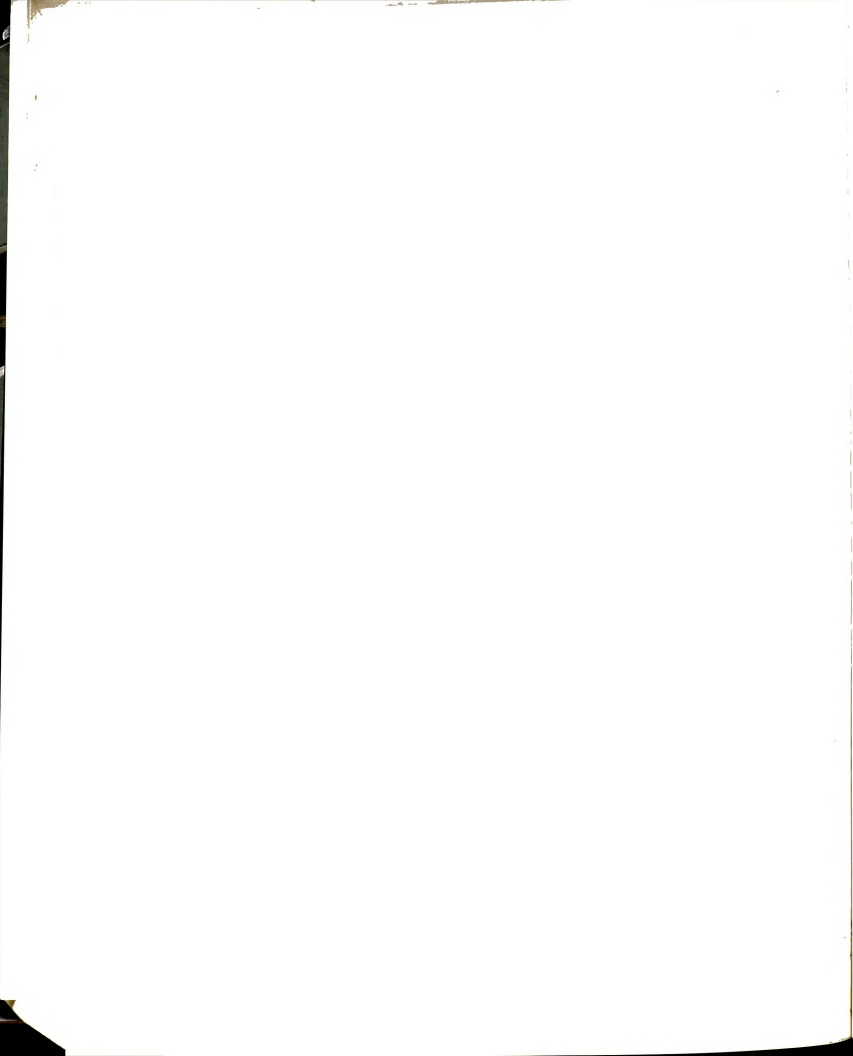
CHAPTER V

SUMMARY, CONCLUSIONS, AND IMPLICATIONS

The first section of this chapter is a summary of the purpose and procedures of this study. The second section is a review of the major findings. The third section outlines the conclusions. The last section contains implications, for both practice and research, and general reflections on the study.

Summary of Purpose and Procedures of Study

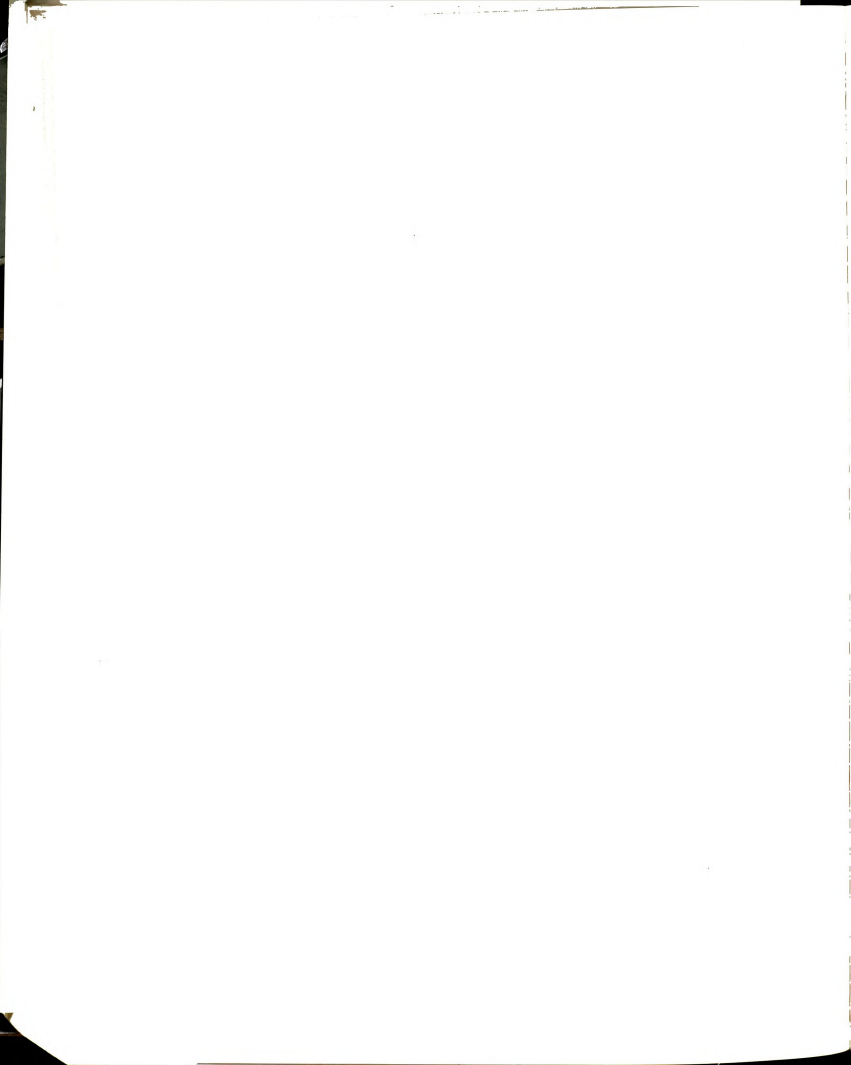
The purpose of this study was to investigate how health care professionals, collectively and by professional specialty groups, in Maine community hospitals viewed patient education for the hospital inpatient population. The study examined views on the following issues: (1) general importance of patient education for hospital inpatients, (2) content areas appropriate for inclusion in hospital patient education programs, (3) roles of professionals in the planning and implementation of patient education activities, (4) roles of former patients and families of present and former patients in the planning and implementation of patient education activities, (5) evaluation of patient education activities, (6) types of patient education programs, (7) which major illness categories present the greatest need for organized patient education programs, (8) the hospital's role in the follow-up of discharged patients who need



further educational services, (9) factors that inhibit development and implementation of organized patient education programs, (10) coordination of hospital patient education, and (11) feasibility of developing or expanding organized patient education programs.

Twenty-two hospitals, almost half of the Maine community hospitals, were selected as a stratified random sample. Equal proportions of those chosen had and did not have operating formal patient education programs. All physicians, allied health professionals, and hospital administrators and one-third of the nurses from these hospitals were surveyed by mailed questionnaires. All patient education staff personnel working in all Maine community hospitals were also surveyed.

The data generated from the survey were presented in several ways. First a display of the data showed how all professionals, collectively and by sub-groups, responded to each question area. The data were then analyzed using Chi-square tests of independence to ascertain the significance of differences in judgments among the professional sub-groups on each of the issues in question. Finally, the data were analyzed again using Chi-square tests of independence to ascertain how responses varied in relation to four additional factors (size of hospital, whether the hospital had a formal patient education program, whether respondents had experience in formal patient education programs, and respondents' training in patient education). This was done with the three largest professional groups, physicians, nurses, and allied health professionals, as a total group and by professional group.

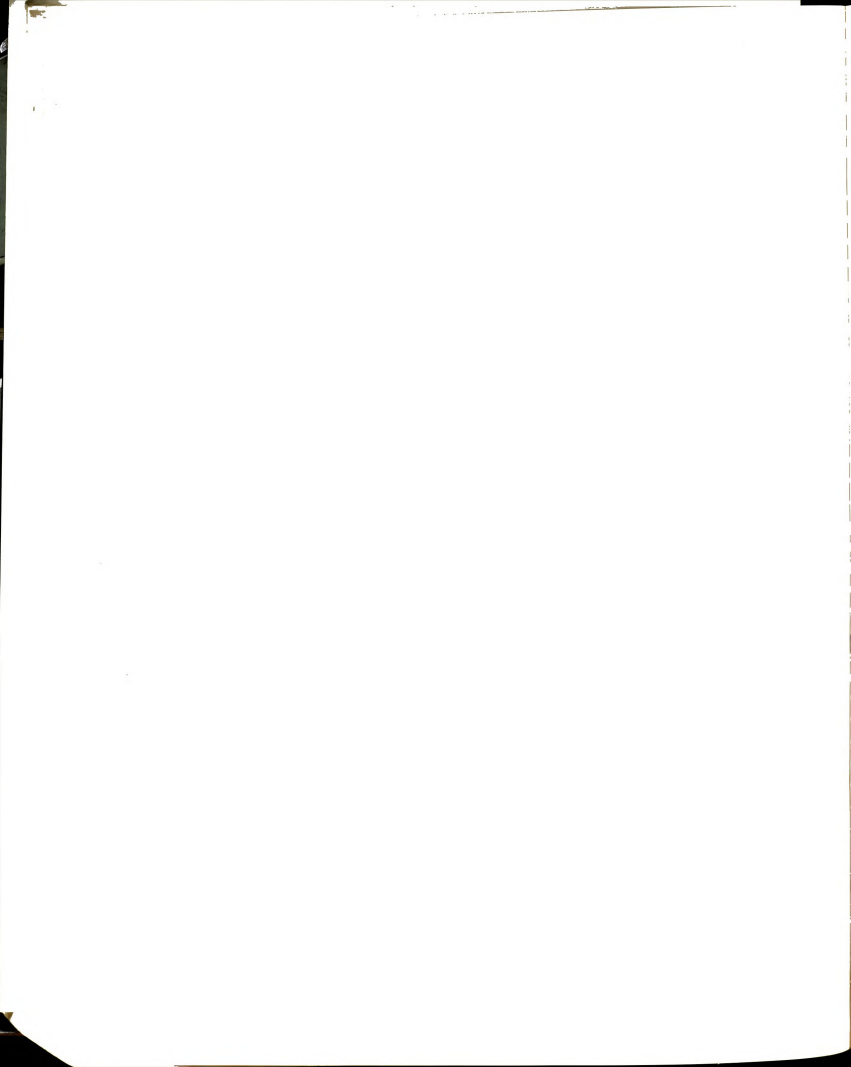


The findings and conclusions of this study are generalizable to Maine community hospitals. Although similar findings might be expected from other settings, the current study included only Maine hospitals and the sample was chosen to represent only that population.

Review of Findings

Professionals overwhelmingly agreed that patient education is an important component of patient care. Thirty-five percent of the total respondent group believed patient education to be extremely important and another 6.5% believed it to be moderately important for some patients, and 44% believed it to be extremely important and another 10.8% believed it to be moderately important for all patients.

A variety of content areas were judged by professionals to be appropriate to include in hospital patient education programs. All professionals rated the most important areas as teaching patients to administer their own treatment (86.1% extremely important and 11.8% moderately important), teaching patients self-care independent living skills (85.3% extremely important and 12.7% moderately important), and explanation of diagnosis and treatment of the health problem (79.4% extremely important and 15% moderately important). Every one of the selected topics was judged to be at least moderately important by more than 80% of all respondents. Patient education staff uniformly rated all of the specified content areas as more important to include than did other professional groups. Physicians

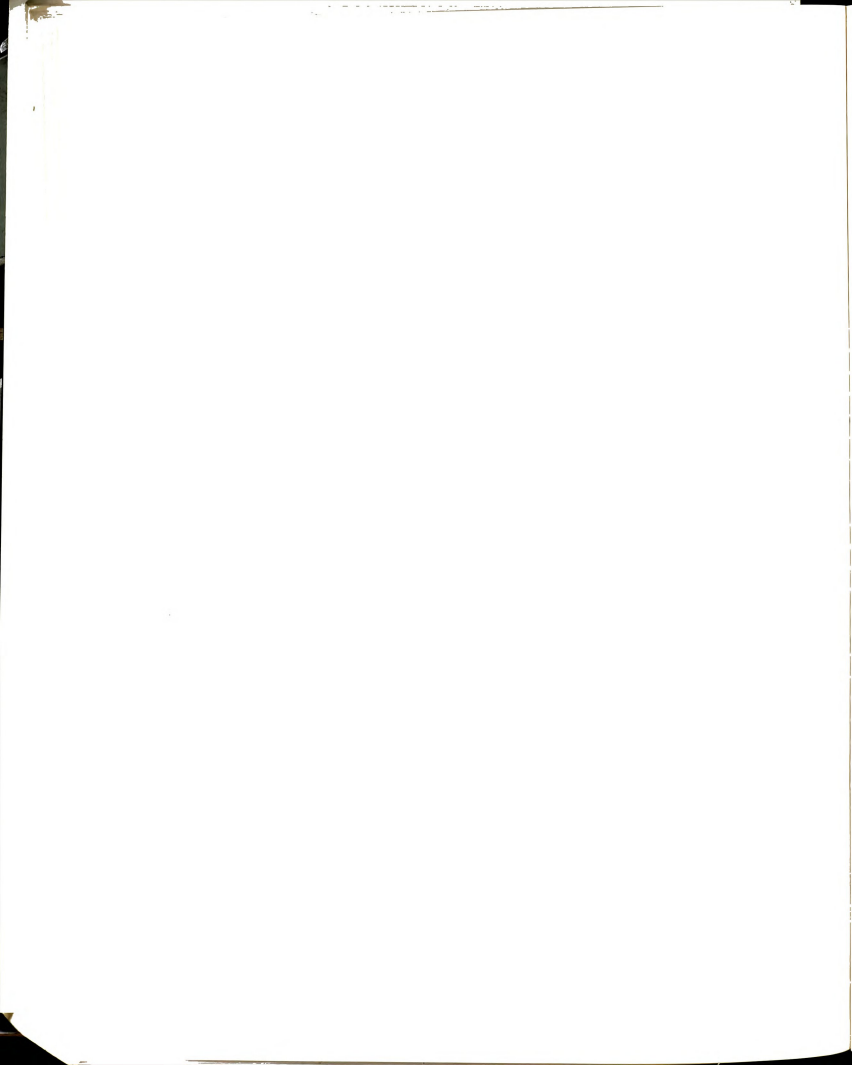


and hospital administrators rated most of the areas as less important to include than did other professional groups.

No one professional group was judged, by a majority of the total respondent group, to have sole overall responsibility for planning and conducting patient education activities. Only one-fourth to one-third of the total respondent group judged that any one group (patient education staff, physicians, nurses, or allied health professionals) should have this overall primary role. Only a very small percentage (4.5%) of them indicated that hospital administrators should have this role. However, each group, except for the hospital administrators, was indicated by the total respondent group as having primary responsibility for planning and conducting of one or more selected content areas.

Each of the professional groups described both its own primary role and the primary roles of other professional groups in the planning and/or conducting of patient education activities somewhat differently than did other groups. Two groups, patient education staff and physicians, more frequently than all the other groups, indicated that their own professional roles should include primary responsibility for planning patient education activities. Two of the other groups, nurses and allied health professionals, also indicated more frequently than all but the patient education staff that their roles should include primary responsibility for both planning and conducting patient education activities.

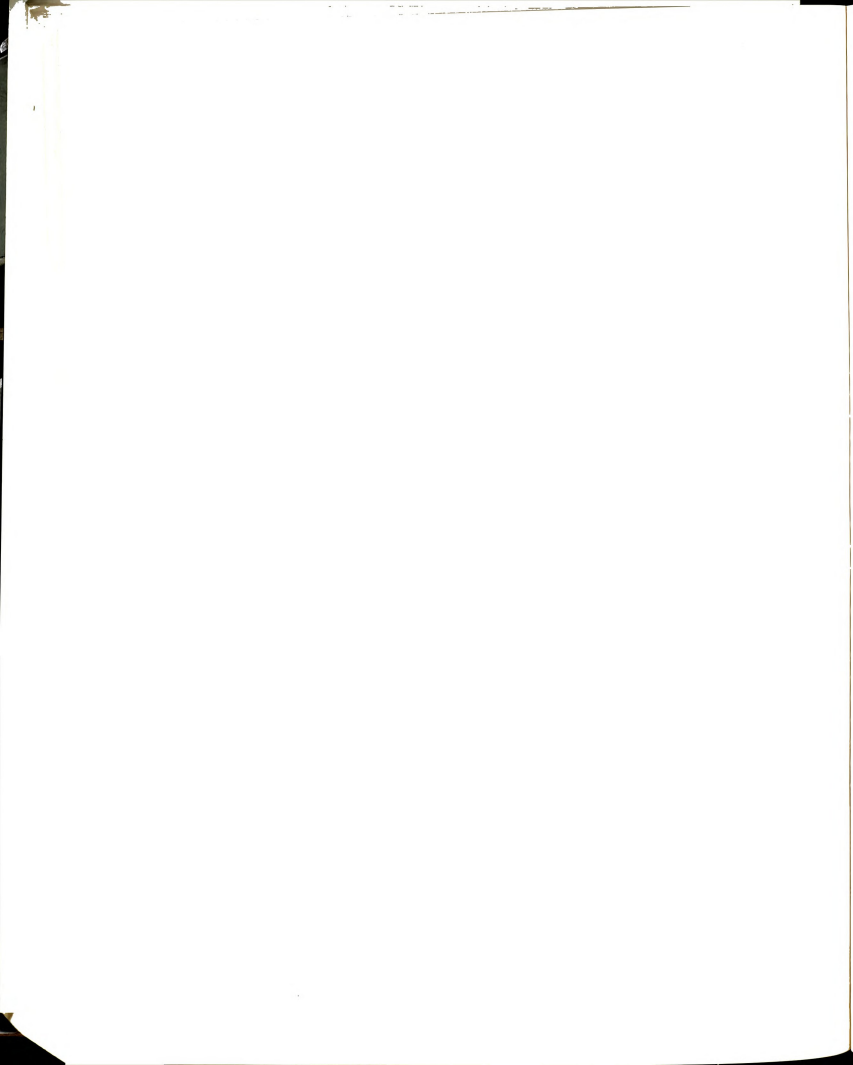
The patient education staff most frequently accorded to nurses a primary role in conducting patient education activities.



The physicians, less frequently than all of the other professional groups, accorded to groups other than themselves primary responsibility for patient education activities. This was especially so in comparison to the patient education staff and the nurses. The nurses less frequently than other groups indicated that physicians should have primary responsibility for planning and conducting patient education.

Each of the professional groups was accorded, both by themselves and by each of the other professional groups, an overall supportive responsibility for planning and conducting patient education activities. The nurses were most frequently given a supportive role by the total respondent group (34%). The allied health professionals were almost as frequently (27.5%) accorded a supportive role. A small percentage of all respondents believed that patient education staff (16.5%), physicians (15%), and hospital administrators (9.3%) should have supportive responsibilities for patient education activities.

Two of the professional groups, patient education staff and hospital administrators, had somewhat different opinions than did other groups about their own supportive roles and the roles of two of the professional groups. Both groups indicated more frequently than others did that their own professional roles should include supportive responsibility for patient education activities. Patient education staff also more frequently included this responsibility in the role of allied health professionals. Hospital administrators more frequently included a supporting role for nurses.

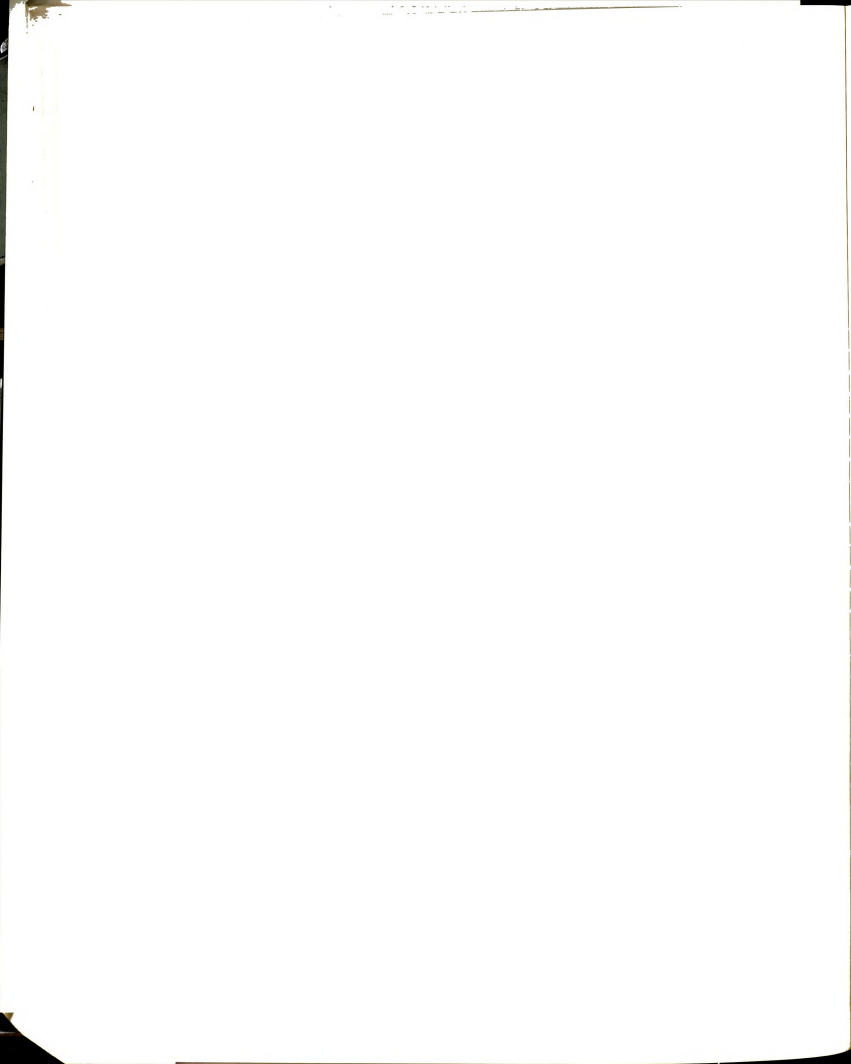


A large percentage of the professionals believed that former patients (84%) and families of present and former patients (75%) should be involved in both planning and conducting of patient education activities. However, there was agreement that the involvement of both groups should be dependent, for the most part, on the health problem of the patient. The patient education staff most frequently indicated that these groups should be included, while the physicians least frequently indicated that they should be involved.

All professional groups judged most frequently that present and former patients and their families (76%) and physicians (68%) should have roles in evaluating patient education activities. Except for the physicians, a large percentage of the professionals also believed that nurses, patient education staff, allied health professionals, and community home health agencies should be involved in the evaluation process.

A large number of the professionals (approximately 80% of the total respondent group) believed that patient education programs should consist of an intentional combination of formal and informal activities. Only 12% of them believed that the activities should be principally formal, and only 8% indicated that they should be principally informal. Among physicians there was a larger minority (20.1%) who believed that the activities should be principally informal.

Diabetes and cardiac-related illnesses were given highest priority ratings by all professional groups as the two health problem areas in which they would first develop organized patient

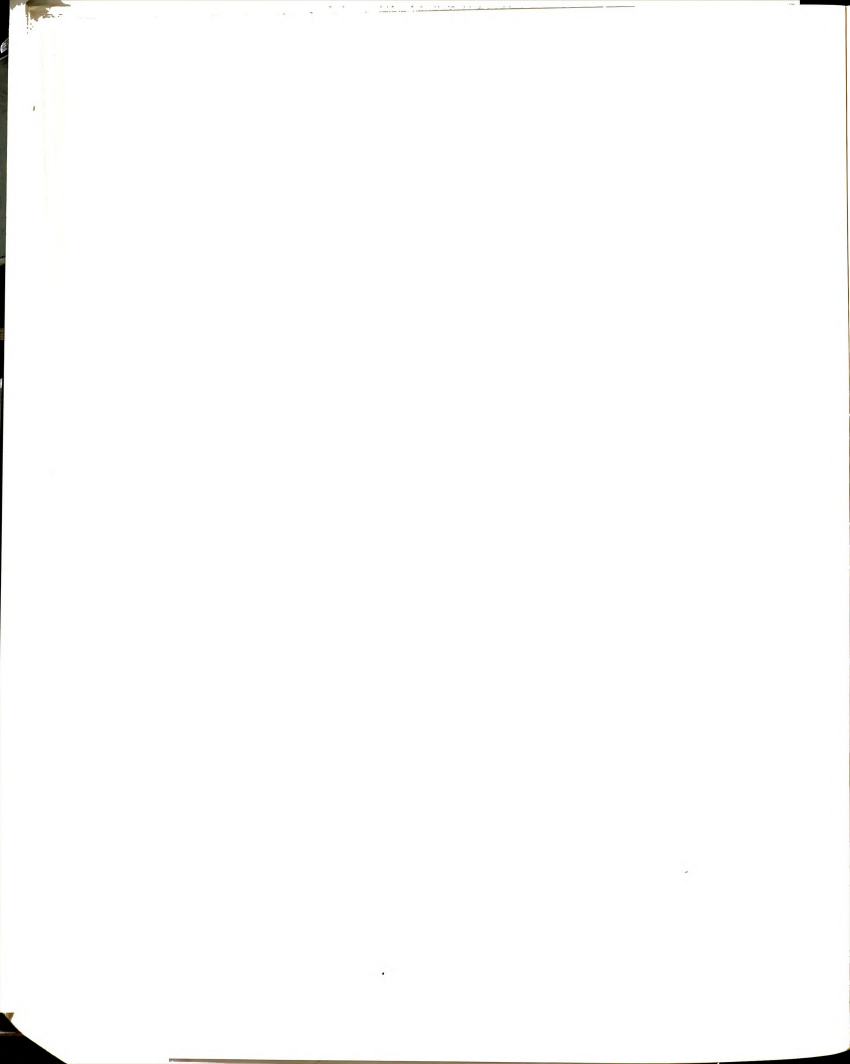


education programs. Other priority categories given by the professional groups included cancer, hypertension, alcohol and drug abuse, pre- and post-natal care, stroke, ostomy care, pulmonary disease, pre- and post-operative care, personal health habits, and mental health.

A majority of the professionals (about 59%) agreed that a combination of the hospital and appropriate community agencies should have the responsibility for providing further education services to hospital inpatients following discharge. There was a large minority (about 39%), however, who indicated that only the community agencies should have responsibility for further educational services needed by discharged patients.

Lack of staff time and a person to coordinate patient education activities were given by the professionals as the two major factors that impede or prevent the development and implementation of organized patient education programs. Other factors also agreed upon by a large number of professionals included cost of patient education, lack of third-party payments, and lack of acceptance by physicians. The professional groups responded somewhat differently as to which factors inhibit the development and implementation of organized patient education programs. The patient education staff and hospital administrators exhibited the greatest differences of opinion.

By far the largest portion, about half, of the professionals believed that a separate educational department would be the best department to coordinate an organized patient education program. A

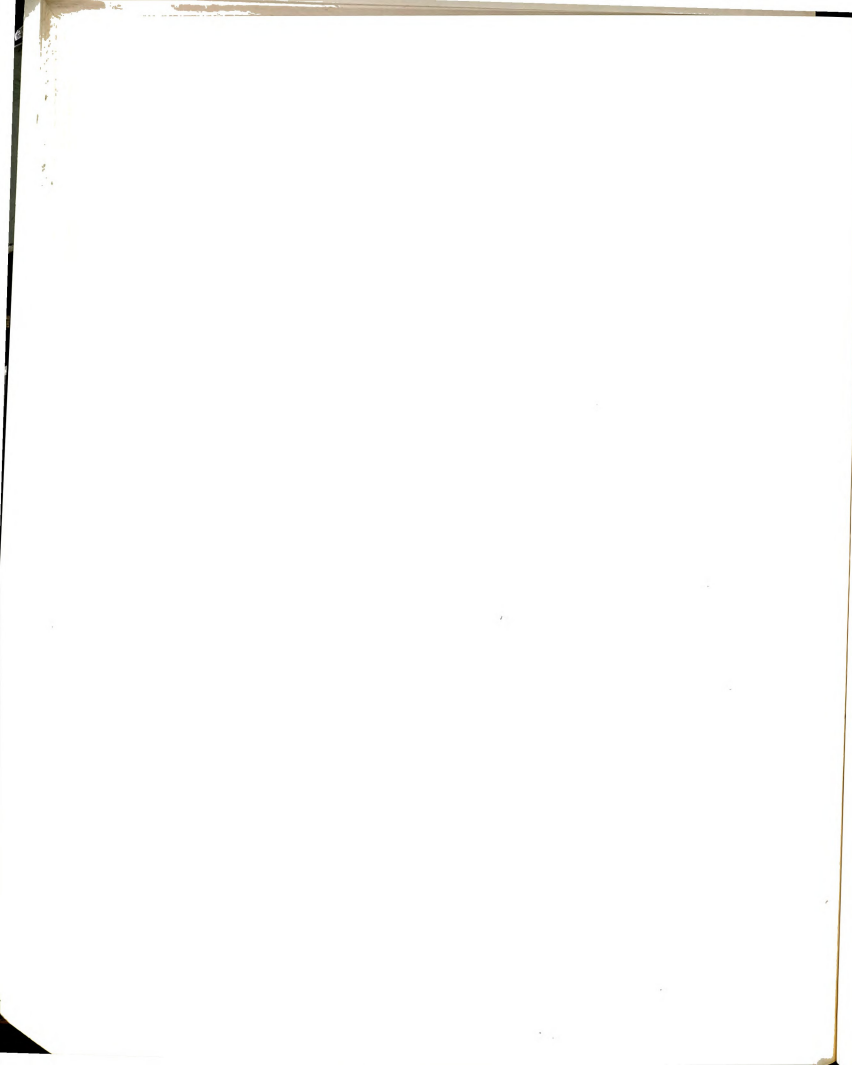


minority, however, of all of the professional groups except the allied health professionals indicated that the nursing department would be better able to do this.

A large percentage of the professionals judged that it was feasible to develop or expand organized patient education programs in their hospitals. Approximately three-fourths of the total respondent group believed this. Larger percentages of the patient education staff (100%) and the nurses (84.5%) than of the physicians (72.4%), allied health professionals (71.7%), and hospital administrators (64.7%) saw development or expansion as feasible.

Three questions (content, roles of professionals, and feasibility of developing organized patient education programs) were further analyzed to ascertain the effect of four additional variables: (1) size of hospital, (2) whether the hospital had a formal patient education program, (3) respondents' experience with formal patient education programs, and (4) respondents' training in patient education or related areas.

Of the four variables, the professionals' experience with formal patient education programs had the greatest effect on the way respondents answered each of the three questions. Higher proportions of professionals with experience than of those without experience endorsed: (1) the inclusion of specified content areas in patient education programs, (2) having health care professionals involved in both planning and conducting patient education activities, and (3) developing or expanding organized patient education programs in their hospitals. The other three variables had only



minimal effect on the way respondents answered the questions related to content areas and roles of professionals.

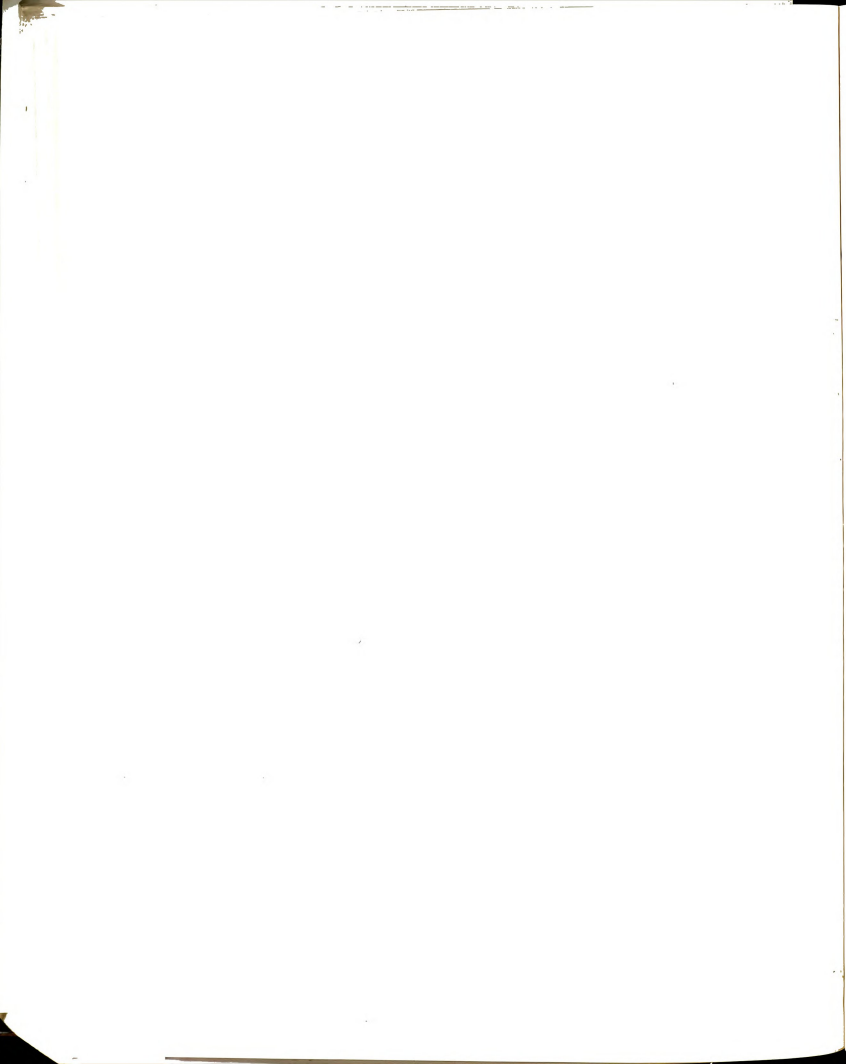
Each of the factors affected the way respondents answered the question concerning the feasibility of developing or expanding organized patient education programs. Respondents who practiced in larger hospitals, who practiced in hospitals with formal patient education programs, who had experience with formal patient education programs, or who had training in or related to patient education also more frequently indicated that it was feasible to develop or expand organized patient education programs in their hospitals.

Conclusions

The conclusions of this study refer to health care professionals who work in Maine community hospitals.

1. Virtually all health care professionals in community hospitals believe that patient education is an important component of patient care. Patient educators and nurses generally believe it is important for all patients, while physicians, hospital administrators, and allied health professionals are divided, some seeing it as important for all patients while others see it as important for some patients but not for all. A very small minority of physicians are doubtful about its importance as a component of hospital care.

2. There is general agreement among community hospital health care professionals that adequate patient education requires a hospital to develop a program which is comprehensive in that it:



a. includes both formal and informal elements intentionally developed and integrated;

b. incorporates significant contributions from each profession, i.e., physicians, nurses, hospital administrators, patient educators, and allied health professionals (physical therapists, occupational therapists, pharmacists, social workers, dietitians, and others); and

c. provides basic educational services generally important to all patients and additional educational services appropriate to the health and health-related problems of individual patients or categories of patients.

3. At least eight general areas of content are agreed upon by members of the principal health care professions as important to include in a hospital's program of patient education. They are:

a. explanation of diagnosis and treatment,

b. teaching patients to administer their own treatment,

c. teaching patients self-care independent living skills,

d. teaching about short- and long-term life style adjustments,

f > e. teaching about appropriate community resources,

" " general preventive medicine,
f. teaching about financial management of the health

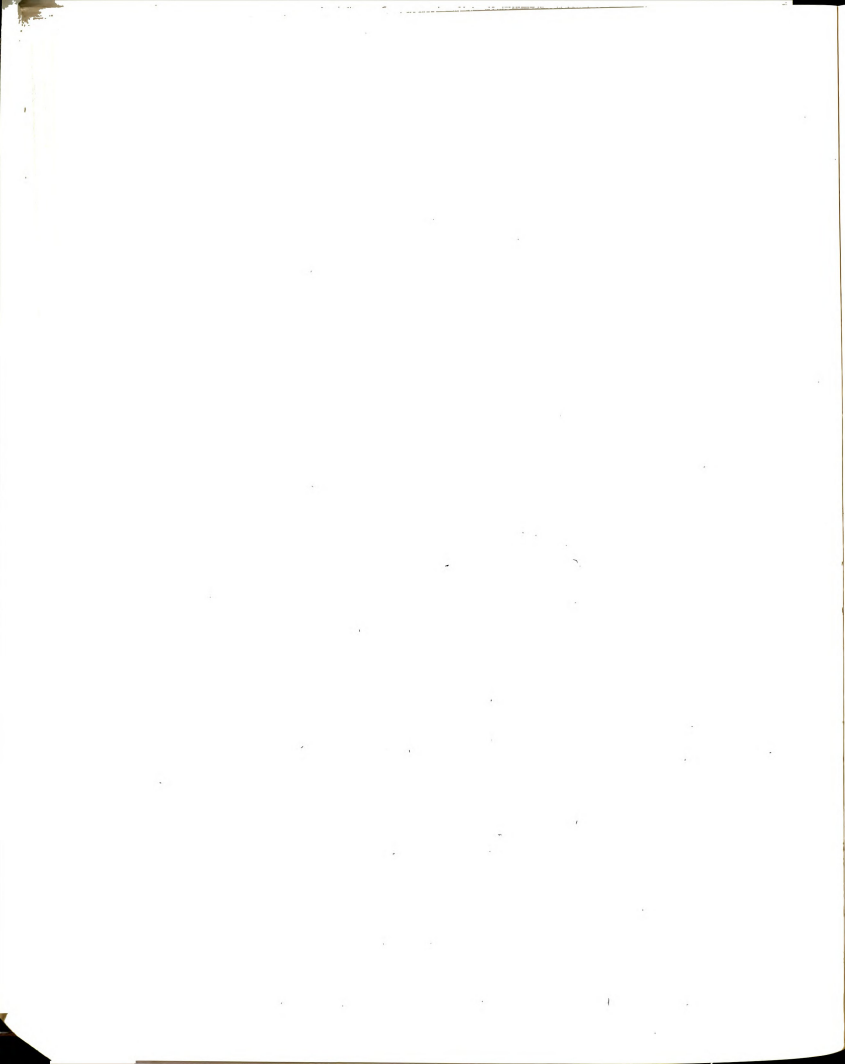
problem, and

h. orientation to hospital facilities and services.

4. In general, each group of community hospital health care

professionals ascribes a greater role in planning and execution of patient education to its own group than do other professional groups.

While these disagreements among professional groups are minor, they



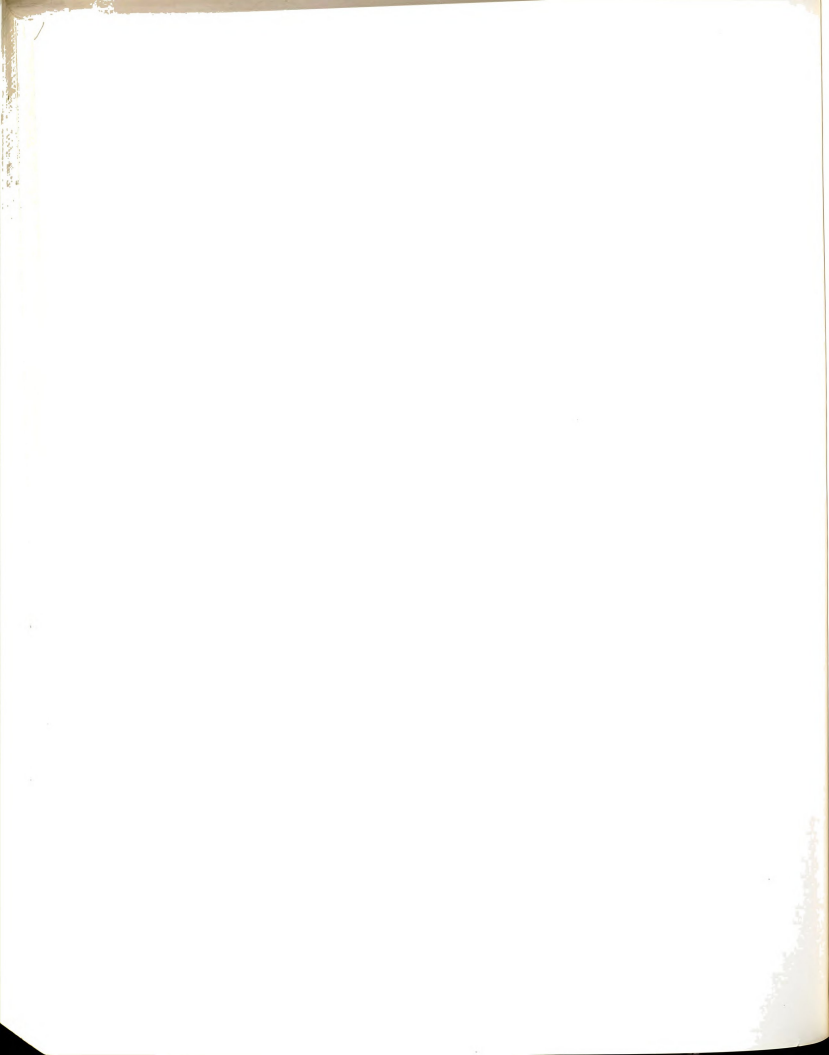
do need to be taken into account in the development of patient education programs. The disagreement will probably most often occur:

a. between the patient educators and other professionals, especially the physicians, as the patient education staff view themselves as having a stronger role than is identified for them by the other professional groups; and

b. between the physicians and other staff, especially patient education staff and nurses, as the physicians identify a greater role for themselves and a less active role for other staff members.

5. Patient education is acknowledged by community hospital health care professionals to be a complex process which requires a systematized and coordinated effort of the hospital professional community.

6. The community hospital health care professionals believe that various staff units within the hospital should be represented in the planning and execution of patient education activities. Physicians, nurses, and allied health professionals should make the greatest contribution to patient education activities, especially in regard to the operation of those activities. The contribution of each professional group should depend on the unique background and training of each group. For example, physicians should contribute the most to planning and execution of the explanation of diagnosis and treatment; the nurses to planning and execution of teaching patients to administer their own treatment; and the allied health professionals to planning and execution of teaching short- and



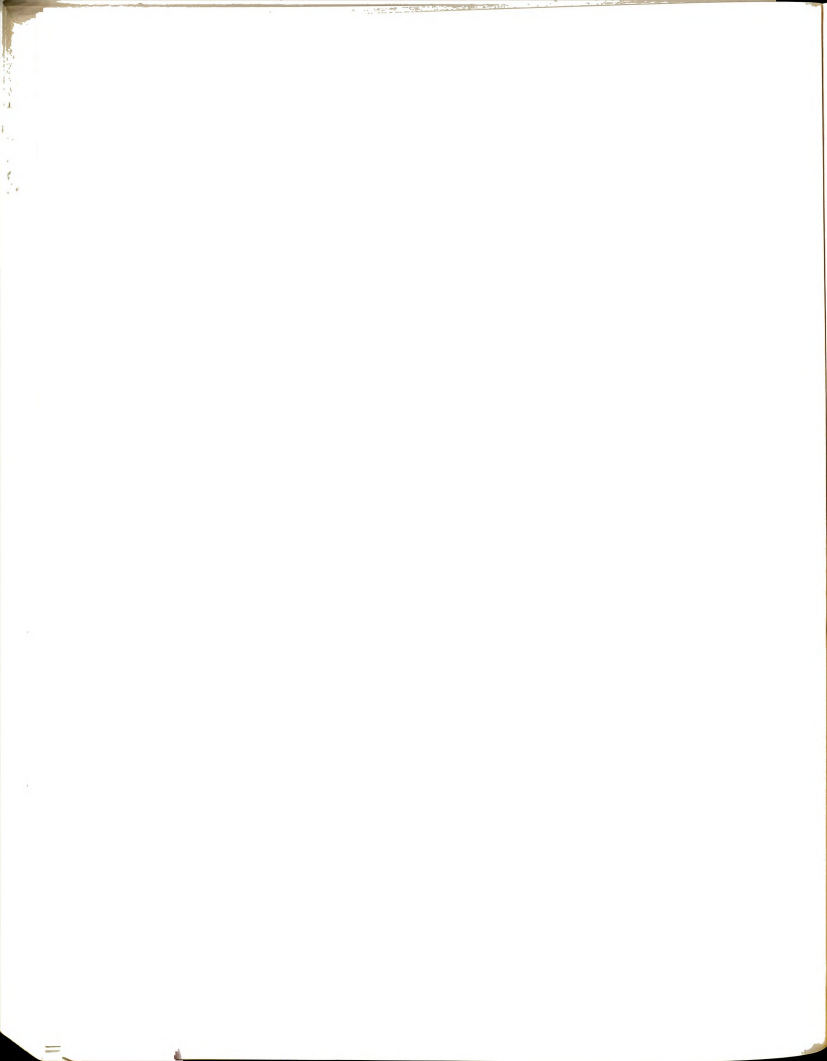
long-term life style adjustments, teaching about financial management, and teaching about community resources.

7. Health care professionals in community hospitals agree that patient education staff should facilitate and coordinate the planning and execution of patient education activities. They should be involved in both the planning and coordination of the general patient education activities for all patients, such as the orientation to hospital facilities and services, and the managing of the more complex patient education programs for specific illness categories.

8. There is general agreement among community hospital health care professionals that a variety of people and agencies should be involved in the evaluation of patient education activities. Included in the evaluation process should be patients and/or their families, physicians, nurses, patient education staff, allied health professionals, and community home health agencies.

9. In general, health care professionals in community hospitals believe that the involvement of former patients and families of present and former patients in planning and conducting patient education activities should depend on the health problem of the patient.

10. Community hospital health care professionals agree that a comprehensive patient education program should include provision for the following health problem areas: diabetes, cardiac-related illness, cancer, hypertension, alcoholism and drug abuse, pre- and post-natal care, stroke, ostomy care, pulmonary disease, pre- and

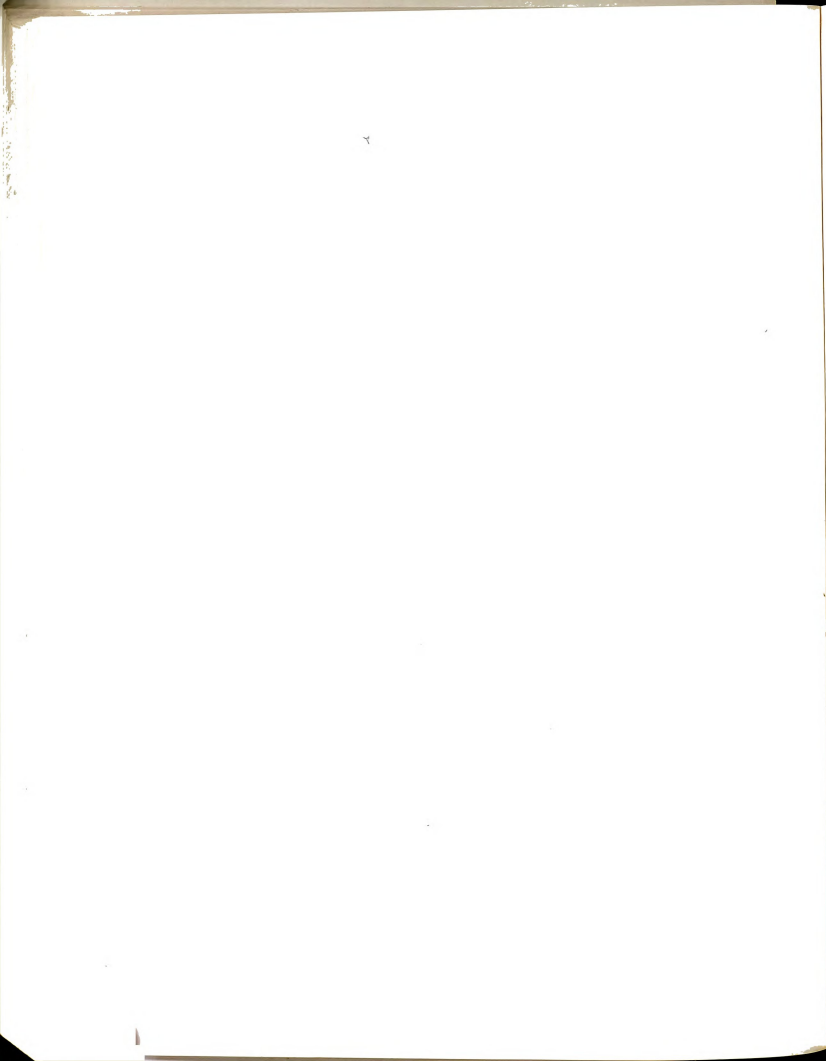


post-operative care, personal health habits, and mental health problems. The highest agreement among the professionals is for programs for patients with diabetes and cardiac-related illnesses.

11. There is general agreement among community hospital health care professionals that hospitals and community agencies should work together to provide educational services for discharged patients. The hospital should take the initiative, through their patient education unit, to develop and maintain a collaborative relationship with the various community agencies to carry through these services.

12. There is general agreement among the health care professionals in community hospitals that no insurmountable problems exist to prevent the development or expansion of organized patient education programs. There are, however, several factors which are slowing the development of patient education programs. Principal inhibiting factors are lack of: (a) staff time to plan and conduct and (b) personnel to coordinate patient education activities. Other inhibiting factors include the cost of patient education, lack of third-party payment, and lack of acceptance by physicians of patient education.

13. Physicians and hospital administrators are seen by other community hospital health care professionals as not being sufficiently vigorous in their support of development or expansion of organized patient education programs. The lack of enthusiasm among these two groups stems primarily from their judgments regarding four factors: (a) lack of funds, (b) lack of staff to do



patient education, (c) lack of interest by professional staff in patient education, and (d) their hospitals are too small to need organized programs.

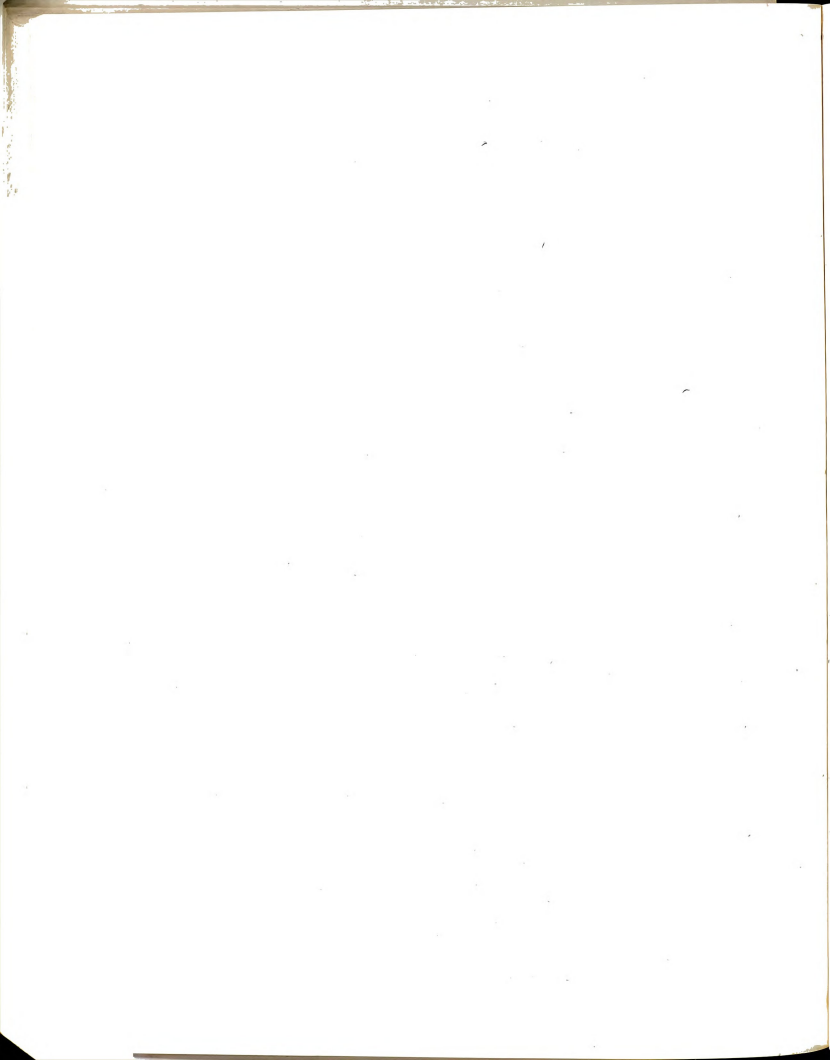
14. In general, health care professionals in community hospitals who have been associated with patient education programs, i.e., have had experience with formal patient education programs, have had training in patient education, or have practiced in hospitals with formal patient education programs, have more positive reactions to patient education than those who have not been associated with it. Experience with formal patient education programs is the most powerful factor in producing these reactions. The convictions of community hospital health care professionals concerning patient education have little relationship to the size of the hospital where they practice.

15. Most community hospital health care professionals believe that it is feasible to develop or expand organized patient education programs within community hospitals. In general, more patient educators and nurses believe that than do physicians, allied health professionals, and hospital administrators.

Implications for Practice

For planning and organizing patient education programs for hospital inpatients, the following guidelines are implied by the findings of this investigation:

1. Appoint a coordinator of patient education programs.



2. Include in the process of planning patient education programs representatives of all professional units, i.e., physicians, nurses, administrators, and allied health professionals, as well as patients and families of patients.

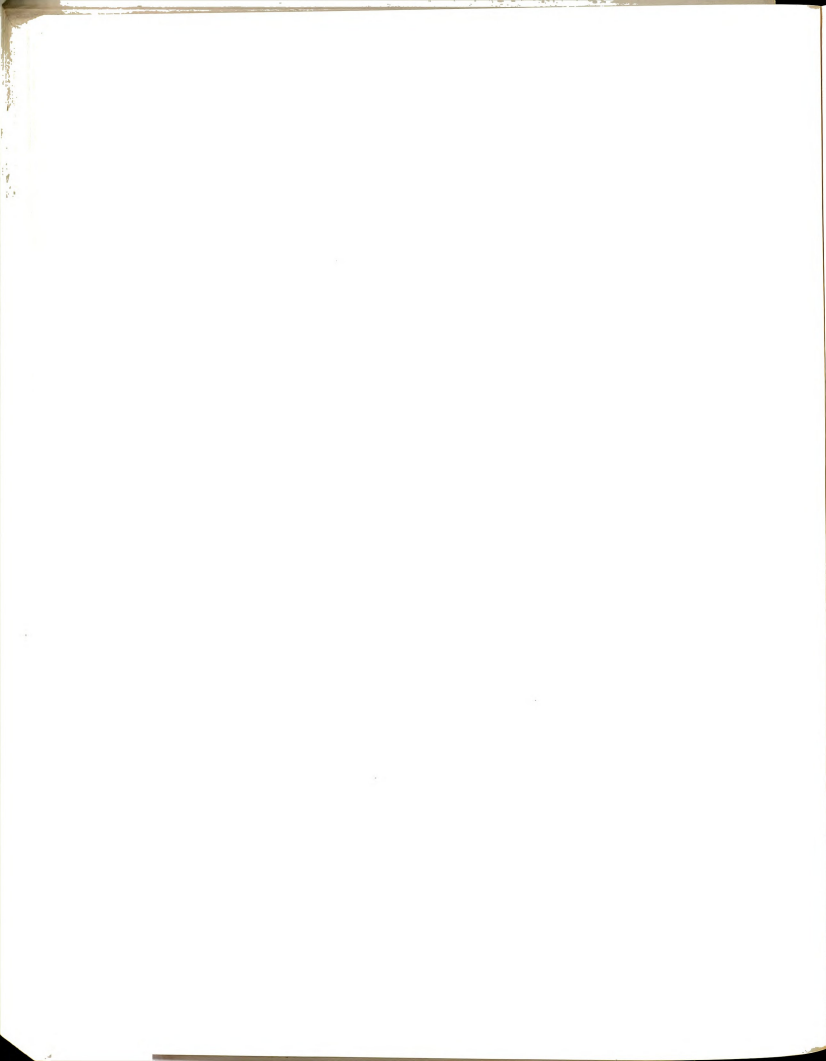
3. Complete a hospital survey which describes both the formal and informal aspects of present patient education activities.

4. Based on the data from the survey and the needs of the hospital patient population, develop a plan for a comprehensive hospital patient education program which provides for the development or expansion of both general patient education activities for all patients, e.g., orientation to hospital facilities and services and teaching short- and long-term life style adjustments, and programs for specific illness categories, e.g., diabetes and cardiac-related illness.

5. Decide which professional staff unit or units can best develop and execute each of the agreed-upon general activities and specified program areas.

6. Develop a plan for the evaluation of patient education programs which includes the patient and/or the patient's family, hospital professionals, and appropriate community home health agency personnel.

7. Provide a plan for the follow-up of patients who need further educational services. This should involve both the hospital and appropriate community agencies. It is likely to require initiative on the part of the hospital(s) to commence and sustain



collaborative action. Community agency personnel should be included in the planning process for this phase.

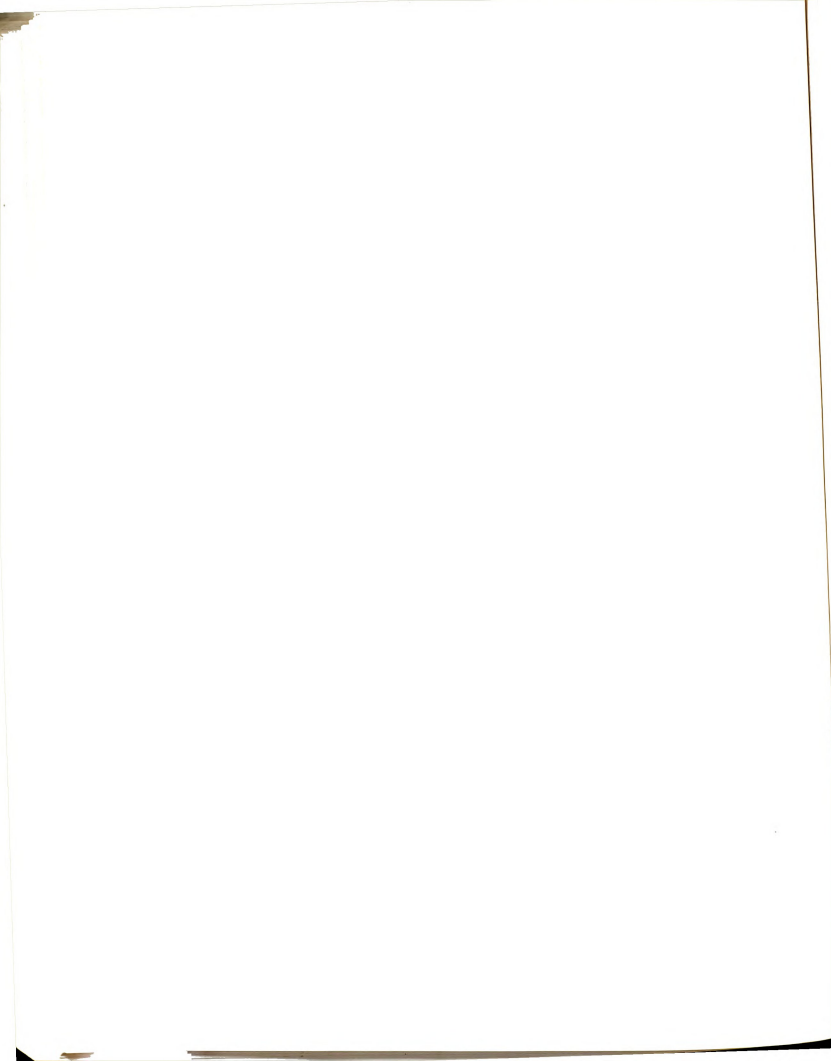
8. Professional staff time and other hospital resources, e.g., space, equipment, and funds, should be committed to both plan and carry through the patient education program.

The preceding guidelines seem to be implied to insure that patient education will become a total hospital community effort, and not delegated to a separate patient education staff. Thus, patient education will need to be a part of each health care professional's job.

If patient education is to become a part of each health care professional's job, professionals will need to be trained in patient education. This training should include a basic knowledge and skill base in: (1) adult psychology and learning, (2) the teaching-learning process, (3) methods of teaching, (4) evaluation procedures, and (5) materials on patient education in general.

Hospitals will need to offer hospital-wide continuing professional education programs on patient education in order for existing hospital staff to be trained. Also, changes in curriculum will be needed in most schools that provide pre-professional training for health care personnel to include patient education. These educational programs should be individually designed in relationship to the role and function of each health care professional group.

In order for patient education to become a total community effort, health care professionals in hospitals will also need, in



most cases, to change their own role perceptions and the perceptions they have of other professional groups. For example, physicians, nurses, and allied health professionals will need to see both themselves and other staff members as teachers of patients. These needed changes in role perceptions are likely to involve a period of role conflict both within and among professional groups.

As stated in the opening section, a patient education coordinator will need to be appointed in order for this community effort of professionals to be integrated and function effectively. This role calls for a patient education coordinator (or in larger hospitals a patient education staff) not necessarily with a traditional health field background, but with both knowledge and skills in the education, community organization, and management fields. Within this framework, the patient education coordinator or staff will then become the manager and not primarily the conductor of patient education activities.

Implications for Research

This investigation involved a comprehensive look at patient education and a description of hospital patient education based on the opinions of community hospital health care personnel in one state which is predominantly rural. The results from similar studies in other types of geographic areas might or might not be the same. To test its generalizability, this study should be replicated in a predominantly non-rural setting and/or on a national basis. These studies would explore whether the opinions of professionals

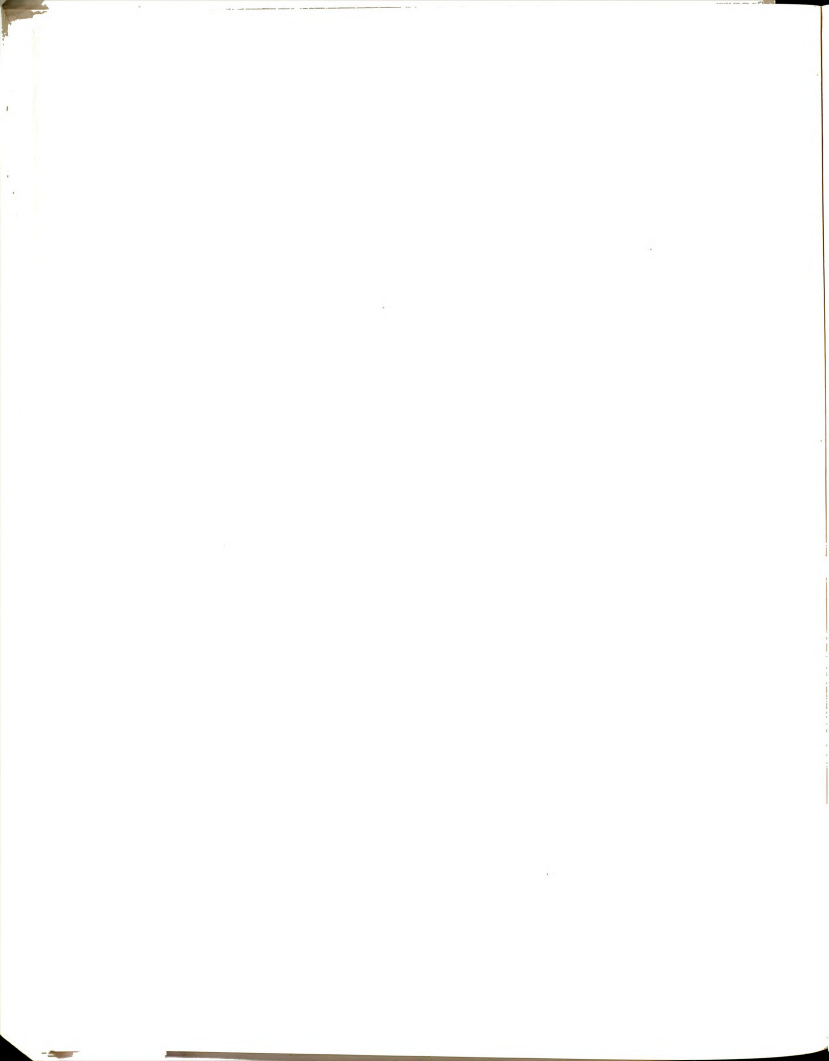


vary according to the population density or other characteristics of settings in which they practice.

The roles of hospital health care professionals in the implementation and coordination of patient education activities should be further investigated for both theoretical and practical application. Examples of questions that need to be answered are: (1) Is it feasible in terms of present resources to have patient education be a part of the role of existing hospital professional staff? (2) Are hospital professional staff members willing to plan and execute patient education as part of their job responsibilities? and (3) Which hospital professional staff units or combination of units are the most appropriate to assume responsibility for planning and executing both general content and specific program areas?

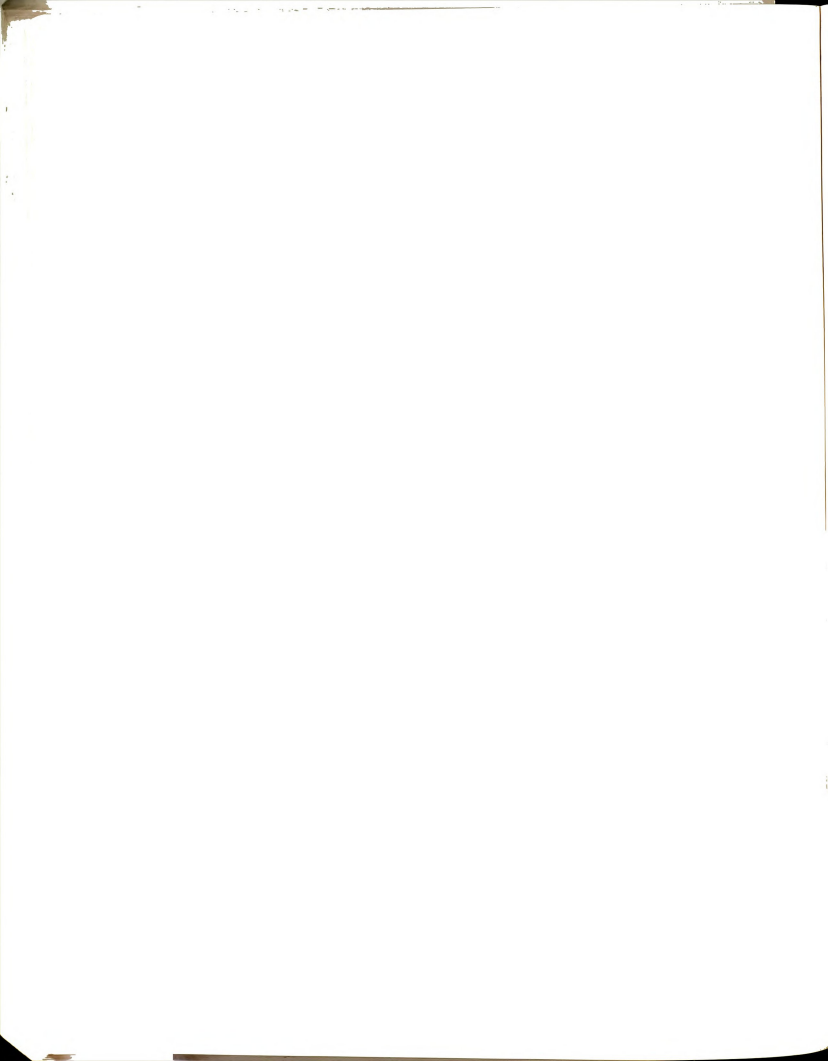
Similar studies should also be executed to ascertain the opinions of health care professionals toward hospital patient education for other than the inpatient population, e.g., out patients, emergency room patients, and the community-at-large. Studies should also be completed that investigate professional opinions about patient education for other institutions and patient populations, e.g., general office practice, community health agencies, and mental health institutions.

As this study was basically exploratory and descriptive in nature, it did not provide an in-depth view of the various question areas, e.g., roles of patients and families in patient education. A great deal more related research needs to be done in those areas.



Apparent additional research questions, though not directly a result of this study, include the following:

1. Do patients have the same perceptions as health care professionals regarding the content areas that are needed for inclusion in hospital patient education programs?
2. What should be the specific roles of patients and families of patients in planning and conducting hospital patient education activities? For what health problem areas is their involvement appropriate?
3. What should be the specific roles of patients and/or their families, hospital health care professionals, and community home health agencies in evaluating patient education activities for hospital inpatients?
4. How can the hospital and community agencies best organize and coordinate the delivery of continued patient education services for discharged hospital patients?
5. What are the informal patient education activities that are presently being conducted for hospital inpatients? Who in the hospital (professional, non-professional, and/or volunteer) is doing what kind of patient education?
6. Which patient education activities can best be performed on an informal basis and which can best be done on a formal basis?
7. What specific factors, e.g., staff to coordinate, funding, resource materials, are most closely associated with success in hospital patient education programs for inpatients?

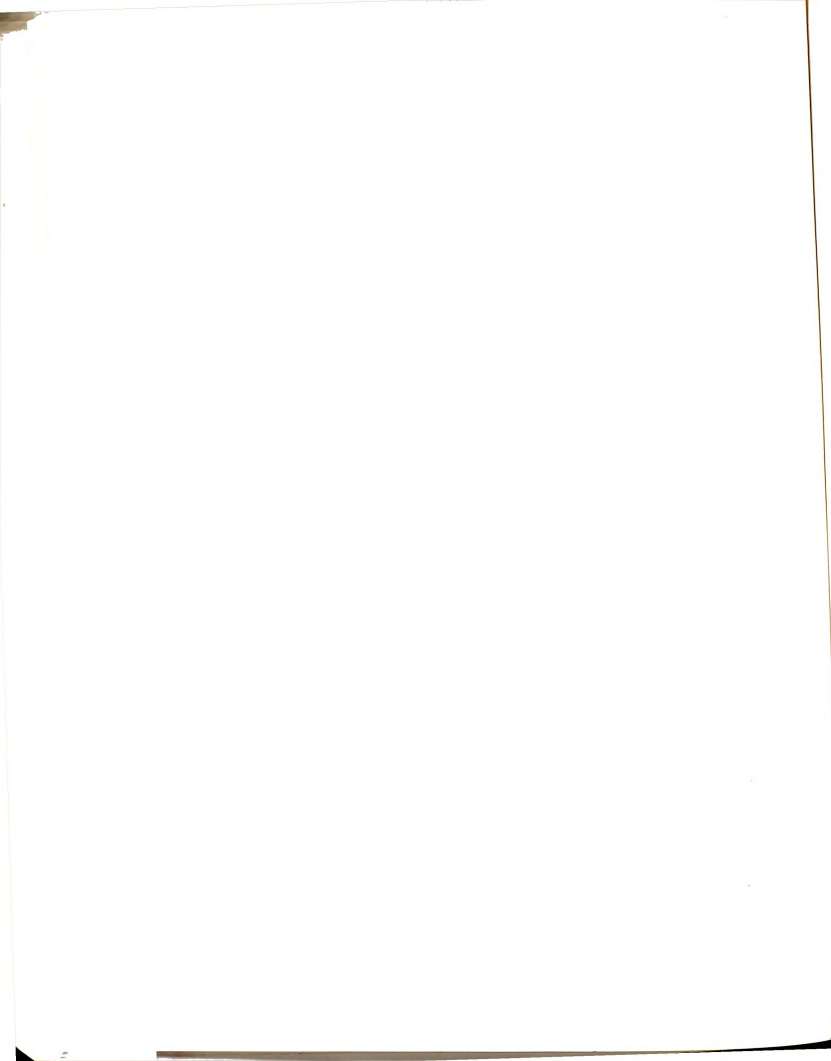


Reflections on the Study

Contemplating further research in the field of patient education, major strengths of this study as well as some suggestions for dealing with special problems should be highlighted. Among its strengths were: (1) involving various professional health associations and groups in its design and implementation, (2) conducting the pre-survey, (3) developing specific objectives, and (4) investigating patient education from the perspective of a variety of health care professionals.

There were some procedures the investigator would do differently in carrying through similar future studies. As sampling lists are difficult to obtain from large (over 200 bed) hospitals due to hospital personnel policies, alternative sampling methods and procedures should be built into the research methodology to ensure maximum representativeness of the population under investigation. For example, the investigator could contract with the large hospitals to have their personnel offices take responsibility for the initial mailing of questionnaires and follow-up procedures for their employees.

The politics of the medical community may play a large part in whether one is allowed to conduct research in specific areas. This is especially true in conducting studies over a variety of professional groups as this study did. Thus, the investigator would plan to spend more initial lead time analyzing the interrelationships, both positive and negative, between the professional groups on both a local, institutional and a more generalized professional level.

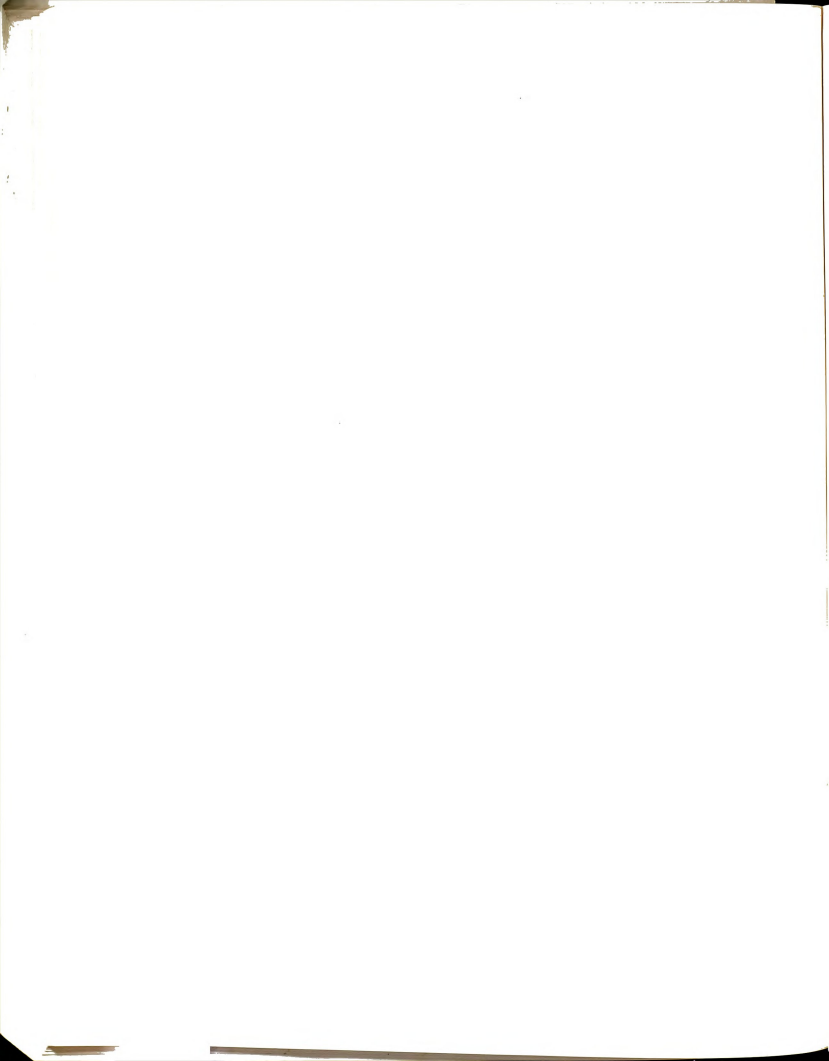


The investigator would also make some changes in the survey instrument. First, she would shorten the instrument to three or four pages versus the present six. And second, she would more carefully define the terms patient education and patient education staff.

The most exciting and challenging conclusions of the study centered on three areas. First patient education is recognized by professional hospital personnel as an extremely important component of patient care for hospital inpatients. This education should include both the medical aspects of the illness and its management, as well as the personal, social, and vocational concerns of the patient in relationship to the illness.

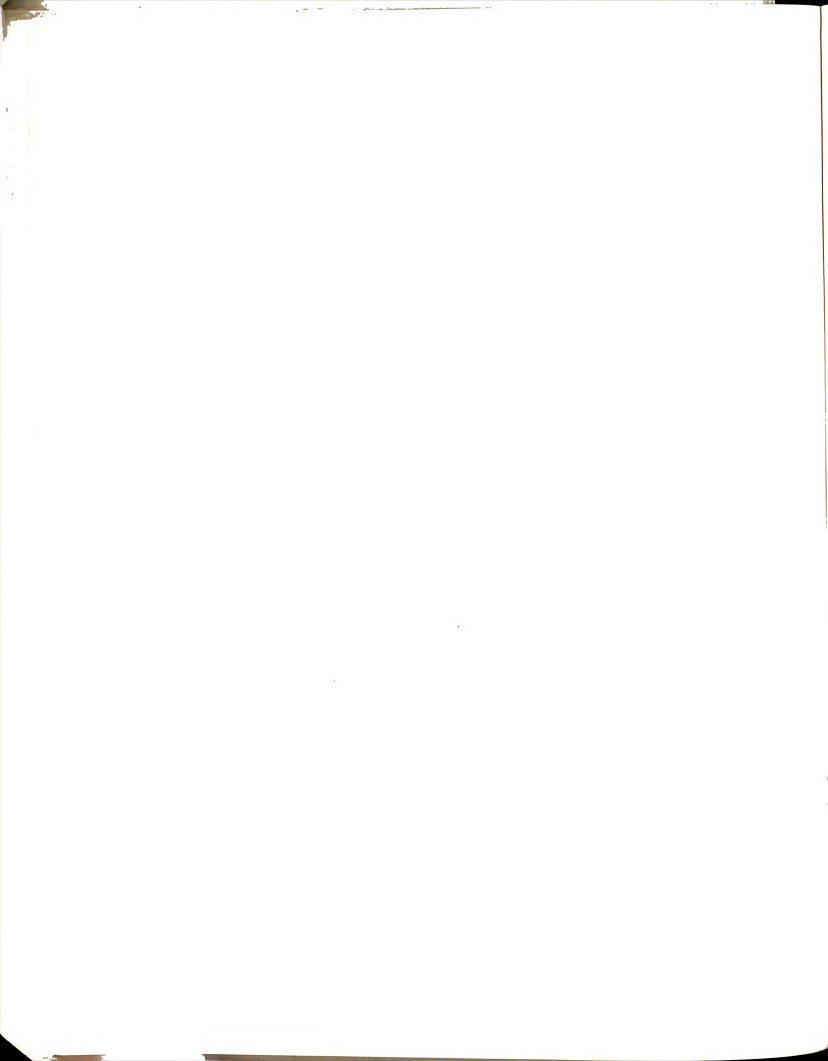
Second, both the concept and day-to-day operation of patient education for hospital inpatients need to be broadened to include both the formal patient education activities and the informal or incidental activities. This would allow for a more complete and comprehensive patient education program for hospital inpatients.

Third, the study calls for a re-examination by the professional community on how patient education activities for hospital inpatients should be both conducted and managed. The model presented by the investigator is one in which the existing professional hospital staff would have as part of their responsibility a role in planning and/or conducting of selected phases of the patient education program. This would require a change in role perceptions and functions for many of the professional staff and a willingness to be part of a community effort so that patient education might become an integral

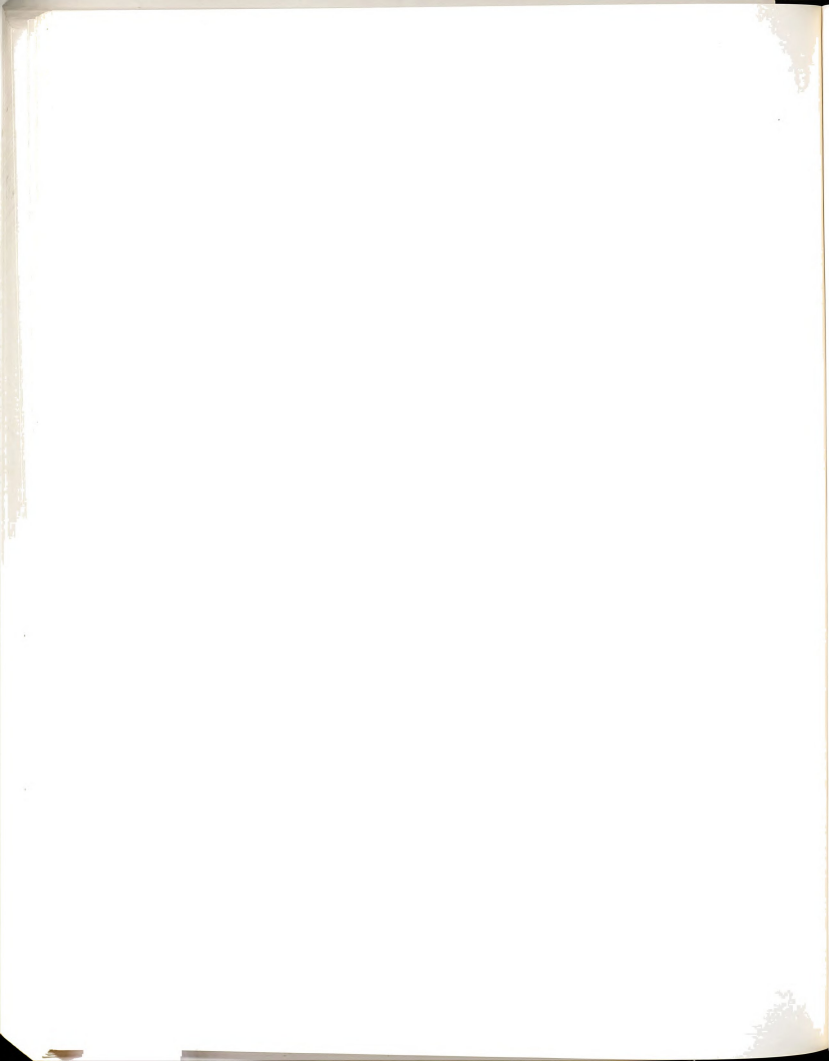


part of patient care. The model has the potential of creating a new functioning unit within the hospital organization, that of a patient education department whose major role would be the coordination and management but not the carrying through of patient education.

The study was both an interesting and challenging one to complete. Hopefully, the data compiled will prove to be both intellectually stimulating and useful in a practical way to both the hospital and health education communities.

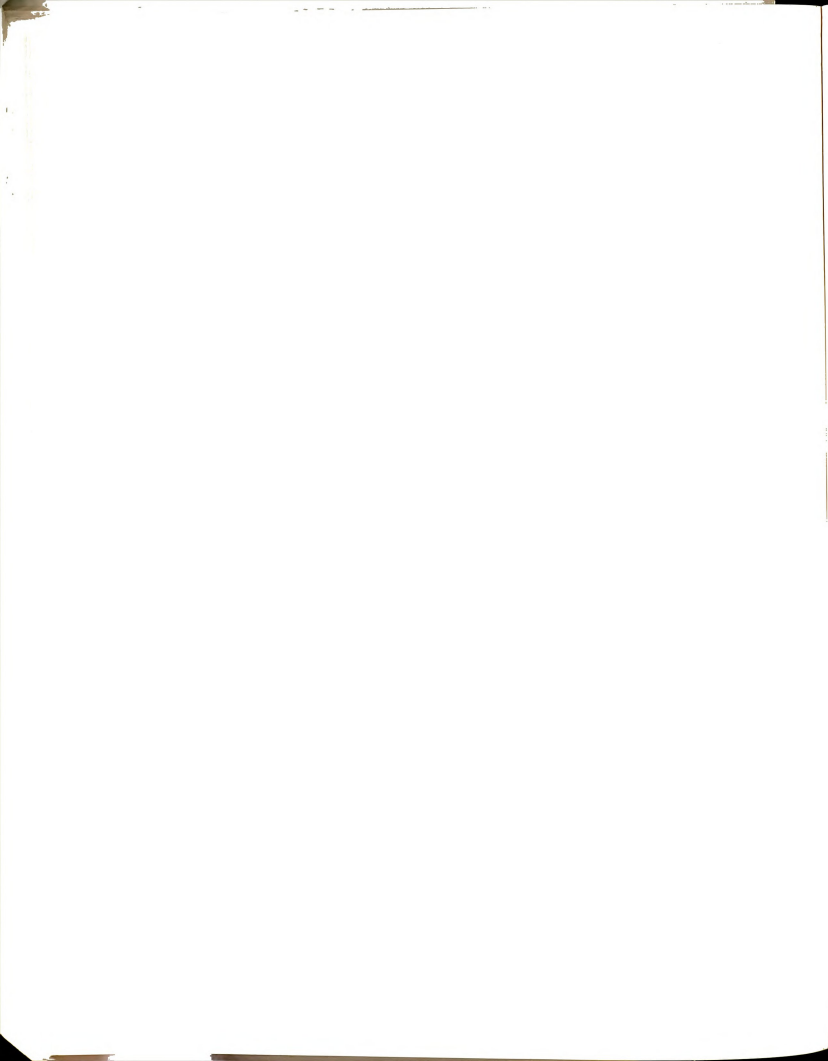


APPENDICES



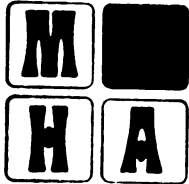
APPENDIX A

PRE-SURVEY FORM AND LETTER



APPENDIX A

PRE-SURVEY FORM AND LETTER



Research and Education Trust

**Maine Hospital Association
151 Capitol Street • Augusta, Maine 04330 • 207-622-4794**

I am writing concerning a research study that is being conducted by Mrs. Rosemary Caffarella on educational activities for the inpatient hospital population. Mrs. Caffarella is on the staff at the University of Maine at Orono and is conducting the research as part of her doctoral program at Michigan State University. The study has been endorsed by the Research and Education Trust and its results will be reported to them.

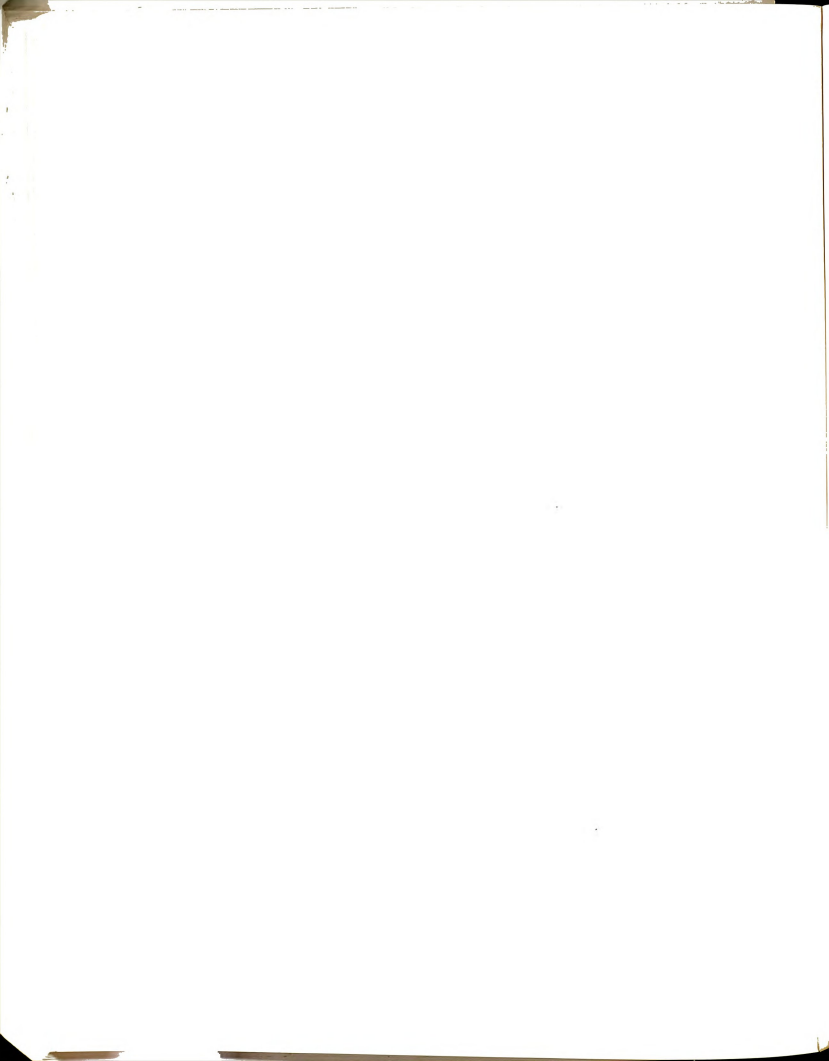
As part of the study Mrs. Caffarella needs to verify and in some cases collect demographic information on Maine hospitals and their education programs for hospitalized patients. The two kinds of information that she needs to either verify and/or collect include:

- (1) number of professional personnel (employed by or practicing in your hospital including hospital administrators, physicians, RNs, LPNs, physical therapists, occupational therapists, pharmacists, dietitians and social workers) by full and part time status; and
- (2) information on your patient education program, if such a program exists within your hospital. For the purpose of this study patient education programs are defined as planned educational activities with goals and objectives for the patient and/or family during inpatient hospitalization.

Mrs. Caffarella will be calling you within the next week to complete this part of the study. Your cooperation will be greatly appreciated. Thank you.

Sincerely,

Douglas Kramer
Program Coordinator



_____ Date

_____ Questionnaire #

QUESTIONNAIRE NUMBER ONEDEMOGRAPHIC DATA

Name of Hospital _____ Telephone Number _____

Address _____

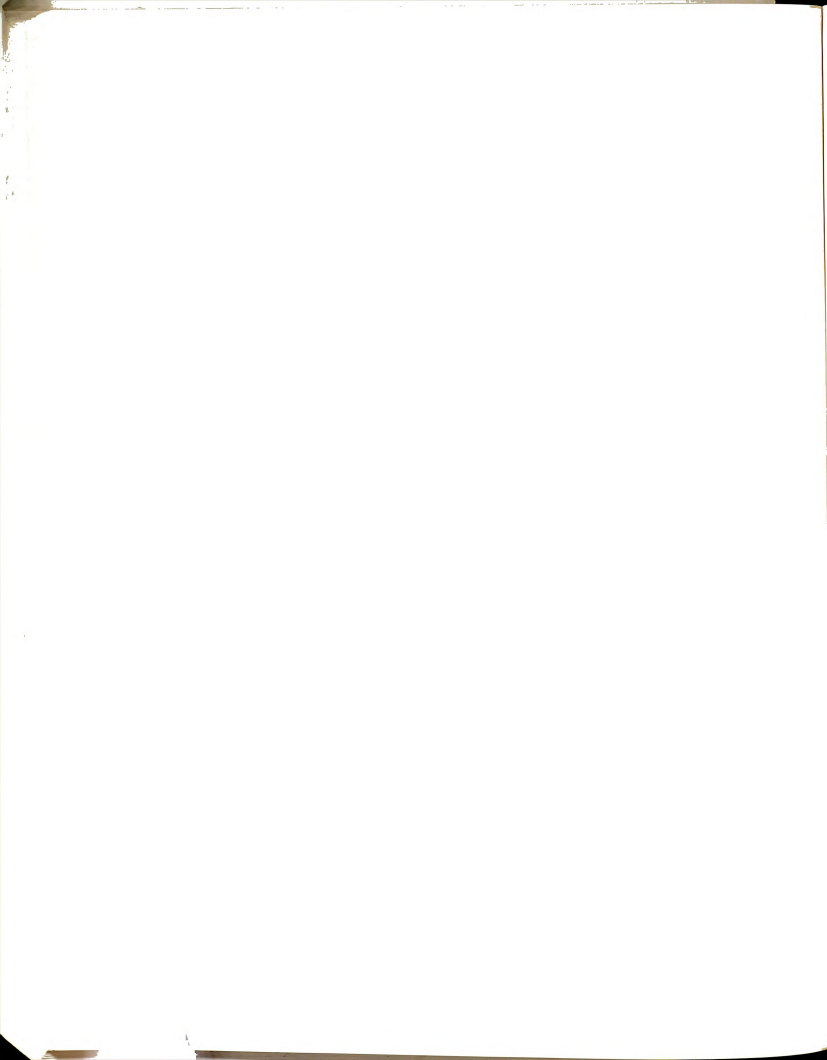
Name and Title of Person Interviewed _____

Community Population _____ Number of Hospital Beds _____

Number of Professional Personnel

Hospital administrators _____ (Chief Executive O. and Assistants,
 Director of Nursing, Director of Personnel, Director of Continuing Education, PE, or HE, Medical Director)

Physicians	Employed by Hospital _____	No. with Practicing Privileges _____
Registered Nurses	Full-time _____	Part-time _____
Licensed Practical Nurses	Full-time _____	Part-time _____
Physical Therapists	Full-time _____	Part-time _____
Occupational Therapists	Full-time _____	Part-time _____
Pharmacists	Full-time _____	Part-time _____
Dieticians	Full-time _____	Part-time _____
Social Workers	Full-time _____	Part-time _____
Speech Therapists	Full-time _____	Part-time _____
Health Educators	Full-time _____	Part-time _____



INFORMATION ON INPATIENT EDUCATION PROGRAMS

Patient education programs for the purpose of this survey are defined as planned educational activities with written goals, and objectives for the patient and/or family during inpatient hospitalization (American Hospital Association's Survey of Hospital Inpatient Education Program, 1975).

1. Does your hospital have patient education programs as defined by the above definition?

Yes _____ No _____

If yes, then continue with the questionnaire.

- 2a. Does your hospital have a written policy regarding inpatient education?

_____ Yes _____ No _____ In planning stages

- b. If yes, when was it originally written? _____
(Month/Year)

Last revised? _____
(Month/Year)

3. Does your hospital have a committee that sets general policy for all inpatient education programs conducted by the hospital?

_____ Yes _____ No _____ In planning stages

- 4a. Has a specific hospital department been designated to coordinate inpatient education activities?

_____ Yes _____ No _____ In planning stages

- b. If yes, which department has this responsibility? (Check one answer only.)

_____ Administration

_____ Education

_____ Nursing

_____ Public relations

_____ Social service

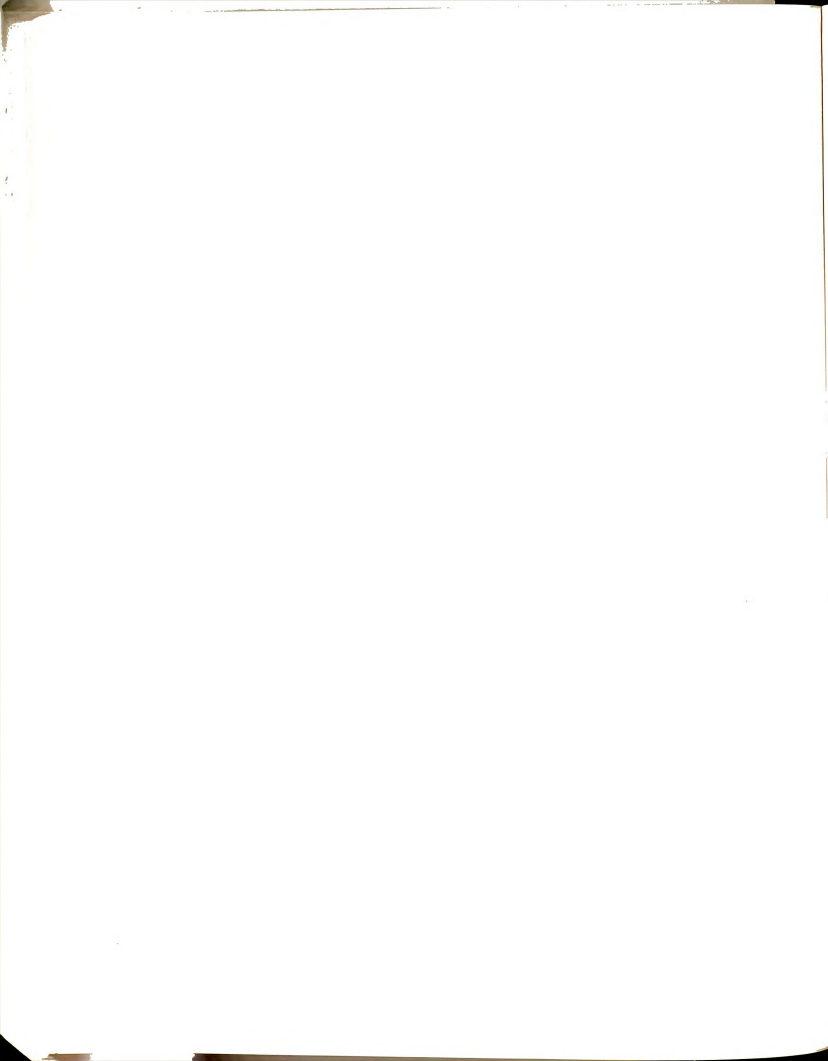
_____ Personnel

_____ Other (please specify) _____

- c. Is there a person from this department designated to coordinate inpatient education in your hospital?

_____ Yes _____ No

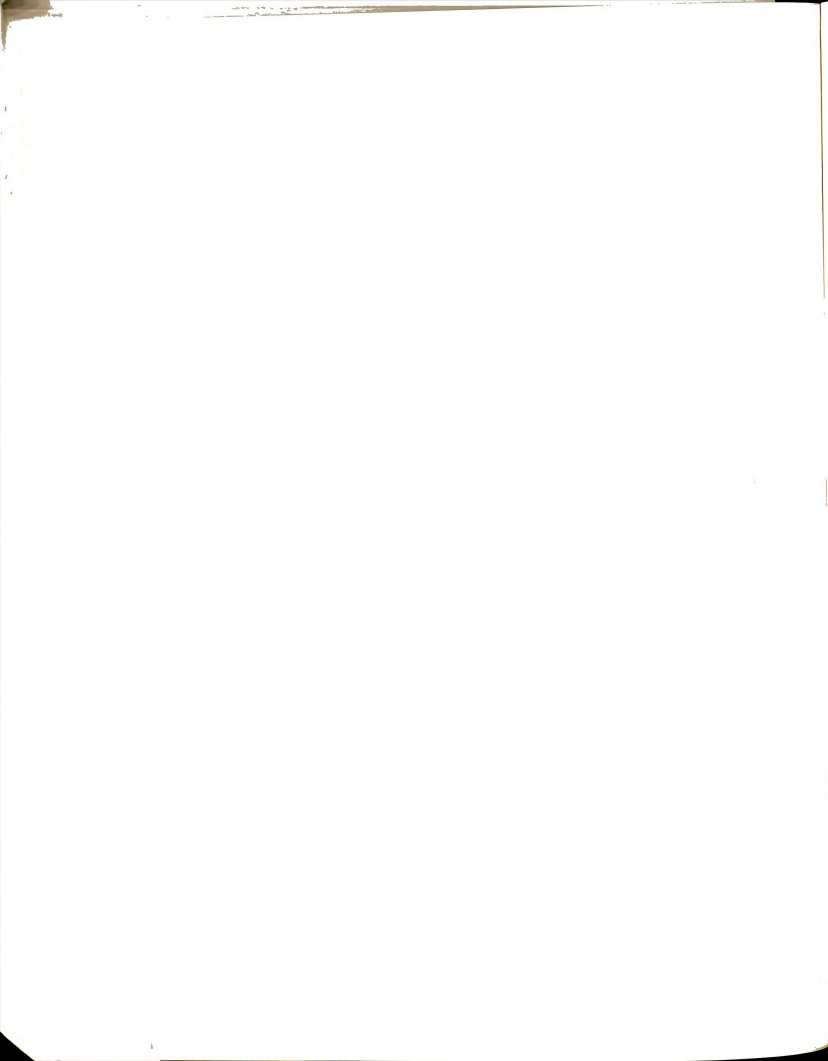
- d. If yes, what is his/her title? _____



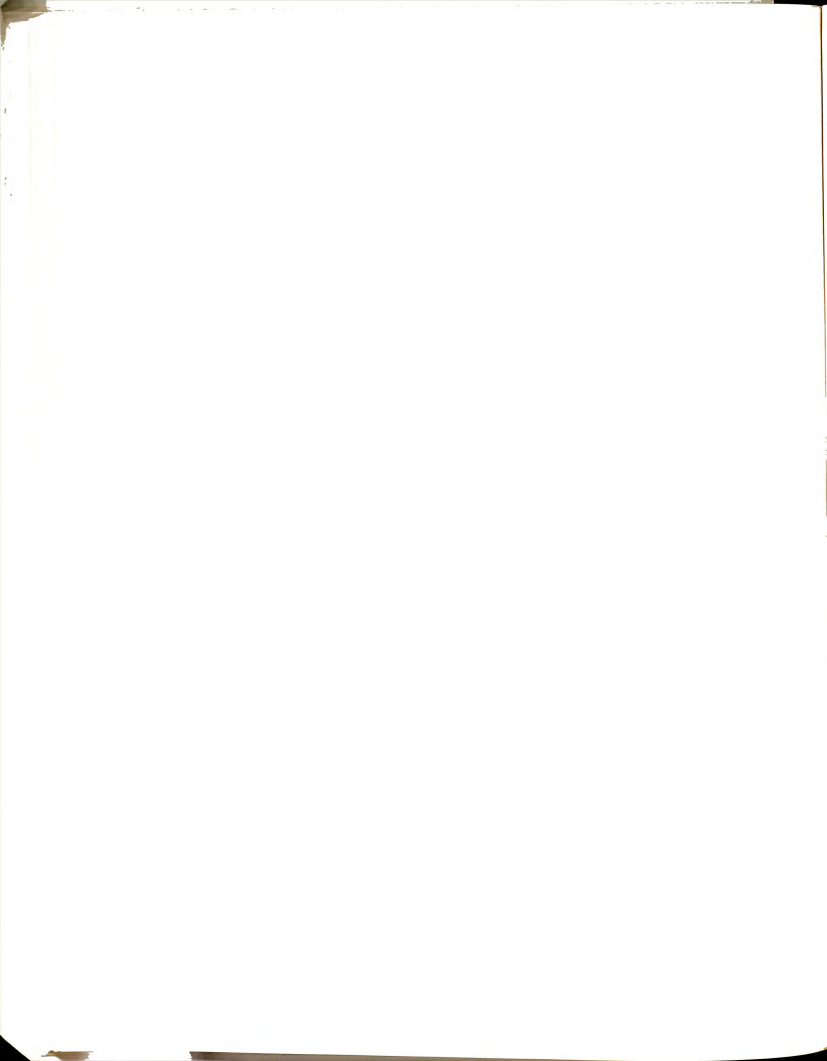
- e. Does this person devote all of his/her time to coordination of inpatient education in your hospital?
 _____ Yes _____ No
- f. If no--approximately how much time? _____
- 5a. Do you use outside consultants to help plan your inpatient education program?
 _____ Yes _____ No
- b. If yes, please name institution(s)/organization(s) in which they are employed.

6. Are funds budgeted for patient education in your hospital?
 _____ Yes _____ No
- 7a. What are the dollar sources for inpatient education in your hospital? (Check as many as applicable.)
 _____ Revenues
 _____ Separate billing
 _____ Gifts or grants
- b. If your hospital bills separately for inpatient education, please indicate the items/services for which you specifically charge. (Check as many as applicable.)
 _____ Educational materials
 _____ Group classes
 _____ Educational services performed by someone other than the staff on the patient unit
 _____ Set fee for each educational service
 _____ Other (please specify) _____
8. What inpatient education programs for specific patient populations does your hospital conduct? (Check as many as applicable.)

	ADULT		PEDIATRIC	
	Opera- tional	In Plan- ning Stages	Opera- tional	In Plan- ning Stages
Alcohol and drug dependency	_____	_____	_____	_____
Arthritis	_____	_____	_____	_____



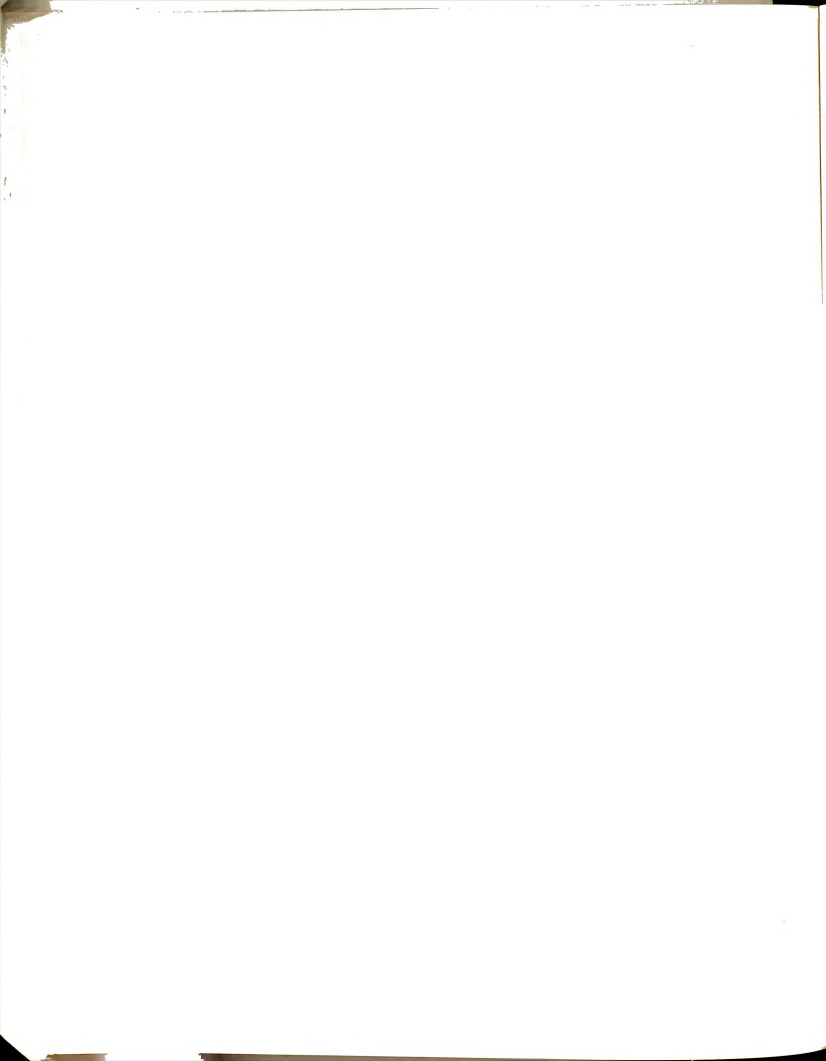
	ADULT		PEDIATRIC	
	Opera- tional	In Plan- ning Stages	Opera- tional	In Plan- ning Stages
Cancer	_____	_____	_____	_____
Ostomy	_____	_____	_____	_____
Mastectomy	_____	_____	_____	_____
Other cancers	_____	_____	_____	_____
Death and dying	_____	_____	_____	_____
Dental	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____
Diagnostic tests	_____	_____	_____	_____
Exercise	_____	_____	_____	_____
Family planning	_____	_____	_____	_____
Gastrointestinal	_____	_____	_____	_____
Genitourinary	_____	_____	_____	_____
Glandular	_____	_____	_____	_____
Heart and circulatory				
Pacemaker	_____	_____	_____	_____
Stroke	_____	_____	NA	NA
Hypertension	_____	_____	_____	_____
Heart attack	_____	_____	NA	NA
Congestive heart failure	_____	_____	_____	_____
Open-heart surgery	_____	_____	_____	_____
Kidney	_____	_____	_____	_____
Nutrition	_____	_____	_____	_____
Orientation to hospital for patients	_____	_____	_____	_____
Orthopedic	_____	_____	_____	_____
Prenatal	_____	_____	_____	_____
Postnatal	_____	_____	_____	_____
Preoperative	_____	_____	_____	_____
Postoperative	_____	_____	_____	_____
Respiratory	_____	_____	_____	_____
Visual or hearing	_____	_____	_____	_____



	ADULT		PEDIATRIC	
	Opera- tional	In Plan- ning Stages	Opera- tional	In Plan- ning Stages
Other (please specify)				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
No specific programs	_____	_____	_____	_____

9. Which of the following help plan and/or teach in specific inpatient programs? (Check as many as applicable.)

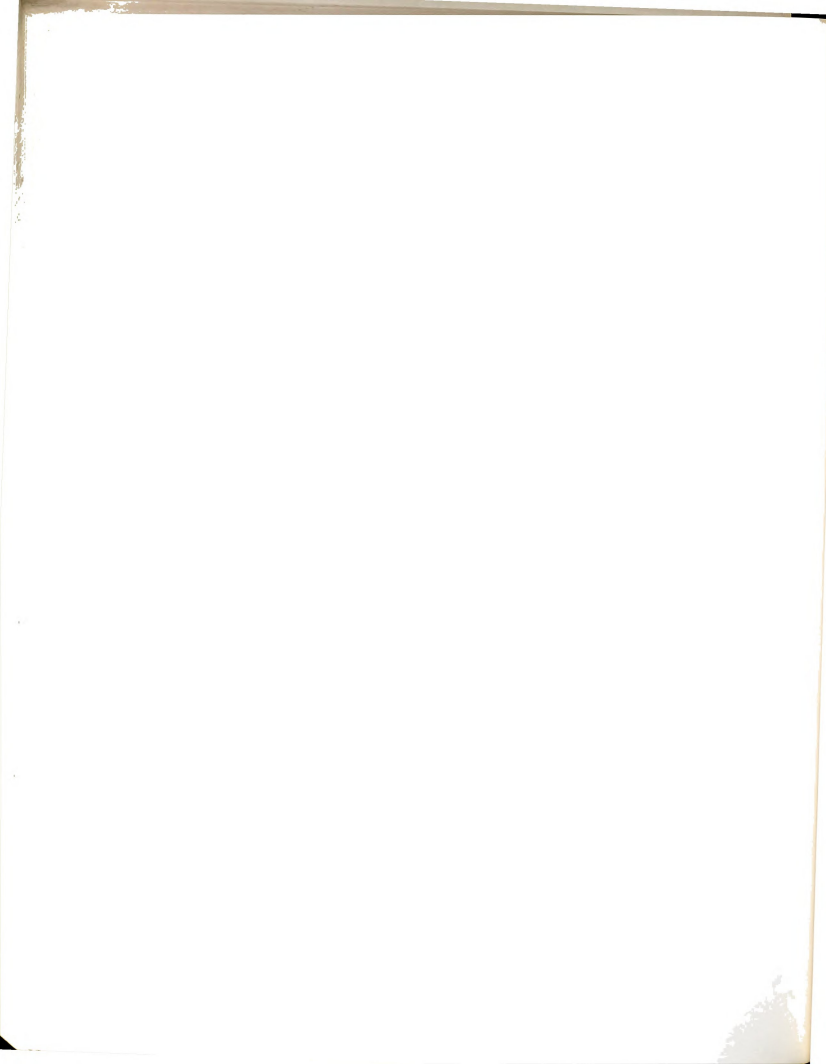
<u>CATEGORIES</u>	<u>PLAN</u>	<u>TEACH</u>
Physicians	_____	_____
RNs on inpatient units	_____	_____
LPNs on inpatient units	_____	_____
Aides, attendants, and orderlies	_____	_____
Dietitians/nutritionists	_____	_____
Pharmacists	_____	_____
Social work staff	_____	_____
Administrative staff (other than education staff)	_____	_____
Nursing in-service staff	_____	_____
Occupational therapists	_____	_____
Physical therapists	_____	_____
Respiratory therapists	_____	_____
Speech and hearing therapists	_____	_____
Clergy	_____	_____
Hospital volunteers	_____	_____
Public relations staff	_____	_____
Dentists	_____	_____
Medical library staff	_____	_____
Psychologists	_____	_____
Education staff	_____	_____
Patient representatives	_____	_____



<u>CATEGORIES</u>	<u>PLAN</u>	<u>TEACH</u>
Community support groups (for example, A.A., ostomy clubs, and so forth)	_____	_____
Other (please specify) _____		

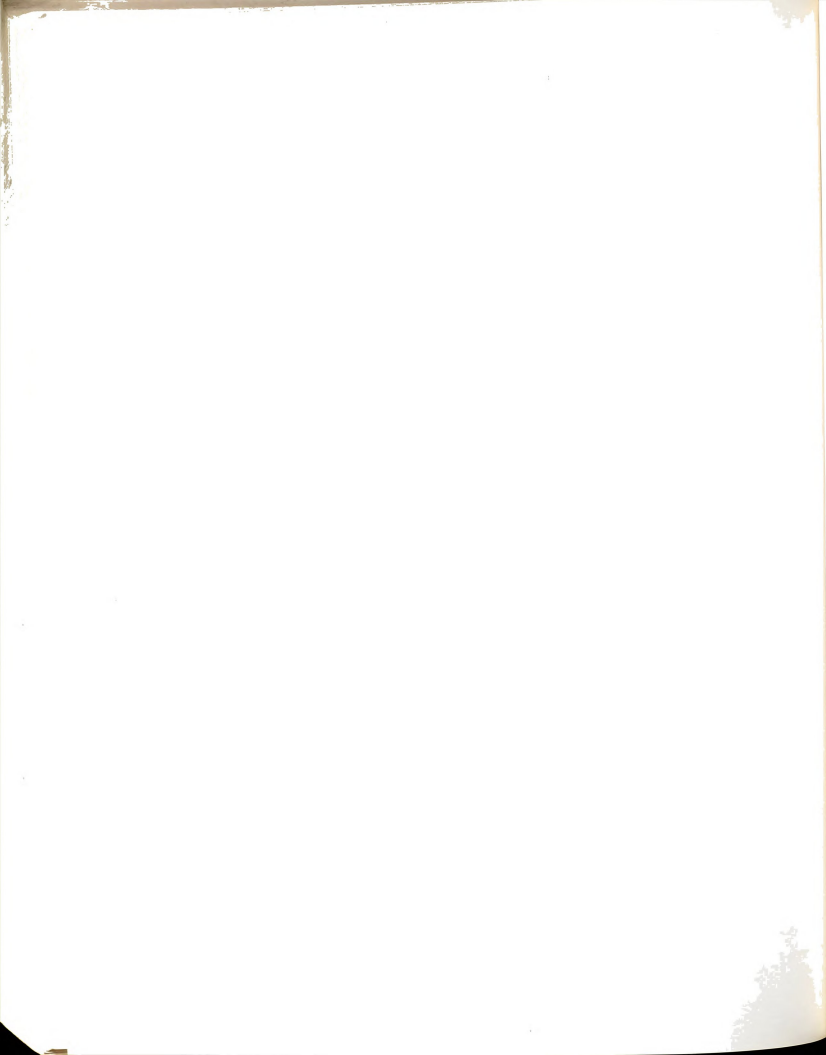
10. Identify professional hospital personnel, other than the program coordinator, that are prominent in your patient education program(s):
- _____
- _____
- _____
- _____

Questions on Patient Education are from the American Hospital Association's Survey of Hospital Inpatient Education Programs, 1975.



APPENDIX B

SUMMARY OF PRE-SURVEY RESULTS AND FOLLOW-UP LETTERS



APPENDIX B

SUMMARY OF PRE-SURVEY RESULTS AND FOLLOW-UP LETTERS

Summary of Patient Education Programs in Maine Community Hospitals

Patient Education--is defined as planned educational activities with written goals and objectives.

Community Hospital--all non-federal short-term general (average length of stay 30 days) and other special hospitals, excluding hospital units of institutions (i.e., colleges), whose facilities and services are available to the public.

Total number of Maine community hospitals	50
Total number reported in this summary	48

Hospitals With Operating Formal Patient Education Programs

--Total number of hospitals with one or more planned patient education programs	20
--Total percentage of hospitals with one or more planned patient education programs	42%

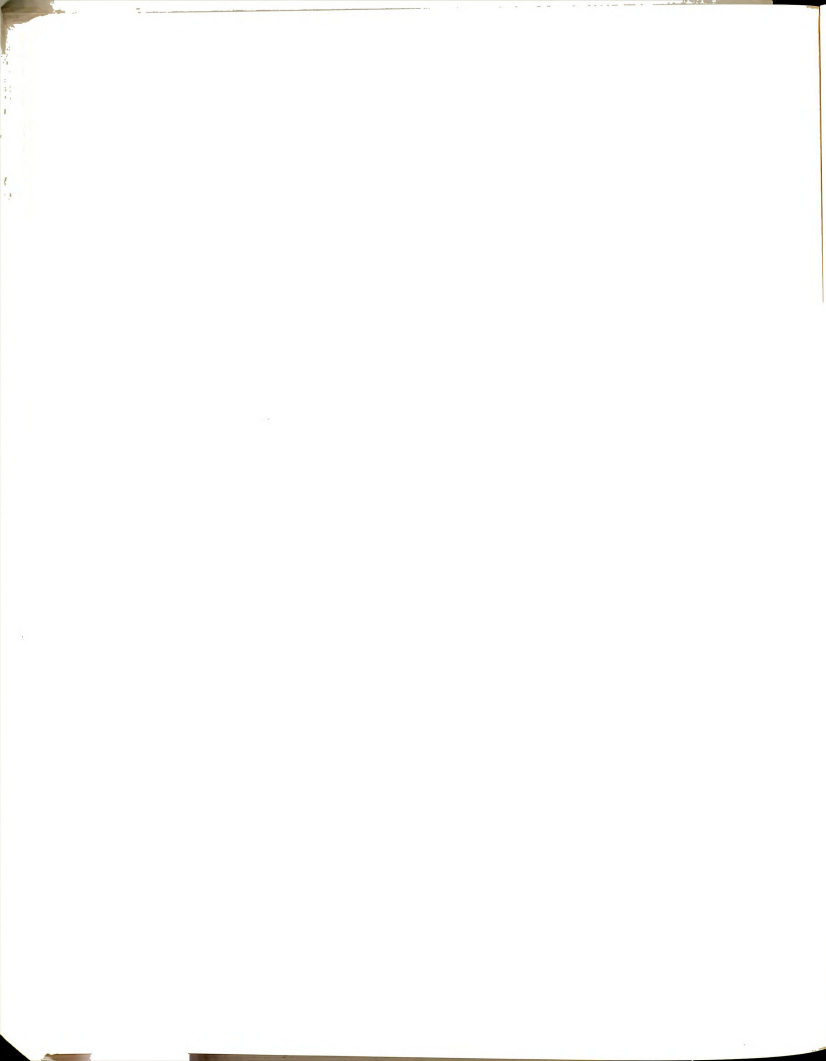
Hospitals With Patient Education Programs in Developmental Stage

--Total number of hospitals	8
--Total percentage of hospitals	16%

Hospitals Without Formal Patient Education Programs*

--Total number of hospitals	20
--Total percentage of hospitals	42%

*Please note that this does not mean that the hospitals do not do any patient teaching. Their activities are not formalized.



Most Common Patient Education Programs in Maine Community Hospitals

*Ostomy	Pre-operative
Prenatal	Respiratory
*Diabetic	Hypertension
Cardiac	

*These two categories comprise the majority of the programs.

Staff Most Often Involved With Patient Education Activities

Nurses--RNs and LPNs
Dieticians

Hospitals With Operating Formal Patient Education Programs

0-49 Beds

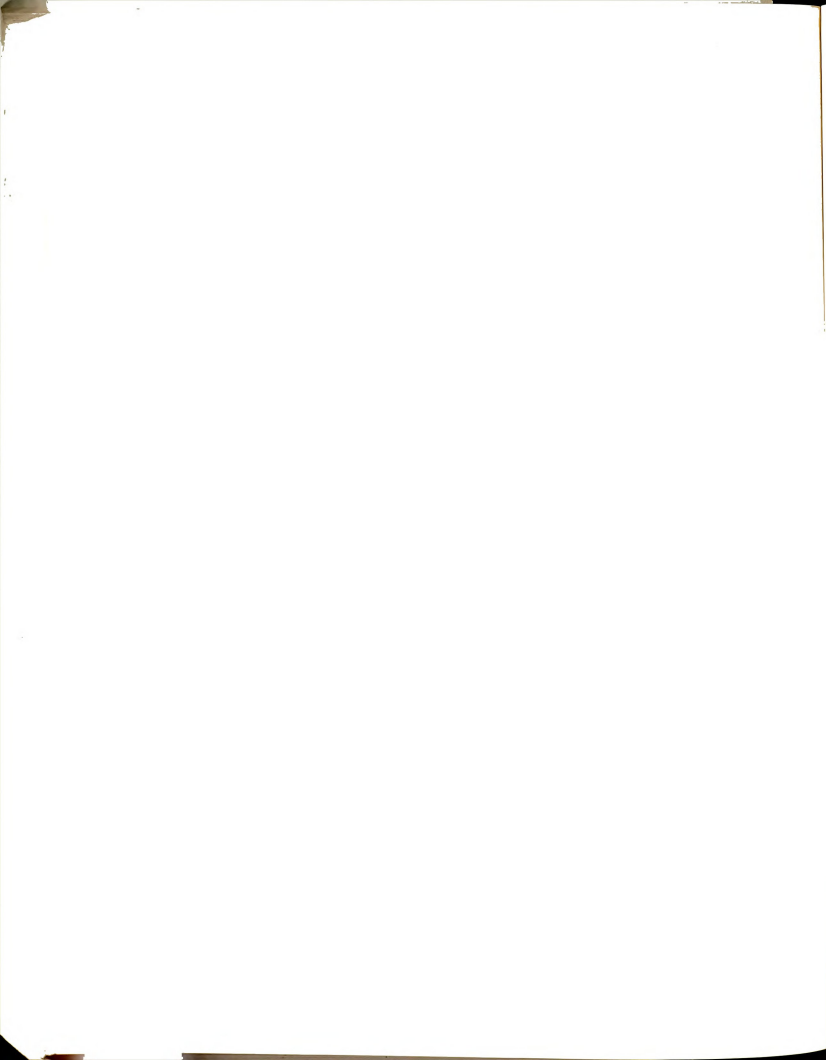
Aroostook Health Center
Camden Community Hospital
Marie Joseph
Penobscot Valley
St. Andrews
Sebastcook Valley
Stephens Memorial

50-100 Beds

Calais Regional
Cary Memorial
Franklin County Memorial
Northern Maine Medical Center
Parkview Memorial
Regional Memorial
Rumford Community
Waterville Osteopathic

100-199 Beds

St. Joseph



200 Beds and Over

Eastern Maine Medical Center
Maine Medical Center
Mid-Maine Medical Center
St. Mary's General

Hospitals With Patient Education Programs in Developmental Stage

50-99 Beds

Arthur R. Gould Memorial
Bath Memorial
Gardiner General
Redington-Fairview General
York Hospital

100-199 Beds

Augusta General
Mercy Hospital
Osteopathic Hospital of Maine

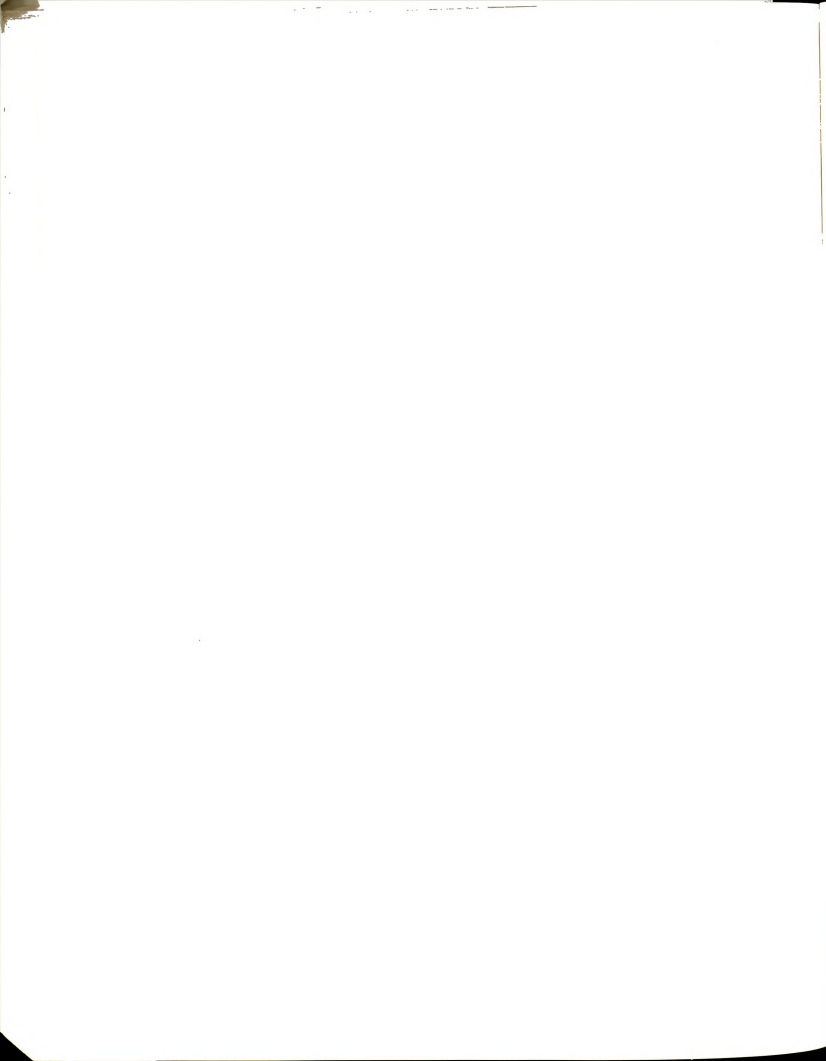
Hospitals Without Formal Patient Education Programs

0-49 Beds

Blue Hill Memorial
Castine Community
Charles A. Dean Memorial
Down East Community (have formats)
Mayo Memorial
Miles Memorial
Millinocket Community
Milo Community
Northern Cumberland Memorial
Plummer Memorial
Van Buren Community
Westbrook Community

50-99 Beds

Community General Hospital (Ft. Fairfield)
Houlton Regional
Mount Desert Island
Waldo County General



100-199 Beds

Henrietta D. Goodall
James A. Taylor Osteopathic
Penobscot Bay Medical Center

200 Beds and Over

Central Maine Medical Center



Summary of Professionals Who Work/Practice in
Maine Community Hospitals--February 1977

Professional hospital personnel for the purposes of this survey include the following groups:

Physicians--Physicians in Maine (both M.D.'s and D.O.'s) who have active staff privileges and/or are employed by Maine community hospitals.*

Nurses--R.N.'s and L.P.N.'s who are employed full- or part-time in Maine community hospitals.

Hospital Administrators--The chief executive officer of each community hospital.

Allied Health Personnel--Physical therapists, occupational therapists, dietitians, pharmacists, social workers, and speech therapists who are employed either full- or part-time by Maine community hospitals.

The data were collected via a telephone survey, under the sponsorship of the Research and Education Trust of the Maine Hospital Association.

*Please note that the number of physicians does not necessarily reflect the number of individual physicians who have active staff privileges within Maine community hospitals as physicians may have active status at two or more hospitals.

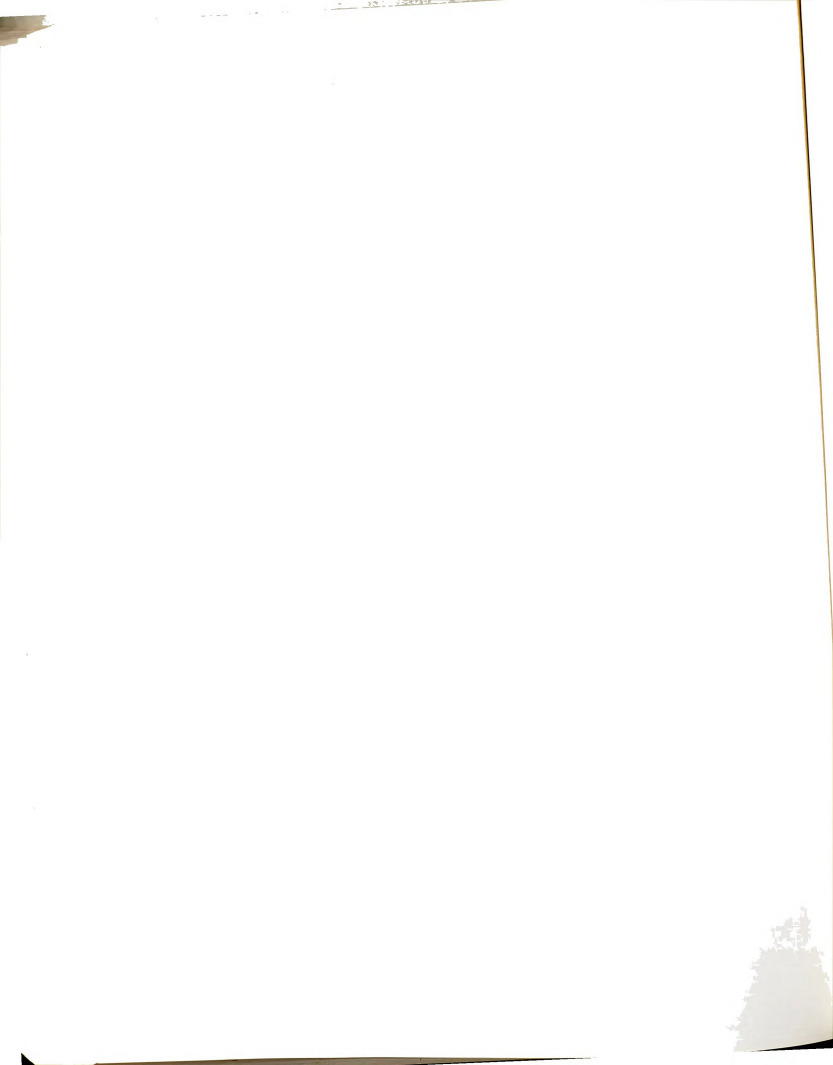


Table B1.---Number of beds, number of staff members in each professional sub-group, and presence of formal patient education programs in Maine community hospitals by hospital name and capacity category.

A. 0-49 Beds (N = 19)												
Hospital Name	Number of Beds	Adminis- trators	Physi- cians	RN's	LPN's	Physical Therapists	Occupational Therapists	Pharma- cists	Dieti- tians	Social Workers	Speech Therapists	Have Formal P.E. Program
Aroostook Health Center	24	1	1	8	5	Consult	-	Consult	Consult	Consult	Contract	Yes
Blue Hill Memorial	24	1	10	15	9	1	-	1	1	-	-	No
Camden Community	33	1	10	22	11	1	1	1	1	2	1	Yes
Castine Community	15	1	4	7	3	-	-	Consult	Consult	-	-	No
Charles A. Dean	44	1	5	12	1	-	-	1	Consult	Consult	-	No
Downeast Community	38	1	8	24	6	2	-	Consult	Consult	1	-	No/Have Formats
Marie Joseph	18	1	8	6	5	-	-	Consult	Consult	Home Health	-	Yes
Mayo Memorial	33	1	10	21	4	Contract	Contract	Consult	Contract	Contract	Contract	No
Miles Memorial	36	1	9	12	8	1	-	1	1	-	-	No
Millinocket Community	34	1	12	25	15	1	-	1	Consult	2	-	No
Milo Community	9	1	3	10	3	-	-	Consult	Consult	-	-	No
Northern Cumberland Mem.	34	1	16	35	10	-	-	2	1	1	-	No
Penobscot Valley	30	1	7	28	15	-	-	1	Consult	1	-	Yes
Plummer Memorial	19	1	3	9	1	-	-	Consult	Consult	-	-	No
St. Andrews	36	1	5	12	3	-	-	Consult	Consult	State Dist.	-	Yes
Sebasticook Valley	36	1	4	18	11	Consult	-	Consult	1	Consult	-	Yes
Stephens Memorial	41	1	17	38	9	1	-	1	Consult	2	-	Yes
Van Buren Community	30	1	3	10	3	-	-	1	Consult	-	-	No
Westbrook Community	30	1	25	23	8	Consult	-	Consult	Consult	1	-	No
Subtotals	-	19	160	335	130	7	1	10	5	10	1	-
Subtotals by Sub-Group												
Physicians	160											
Nurses	465											
Administrators	19											
Allied Health	34											
Subtotal	678											



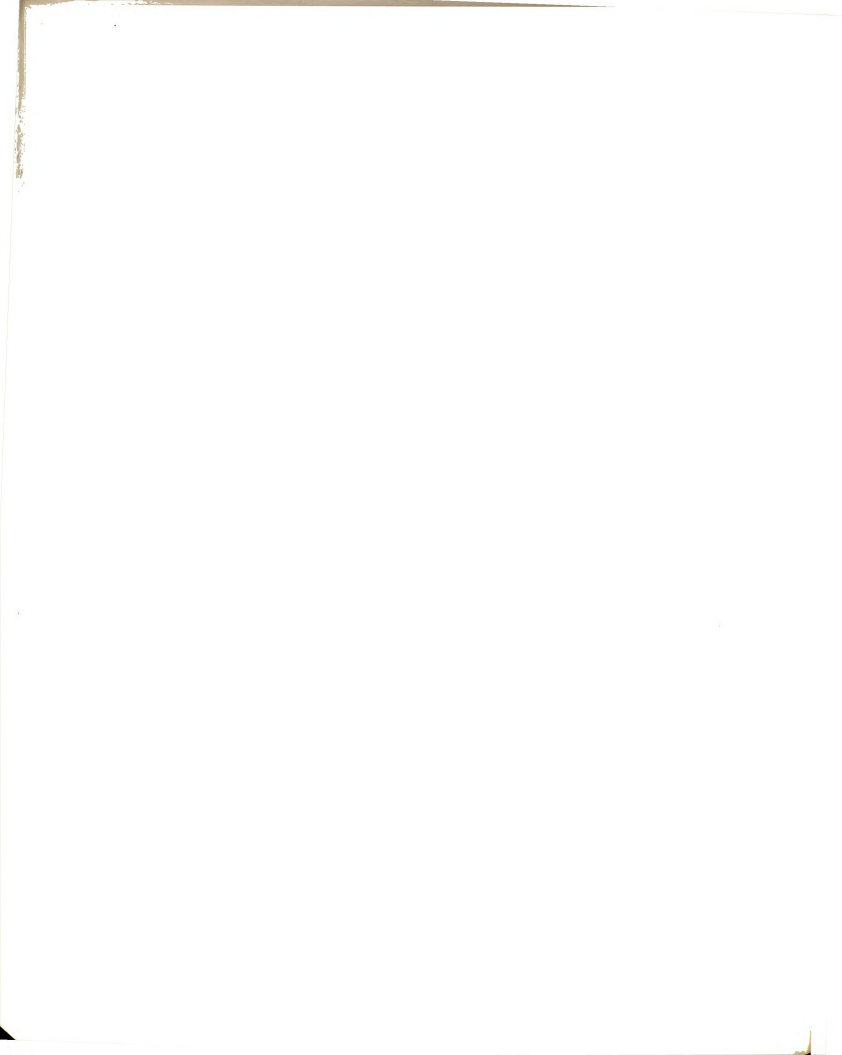
B. 50-99 Beds (N = 18)

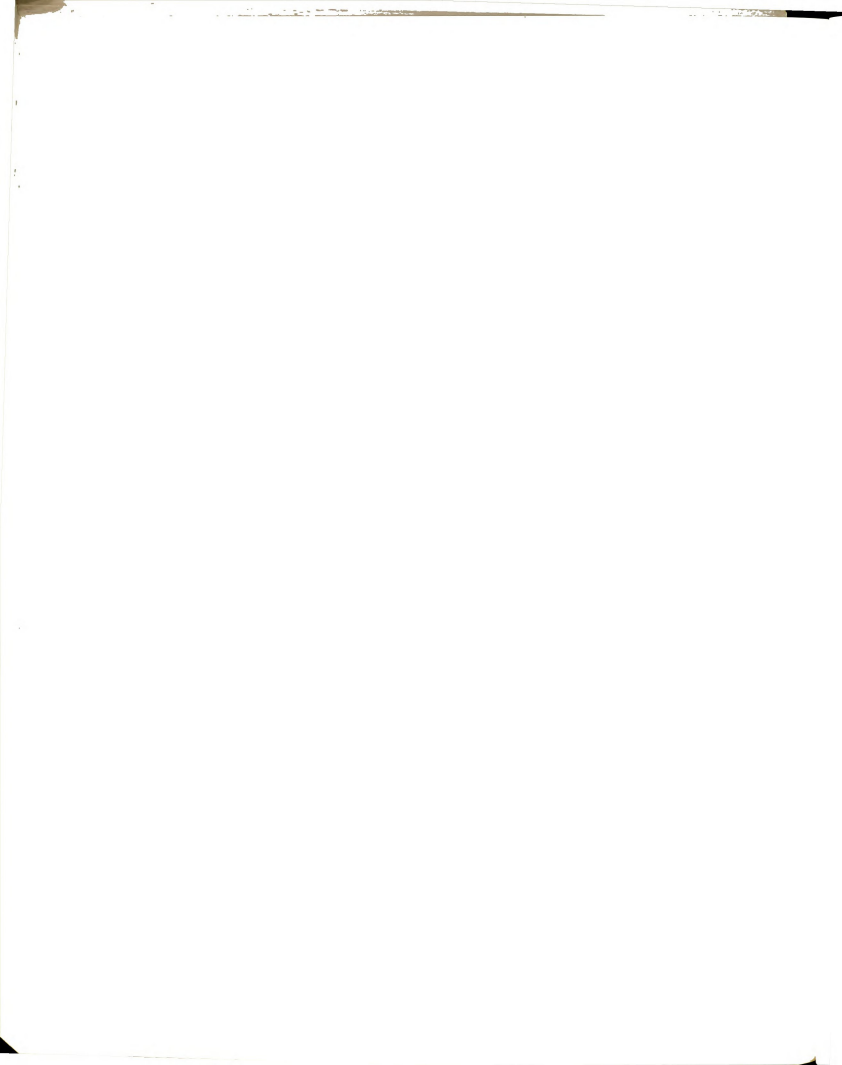
Hospital Name	Number of Beds	Administrators	Physicians	RN's	LPN's	Physical Therapists	Occupational Therapists	Pharmacists	Dietitians	Social Workers	Speech Therapists	Have Formal P.E. Program
Arthur R. Gould Memorial	81	1	22	55	55	2	-	2	Consult	1	-	No--Under discussion
Bath Memorial	92	1	24	46	25	2	-	1	1	1	-	No--Planning
Calais Regional	71	1	12	58	9	1	-	1	Contract	-	From Pine Tree Soc.	Yes
Cary Memorial	73	1	19	72	63	2	-	1	Contract	1	Contract	Yes
Community General	65	1	9	24	18	Consult	Activity Director	1	1	1	-	No
Franklin County Memorial	60	1	22	60	22	1	-	1	1	2	-	Yes
Gardiner General	52	1	30	21	14	2	-	1	1	1	-	No--Planning
Houlton Regional	98	1	9	55	40	2	-	1	1	1	-	No
Maine Coast	64	Non-responsive										
Mt. Desert Island	92	1	13	31	9	1	-	1	1	1	-	No
Northern Maine Medical Center	70	1	10	36	14	1	-	Consult	Consult	1	-	Yes
Parkview Memorial	53	1	32	50	17	2	-	1	1	1	-	Yes
Redington-Fairview General	92	1	25	70	41	1	-	2	1	2	-	No--Planning
Regional Memorial	98	1	38	56	36	3	1	1	Consult	1	Contract	Yes
Rumford Community	97	1	18	53	25	2	-	1	1	1	-	Yes
Waldo County	60	1	6	25	15	1	-	1	Consult	1	Is One Available	No
Waterville Osteopathic	78	1	20	69	25	2	-	2	1	1	Consult	Yes
York Hospital	86	1	22	49	19	4	Arr. as Needed	1	1	1	As Needed	No--Planning
Subtotals	-	17	331	830	447	28	1	19	1	15	-	-

1 non-responsive

Subtotals by Sub-Group

Physicians	331
Nurses	1277
Administrators	17
Allied Health	73
Subtotal	1698





Follow-Up Letters to Hospitals on Pre-Survey

Letter I--To hospitals with operating patient education programs

Dear _____

I am writing to thank you for your hospital's cooperation in assisting me to gather the initial data that is needed to conduct my research study on patient education. Your operating patient education programs sound very interesting. I enjoyed learning about them.

A summary of the data collected can be obtained from the Research & Education Trust of the Maine Hospital Association.

Again, thank you for your cooperation.

Sincerely,

Rosemary S. Caffarella

Letter II--To hospitals in the process of planning patient education programs

Dear _____

I am writing to thank you for your hospital's cooperation in assisting me to gather the initial data that is needed to conduct my research study on patient education. I was glad to hear that your hospital is in the process of developing a formal patient education program. If I can be of any assistance in that process, please feel free to contact me.

A summary of the data collected can be obtained from the Research & Education Trust of the Maine Hospital Association.

Again, thank you for your cooperation.

Sincerely,

Rosemary S. Caffarella



Letter III--To hospitals without patient education programs

Dear _____

I am writing to thank you for your hospital's cooperation in assisting me to gather the initial data that is needed to conduct my research study on patient education. It is my understanding that your hospital does not presently have a formal patient education program, but conducts patient teaching on an informal basis.

A summary of the data collected can be obtained from the Research & Education Trust of the Maine Hospital Association.

Again, thank you for your cooperation.

Sincerely,

Rosemary S. Caffarella



APPENDIX C

LETTERS TO HOSPITAL ADMINISTRATORS REQUESTING SAMPLING
LIST, THANK-YOU LETTER TO HOSPITAL ADMINISTRATORS FOR
LISTS, AND LIST OF PARTICIPATING HOSPITALS

APPENDIX C

LETTER TO HOSPITAL ADMINISTRATORS REQUESTING SAMPLING LISTS



UNIVERSITY OF MAINE *at Orono*

Office of Cooperative Education
Field Experience
University of Maine at Orono

Office at:
251 Aubert, Orono
(207) 581-2640

Dear (Personally Addressed to each Hospital Administrator)

Recently you provided some preliminary information of the patient education programs in your hospital for a study that I am undertaking in cooperation with the Maine Hospital Association's Research & Education Trust. We are now moving into the major section of the data collection and I would again like to enlist your support.

The data collected in this stage will involve surveying randomly selected physicians, nurses (RN's and LPN's), hospital administrators, and allied health professionals (i.e., occupational therapists, physical therapists) that work and/or practice in Maine hospitals. They will be surveyed through a short mail questionnaire. The purpose of the questionnaire is to determine the opinions that hospital professionals have of patient education (i.e., how they define it, what their professional role should be).

In order for me to carry through this phase of the study I will need your assistance in obtaining the names of the following professionals that work and/or practice with your hospital:

- a. Active Physician Staff
- b. Registered Nurses that work a minimum of 20 hours per week
- c. Licensed Practical Nurses that work a minimum of 20 hours per week
- d. Physical Therapists
- e. Occupational Therapists
- f. Dietitians
- g. Social Workers
- h. Pharmacists
- i. Speech Therapists

The lists that I obtain will be kept confidential and returned to the hospital after the study is completed.



The data that will be generated for the study will not be identified nor displayed by individual hospital. Rather the data will be shown by composite groups only (i.e., by professional staff grouping, size of hospital).

Your hospital will of course be given credit for their participation in the study. I will also be happy to share a copy of the draft questionnaire with you so that you can see the types of questions.

I will plan to call you in the next week to discuss further the study and the possibility of obtaining the lists of names from your hospital that I need. I will be more than happy to meet with you at your convenience to further outline the purpose of the study if that would be helpful to you.

Thank you for your consideration and assistance.

Sincerely,

Rosemary S. Caffarella
Director
Cooperative Education/
Field Experience
(on leave of absence)



THANK-YOU LETTER--HOSPITAL ADMINISTRATORS



UNIVERSITY OF MAINE *at Orono*

Office of Cooperative Education
Field Experience
University of Maine at Orono

Office at:
251 Aubert, Orono
(207) 581-2640

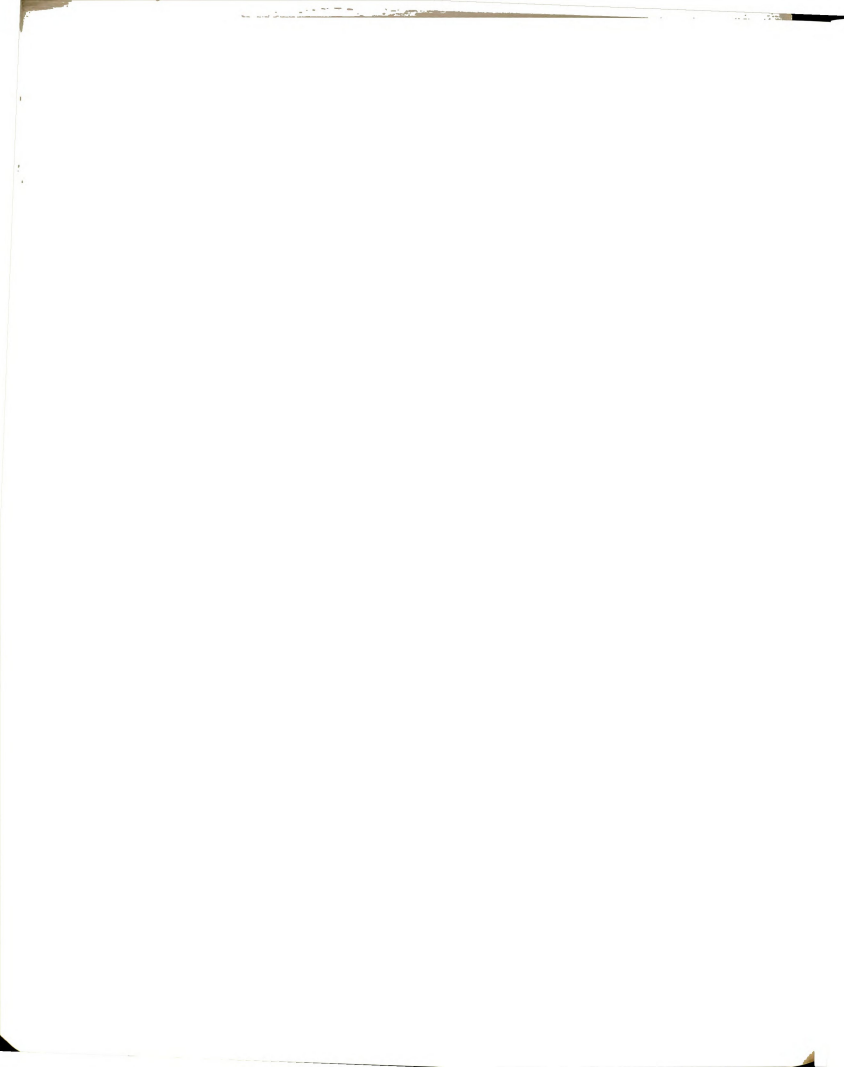
Dear (Personally Addressed to each Hospital Administrator)

Thank you for sharing with me a list of your hospital's personnel for my study on patient education. Your cooperation in this matter was really appreciated.

Enclosed are your original lists.

Sincerely,

Rosemary S. Caffarella
Director
Cooperative Education/
Field Experience
(on leave of absence)



LIST OF HOSPITALS PARTICIPATING IN THE STUDY

Blue Hill Memorial Hospital, Blue Hill
Calais Regional Hospital, Calais
Castine Community Hospital, Castine
Community General Hospital, Fort Fairfield
Henrietta A. Goodall Hospital, Sanford
Houlton Regional Hospital, Houlton
James A. Taylor Memorial Hospital, Bangor
Maine Medical Center, Portland
Miles Memorial, Damariscotta
Mount Desert Hospital, Bar Harbor
Northern Maine Medical Center, Fort Kent
Penobscot Bay Medical Center, Rockland
Penobscot Valley Hospital, Lincoln
Plummer Memorial Hospital, Dexter
Regional Memorial Hospital, Brunswick
Rumford Community Hospital, Rumford
St. Andrews Hospital, Boothbay Harbor
St. Joseph Hospital, Bangor
Stephens Memorial Hospital, Norway
Van Buren Community Hospital, Van Buren
Westbrook Community Hospital, Westbrook
York Hospital, York



APPENDIX D

COVER LETTERS AND SURVEY INSTRUMENT



APPENDIX D

COVER LETTERS AND SURVEY INSTRUMENT



APPENDIX D

COVER LETTERS AND MAIL SURVEY INSTRUMENT



MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501(387)
University of Maine at Farmington

EXECUTIVE DIRECTOR
John Rosser E.D.

ADVISORY BOARD OF DIRECTORS

Stanley L. Freeman Ed.D./Chairman
Kenneth W. Allen Ph.D.
Fletcher Bingham M.D.
William J. Carney
Richard T. Chamberlin M.D.
Walter F. Christie M.D.
Wendell Eaton
Pearl R. Fisher R.N.
Harland Goodwin
John A. LaCasse
George T. Nilson
Daniel K. Olson M.D.
Robert H. Remy
Neil Rolde
William E. Schumacher M.D.
Halsey Smith
F. Ernest Stallworth
Erik Van de Bogen

EX OFFICIO MEMBERS

Dr. Emur A. Olsen, President, UMF
Dr. D. Conrad Rice, Vice President,
Academic Affairs, UMF
Dr. David Fearon, Dean,
Public Service Division, UMF

A research study on hospital patient education is being conducted by Rosemary Caffarella. The purpose of this study is to develop a description of how physicians, hospital administrators, nurses, and allied health professionals view patient education for inpatients. Mrs. Caffarella is on the faculty at the University of Maine at Orono and a doctoral candidate at Michigan State University.

The study has been endorsed by the Maine Health Education Resource Center, and the Maine Medical Association. The information generated from this study will be used by these and other health related organizations in Maine in the development of patient education programs.

Your response to the study as a physician is especially needed to ensure the comprehensiveness of the study.

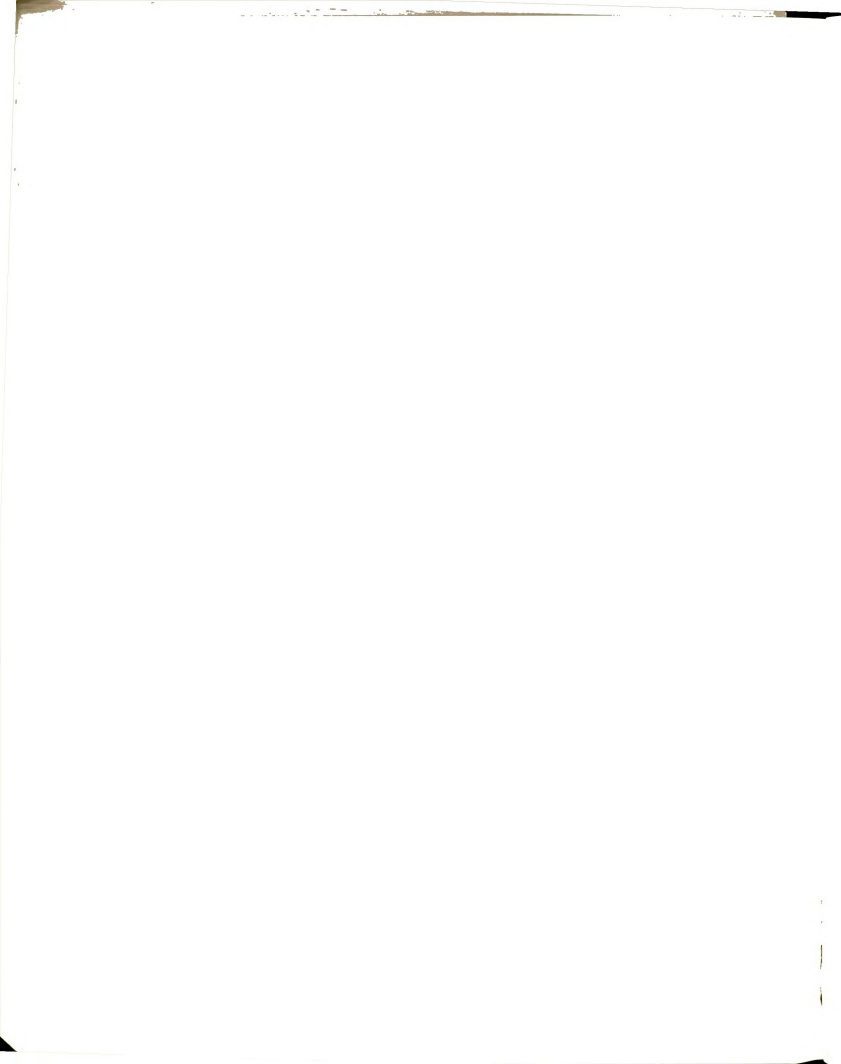
Please complete the enclosed survey form and return it to Mrs. Caffarella in the enclosed envelope by Friday, June 10, 1977. As you may notice there is an identification number on the return envelope for record keeping purposes only. The confidentiality of your responses will be insured by separating the envelope and survey form when they are returned.

I would appreciate your cooperation in this study.

Sincerely,

Richard T. Chamberlin, M.D.
Richard T. Chamberlin, M.D.

Duffy House/University of Maine at Farmington/100 Main Street O4938
Stoddard House/University of Maine at Augusta





MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501 (387)
University of Maine at Farmington

EXECUTIVE DIRECTOR
John Rosser Ed.D.

ADVISORY BOARD OF DIRECTORS

Stanley L. Freeman Ed.D./Chairman
Kenneth W. Allen Ph.D.
Fletcher Bingham M.D.
William J. Carney
Richard I. Chamberlin M.D.
Walter P. Christie M.D.
Wendell Eaton
Paul R. Fisher R.N.
Harland Goodwin
John A. LaCase
George T. Nelson
Daniel K. Olson M.D.
Robert H. Remy
Neil Rolde
William E. Schumacher M.D.
Halley Smith
F. Ernest Stallworth
Erik Van de Bogert

EX OFFICIO MEMBERS

Dr. Linus A. Olsen, President, UMF
Dr. D. Conrad Rice, Vice President,
Academic Affairs, UMF
Dr. David Pearson, Dean,
Public Service Division, UMF

May 20, 1977

Dear Nursing Professional:

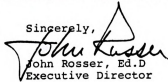
A research study on hospital patient education is being conducted by Rosemary Caffarella. The purpose of this study is to develop a description of how nurses, physicians, hospital administrators, allied health professionals, and patient education coordinators view patient education activities for inpatients. Mrs. Caffarella is on the faculty at the University of Maine at Orono and a doctoral candidate at Michigan State University.

The study is supported by a number of health related groups in Maine including the Maine Health Education Resource Center. The information generated from the study will be used by these groups in the development of patient education programs and staff development activities on patient education.

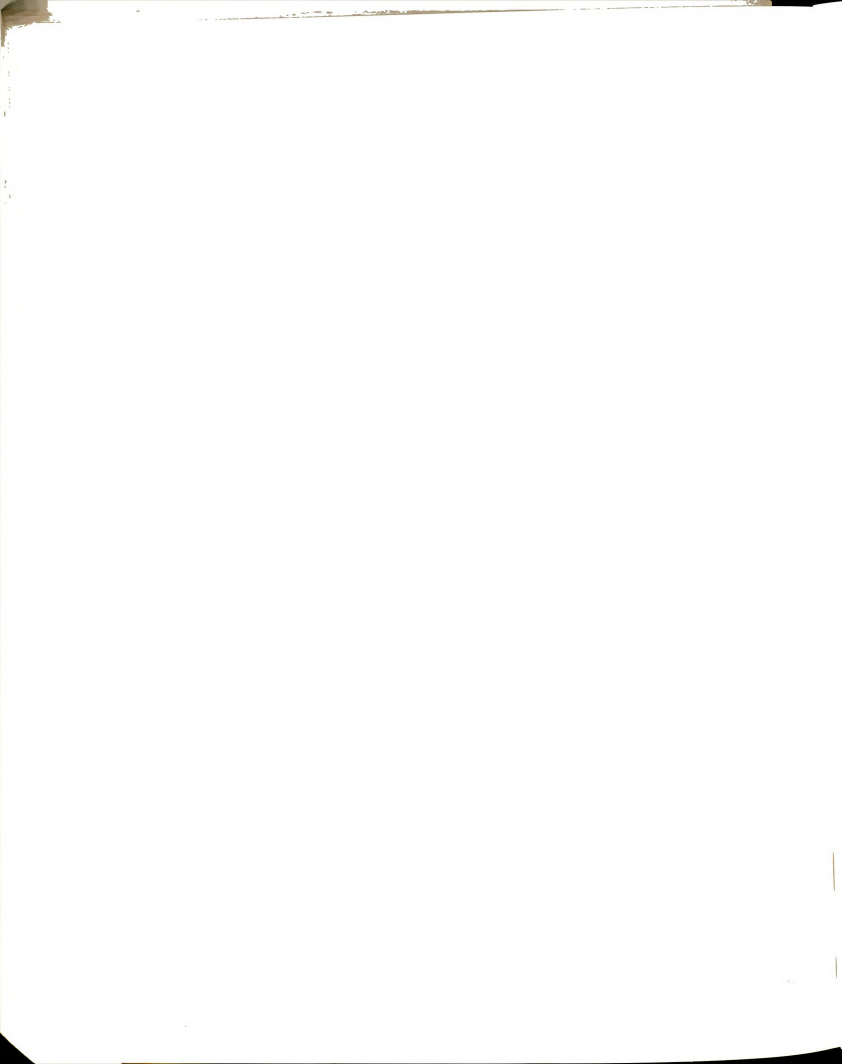
Your response to the study as a nurse that practices in a hospital setting will be especially useful. Please complete the enclosed survey form and return it to Mrs. Caffarella in the enclosed envelope by Friday, June 10, 1977. As you will see there is an identification number on the return envelope for record keeping purposes only. The confidentiality of your response will be insured by separating the envelope and the survey form when they are returned.

We would appreciate your cooperation in this study.
Thank you.

Sincerely,


John Rosser, Ed.D.
Executive Director

Duffy House/University of Maine at Farmington/100 Main Street O4938
Stoddard House/University of Maine at Augusta





UNIVERSITY OF MAINE *at Orono*

Office of Cooperative Education
Field Experience
University of Maine at Orono

Office at:
251 Auburn, Orono
(207) 581-2610

I am writing concerning the research study that I am conducting on patient education. The study is being done in cooperation with the Research & Education Trust of the Maine Hospital Association and the Maine Health Education Resource Center at the University of Maine at Farmington.

The enclosed survey is being used to gather the major data for the study, the focus of which is how health care professionals view patient education activities for inpatients. I would like you to respond to the survey as an individual hospital administrator and not as a representative of your specific hospital.

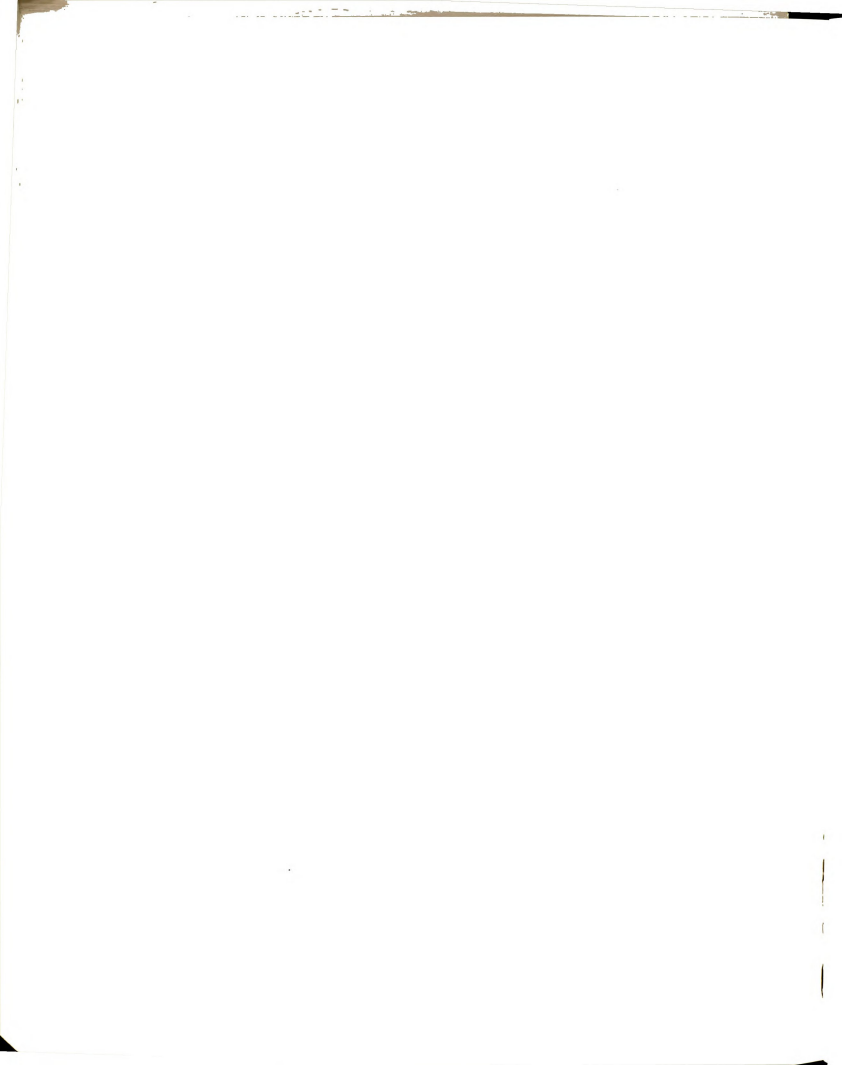
Please place the completed survey form in the enclosed envelope and return it by Friday, June 10, 1977. As you may notice there is an identification number on the return envelope for record keeping purposes only. The confidentiality of responses will be insured by separating the envelope and survey form when they are returned.

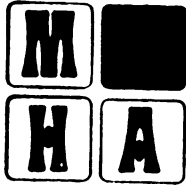
Your continuing cooperation in this study is appreciated. Thank you.

Sincerely,

Rosemary S. Caffarella

Rosemary S. Caffarella
Director (on leave)





Research and Education Trust

Maine Hospital Association
151 Capitol Street • Augusta, Maine 04330 • 207-622-4794

May 20, 1977

Dear Allied Health Professional:

A research study on hospital patient education is being conducted by Rosemary Caffarella. The purpose of this study is to develop a description of how allied health professionals, physicians, nurses and hospital administrators view patient education for inpatients. Mrs. Caffarella is on the faculty at the University of Maine at Orono and a doctoral candidate at Michigan State University.

The study has been endorsed by the Research & Education Trust of the Maine Hospital Association and the Maine Health Education Resource Center of the University of Maine at Farmington. The information generated from the study will be used by these and other health related organizations in Maine in the development of patient education programs.

Your response to the study as an allied health professional that practices in a hospital setting will be especially useful. Please complete the enclosed survey form and return it to Mrs. Caffarella in the enclosed envelope by Friday, June 10, 1977. As you may notice there is an identification number on the return envelope for record keeping purposes only. The confidentiality of your responses will be insured by separating the envelope and survey form when they are returned.

We would appreciate your cooperation in this study.

Sincerely,

A handwritten signature in black ink that reads "Douglas Kramer".

Douglas Kramer
Program Coordinator



MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501(387)
University of Maine at Farmington

EXECUTIVE DIRECTOR

John Rosser Ed.D.

ADVISORY BOARD OF DIRECTORS

Stanley L. Freeman Ed.D./Chairman
Kenneth W. Allen Ph.D.
Fletcher Bingham M.D.
William J. Carey
Richard T. Chamberlin M.D.
Walter P. Christie M.D.
Wendell Eaton
Pearl R. Fisher R.N.
Harland Goodwin
John A. LaCasse
George T. Nelson
Daniel K. Onyon M.D.
Robert H. Remy
Neil Rolfe
William E. Schumacher M.D.
Haley Smith
F. Ernest Stillworth
Erik Van de Bogart

EX OFFICIO MEMBERS

Dr. Einar A. Olsen, President, UMF
Dr. D. Gottard Rice, Vice President,
Academic Affairs, UMF
Dr. David Francis, Dean,
Public Service Division, UMF

A research study on hospital patient education is being conducted by Rosemary Caffarella. The purpose of this study is to develop a description of how nurses, physicians, hospital administrators, allied health professionals, and patient education coordinators view patient education activities for inpatients. Mrs. Caffarella is on the faculty at the University of Maine at Orono and a doctoral candidate at Michigan State University.

The study is supported by a number of health related groups in Maine including the Maine Health Education Resource Center. The information generated from the study will be used by these groups in the development of patient education programs and staff development activities on patient education.

Your contribution as a patient education coordinator/teacher will be especially valuable. Mrs. Caffarella would be more than happy to share a summary of the results of her study with you and/or share the literature research on patient education that she completed. If you are interested in either materials, please return the enclosed post card with the survey form.

Please complete the enclosed survey form and return it to Mrs. Caffarella in the enclosed envelope by Friday, June 10, 1977. As you will see there is an identification number on the return envelope for record keeping purposes only. The confidentiality of your response will be insured by separating the envelope and the survey form when they are returned.

We would appreciate your cooperation in this study. Thank you.

Sincerely,

John Rosser, Ed.D.
Executive Director

Duffy House/University of Maine at Farmington/100 Main Street O4938
Stoddard House/University of Maine at Augusta

PATIENT EDUCATION SURVEY

The purpose of the study is to determine the opinions professional hospital staff have of patient education for hospital inpatients. Please answer the survey as completely as possible and return it in the enclosed envelope.

Patient Education for Hospital Inpatients

1. How important is patient education as a component of patient care for hospital inpatients? (Please check the one response which best expresses your opinion.)

☐ Undesirable (definitely should not be done)
☐ Of little importance
☐ Moderately important for some patients
☐ Moderately important for all patients
☐ Extremely important for some patients
☐ Extremely important for all patients
☐ Don't know

If you have checked "Undesirable", "Of little importance", or "Don't know", please go directly to question 13. If you checked any of the other lines please continue to question number 2.

2. Do you believe that patient education for hospital inpatients should consist of (Please check one response):

☐ principally informal (incidental) educational activities.
☐ principally formal (specifically planned and organized) educational activities.
☐ an intentional combination of formal and informal educational activities.

3. In your opinion, how important is it that a hospital provide inpatient education activities in each of the listed areas? (Please check the most appropriate box for each item and add any additional responses.)

OF NO IMPORTANCE OF LITTLE IMPORTANCE MODERATELY IMPORTANT EXTREMELY IMPORTANT UNCERTAIN

- a. Orientation to hospital facilities and services (i.e., printed materials, tours, video tapes)..... ☐ ☐ ☐ ☐ ☐
- b. Explanation of the diagnosis and treatment of the health problem..... ☐ ☐ ☐ ☐ ☐
- c. Teaching the patient to administer own treatment as prescribed by physician..... ☐ ☐ ☐ ☐ ☐
- .. Teaching the patient self-care, independent living skills..... ☐ ☐ ☐ ☐ ☐

- | | <u>OF NO
IMPORTANCE</u> | <u>OF LITTLE
IMPORTANCE</u> | <u>MODERATELY
IMPORTANT</u> | <u>EXTREMELY
IMPORTANT</u> | <u>UNCERTAIN</u> |
|--|-----------------------------|---------------------------------|---------------------------------|--------------------------------|--------------------------|
| e. Teaching about needed short & long term life style adjustments (i.e., social, vocational, dietary)..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Teaching about appropriate community resources for discharged patients..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| g. Teaching about financial management of the health problem..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| h. Teaching of general preventive medicine..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| i. Others _____ | ☐ | ☐ | ☐ | ☐ | ☐ |
| _____ | ☐ | ☐ | ☐ | ☐ | ☐ |

4. Which professional hospital staff(s) should have the responsibility for the planning and conducting of inpatient education activities in each area?

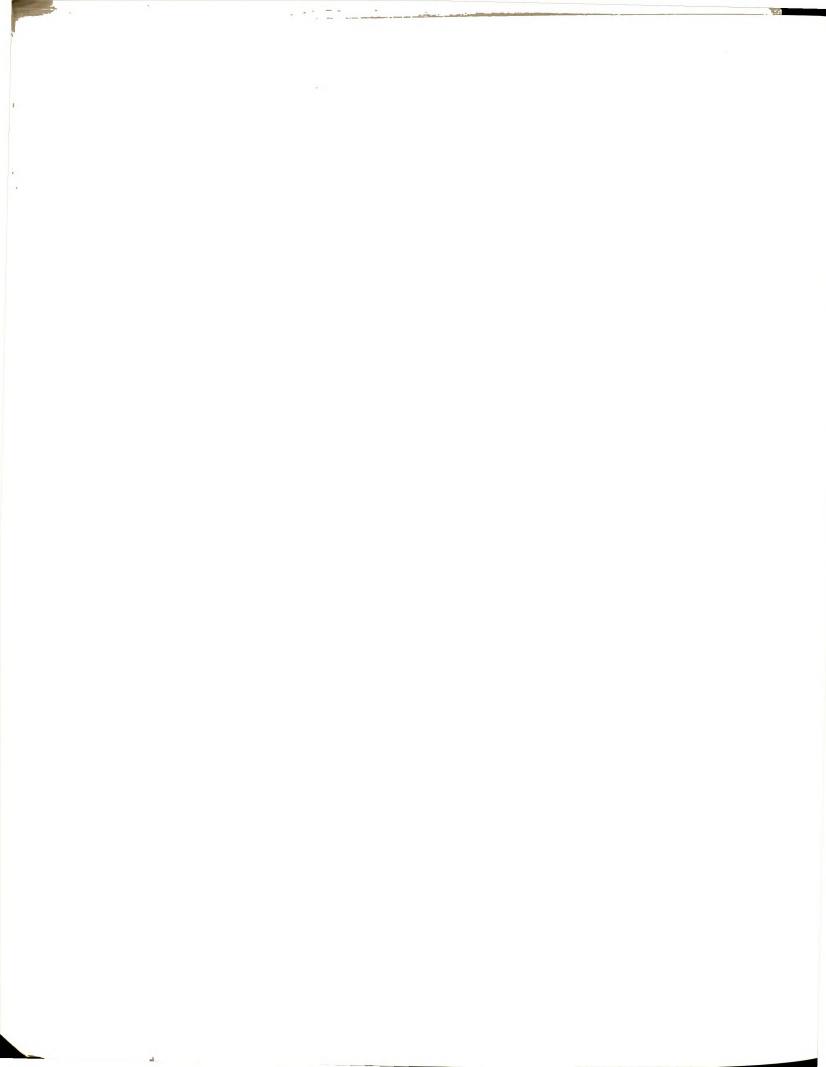
Insert ☐ in each box for Group(s) with PRIMARY responsibility for each activity

Insert ☐ in each box for Group(s) with SUPPORTIVE responsibility for each activity

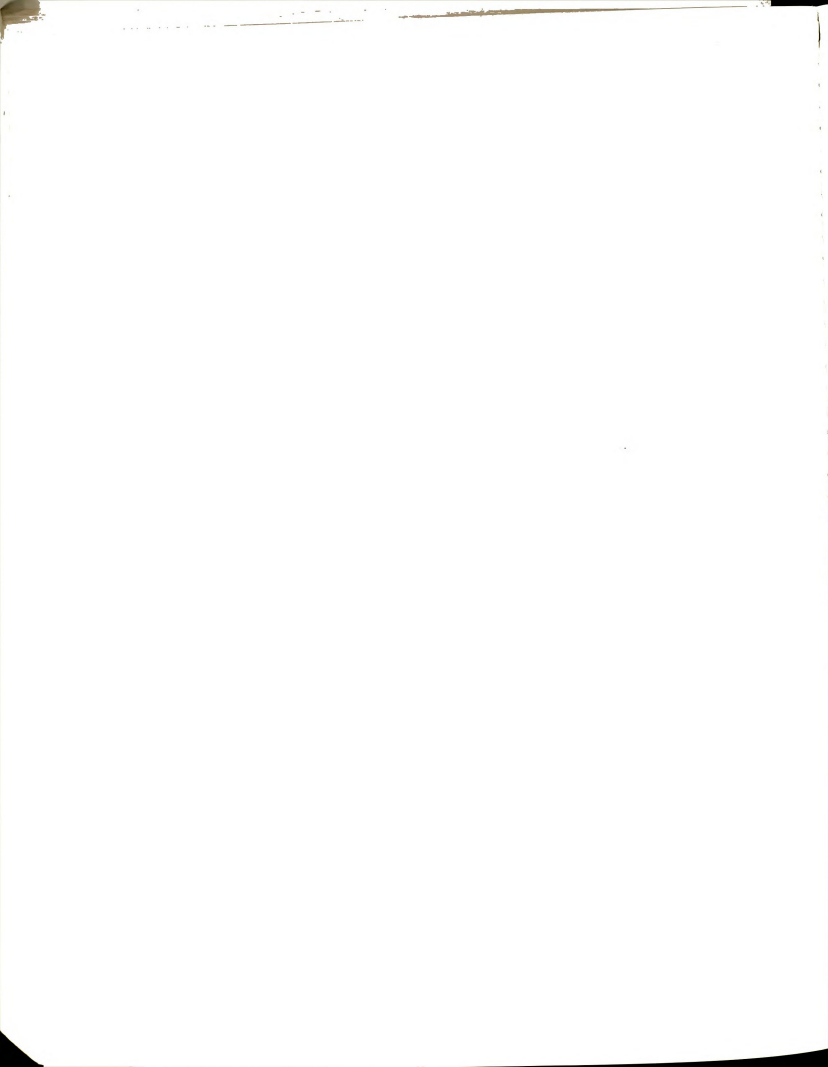
Leave all other boxes blank

(For the purpose of this question allied health professionals include dietitians, occupational therapists, physical therapists, pharmacists, social workers & speech therapists.)

- | | <u>PATIENT
EDUCATION
STAFF</u> | <u>PHYSICIANS</u> | <u>NURSES</u> | <u>ALLIED HEALTH
PROFESSIONALS</u> | <u>HOSPITAL
ADMINISTRATORS</u> |
|--|--|--------------------------|--------------------------|--|------------------------------------|
| <u>Orientation to Hospital Facilities & Services</u> | | | | | |
| a. Planning the orientation | ☐ | ☐ | ☐ | ☐ | ☐ |
| b. Carrying through the orientation..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| <u>Explanation of the Diagnosis of the Health Program</u> | | | | | |
| c. Planning of the explanation..... | ☐ | ☐ | ☐ | ☐ | ☐ |
| d. Giving the explanation.. | ☐ | ☐ | ☐ | ☐ | ☐ |
| <u>Explanation of the General Treatment for the Health Problem</u> | | | | | |
| e. Planning the explanation | ☐ | ☐ | ☐ | ☐ | ☐ |
| f. Giving the explanation . | ☐ | ☐ | ☐ | ☐ | ☐ |



	<u>PATIENT EDUCATION STAFF</u>	<u>PHYSICIANS</u>	<u>NURSES</u>	<u>ALLIED HEALTH PROFESSIONALS</u>	<u>HOSPITAL ADMINISTRATORS</u>
<u>Teaching the Patient to Admin- istrator Own Treatment as Prescribed by Physician</u>					
g. Planning the activity...	☐	☐	☐	☐	☐
h. Conducting the activity.	☐	☐	☐	☐	☐
<u>Teaching the Patient Self-Care Independent Living Skills</u>					
i. Planning the activity...	☐	☐	☐	☐	☐
j. Conducting the activity.	☐	☐	☐	☐	☐
<u>Teaching About Needed Short & Long Term Life Style Adjust- ments (i.e., social, vocation- al, family, dietary)</u>					
k. Planning the activity...	☐	☐	☐	☐	☐
l. Conducting the activity.	☐	☐	☐	☐	☐
<u>Teaching About Appropriate Community Resources for Discharged Patients</u>					
m. Planning the activity...	☐	☐	☐	☐	☐
n. Conducting the activity.	☐	☐	☐	☐	☐
<u>Teaching About Financial Manage- ment of the Health Problem</u>					
o. Planning the activity...	☐	☐	☐	☐	☐
p. Conducting the activity.	☐	☐	☐	☐	☐
<u>Teaching of General Preven- tive Medicine</u>					
q. Planning the activity...	☐	☐	☐	☐	☐
r. Conducting the activity.	☐	☐	☐	☐	☐
5. Should former hospital patients be involved in the planning and conducting of hospital inpatient education activities? (Please check the most appropriate box for each item.)					
	<u>YES</u>	<u>NO</u>	<u>DEPENDS ON THE HEALTH PROBLEM</u>	<u>UNCERTAIN</u>	
a. Planning the activities.....	☐	☐	☐	☐	
b. Conducting the activities.....	☐	☐	☐	☐	



6. Should families of present and/or former hospital patients be involved in the planning and conducting of hospital inpatient education activities?

YES NO DEPENDS ON THE
HEALTH PROBLEM UNCERTAIN

- a. Planning the activities..... ☐ . ☐ ☐ ☐
- b. Conducting the activities..... ☐ . ☐ ☐ ☐

7. Who should be involved in the evaluation of the effectiveness of patient education activities for inpatients? (Please check one or more of the items as you see appropriate.)

☐ Allied Health Professionals ☐ Patient Education Staff
☐ Community Home Health Agencies ☐ Patients and/or their
☐ Hospital Administrators families
☐ Nurses ☐ Physicians

8. What should the responsibility of the hospital be for inpatients who will need further educational services once they are discharged? (Please check the one response which best expresses your opinion.)

- ☐ principally have the hospital continue to provide the services once the patient is discharged.
- ☐ principally refer the patient to appropriate community agencies upon discharge.
- ☐ a combination of both activities, having the hospital continue to provide the services and referral to appropriate community agencies.

9. Which of the following factors, in general, prevent the development and implementation of inpatient education activities? (Please check the most appropriate box for each item and add any additional reasons.)

AGREE DISAGREE UNCERTAIN

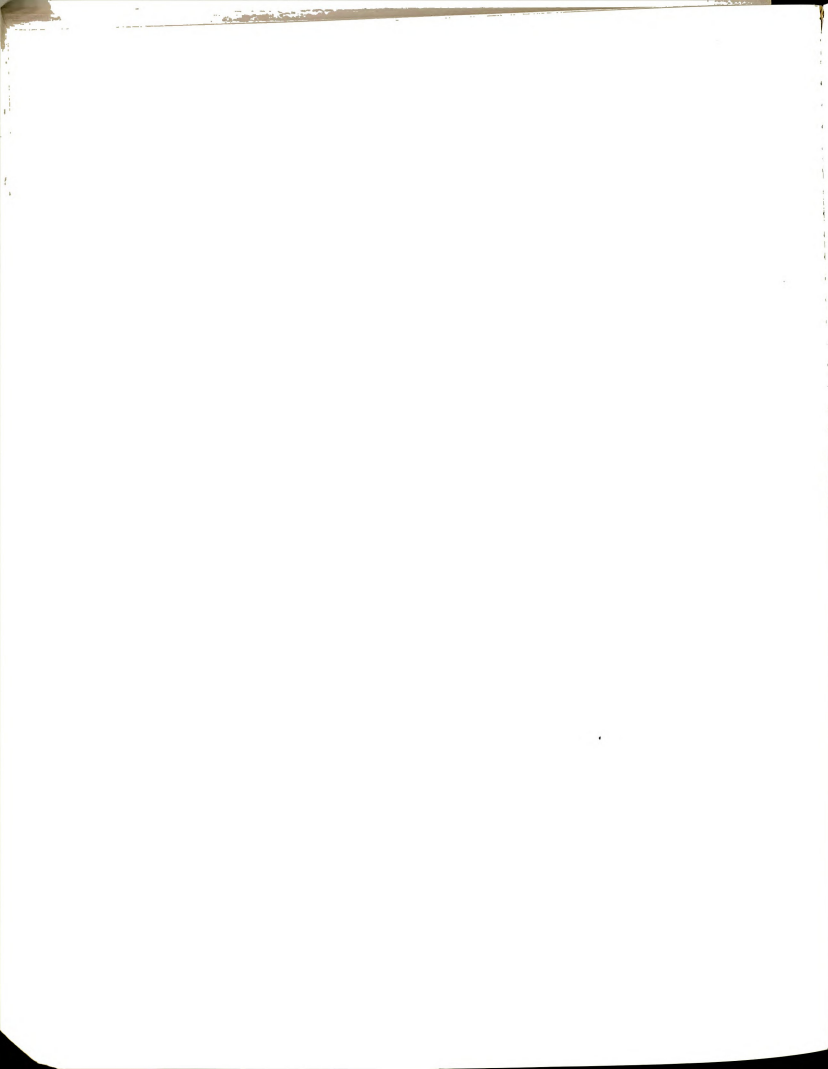
- a. Lack of acceptance of patient education by

1. Administrators..... ☐ ☐ ☐
2. Allied Health Professionals..... ☐ ☐ ☐
3. Nurses..... ☐ ☐ ☐
4. Physicians..... ☐ ☐ ☐
5. Other Staff (Specify) _____. ☐ ☐ ☐

- b. Lack of staff competence to do patient education..... ☐ ☐ ☐

- c. Lack of staff interest in doing patient education..... ☐ ☐ ☐

- d. Lack of staff time to do patient education..... ☐ ☐ ☐



AGREE DISAGREE UNCERTAIN

- e. Lack of an identified staff member to coordinate patient education..... ☐ ☐ ☐
- f. Cost of patient education..... ☐ ☐ ☐
- g. Lack of necessary facilities and equipment..... ☐ ☐ ☐
- h. Lack of necessary resource materials (i.e., printed, audio-visual)..... ☐ ☐ ☐
- i. Lack of patient interest in patient education activities while they are hospitalized..... ☐ ☐ ☐
- j. Lack of, in most cases, third party payments for patient education..... ☐ ☐ ☐
- k. Others _____, ☐ ☐ ☐
- ☐ ☐ ☐

10. If you were to develop an organized patient education program, which five of the following health problem areas would you choose to develop programs first? (Please check only five.)

- ☐ Alcohol & Drug Dependency
- ☐ Arthritis
- ☐ Cancer (General)
- ☐ Cardiac
- ☐ Diabetes
- ☐ Gastrointestinal diseases
- ☐ Hypertension
- ☐ Kidney
- ☐ Mastectomy
- ☐ Mental Health
- ☐ Orthopedic diseases & injuries

- ☐ Ostomy
- ☐ Personal health habits (i.e., smoking)
- ☐ Pre & Post Natal
- ☐ Pre & Post Operative (General)
- ☐ Pulmonary Disease
- ☐ Speech & Hearing
- ☐ Spinal Cord injuries
- ☐ Stroke
- ☐ Vision
- ☐ Others

17. Which hospital department in your opinion can best coordinate an organized patient education program? (Please check one response.)

☐ Education ☐ Personnel
☐ Nursing ☐ Social Services
☐ Other (Please specify) _____

12. Is it feasible in your opinion to develop or expand organized patient education programs in your hospital?

YES

NO

UNCERTAIN

12a. (If NO or UNCERTAIN) Please briefly explain



General Information

In this section of the survey we would appreciate your answering several questions pertaining to your professional activities. The purpose of requesting this information is to aid us in the analysis of the data secured in this survey.

13. What is your professional background? (Please check the appropriate response(s).)

☐ Dentist	☐ Pharmacist
☐ Dietitian	☐ Physical Therapist
☐ Health Educator	☐ Physician (D.O.)
☐ Hospital Administrator	☐ Physician (M.D.)
☐ Nurse (L.P.N.)	☐ Social Worker
☐ Nurse (R.N.)	☐ Speech Therapist
☐ Occupational Therapist	☐ Other (Please specify) _____

14. Are you presently active or have you been active in educational activities for hospital inpatients?

<u>VERY</u> <u>ACTIVE</u>	<u>SOMEWHAT</u> <u>ACTIVE</u>	<u>NOT</u> <u>ACTIVE</u>
------------------------------	----------------------------------	-----------------------------

- a. Informal patient education activities..... ☐ ☐ ☐
- b. Formal patient education program..... ☐ ☐ ☐

15. Have you ever attended an educational program/class specifically concerned with patient education or an area related to patient education (i.e., education methods, health education, adult education, program evaluation)?

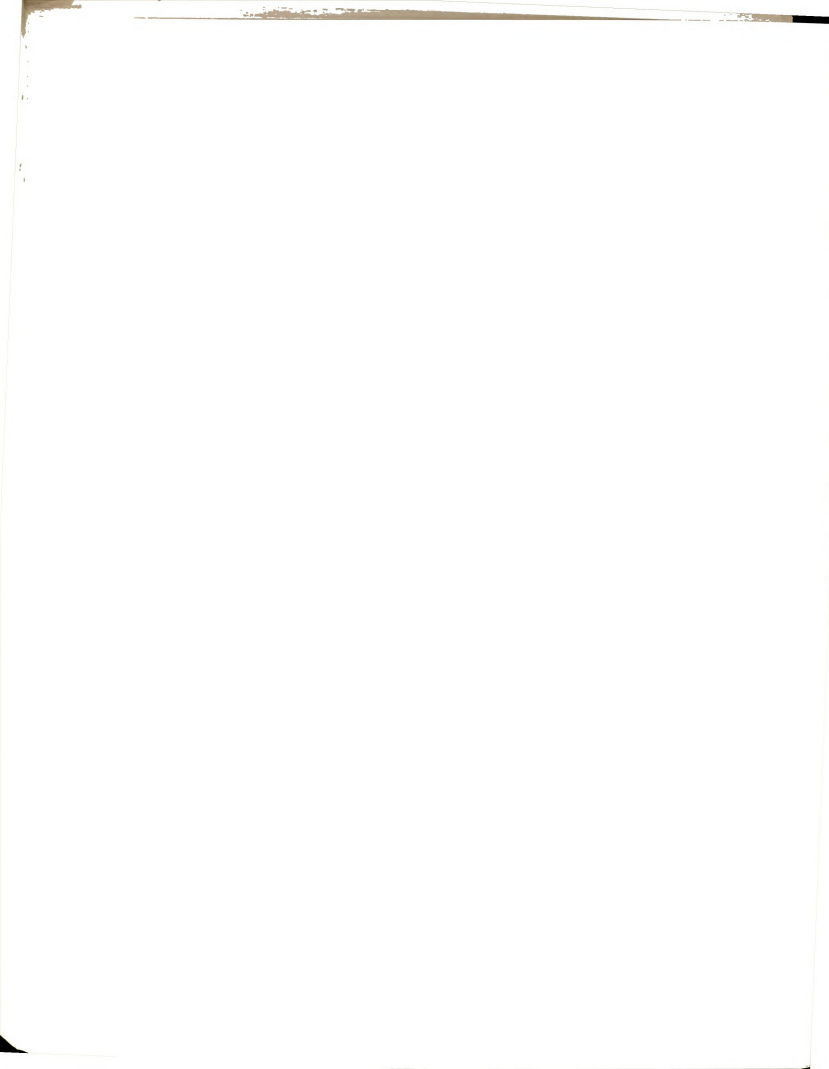
<u>YES</u>	<u>NO</u>
------------	-----------

- a. Program/class on Patient Education..... ☐ ☐
- b. Program/class on Area Related to Patient Education..... ☐ ☐
- c. (If YES to either 15a or 15b) Please briefly describe the program(s)/class(es)

16. If a program/class on hospital patient education were to be held, would you be interested in attending such a program?

☐ YES
 ☐ NO
 ☐ UNCERTAIN

THANK YOU FOR YOUR COOPERATION!



APPENDIX E

FOLLOW-UP POSTCARDS AND FOLLOW-UP LETTERS



APPENDIX E

FOLLOW-UP POSTCARDS AND FOLLOW-UP LETTERS



MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501(387)
University of Maine at Farmington

Dear Physician:

About a week ago you received a survey form on patient education from the Maine Health Education Resource Center. If you have already completed the survey, our sincere thanks for your help.

If you have not yet had a chance to complete and return the survey, could you please do so at your earliest convenience? Thank you.

Sincerely,

Richard T. Chamberlin, MD
Richard T. Chamberlin, M.D.



MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501(387)
University of Maine at Farmington

Dear Nursing Professional:

About a week ago you received a survey form on patient education from the Maine Health Education Resource Center. If you have already completed the survey, our sincere thanks for your help.

If you have not yet had a chance to complete and return the survey, could you please do so at your earliest convenience? Thank you.

Sincerely,

John Rosser
John Rosser, Ed.D.
Executive Director





Research and Education Trust

Maine Hospital Association
151 Capitol Street • Augusta, Maine 04330 • 207-622-4794

Dear Allied Health Professional:

About a week ago you received a survey form on patient education from the Research & Education Trust of the Maine Hospital Association. If you have already completed the survey, our sincere thanks for your help.

If you have not yet had a chance to complete and return the survey, could you please do so at your earliest convenience? Thank you.

Sincerely,

Douglas Kramer
Douglas Kramer
Program Coordinator

Office of Co-op/Field Experience
U. of Maine at Orono

Dear

About two weeks ago you received a survey form on patient education. If you have already completed the survey, my sincere thanks for your help.

If you have not yet had a chance to complete and return the survey, could you please do so at your earliest convenience? Thank you.

Sincerely,

Rosemary Caffarella



MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501 (387)
University of Maine at Farmington

EXECUTIVE DIRECTOR
John Rouser Ed.D.

June 17, 1977

ADVISORY BOARD OF DIRECTORS
Stanley L. Freeman Ed.D./Chairman
Kenneth W. Allen Ph.D.
Fletcher Bingham M.D.
William J. Carney
Richard T. Chamberlin M.D.
Walter P. Christie M.D.
Wendell Eaton
Pearl R. Fisher R.N.
Harland Goodwin
John A. LaCasse
George T. Nilson
Daniel K. Olson M.D.
Robert H. Rony
Neil Rolde
William E. Schumacher M.D.
Haley Smith
F. Ernest Stallworth
Erik Van de Bogaert

Dear Physician:

About four weeks ago we sent you a survey relating to patient education in the hospital setting. The study is being conducted in cooperation with the Maine Health Education Resource Center and the Maine Medical Association.

Since we have not received your completed questionnaire we are assuming that it may not have reached you or may have been misplaced. We are therefore sending you another survey and a postage-paid return envelope. We would appreciate it if you would take a few minutes to fill out and return the enclosed form. You may be assured that all responses will be kept confidential.

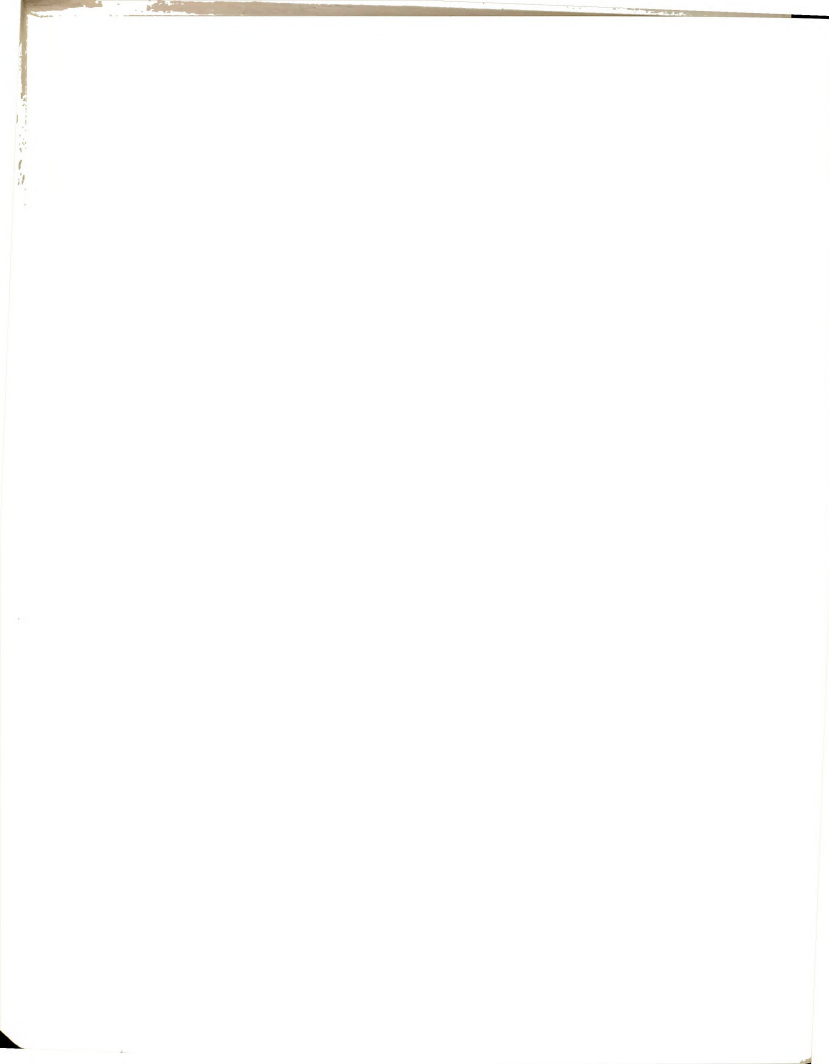
If you have already returned the survey, you may want to keep this second copy for your file. Thank you for your cooperation in this very important study.

Sincerely,

Richard T. Chamberlin, M.D.
Richard T. Chamberlin, M.D.

EX OFFICIO MEMBERS
Dr. Einar A. Olsen, President, UMF
Dr. D. Conrad Rice, Vice President,
Academic Affairs, UMF
Dr. David Fearon, Dean,
Public Service Division, UMF

Duffy House/University of Maine at Farmington/100 Main Street O4938
Soddard House/University of Maine at Augusta





MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501 (887)
University of Maine at Farmington

EXECUTIVE DIRECTOR
John Rosser Ed.D.

June 17, 1977

ADVISORY BOARD OF DIRECTORS

Stanley L. Freeman Ed.D./Chairman
Kenneth W. Allen Ph.D.
Fletcher Bingham M.D.
William J. Carney
Richard T. Chamberlin M.D.
Walter F. Christie M.D.
Wendell Eaton
Paul R. Fisher R.N.
Harland Goodwin
John A. LaCasse
George T. Nilson
Daniel K. Olson M.D.
Robert H. Remy
Neil Rolde
William E. Schumacher M.D.
Haley Smith
F. Ernest Stallworth
Edik Van de Bunt

EX OFFICIO MEMBERS

Dr. Einar A. Olsen, President, UMF
Dr. D. Conrad Rice, Vice President,
Academic Affairs, UMF
Dr. David Pearson, Dean,
Public Service Division, UMF

Dear Nursing Professional:

About four weeks ago we sent you a survey relating to patient education in the hospital setting. The study is being conducted in cooperation with the Maine Health Education Resource Center and other health related groups in Maine.

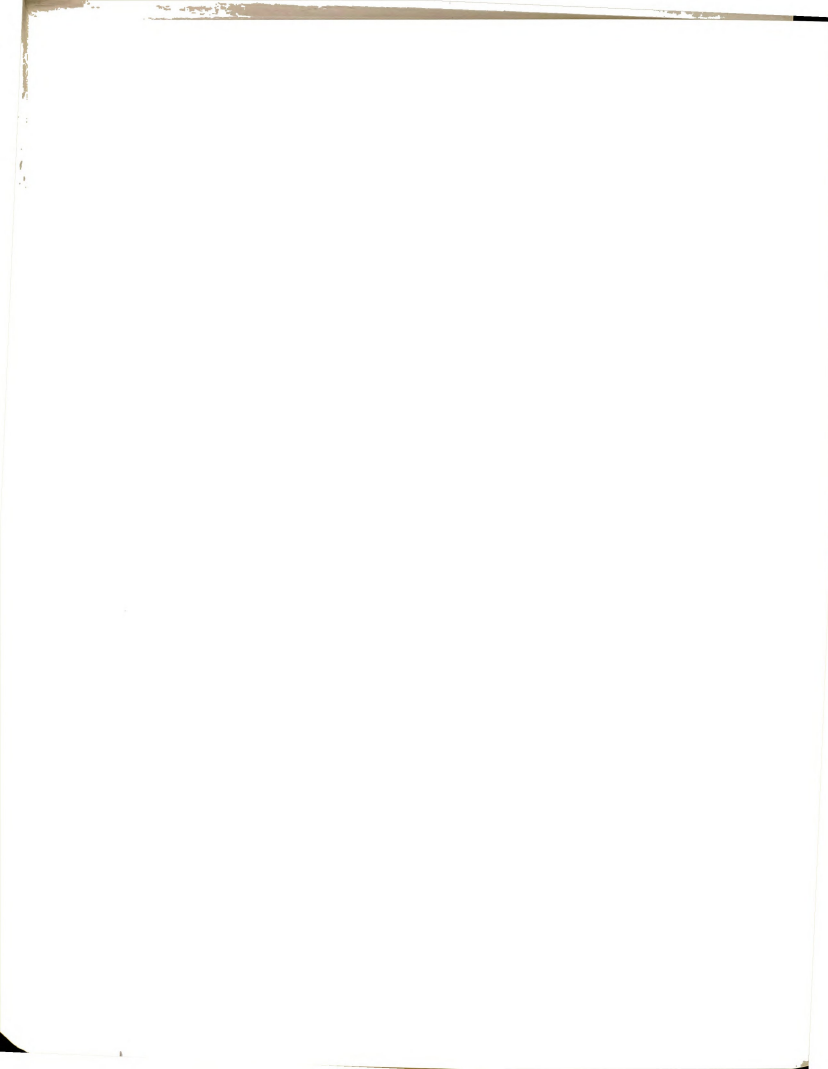
Since we have not received your completed questionnaire we are assuming that it may not have reached you may have been misplaced. We are therefore sending you another survey and a postage-paid return envelope. We would appreciate it if you would take a few minutes to fill out and return the enclosed form. You may be assured that all responses will be kept confidential.

If you have already returned the survey, you may want to keep this second copy for your file. Thank you for your cooperation in this very important study.

Sincerely,

John Rosser
Executive Director
Maine Health Education Resource
Center

Duffy House/University of Maine at Farmington/100 Main Street O4938
Stoddard House/University of Maine at Augusta





Research and Education Trust

Maine Hospital Association
 151 Capitol Street • Augusta, Maine 04330 • 207-622-4794

June 17, 1977

Dear Allied Health Professional:

About four weeks ago we sent you a survey relating to patient education in the hospital setting. The study is being conducted in cooperation with the Research and Education Trust of the Maine Hospital Association and the Maine Health Education Resource Center.

Since we have not received your completed questionnaire we are assuming that it may not have reached you or may have been misplaced. We are therefore sending you another survey and a postage-paid return envelope. We would appreciate it if you would take a few minutes to fill out and return the enclosed form. You may be assured that all responses will be kept confidential.

If you have already returned the survey, you may want to keep this second copy for your file. Thank you for your cooperation in this very important study.

Sincerely,

A handwritten signature in dark ink that reads "Douglas Kramer".

Douglas Kramer
 Program Coordinator



UNIVERSITY OF MAINE *at Orono*

Office of Cooperative Education
Field Experience
University of Maine at Orono

Office at:
251 Aubert, Orono
(207) 581-2610

About four weeks ago I sent you a survey relating to patient education in the hospital setting. The study is being conducted in cooperation with the Research and Education Trust of the Maine Hospital Association & the Maine Health Education Resource Center.

Since I have not received your completed questionnaire I am assuming that it may not have reached you or may have been misplaced. I am therefore sending you another survey and a postage-paid return envelope. I would appreciate it if you would take a few minutes to fill out and return the enclosed form. You may be assured that all responses will be kept confidential.

If you have already returned the survey, you may wish to keep this second copy for your file. Thank you for your cooperation in this very important study.

Sincerely,

Rosemary S. Caffarella

Rosemary S. Caffarella
Director
Cooperative Education/
Field Experience





MAINE HEALTH EDUCATION RESOURCE CENTER

dedicated to the health education of the total public/207-778-3501 (387)
University of Maine at Farmington

EXECUTIVE DIRECTOR
John Rosser *E.D.*

ADVISORY BOARD OF DIRECTORS

Stanley L. Freeman *Ed.D./Chairman*
Kenneth W. Allen *Ph.D.*
Fletcher Bingham *M.D.*
William J. Carney
Richard T. Chamberlin *M.D.*
Walter P. Christie *M.D.*
Wendell Eaton
Pearl R. Fisher *R.N.*
Harland Goodwin
John A. LaCasse
George T. Nelson
Daniel K. O'Brien *M.D.*
Robert H. Reay
Neil Rolde
William E. Schumacher *M.D.*
Halney Smith
F. Ernest Stalworth
Erik Van de Bogaert

EX OFFICIO MEMBERS

Dr. Elmer A. Olsen, *President, UMF*
Dr. D. Conrad Rice, *Vice President,
Academic Affairs, UMF*
Dr. David Pearson, *Dean,
Public Service Division, UMF*

June 17, 1977

Dear Patient Education Coordinator/Teacher:

About four weeks ago we sent you a survey relating to patient education in the hospital setting. The study is being conducted in cooperation with the Maine Health Education Resource Center and other health related groups in Maine.

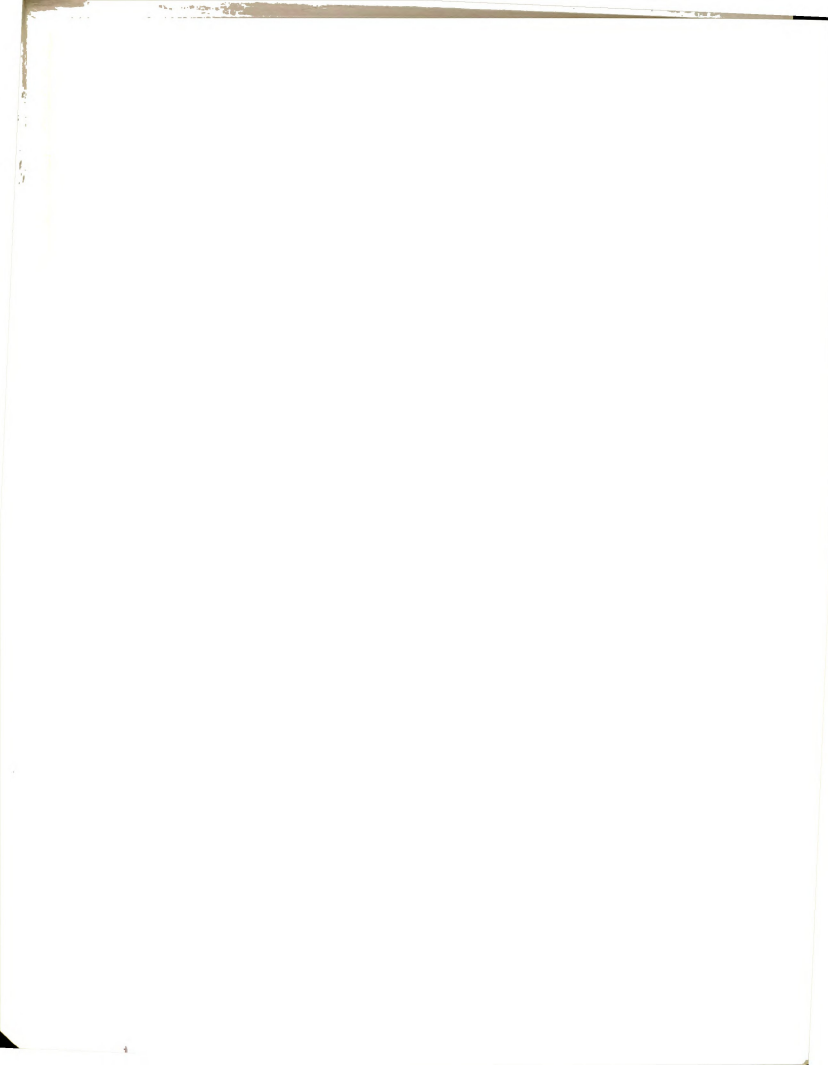
Since we have not received your completed questionnaire we are assuming that it may not have reached you or may have been misplaced. We are therefore sending you another survey and a postage-paid return envelope. We would appreciate it if you would take a few minutes to fill out and return the enclosed form. You may be assured that all responses will be kept confidential.

If you have already returned the survey, you may want to keep this second copy for your file. Thank you for your cooperation in this very important study.

Sincerely,

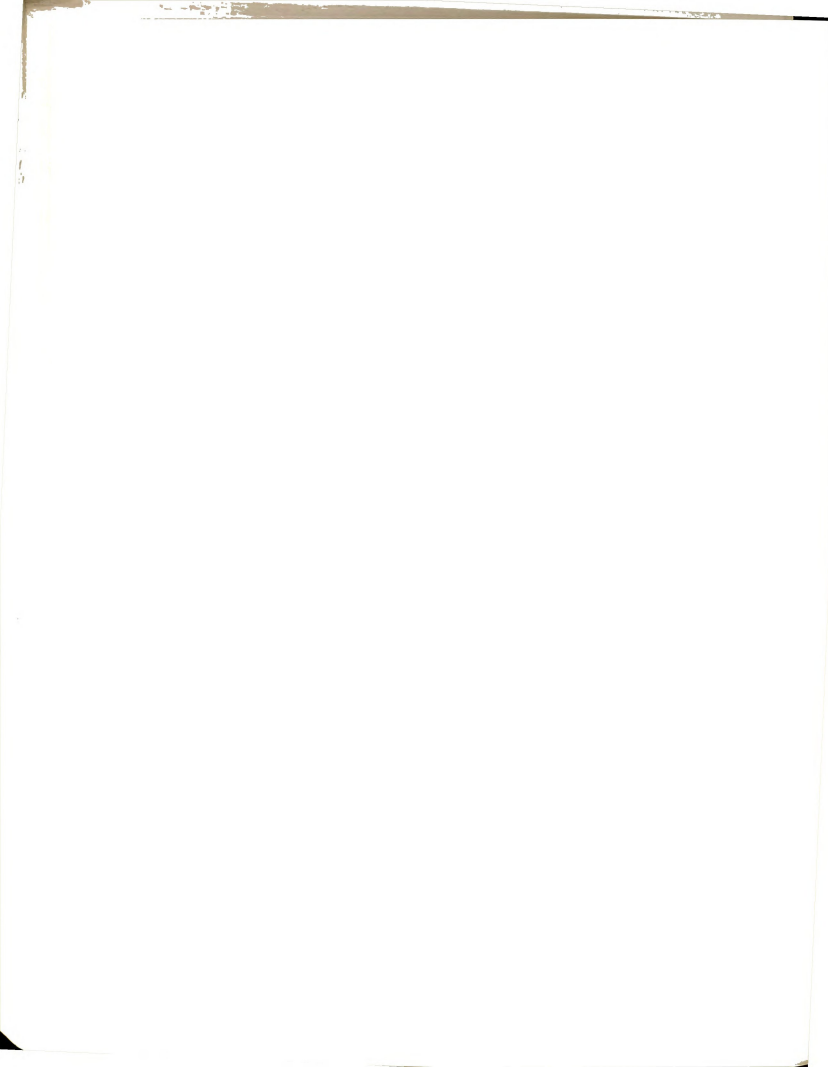
John Rosser
Executive Director
Maine Health Education
Resource Center

Duffy House/University of Maine at Farmington/100 Main Street O4938
Stoddard House/University of Maine at Augusta



APPENDIX F

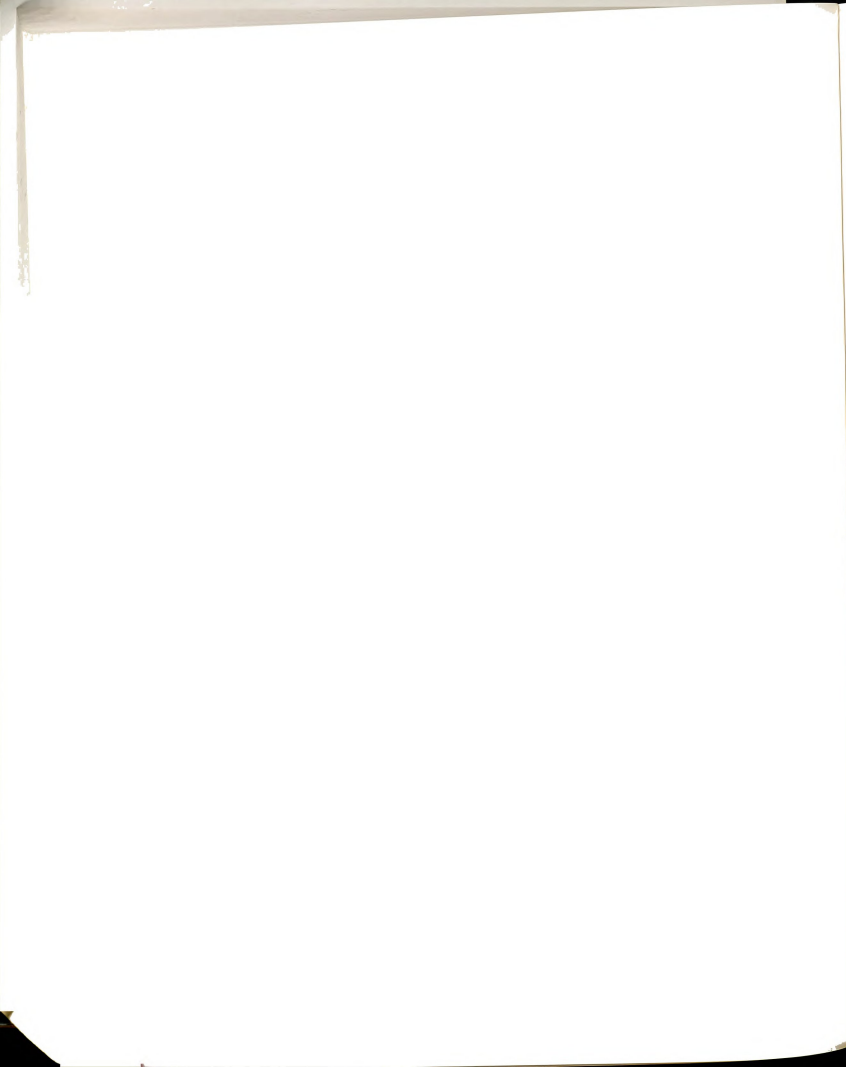
PEOPLE CONSULTED ON DEVELOPMENT OF
SURVEY INSTRUMENTS



APPENDIX F

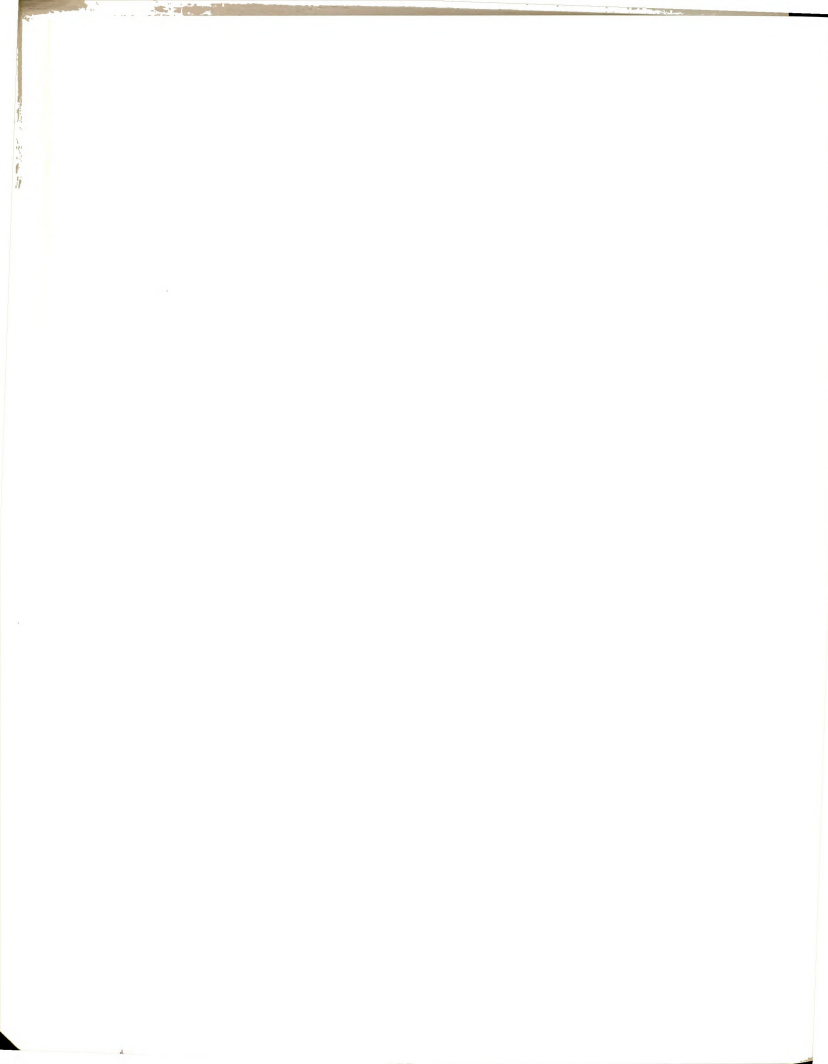
PEOPLE CONSULTED ON DEVELOPMENT OF SURVEY INSTRUMENTS

1. Dr. Stanley Freeman--University of Maine faculty; Eastern Maine Medical Center Trustee; Chairman of Advisory Council for Maine Health Education Resource Center; member of Health Systems Agency Advisory Committee
2. Lois Estes--R.N.; Patient Education & Staff Education Coordinator, Eastern Maine Medical Center, Bangor, Maine
3. Mike Skaling--Director, Project RISE, Waterville, Maine
4. John Johnson--Associate Director, Eastern Maine Medical Center; Chairman, Maine Hospital Association
5. Douglas Kramer--Staff Association, Research & Education Trust of the Maine Hospital Association
6. Dr. John Rosser--Director, Maine Health Education Resource Center
7. Edward Miller--Bureau of Health Education, State of Maine
8. Earnest Stallworth--Director of Education, Maine Health Systems Agency
9. Dr. Richard Chamberlin--Medical Director, Pine Tree Organization for Professional Standards Review; member Advisory Committee, Maine Health Education Resource Center
10. Dr. Kenneth Hayes--Acting Director, Social Sciences Research Institute, University of Maine
11. Dr. Dennis Watkins--Associate Professor, University of Maine, Department of Agricultural & Resource Economics
12. Dr. Louis Ploch, Professor, University of Maine, Department of Agricultural & Resource Economics
13. Larry Nanney, Director of Long Range Planning, Mid-Maine Medical Center, Waterville, Maine
14. Ann Spencer, Director of Occupational Therapy, Eastern Maine Medical Center, Bangor, Maine



APPENDIX G

PERCENTAGE OF RESPONDENTS BY PROFESSIONAL SUB-GROUP WHO
INDICATED THAT SPECIFIED CONTENT AREAS ARE IMPORTANT
FOR INCLUSION IN HOSPITAL PATIENT EDUCATION
PROGRAMS FOR INPATIENTS



APPENDIX G

Table G1.--Percentage of the physicians who indicated that specified content areas are important for inclusion in hospital patient education programs for inpatients.

Content Areas	Of No Importance	Of Little Importance	Moderately Important	Extremely Important
Orientation to Hospital Facilities and Services	4.8	19.8	49.5	24.2
Explanation of Diagnosis and Treatment	5.6	6.4	18.7	68.5
Teaching Patient to Administer Own Treatment	.7	1.5	16.5	80.5
Teaching Patient Self-Care Independent Living Skills	1.1	5.5	35.5	56.8
Teaching About Short- and Long-Term Life Style Adjustments	.7	2.2	21.9	73.7
Teaching About Appropriate Community Resources	.7	4.1	43.5	51.3
Teaching About Financial Management of the Health Problem	1.8	5.5	45.2	43.4
Teaching of General Preventive Medicine	3.3	12.5	35.2	47.3

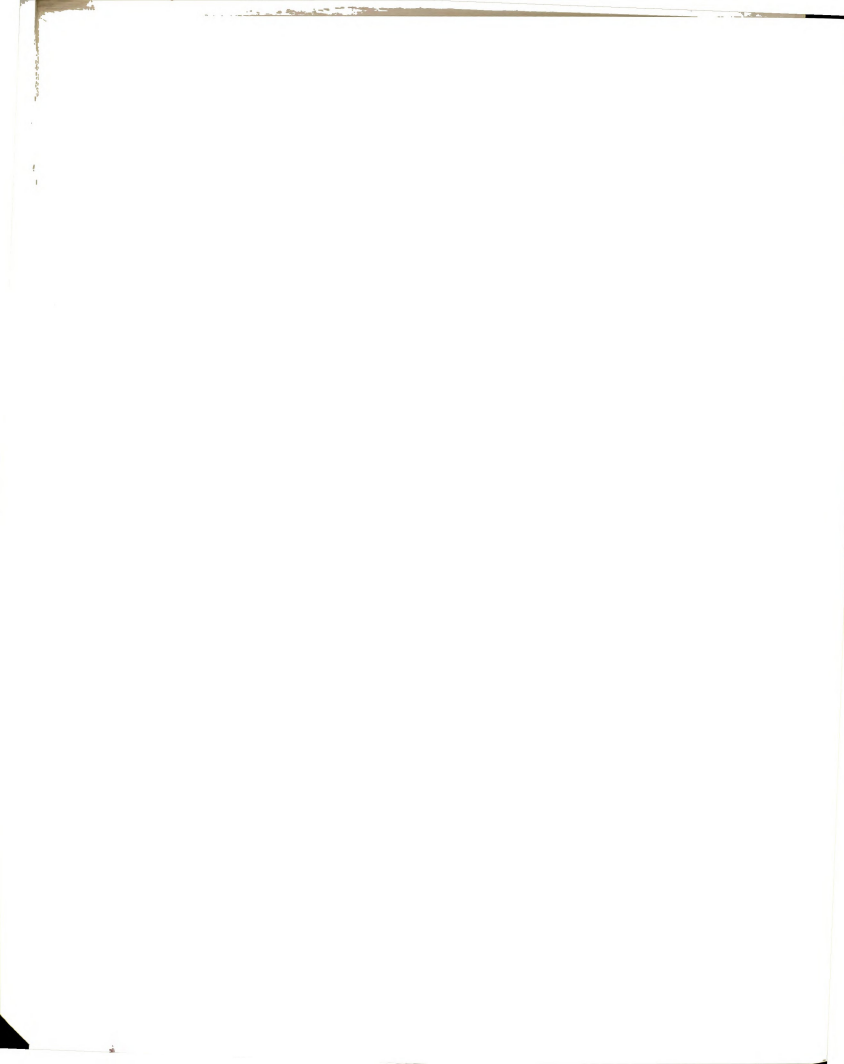


Table G2.--Percentage of the nurses who indicated that specified content areas are important for inclusion in hospital patient education programs for inpatients.

Content Areas	Of No Importance	Of Little Importance	Moderately Important	Extremely Important
Orientation to Hospital Facilities and Services	1.5	9.7	55.6	31.7
Explanation of Diagnosis and Treatment	.4	.0	12.5	86.7
Teaching Patient to Administer Own Treatment	.7	.0	9.6	80.9
Teaching Patient Self-Care Independent Living Skills	.0	.7	15.6	83.3
Teaching About Short- and Long-Term Life Style Adjustments	.4	.0	4.9	94.8
Teaching About Appropriate Community Resources	.0	.7	21.6	77.7
Teaching About Financial Management of the Health Problem	.0	3.0	28.5	65.9
Teaching of General Preventive Medicine	.0	1.9	11.6	86.2

Table G3.--Percentage of the allied health professionals who indicated that specified content areas are important for inclusion in hospital patient education programs for inpatients.

Content Areas	Of No Importance	Of Little Importance	Moderately Important	Extremely Important
Orientation to Hospital Facilities and Services	1.0	8.2	57.1	33.7
Explanation of Diagnosis and Treatment	.0	.0	23.5	87.7
Teaching Patient to Administer Own Treatment	.0	2.0	7.1	89.9
Teaching Patient Self-Care Independent Living Skills	.0	.0	18.2	81.8
Teaching About Short- and Long-Term Life Style Adjustments	.0	.0	9.3	90.7
Teaching About Appropriate Community Resources	.0	1.0	26.3	71.7
Teaching About Financial Management of the Health Problem	.0	6.1	30.3	62.6
Teaching of General Preventive Medicine	.0	1.0	19.2	78.0

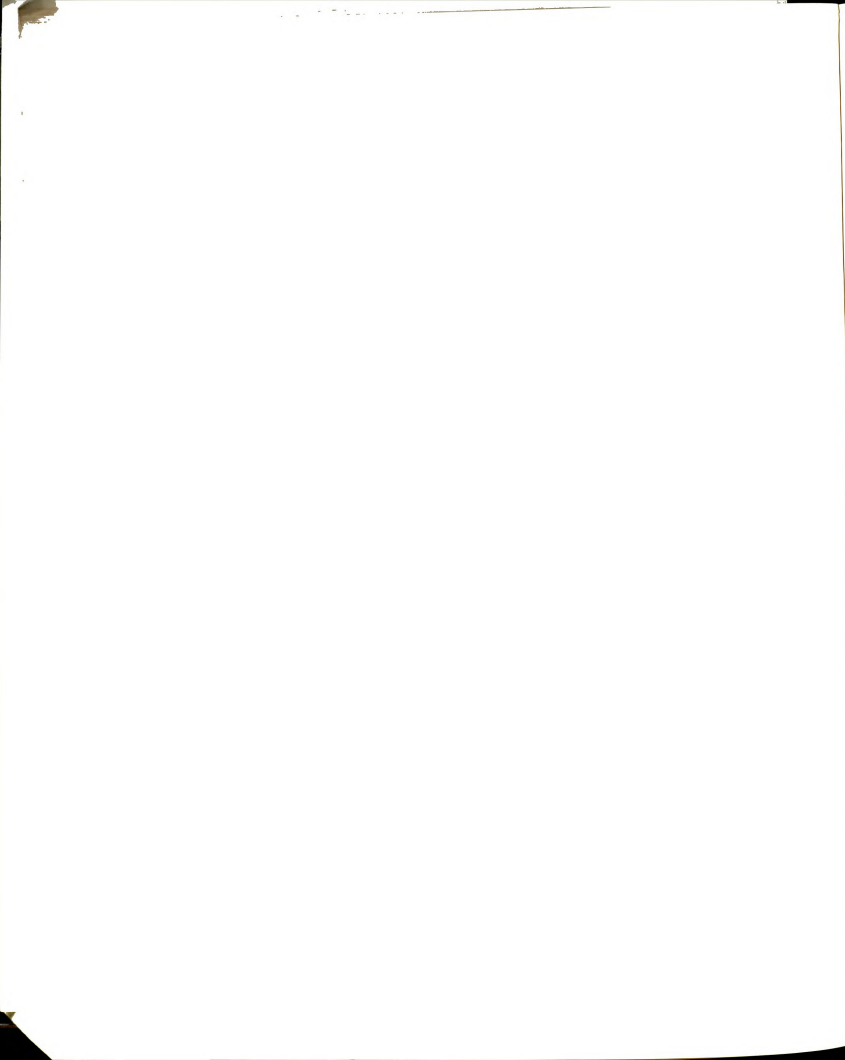


Table G4.--Percentage of the patient education staff who indicated that specified content areas are important for inclusion in hospital patient education programs for inpatients.

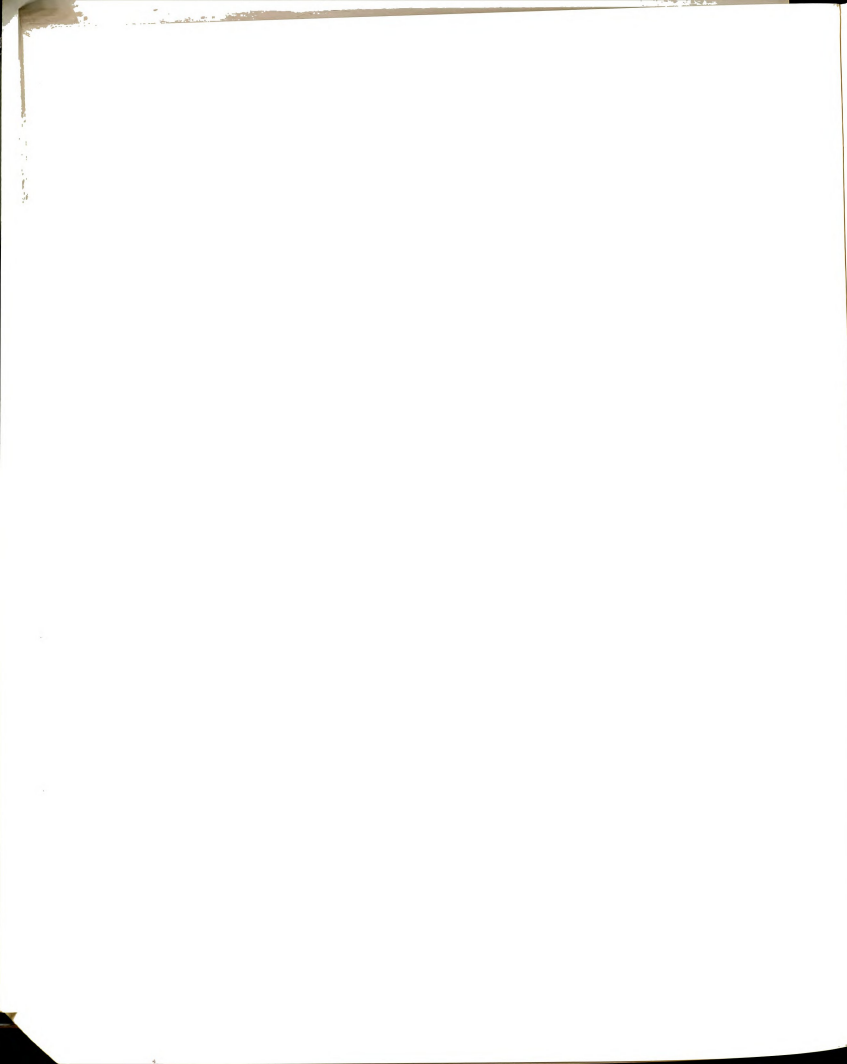
Content Areas	Of No Importance	Of Little Importance	Moderately Important	Extremely Important
Orientation to Hospital Facilities and Services	.0	7.7	65.4	23.1
Explanation of Diagnosis and Treatment	.0	.0	7.7	92.3
Teaching Patient to Administer Own Treatment	.0	.0	.0	100.0
Teaching Patient Self-Care Independent Living Skills	.0	.0	4.0	92.0
Teaching About Short- and Long-Term Life Style Adjustments	.0	.0	3.8	96.2
Teaching About Appropriate Community Resources	.0	.0	7.7	84.6
Teaching About Financial Management of the Health Problem	.0	.0	24.0	72.0
Teaching of General Preventive Medicine	.0	.0	7.7	92.3

Table G5.--Percentage of the hospital administrators who indicated that specified content areas are important for inclusion in hospital patient education programs for inpatients.

Content Areas	Of No Importance	Of Little Importance	Moderately Important	Extremely Important
Orientation to Hospital Facilities and Services	.0	22.2	55.6	22.2
Explanation of Diagnosis and Treatment	.0	.0	11.2	76.5
Teaching Patient to Administer Own Treatment	.0	.0	16.7	83.3
Teaching Patient Self-Care Independent Living Skills	.0	5.9	35.3	52.9
Teaching About Short- and Long-Term Life Style Adjustments	.0	5.6	22.2	72.2
Teaching About Appropriate Community Resources	.0	5.6	61.1	33.3
Teaching About Financial Management of the Health Problem	.0	16.7	33.3	38.9
Teaching of General Preventive Medicine	.0	5.6	38.9	50.0

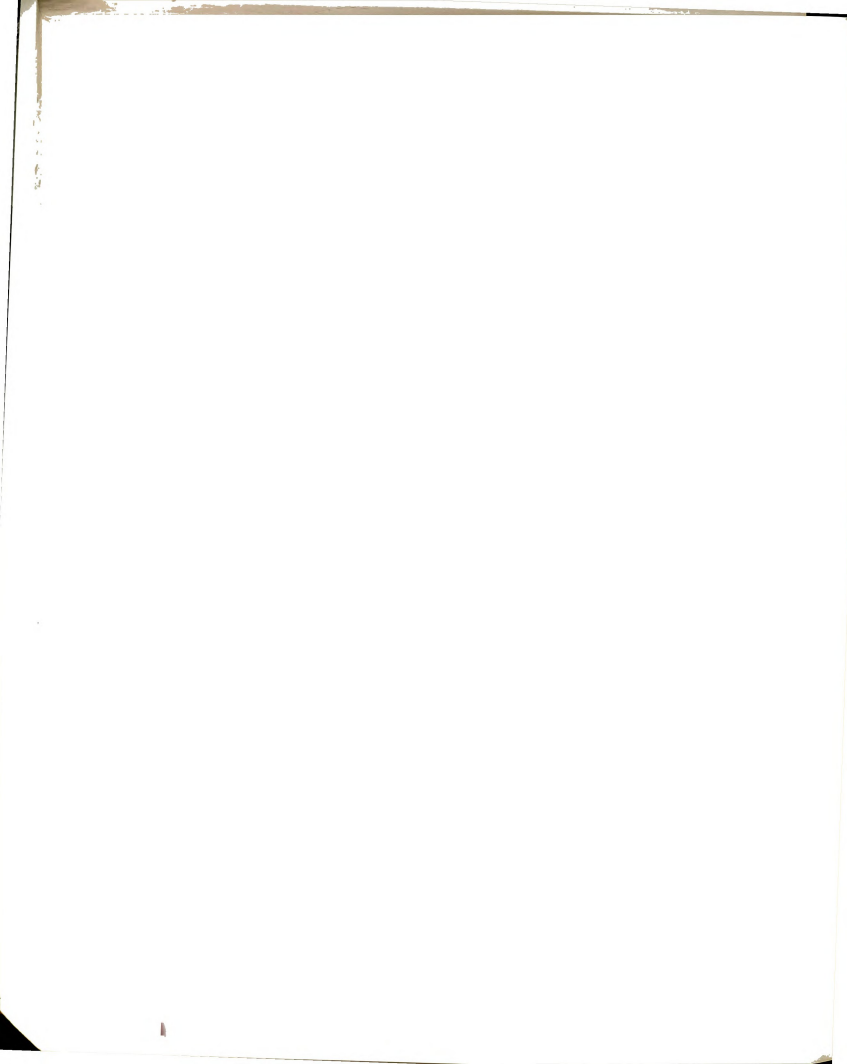


BIBLIOGRAPHY

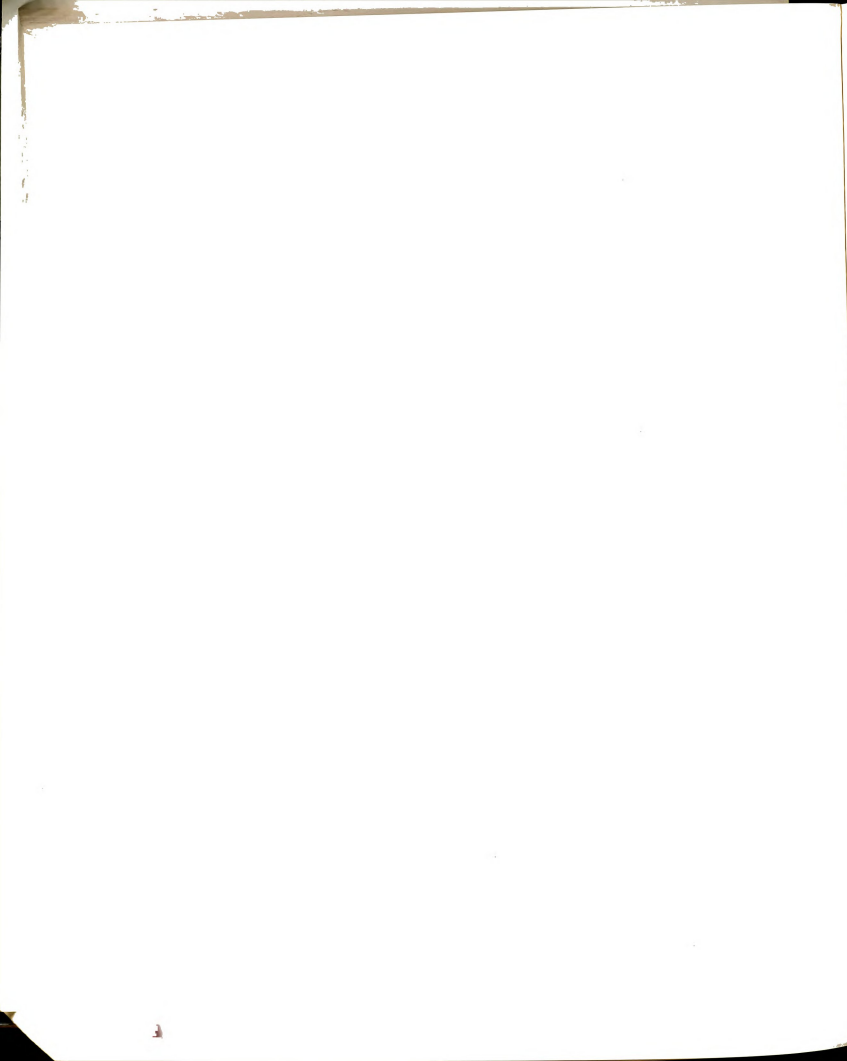


BIBLIOGRAPHY

- "AHA Research Capsules: Patient Education Programs in Community Hospitals." Hospitals 46 (December 1, 1972): 102.
- Alexander, Carol; Schrader, Elinor; and Knnedler, Julia. "Pre-Operative Visits: The Operating Nurse Unmasks." AORN Journal 19 (February 1974): 401-12.
- Alt, Richard. "Patient Education Program Answers Many Unanswered Questions." Hospitals 40 (November 16, 1966): 76-78.
- American Group Practice Association. "Statement on Patient Education." Alexandria: American Group Practice Association, November 1974. (Mimeographed.)
- American Hospital Association. Guide to the Health Care Field. Chicago: American Hospital Association, 1976.
- _____. Health Education in the Hospital. Chicago: American Hospital Association, 1964.
- _____. Hospital Statistics, 1976 Edition. Chicago: American Hospital Association, 1976.
- _____. "Overview of AHA Patient Education Project Results." Chicago, 1976. (Mimeographed.)
- _____. "A Patient's Bill of Rights." Chicago: American Hospital Association, 1975.
- _____. Statement on the Role and Responsibility of Hospitals and Other Health Care Institutions in Personal and Community Health Education. Chicago: American Hospital Association, 1974.
- _____. Strategies in Patient Education. Chicago: American Hospital Association, 1969.
- _____. "Survey Form on Inpatient Education Programs." Chicago: American Hospital Association, 1975.
- American Medical Association. "Definition and Role of Planned Patient Education Programs." Chicago: American Medical Association's Department of Health Education, 1975.



- American Nurses' Association. "The Professional Nurse and Health Education." Kansas City, Missouri: American Nurses' Association, 1975.
- American Society of Hospital Pharmacists. "Statement on Pharmacist-Conducted Patient Counseling." Washington, D.C.: American Society of Hospital Pharmacists, 1976.
- Ayers, Carole, and Walton, Linda. "A Guide for the Pre-Operative Visit." AORN Journal 19 (February 1974): 413-18.
- Bartlett, Marjorie; Johnston, Ann; and Meyer, Thomas. "Dial Access Library--Patient Information Service." The New England Journal of Medicine 288 (May 10, 1973): 994-97.
- Bartlett, Marjorie, and Meyer, Thomas. "Patients Receive Current, Concise Health Information by Telephone." Hospitals 50 (February 16, 1976): 79-82.
- Batten, T. R. The Human Factor in Community Work. London: Oxford University Press, 1965.
- Becker, Marshall, and Maimex, Lois. "Sociobehavioral Determinants of Compliance With Health and Medical Care Recommendations." Medical Care 13 (January 1975): 10-24.
- Belsky, M.; Renner, J.; and Sehnert, K. "Making the Savvy Patient a Practice Asset." Patient Care 8 (January 1, 1974): 102-104.
- Bernheimer, Elizabeth, and Clever, Linda. The Team Approach to Patient Education: One Hospital's Experience in Diabetes. Atlanta: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, 1977.
- Bernheimer, L. "The Physician's Role in a Hospital's Patient Education Program." Public Health Reports 91 (May-June 1976): 271-73.
- Besta, Donald F. "New Services Generate Teaching Role." Hospitals 47 (March 1, 1973): 141-46.
- Billie, Donald, and Przybylski, Mary Jo. "Increasing the Visibility of the Nurse in Teaching of Patients." Cross-Reference 6 (March-April 1976): 7-11.
- Blue Cross Association. "White Paper: Patient Health Education." Chicago: Health Care Service, Blue Cross Association, 1974. (Mimeographed.)



- Breckon, Donald J. "Highlights in the Evolution of Hospital Based Patient Education Programs." Journal of Allied Health 35 (Summer 1976): 35-39.
- _____. "Hospital Health Education: Possible Functions." Mt. Pleasant: Central Michigan University, 1976. (Mimeographed.)
- _____. "Patient Education Programs for the Aged in Michigan Nursing Care Facilities." Ph.D. dissertation, Michigan State University, 1977.
- Brown, Esther Lucile. Newer Dimensions of Patient Care. New York: Russell Sage Foundation, 1965.
- Burton, John. "Doctor Means Teacher." International Journal of Health Education 1 (January 1958): 4-12.
- Canfield, Robert E. "The Physician as a Teacher of Patients." Journal of Medical Education 48 (December 1973): 79-87.
- Caplan, Richard M. "Educating Your Patient." Archives of Dermatology 107 (June 1973): 837-39.
- "Cardiac Education Teaching Manual." Urbana, Illinois: Cardiac Education Section, Patient Service of Carle Foundation Hospital and Carle Clinic Association, 1976.
- Clark, Duncan, and MacMahon, Brian, eds. Preventive Medicine. Boston: Little-Brown, and Company, 1967.
- Collen, F. Bobbie, and Soghikian, Krikor. "A Health Education Library for Patients." Health Service Reports 89 (May-June 1974): 236-43.
- Collen, Frances; Maders, Blanche; Soghikian, Krikor; and Garfield, Sidney. "Kaiser-Permanente Experiment in Ambulatory Care." American Journal of Nursing 71 (July 1971): 1371-74.
- Collins, Roselle Denison. "Problem Solving: A Tool for Patients, Too." American Journal of Nursing 7 (July 1968): 1483-85.
- Copp, Laurel A. "The Waiting Room--A Health Teaching Site." Nursing Outlook 19 (July 1971): 481-83.
- Cue, Elaine. "The Hospital Pharmacist's Role in Health Education." American Journal of Hospital Pharmacy 28 (September 1971): 697-99.
- Cutting, W. A. M. "Health Team Leadership: The Doctor's Role." Tropical and Geographical Medicine 26 (June 1974): 216-22.



- Davis, Milton. "Documenting the Needs." Strategies in Patient Education. Chicago: American Hospital Association, 1969.
- Davis, Roy. Director of the Community Program Development Division, Bureau of Health Education, Center for Disease Control, Atlanta, Georgia. Presentation at Project RISE meeting, 3 February 1977.
- DeCicco, Anne L., ed. A Guide to the Development of a Hospital Based Consumer Education Program. Piscataway, New Jersey: Office of Consumer Health Education, College of Medicine and Dentistry of New Jersey, January 1975.
- Devillier, Becky. "Preoperative Teaching of the Cardiovascular Patient." Heart and Lung 2 (July-August 1973): 522-25.
- Diggins. Sparrow Hospital, Lansing, Michigan. Interview, 13 December 1976.
- Doolittle, Meg. "Making Patient Education a Reality." Cross-Reference 5 (June 1975): 4-6.
- Dowling, H. F., and Shakow, David. "Time Spent by Internists on Adult Education and Preventive Medicine." Journal of the American Medical Association 149 (June 1952): 628-31.
- Duncan, Joy; Grandbouche, Ardith; and Moody, Ginevra. "A Program for the Teaching of Cardiovascular Patients." Heart and Lung 2 (July-August 1973): 508-11.
- Eardley, Anne; Davis, Frances; and Wakefield, John. "Health Education by Chance." International Journal of Health Education 18 (1975): 19-25.
- Egbert, Lawrence D.; Battit, George E.; Welch, Claude E.; and Bartlett, Marshall K. "Reduction of Postoperative Pain by Encouragement and Instruction of Patients." New England Journal of Medicine 240 (April 16, 1964): 825-27.
- Estes, Lois. Eastern Maine Medical Center, Bangor, Maine. Interview, 13 January 1977.
- Etzwiler, Donnell. "The Contract for Health Care (editorial)." Journal of the American Medical Association 224 (May 14, 1973): 1034.
- _____. "Current Status of Patient Education." Journal of the American Medical Association 220 (April 24, 1972): 583.



- _____; Tyrell, M.; Ulrich, M.; Wrynt, J.; and Hirsch, A. "Patient Education in Community Hospitals." Minnesota Medicine 55 (December 1972): 33-37.
- Field, Minna. Patients Are People. New York: Columbia University Press, 1967.
- Fralic, Maryann. "Developing a Viable Inpatient Education Program --A Nursing Director's Perspective." Journal of Nursing Administration 6 (September 1976): 30-36.
- Fylling, Carolyn P., and Etzwiler, Donnell D. "Administrative Reviews Health Education." Hospitals 49 (April 1975): 95-98.
- Garrett, James F., and Levine, Edna S. Rehabilitation Practices With the Physically Disabled. New York: Columbia University Press, 1973.
- Gatzke, Herbert K., and Yenney, Sharon L. "Hospital Education and Training." Hospitals 47 (March 1, 1973): 93-97.
- Gillum, R. F. "Patient Education." Journal of the National Medical Association 66 (March 1974): 156-59.
- Green, Lawrence. "The Potential of Health Education Includes Cost Effectiveness." Hospitals 50 (May 1, 1976): 56-61.
- Greiner, Gary. "The Pharmacist's Role in Patient Discharge Planning." American Journal of Hospital Pharmacists 29 (January 1972): 72-76.
- Gusfa, Anne; Christoff, Virginia; and Headley, Lorraine. "Patient Teaching: One Approach." Supervisor Nurse 6 (December 1975): 174.
- Hay, Stella I., and Anderson, Helen C. "Are Nurses Meeting Patients' Needs?" American Journal of Nursing 36 (December 1963): 96-99.
- Health Education in Medical Care: Needs and Opportunities. Berkeley: Health Education Division, School of Public Health, University of California, 1962.
- Health Education 1972, Selected Views. Health Education Monographs, No. 31. San Francisco: Society for Public Health Education, 1972.
- Herje, Pat Angirk. "The Ambulatory Clinic Patient as a Learner." Biomedical Communications 2 (November 1975): 20-23.



- Hopkins, C. "Patient Education: A Part of Quality Health Care?" Journal of Arkansas Medical Society 71 (December 1974): 231-32.
- Horwitz, Illajean. "Television Provides Patient Education." Hospitals 46 (January 16, 1972): 57-60.
- Houle, Cyril O. The Design of Education. San Francisco: Jossey-Bass, 1972.
- Houston, Charles S., and Pasanen, Wayne E. "Patients' Perceptions of Hospital Care." Hospitals 46 (April 16, 1972): 70-74.
- Illich, Ivan. Medical Nemesis. New York: Pantheon Books, 1976.
- Ivey, Marianne; Tso, Vonne; and Tso, Stanan. "Communication Techniques for Patient Instruction." American Journal of Hospital Pharmacists 32 (August 1976): 828-31.
- Jamplis, Robert W. "The Practicing Physician and Patient Education." Hospital Practice 10 (October 1975): 93-99.
- Jernigan, Anne. "Diabetics Need to Know More About Diet." Hospitals 42 (November 16, 1968): 91-93.
- . "Discharge Diet Versus Patient Education." Hospitals 45 (February 16, 1971): 100-102.
- Jinks, M. "The Hospital Pharmacist in an Interdisciplinary Inpatient Teaching Program." American Journal of Hospital Pharmacists 31 (June 1974): 569-73.
- Johnson, Alice M., and Johnson, Clifford S. "Health Education in the Hospitals." Health Education Journal 10 (July 1952): 175-85.
- Kelsey, Helen, and Beamer, Virginia. "A Post-Hospital Health Education Program." Heart and Lung 2 (July-August 1973): 512-14.
- Kidd, J. R. How Adults Learn. New York: Association Press, 1973.
- Knowles, Malcolm S. The Modern Practice of Adult Education. New York: Association Press, 1970.
- Kucha, Delores. "The Health Education of Patients: Development of a System." Supervisor Nurse 5 (May 1974): 8-21.
- Lambertsen, Eleanor C. "Nurses Must Be Teachers and Must Know These Principles." Modern Hospital 110 (February 1968): 126.

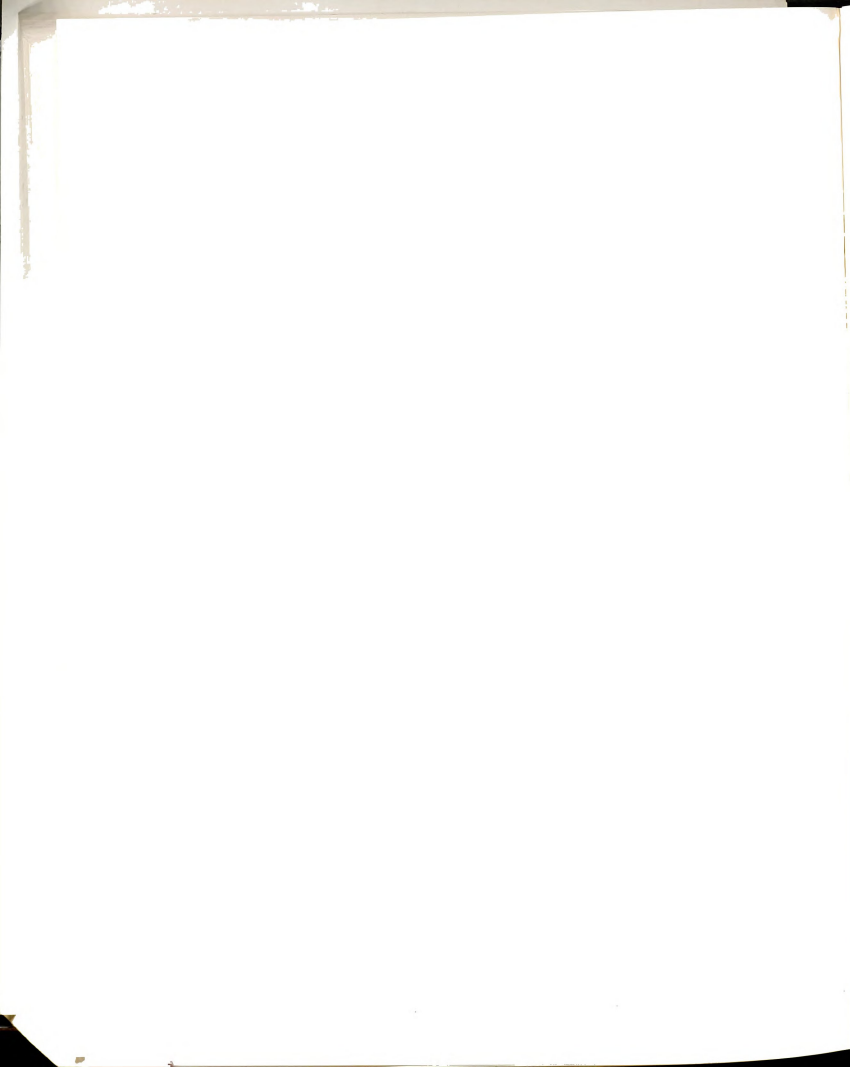


- Lasperre, Michael. "The Patients as Health Students." Hospitals 44 (March 16, 1970): 75-80.
- Lee, Elizabeth. "Annual Administrative Reviews: Health Education." Hospitals 48 (April 1974): 133-39.
- Levine, Dale C., and Fiedler, June P. "Fears, Facts, and Fantasies About Pre- and Post-Operative Care." Nursing Outlook 18 (February 1970): 26-28.
- Levine, Peter. "Efficacy of Self-Therapy in Hemophilia: A Study of Seventy-Two Patients With Hemophilia A and B." New England Journal of Medicine 291 (December 1974): 1381-84.
- Lewin, Kurt, and Lewin, Gertrude Weiss. Resolving Social Conflicts. New York: Harper and Brothers Publishers, 1948.
- Linderman, Carol A. "Influencing Recovery Through Pre-Operative Teaching." Heart and Lung 2 (July-August 1973): 515-21.
- . "Study Evaluates Effects of Pre-Operative Visits." AORN Journal 19 (February 1974): 427-38.
- , and Aernam, Betty Van. "Nursing Intervention With the Presurgical Patient--The Effects of Structured and Unstructured Pre-Operative Teaching." Nursing Research 20 (July-August 1971): 319-32.
- Linehan, Dorothy T. "What Does the Patient Want to Know?" American Journal of Nursing 66 (May 1966): 1066-70.
- Logan, Katherine. "National Agency to Be Health Education Troubleshooter." Hospitals 50 (May 1976): 69-71.
- McNerney, Walter J. "The Missing Link in Health Services." Journal of Medical Education 50 (January 1975): 11-23.
- "Make Patient Teaching Visible." Inservice Training 5 (August 1976): 20-27.
- "Making the Patient a Part of Patient Care." Modern Hospital 121 (October 1973): 105-10.
- Mausher, Judith, and Bahn, Anita. Epidemiology: An Introductory Text. Philadelphia: W. B. Saunders Co., 1974.
- Miller, Edward. Bureau of Health, State of Maine, Augusta, Maine. Interview, 14 January 1977.

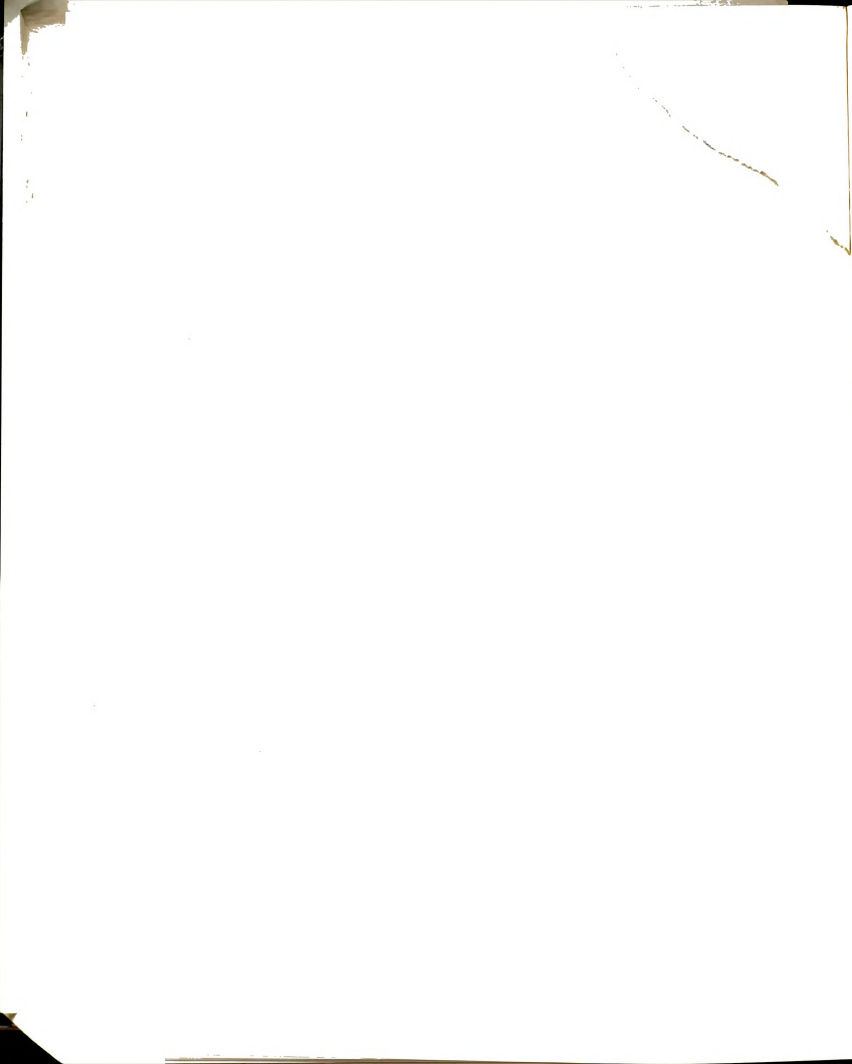


- Miller, Marcie, and Conrad, Wayne. "Pharmacist Involvement in an Education Program for Patients With Chronic Obstructive Pulmonary Disease." American Journal of Hospital Pharmacists 32 (September 1975): 909-11.
- "Minnesota Hospitals Must Tell Patients About Their Rights." Modern Hospital 121 (September 1973): 42.
- Monaco, Rose Mary; Salfen, Linda; and Spratt, John S. "The Patient as an Education Participant in Health Care." Missouri Medicine 69 (December 1972): 932-33.
- Monteiro, Lois A. "Notes on Patient Teaching--A Neglected Area." Nursing Forum 3 (1964): 26-33.
- Moran, Marle K., and Parris, Elizabeth. "Patient Education Coordination in Greenville, S.C. Hospitals." Public Health Reports 9 (May-June 1976): 274-75.
- Mullen, Patricia Dolan. "Health Education for Heart Patients in Crisis." Health Service Reports 88 (August-September 1973): 669-75.
- Nichoff, Arthur. A Casebook of Social Change. Chicago: Aldine Publishing Company, 1966.
- "Not Primarily a Hospital but a Public School." Hospitals 48 (March 16, 1974): 99.
- Ogden, Horace. "Health Education: A Federal Overview." Public Health Reports 91 (May-June 1976): 199-205.
- "Patient Education System." New York: Core Communications in Health, Inc., 1976.
- Pender, Nola J. "Patient Identification of Health Information Received During Hospitalization." Nursing Research 23 (May-June 1974): 263-67.
- Peters, Susan Jane. "A Survey of Health Education Programs in Selected Hospitals in the United States With a Proposed Model for a Comprehensive Health Education Program in a Hospital Setting." Ph.D. dissertation, Southern Illinois University, 1974.
- Pocock, D. G. "Teaching Patients--Why and How?" Southern Medicine 62 (February 1974): 9-13.
- Podell, Richard, and Gary, Louis. "Compliance: A Problem of Medical Management." AFP, Vol. 13, pp. 74-80.

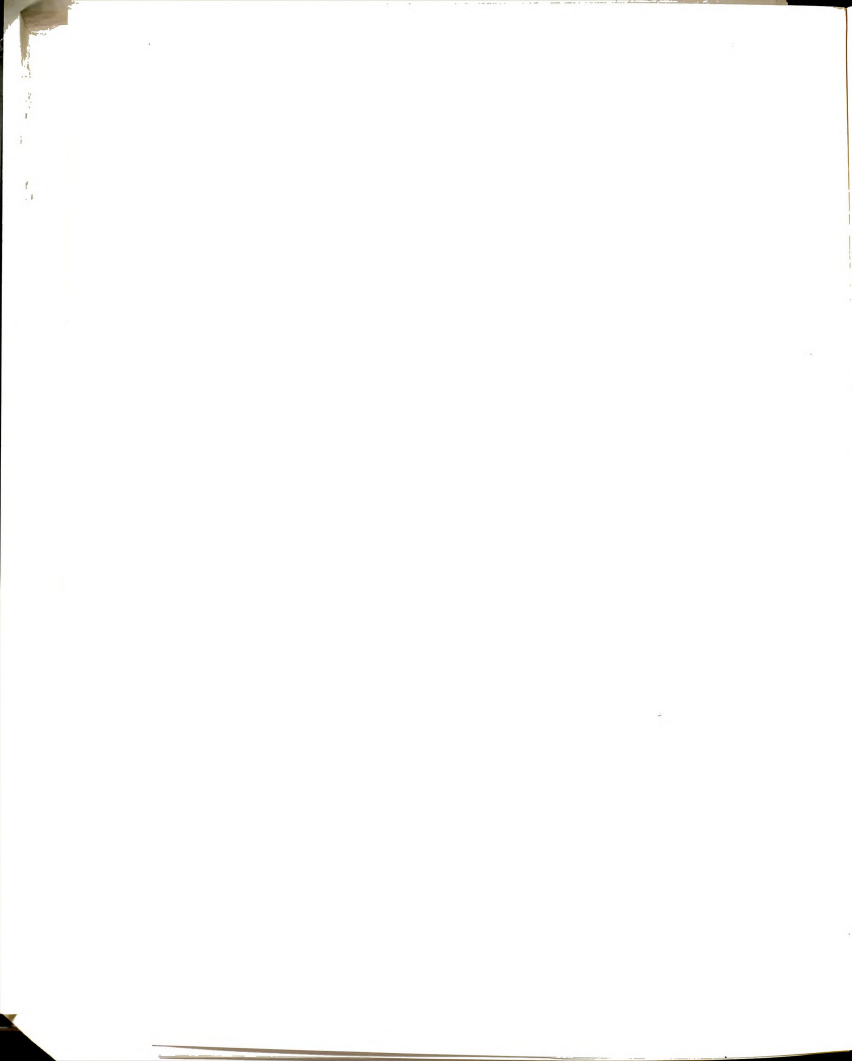
- Pohl, Margaret. "A Study of the Teaching Activities of the Nursing Practitioner." Ph.D. dissertation, Columbia University, 1963.
- _____. "Teaching Activities of the Nursing Practitioner." Nursing Research 14 (Winter 1965): 4-11.
- _____. The Teaching Functions of the Nursing Practitioner. Dubuque, Iowa: Wm. C. Brown Company, 1968.
- Pratt, Lois; Seligmann, Arthur; and Reader, George. "Physicians' Views on the Level of Medical Information Among Patients." American Journal of Public Health 47 (October 1957): 1277-83.
- Putt, Arlene. "One Experiment in Nursing Adults With Peptic Ulcers." Nursing Research 19 (November-December 1965): 484-93.
- Reader, George G., ed. Proceedings of the Will Rogers Conference on Health Education. Health Education Monographs, Vol. 2, No. 1. San Francisco: Society for Public Health Education, September 1, 1974.
- _____, and Schwartz. "Developing Patients' Knowledge of Health." Hospitals 47 (March 1, 1973): 111-14.
- Redman, Barbara. "Guidelines for Quality of Care in Patient Education." The Canadian Nurse 71 (February 1975): 19-21.
- _____. The Process of Patient Teaching in Nursing. St. Louis: The C. V. Mosby Company, 1976.
- Review of Research and Studies Related to Patient Education. Health Education Monograph, No. 26. San Francisco: Society for Public Health Education, 1968.
- Richards, Ruth F., and Kalmer, Howard, eds. Patient Education. Health Education Monographs, Vol. 2, No. 1. San Francisco: Society for Public Health Education, Spring 1974.
- Robbins, Janet. "Planned Versus Incidental Teaching for Hospitalized Patients With Insulin-Dependent Diabetes." Ph.D. dissertation, University of Pittsburgh, 1976.
- Roccella, Edward J. "Potential for Reducing Health Care Costs by Public and Patient Education." Public Health Reports 19 (May-June 1976): 223-25.
- Rogers, Everett, and Shoemaker, Floyd. Communication of Innovations. New York: The Free Press, 1971.



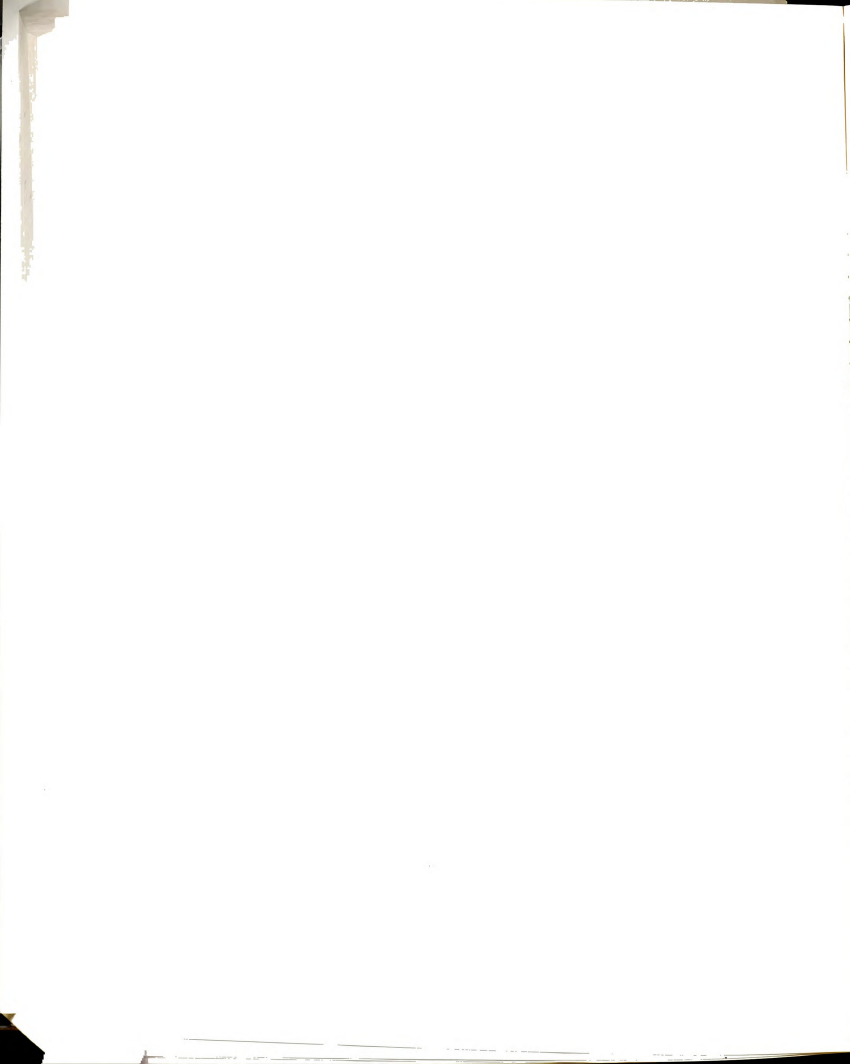
- Rosenberg, Stanley. "A Case for Patient Education." Hospital Formulary Management 6 (June 1971): 1-4.
- _____. "Patient Education Leads to Better Care for Heart Patients." HSMHA Health Reports 86 (September 1971): 793-802.
- "Roundtable/Patient Education: Making Your Patient a Partner in Care." Patient Care 8 (September 15, 1974): 1084.
- Royle, Joan. "Coronary Patients and Their Families Receive Incomplete Care." Canadian Nurse 69 (February 1973): 3135.
- Rusk, Howard A. "Rehabilitation Belongs in the General Hospital." American Journal of Nursing 62 (September 1962): 62-63.
- Schiller, Sister Rosita. "The Dietitian's Changing Role." Hospitals 47 (December 1, 1973): 97-122.
- Schoenrich, Edyth. "Patient Education in Contemporary Health Service Delivery." In Proceedings . . . Workshop on Patient Education Programing, pp. 3-10. Washington, D.C.: U.S. Department of Health, Education, and Welfare, 1973.
- Shaw, Jane S. "New Hospital Commitment: Teaching Patients How to Live With Illness and Injury." Modern Hospital 121 (October 1973): 98-102.
- Shontz, Franklin C. The Psychological Aspects of Physical Illness and Disability. New York: Macmillan Publishing Company, 1975.
- Silverman, Mark, and Hurst, Willis. "Education and the Community Hospital." Journal of the Medical Association of Georgia 63 (April 1974): 141-44.
- Silverman, Mark, and Lamitina, Donnah. "Improved Patient Care Through Patient Education." Journal of the Medical Association of Georgia 65 (April 1976): 111-13.
- Simmons, Jeannette. "An Overview of Patient Education." In Patient Education Workshop: Summary Report, pp. 19-26. Atlanta: U.S. Department of Health, Education, and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education, 1976.
- Simonds, Scott. Current Issues in Patient Education. New York: Core Communications in Health, Inc., 1974.



- _____. "Focus on the Issues." In Strategies in Patient Education, pp. 2-12, by American Hospital Association. Chicago: American Hospital Association, 1969.
- _____. "Health Education and Medical Care: Focus on the Patient." In Health Education Monograph, No. 16, pp. 32-40. San Francisco: Society for Public Health Education, 1963.
- _____. "Health Education and Social Policy." In Health Education Monographs, Vol. 2, No. 1, pp. 1-9. San Francisco: Society for Public Health Education, September 1, 1974.
- _____. "President's Committee on Health Education." Hospitals 47 (March 1, 1973): 54-60.
- "Sisters of St. Joseph, Wichita, Adopt Hospital-Patient Code." Hospital Progress 54 (November 1973): 20.
- Skaling, Michael. Project RISE, Waterville, Maine. Interview, 3 February 1977.
- Skiff, Ann. "Hospital Office Promotes Health Education." Hospitals 47 (March 1, 1973): 117-20.
- Skillern, Penn G. "Patient Education in the Group Clinic: A New Approach." Paper presented at the Third International Congress on Group Medicine, Paris, 21-26 June 1976.
- Skipper, James. "Communication and the Hospitalized Patient." In Social Interaction and Patient Care, pp. 61-83. Edited by James Skipper and Robert Leonard. Philadelphia: J. B. Lippincott Company, 1965.
- _____, and Leonard, Robert, eds. Social Interaction and Patient Care. Philadelphia: J. B. Lippincott Company, 1965.
- Somers, Anne R., ed. Promoting Health, Consumer Education and National Policy. Germantown, Maryland: Aspen Systems Corporation, 1976.
- Stetzer, Steven. "Pre-Operative Visits Meet Patient's Tangible Needs." AORN Journal 19 (February 1974): 441-48.
- Storlie, Frances. "Some Latent Meanings of Teaching of Patients." Heart and Lung 2 (July-August 1973): 506-507.
- Streeter, Virginia. "The Nurse's Responsibility for Teaching Patients." American Journal of Nursing 53 (July 1953): 818-20.



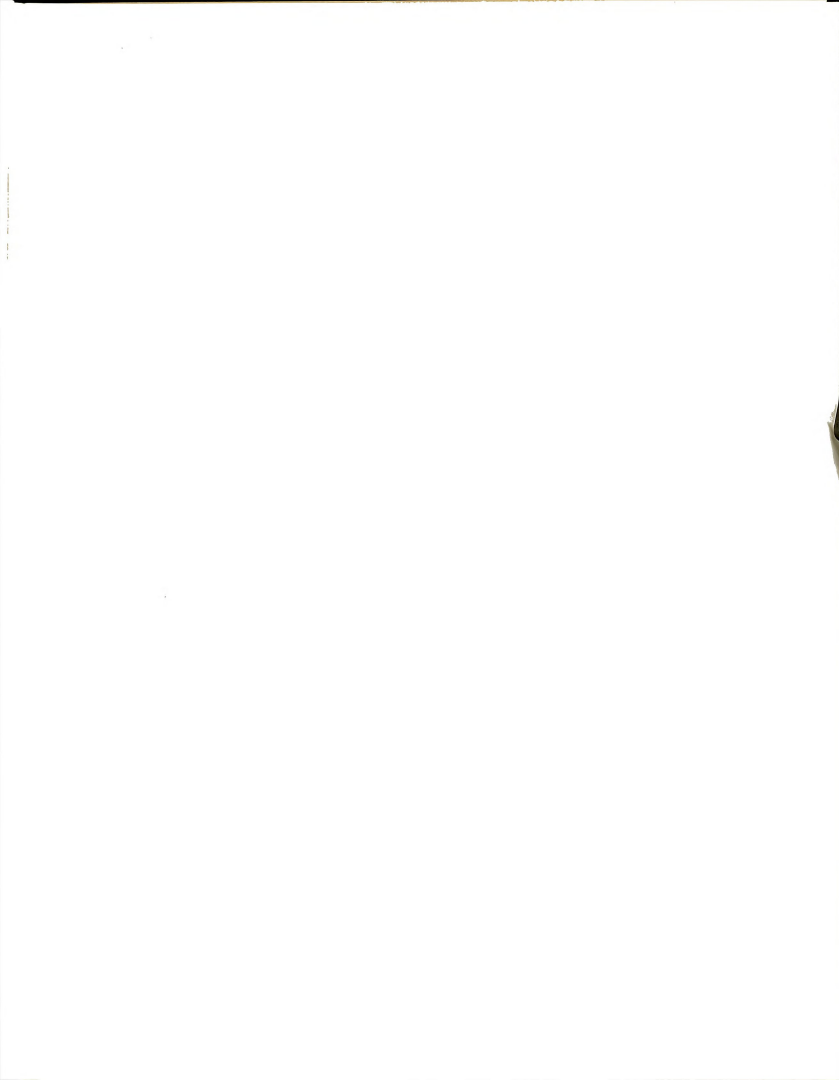
- "Summary of Findings and Recommendations of the President's Committee on Health Education," pp. 24-25. (Mimeographed.)
- Summit, Leon, and Norwood, Joyce. How to Set Up a Stroke Program. New York: Nassau-Suffolk Regional Medical Program, Inc., August 1974.
- Task Force on Patient Education for the President's Committee on Health Education. "The Concept of Planned, Hospital Based Patient Education Programs." In Patient Education, pp. 1-11. Health Education Monographs, Vol. 2, No. 1. San Francisco: Society for Public Health Education, Spring 1974.
- Thompson, Diana, and Elders, M. Jocelyn. "Education of the Juvenile Diabetic." The Journal of the Arkansas Medical Society 72 (November 1975): 239-46.
- Tryon, Phyllis, and Leonard, Robert. "Giving the Patient an Active Role." In Social Interaction and Patient Care, pp. 121-41. Edited by James Skipper and Robert Leonard. Philadelphia: J. B. Lippincott Company, 1965.
- Ulrich, Marian. "The Hospital as a Center for Health Education." In Health Education 1972, Selected Views, pp. 99-108. Health Education Monographs, No. 31. San Francisco: Society for Public Health Education, 1972.
- _____, and Kelley, Kenneth M. "Patient Education Includes Teaching." Hospitals 46 (April 16, 1972): 59-65.
- U.S. Department of Defense. Veteran's Administration. Medical District 15. "Orientation Conference on Patient Education." Ann Arbor, Michigan: n.p., April 29, 1975. (Mimeographed.)
- _____. "Patient Education and the Hospital Program," by George Beauchamp. In V.A. Technical Bulletin TB, 10-88. Washington, D.C.: Veteran's Administration, April 27, 1953.
- U.S. Department of Health, Education, and Welfare. Proceedings . . . Workshop on Patient Education Programing. Washington, D.C.: Department of Health, Education, and Welfare, 1973.
- _____. Public Health Service. Center for Disease Control. Bureau of Health Education. Patient Education Workshop: Summary Report. Atlanta: Bureau of Health Education, 1976.



- _____. Public Health Service. Health Resources Administration. A Model for Planning Patient Education. Washington, D.C.: Government Printing Office, 1972.
- Vega, Marguerita. "New Focus on the Hospital as a Health Education Center." Hospitals 40 (July 16, 1966): 78-82.
- Verstraete, Dorothy, and Manfred, Maier. "Patient Education in a Health Science Center." Minnesota Medicine 56 (October 1975): 31-35.
- Week, Lawrence L. Medical Records, Medical Education, and Patient Care. Cleveland: Western Reserve University Press, 1969.
- Weinberg, Sylvan Lee. "Patient Education as a Part of Critical Care." Heart and Lung 3 (January-February 1974): 47-48.
- "Why Patients Don't Follow Orders." Medical World News. New York: McGraw-Hill, Inc., 1972.
- Williams, Jeannette. "A Hall of Wealth." Hospital Forum 18 (May 1976): 4-5, 18.
- Winslow, Elizabeth Hahn. "The Role of the Nurse in Patient Education Focus: The Cardiac Patient." The Nursing Clinics of North America 11 (June 1976): 213-22.
- Wolle, Joan M. "Multidisciplinary Teams Develop Programming for Patient Education." Health Services Reports 89 (January-February 1974): 8-12.
- Wooden, Howard. "The Inseparability of Education and Patient Care." In Health Education in the Hospital, pp. 39-46, by the American Hospital Association. Chicago: American Hospital Association, 1965.









MICHIGAN STATE UNIV. LIBRARIES



31293101525354