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A Philosophical Concept of Patient Education in the Small Hospital

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A PHILOSOPHICAL CONCEPT OF PATIENT EDUCATION IN THE SMALL HOSPITAL

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A PHILOSOPHICAL CONCEPT OF PATIENT EDUCATION

IN THE SMALL HOSPITAL

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In recent years, many dramatic changes have occurred in the nation's health care delivery system, particularly in health education. The National Consumer Health Information and Promotion Act was enacted in 1976. In response to this legislation, the nation's health education efforts were greatly expanded through the creation of a Bureau of Health Education within the Center for Disease Control and establishment of the Office of Health Information and Promotion in the Office of the Assistant Secretary for Health, Department of Health, Education and Welfare. A National Center for Health Education was also established. Health education was prominently included among the ten national health priorities outlined in the National Health Planning and Resources Development Act of 1974. Concurrent to these developments have been intensified demands among health organizations and the public for an expanded health education component of the health care delivery system. Health education of the hospital patient (or hospital patient education) is a significant aspect of the broader area of health education. This thesis examines the relationship between some of the national health education developments and the patient education responsibilities of small hospitals. Issues inherent in these responsibilities are identified and analyzed in an attempt to develop a philosophy (or concept) of the extent to which small hospitals should provide patient education.

For purposes of this study, small hospitals are defined as general, acute-care hospitals of the 100-bed and less category. To facilitate understanding of how patient education hospitals has reached its present position, a brief history of hospital patient education is presented. This history leads to an overview of current hospital patient education activities and the identification of issues and trends in this area relative to the small hospital. This thesis examines some of the current questions raised on the appropriate role of the small hospital in meeting the health education needs of its patients. Specific aspects of hospital patient education are also discussed; for example: philosophies, planning, coordination, methodologies, financing, materials, cost effectiveness, and evaluation.

After discussing the above-mentioned issues, this thesis concludes with the presentation of a concept of patient education in the small hospital and some recommendations relating to the small hospitals' patient education activities. The concept presented was based on the conclusion that the philosophical and humanitarian tenets upon which small hospitals provide service demand the provision of maximal patient education which is integrated into routine patient care regimens.

Chapter I

INTRODUCTION

Planned, hospital-based patient education programs have been the subject of numerous studies reported in recent publications of hospital, public health, and health professionals' associations. Many of these studies addressed the potential impact of hospital patient education programs in reducing morbidity, mortality, health care costs, and medical malpractice litigation of patients of the nation's hospitals. The latter two of these areas were certainly not as important as possible reductions in disease and deaths; however, they were found to constitute crisis issues which confronted the nation's health care delivery system. Hospital costs have risen at a rate of approximately 15 percent a year recently, more than twice as fast as the consumer price index.[1] Likewise, increasing medical malpractice suits have caused hospital liability insurance rates to rise drastically.[2]

Hospital patient education is operationally defined as health education which is provided to the hospital patient. The need for

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[1]"Carter's Health Cost Controls to Seek Lid of 9% a Year on Hospital Revenue Boosts," The Wall Street Journal, (April 25, 1977), 8.

[2]U.S. Department of Health, Education and Welfare, Public Health Service, Forward Plan for Health--FY 1978-82, DHEW Pubn. No. (OS) 76-50046, (1976), 5.

health education was included among the ten national priorities which the 93rd Congress of the United States outlined in the National Health Planning and Resources Development Act of 1974 (Public Law 93-641).[3] This health education priority was linked to the three overall goals of Public Law 93-641, which were equal access to health services, improved quality of health care, and containment of health care costs.[4] These goals were also outlined in the Public Health Service's plan for health which covered the period of 1978 through 1982. Health education was again presented as a major component in this aggressive strategy to improve the health status of Americans.[5]

The federal government recently engaged in additional health education activities. The more prominent of these include the following:

1. Enactment of the National Consumer Health Information and Promotion Act of 1976 (P.L. 94-317).[6]

2. Establishment of the Office of Health Information and Health Promotion in the Office of the Assistant Secretary for Health, Department of Health, Education and Welfare.[7]

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[3]National Health Planning and Resources Development Act of 1974, 88 Stat., 2225, (1975), 42 U.S.C. 300k, (1975), 1-4.

[4]National Health Planning and Resources Development Act of 1974, pp. 1-4.

[5]U.S. DHEW, Public Health Service, pp. 1-6.

[6]U.S. Department of Health, Education and Welfare, HEW News, (November 9, 1976), 1.

[7]U.S. DHEW, HEW News, pp. 1-3.

3. Creation of a Bureau of Health Education within the Center for Disease Control.[8]

4. Establishment of a National Center for Health Education.[9]

The prevalence of recent studies and writings on the subject of patient education paralleled a recent and growing wave of consumerism which permeated various businesses and public services throughout the nation. In response to this pervading demand by consumers to be informed, health organizations including the American Hospital Association, American Medical Association, Blue Cross Association, American Nurses' Association, Society for Public Health Education, and American Society of Hospital Pharmacists have adopted formal statements relating to the rights of consumers--specifically, the patient's right to be knowledgeable concerning the various services provided by the constituencies of these groups. A listing of these documents is appended.

Patient education has been (1) the subject of numerous recent health-related publications and studies, (2) identified as a specific type of health education which was gaining recognition at the national level, and (3) promoted as an essential component of health care which has potential for helping alleviate some of the major problems confronting the nation's health care delivery system. As hospital officials recognized these characteristics of patient education,

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[8]Horace G. Ogden, "Health Education: A Federal Overview," Public Health Reports, XCI, No. 3, (May-June, 1976), 201.

[9]Ogden, p. 201.

many began to focus on the extent to which patient education should be provided in their institutions.

In response, many larger hospitals throughout the nation have recently initiated organized patient education programs.[10] These were somewhat limited, due to the lack of direct reimbursement of hospitals for patient education services through the various health insurance programs and third party payment mechanisms. The most typical hospital to initiate an institution-wide patient education program was the community hospital (not a medical center) of 300- to 800-bed size.[11] These data and the nature of recent writings on patient education indicated that major patient education activities seemed to be limited to larger hospitals.

It was surmised that little attention had been provided to hospitals of the 100-bed and smaller category relative to patient education. Few of the recent writings addressed the patient education needs, resources, and programs of small hospitals. In response to the apparent dearth of writings on planned patient education in the small hospital, and as a result of this investigator's interest in this area as a health educator and registered nurse, this philosophical study emerged.

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[10]Elizabeth A. Lee and Jeanne L. Garvey, "How is Inpatient Education Being Managed?" Hospitals, LI, No. 1, (June 1, 1975), 75.

[11]U.S. Department of Health, Education and Welfare, Center for Disease Control, Bureau of Health Education, Patient Education Workshop: Summary Report, (1976), 21.

PURPOSE AND NEED

The purpose of this study was to present a philosophical concept of the patient education activities which should be provided by the small hospital. This concept was based on an analysis of current patient education issues and trends. It was designed to provide a coherent frame of reference within which officials of small hospitals could examine and compare their hospitals' patient education activities, issues, resources, and plans. It was also purposed that this study serve as a stimulus for health professionals to further develop their patient education interests and capabilities, and to encourage additional study in this area.

The need for this study was based on the apparent lack of current writings which were specific to patient education in the small hospital. This need was also supported by several officials of small hospitals who discussed, with this investigator, their interests in initiating or expanding patient education activities.

Many of the issues concerning patient education in the small hospital did not lend themselves to resolution by factual inquiry alone. For example, problems and issues relative to the hospital's responsibility concerning financial support of patient education posed a philosophical dilemma, which was likely to be resolved in the final analysis only in humanitarian terms. This philosophical study was a response to the need to examine some of the issues concerning patient education in view of the increased emphasis on health education at the national level and the trend for expanding planned, patient education activities in hospitals. Additional factors which

reflected the need for further study on this subject included the patient's rights movement and the increasingly identified potential of patient education in reducing morbidity, mortality, health care costs, and medical malpractice suits.

STATEMENT OF THE PROBLEM

The problem of this philosophical study was, To what extent should general, acute care hospitals of the 100-bed and smaller category provide patient education?

Through a review of related literature and a subjective analysis of this problem, the following hypothesis was induced: The philosophical and humanitarian tenets upon which small hospitals provide service demand the provision of maximal patient education which is integrated in routine patient care regimens.

ASSUMPTIONS

The problem of this research contained implicit basic assumptions which were (1) that the question was asked within the context of a universe of small hospitals (100-bed and smaller, general, acute care hospitals) which were assumed to have generally the same types of patient education needs and resources, (2) that something called "patient education" was an existing or potential activity of these small hospitals, and (3) that similar patient education issues confronted most of the hospitals as defined above.

LIMITATIONS

The dearth of writings on patient education in the small hospital constituted a weakness for this study. The prevalence of general patient education resources, however, provided data which were applied to this study.

It was also recognized that a weakness existed in this philosophical study in attempting to assess and project patient education needs of small hospitals as a group. Certainly, each small hospital had unique patient education needs and resources which could not be assessed completely within the scope of this study.

DELIMITATIONS

The scope of this philosophical study is that of identification and discussion of the major issues concerning patient education which confront small hospitals, from which logical inductions were drawn to develop a philosophical concept of patient education in these hospitals. Data for this study were derived from related literature and from this investigator's experiences in hospital nursing and health education.

DEFINITIONS

Patient education is defined by the Joint Committee on Health Education Terminology (American Public Health Association and Society of Public Health Education) as follows:

> Those health experiences designed to influence learning which occurs as a person receives preventive, diagnostic, therapeutic and/or rehabilitative services, including

> experiences which arise from coping with symptoms, referrals to sources of information, prevention, diagnosis, and care; and contacts with health institutions, health personnel, family, and other patients.[12]

Health education activities have been classified into numerous categories according to target group, method, and setting. Patient health education, or simply patient education, has been defined as a specific type or classification of health education. Patient education itself has been further classified according to the type of patient receiving health education. Even hospital patient education has been separated into more specific types of health education according to whether the patient is an inpatient or outpatient.

For purposes of this study, hospital patient education was defined as organized health education experiences planned by physicians, health educators, and other hospital personnel to meet the specific learning needs, interests, and capabilities of hospital patients. The term "small hospital," as used in this study, was defined as general, acute-care hospitals of the 100-bed and smaller category.

ORGANIZATION OF THE STUDY

This study is presented in a format which provides an overview of the history of patient education in the United States, with an emphasis on planned, hospital-based patient education. This overview leads to the identification of current patient education issues and trends which were pertinent to small hospitals. In the

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[12]"New Definitions: Report of the 1972-73 Joint Committee on Health Education Terminology," Health Education Monographs, No. 33, (1973), 67.

ensuing analysis of the issues identified, patient education planning, management, personnel, materials, methodology, evaluation, and financing are discussed.

The issues related to the hypothesis of this study were identified and analyzed in view of existing pertinent data and current philosophies concerning patient education. Every attempt was made to maintain a logical, critical, and unbiased approach to this study considering as many factors as possible which were relevant to the problem. The culmination of these analyses and related judgments constitutes the presentation of a philosophical concept of patient education in the small hospital. One test of the defensibility of the tested hypothesis, which is the set of conclusions of this study, is its power to generate further thinking about the problem. Hence, testing of the presented philosophical concept of patient education in the small hospital will extend into the future.

Chapter II

REVIEW OF LITERATURE

A search of the literature on hospital patient education revealed six general types of writings on this subject. These were (1) writings providing an overview of patient education of various types, (2) descriptions and summaries of clinical research on patient education, (3) approaches to educating patients with specific chronic diseases such as diabetes and hypertension, (4) patient education activities of national organizations and federal agencies, (5) descriptions of organized approaches to hospital-wide patient education, and (6) general health education literature in which hospital patient education writings are integrated. Many of these writings covered various aspects of hospital patient education and the larger subject of patient education. For this reason, a variation of the above categories will comprise this report on the literature as follows: history of patient education, overview of current patient education activities in hospitals, and identification of current issues and trends in hospital patient education.

History of Hospital Patient Education

An outline of the historical development of organized patient education in hospitals was presented as part of a position paper prepared by the Task Force on Patient Education for the President's

Committee on Health Education.[1] This outline identified sporadic interests in patient education dating back to the turn of the century. Significant in the history of hospital patient education were the patient education demonstration projects and studies of the late 1940's and early 1950's. These projects were the impetus for national attention to patient education.[2]

The literature indicated that the American Hospital Association has led in the promotion of hospital patient education. In cooperation with several other interested national organizations, the American Hospital Association sponsored a variety of conferences and institutes on hospital patient education. The first of these was held in 1964, with later programs conducted in 1969 and 1971.[3]

The Task Force on Patient Education for the President's Committee on Health Education reported a search of the literature from 1950 to 1967, which suggested that organized patient education programs in hospitals were "the exception rather than the rule."[4] In 1975, the American Hospital Association surveyed 5,770 of its

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[1]Task Force on Patient Education for the President's Committee on Health Education, "The Concept of Planned, Hospital-Based Patient Education Programs," Health Education Monographs, II, No. 1, (Spring, 1974), 1.

[2]Task Force on Patient Education for the President's Committee on Health Education, p. 5.

[3]Task Force on Patient Education for the President's Committee on Health Education, p. 5.

[4]Task Force on Patient Education for the President's Committee on Health Education, p. 6.

over 7,000 member hospitals to obtain information on inpatient education programs in these facilities; 4,669 of these hospitals responded (80.9 percent). A total of 1,278 hospitals reported a specific unit responsible for coordination of inpatient education activities; 2,680 hospitals reported one or more adult patient education programs with written goals and objectives. According to the authors of the preliminary report for this survey, this latter statistic "indicates a greater degree of program development for patient education at the level of specific patient population."[5]

During January of 1976, the Bureau of Health Education, Center for Disease Control, conducted a patient education workshop which was designed to bring together selected health education practitioners and health administrators to appraise the state of patient education in the nation. Fourteen such individuals from a number of different hospital and health care settings met with the staff of the Bureau of Health Education, Center for Disease Control, to determine what is expected from and what can be provided by the Bureau of Health Education in the area of patient education.[6] The findings of this workshop are discussed later in this paper.

Highlights of the history of patient education must include reference to formal policy statements concerning this subject, which were adopted by leading, national health organizations. As indicated

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[5]American Hospital Association, Preliminary Report of the Survey of Inpatient Education, (January, 1977), 1.

[6]U.S. Department of Health, Education and Welfare, Center for Disease Control, Bureau of Health Education, Patient Education Workshop: Summary Report, (1976), 21.

previously, bibliographic references for these are appended.

Additional developments in patient education include the health education activities of the federal government. In a recent article, Horace G. Ogden, Director of the Bureau of Health Education, Center for Disease Control, provided an overview of various health education activities of the federal government. Ogden traced the history of patient education activities back to the 1950's and 1960's. Activities during this period reflected only sporadic health education campaigns. He used the term "significant turning point"[7] (in the development of a national plan for health education) to describe the events that were initiated by the President's 1971 Health Message to the Congress, which included the appointment of a President's Committee on Health Education. This committee was charged with recommending "ways to develop in the general public a sense of 'health consumer citizenship.'"[8] The report of the President's Committee on Health Education, presented to the White House in 1973, recommended the establishment of an office within the Department of Health, Education and Welfare to coordinate health education activities of various federal agencies. Ogden's article continued with a description of the establishment of the National Center for Health Education in 1975, establishment of the Bureau of Health Education at the Center for Disease Control in 1974, and the provision

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[7]Horace G. Ogden, "Health Education: A Federal Overview," Public Health Reports, XCI, No. 3, (May-June, 1976), 200.

[8]Ogden, p. 201.

of health education activities by various Public Health Service agencies including the Center for Disease Control, Food and Drug Administration, Health Resources Administration, Health Services Administration, and National Institutes of Health.[9]

Frequently mentioned in the literature concerning patient education were a number of national study commissions and federal legislation which relate to this subject and the broader topic of health education. A publication of the federal Health Resources Administration outlined the more prominent of these as follows:

1. National Commission on Community Health Services (1966),
2. Health Maintenance Act of 1973 (Public Law 93-222),
3. President's Committee on Health Education (1973),
4. National Diabetes Mellitus Research and Education Act of 1974 (Public Law 93-354),
5. National Health Planning and Resources Development Act of 1974 (Public Law 93-641),
6. National Conference on Preventive Medicine (1975), and
7. National Consumer Health Information and Health Promotion Act of 1976 (Public Law 94-317).[10]

Much of the literature providing patient education history frequently referenced the optimal standards for hospital care which

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[9]Horace G. Ogden, "Health Education: A Federal Overview," Public Health Reports, XCI, No. 3, (May-June, 1976), 201.

[10]U.S. Department for Health, Education and Welfare, Public Health Service, Health Resources Administration, Papers on the National Health Guidelines: Baselines for Setting Health Goals and Standards, DHEW No. (HRA)76-640, (September, 1976), 18-38.

had been outlined in various issues of the Joint Commission on Accreditation of Hospitals' Accreditation Manual for Hospitals. The Joint Commission on Accreditation of Hospitals has been widely accepted as representing the philosophies of various health professions for optimal hospital services.

A large category of patient education literature consisted of reports of clinical research concerning the relative value or effectiveness of patient education. Such studies, the majority of which appear to have been conducted during the 1960's, also reflect the history of patient education. Early clinical studies in patient education dealt with evaluation of the effectiveness and other aspects of instruction to patients with chronic diseases such as tuberculosis and diabetes. More recent clinical studies in hospital patient education involve subjects including diabetes, nutrition, prenatal, postnatal, ostomy, mastectomy, myocardial infarction, stroke, preoperative, and postoperative instruction. A thorough review of these aspects of education and related research was published in 1968 and 1974 by the Society of Public Health Educators.[11, 12]

The literature on patient education contained many references to the work in this area by Lawrence W. Green, Head, Division of Health Education, School of Hygiene and Public Health, Johns Hopkins University. Green purported that patient education could be justified

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[11]Marjorie A. C. Young, "Review of Research and Studies Related to Health Education Practice (1961-1966) - Patient Education," Health Education Monographs, No. 26, (1968), 1-64.

[12]Ruth F. Richards and Howard Kalmer, "Patient Education," Health Education Monographs, II, No. 1, (Spring, 1974), 1-92.

in economic terms and suggested designs for evaluation.[13] In a recent article, Green indicated that the question of whether health education should be an institutionalized part of medical care had already been decided. The position statements on patient education of various national health organizations also supported the contention that patient education should be an essential component in health care. Green continued this article by discussing a variety of related clinical research and outlining benefits of patient education in the following areas:

1. reduces broken appointments,
2. reduces unpaid bills,
3. reduces malpractice suits,
4. gains community support for the hospital,
5. improves and speeds diagnosis,
6. improves patient compliance,
7. achieves best cost benefits,
8. encourages consumer role, and
9. reduces morbidity and mortality.[14]

In summary, hospital patient education has a history that is rather short, with the majority of the historical developments of this area centering around the latter 1960's and early 1970's. Few hospital-wide programs of organized patient education existed prior to

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[13]Lawrence W. Green and Irene Figa'-Talamanca, "Suggested Designs for Evaluation of Patient Education Programs," Health Education Monographs, II, No. 1, (Spring, 1974), 54-71.

[14]Lawrence W. Green, "The Potential of Health Education Includes Cost Effectiveness," Hospitals, L, No. 1, (May, 1976), 57-61.

the seventies. Some of the hospitals with expanded, organized patient education activities were supported by grants from the Public Health Service and other governmental agencies demonstration projects. Hospitals in California, New Jersey, Connecticut, Massachusetts, and New York were involved in these federally funded patient education demonstration projects and programs.[15] The history of hospital patient education activities related primarily to records of such activities in medium to large hospitals. Specific information on the history of patient education in small hospitals was extremely limited.

Overview of Current Hospital Patient Education Activities

The 1975 American Hospital Association "Survey of Inpatient Education" produced extensive data which was just beginning to be reported at the time of this study. This survey was designed to provide an overview of patient education activities in the nation's hospitals. A preliminary report of data from this survey was presented in an article published in June, 1977.[16]

An overview of hospital patient education in the United States was also provided in the report on the Patient Education Workshop conducted in 1976, by the federal Bureau for Health Education.

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[15]Florence B. Fiori, Marguerite de la Vega, and Mary J. Vaccaro, "Health Education in a Hospital Setting: Report of a Public Health Service Project in Newark, New Jersey," Health Education Monographs, II, No. 1, (Spring, 1974), 11.

[16]Elizabeth A. Lee and Jeanne L. Garvey, "How is Inpatient Education Being Managed?" Hospitals, LI, (June 1, 1977), 75-82.

This report also included an extensive listing of patient education materials.[17]

Recent articles describing patient education in individual hospitals were included in the literature which addressed current patient education activities in the United States. These articles are listed in the bibliography of this paper.

Current Issues and Trends in Hospital Patient Education

A search of the literature revealed a common set of issues facing hospitals involved in, or planning, patient education activities. A comprehensive delineation of these issues was provided in a recent speech by Robert L. Johnson, President, National Center for Health Education. Johnson identified current issues concerning patient education in the following excerpt from his remarks delivered at a conference entitled, "Patient Education in the Primary Care Setting," held April 19, 1977, in Madison, Wisconsin:

> When one takes a broad look at the patient education activity extant, one quickly sees a host of questions which needs further resolution. Who does the patient education--the physician, the nurse, the educator,--all of them? Where is patient education best done, in the hospital, in out-patient settings, in free standing education centers, in the work setting, in the physician's office, at home? Is patient education most effective with families? Who should pay for patient education? Upon what basis should payment be made? Who sets the objectives for patient education--the provider, the payor, the patient? How should the quality of patient education be assessed? What is the primary role of the educator in patient education,--that of administrator, teacher,

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[17]U.S. Department of Health, Education and Welfare, Center for Disease Control, Bureau of Health Education, Patient Education Workshop: Summary Report, (1976), 1-105.

> facilitator, or coordinator? How do patients qualify for or obtain patient education, can they avail themselves of an open market or should patient education be upon prescription? In those instances where patient compliance is absolutely necessary and agreed upon, are other techniques more effective than education? How is self-care distinct from patient education, in what areas do these two concepts merge and find compatibility? In what aspects of health or illness is patient education most effective, in what aspects does it have the least impact? How good are the teaching aids that are available, what new or better ones need to be produced?[18]

Although the literature which addressed these issues and questions was extensive, there remained much to be resolved in more definitive analysis. Articles and reports of available studies were of limited scope and often reflected only a single perspective relative to the current issues.

David Schlesinger, Director, Social Service, St. Luke's Hospital, Milwaukee, Wisconsin, very forcefully stated in a 1973 article his impressions of trends in patient education as follows:

> We can neither countenance nor further tolerate a health care system in which the consumer's right and need to know is ignored. Recent writings emphasize that continuing in this short sighted way is also wasteful of manpower and economic resources and will be an intolerable burden under any national health plan. Assisting people toward an active, informed, participative role in their own health maintenance, treatment, and care will become an essential of every health-oriented effort. The pace of this trend will increase to the extent that all persons in health professions recognize and take responsibility for stimulating and engaging in patient-family health education.[19]

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[18]Robert L. Johnson, "National Update on Health Education" (paper presented at the Conference on Patient Education in the Primary Care Setting, Madison, Wisconsin, April, 19, 1977), 3-4.

[19]A. David Schlesinger, "Annual Administrative Reviews: Health Education," Hospitals, XLVII, (April, 1973), 140.

Fylling and Etzwiler, also addressing trends in patient education, predicted, "patient education will become a leading factor in improving health care in the United States."[20] There seemed to be a growing consensus among health leaders at the national level concerning the importance of patient education. For example, Walter J. McNerney, President, Blue Cross Association, stated, "Ultimately, we are convinced that health education will be considered a routine element of all health services, and hence of health service cost and payment. . ."[21]

The trend of the population of the United States becoming increasingly better educated was also recognized as having several consequences for the nation's health care system. Included among these was the impact of this pattern on patient education in the following areas:

1. Better educated people generally make greater use of health services, for there is increased awareness of the value and importance of seeking prompt medical treatment,

2. Education about health care is usually more successful among people with high educational attainments,

3. The increasing educational level of the population has stimulated the demand for technologically advanced methods of care and for higher apparent quality of care,

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[20]Carelyn P. Fylling, R.N., and Donnell D. Etzwiller, M.D., "Administrative Reviews: Health Education," Hospitals, XLIX, (April 1, 1975), 97.

[21]Walter J. McNerney, "The Missing Link in Health Service," Journal of Medical Education, L, (January, 1975), 20.

4. Health care institutions can expect increasing public examination and criticism of their operations and growing insistence that the public be given some voice in determining their policies, and

5. Doctors will be subject to more criticism, especially about the efficacy and efficiency with which they provide medical care to the public.[22]

In summary, writers have agreed that numerous factors have contributed to the increased demand for, and prevalence of, hospital patient education. The factors which led to this trend have been accompanied by the emergence of a common set of issues concerning hospital patient education. These issues were found to be universal among various types of hospitals; however, few of the writings offered direct insights into the impact of these issues on the small hospital.

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[22]U.S. Department of Health, Education and Welfare, Public Health Service, Health Resources Administration, Trends Affecting the U.S. Health Care System, DHEW Publication No. HRA 76-14503 (January, 1976), 17-19.

Chapter III

METHODOLOGY AND ANALYSIS

The problem of this philosophical study was, To what extent should general, acute-care hospitals of the 100-bed and smaller category provide patient education? In attempting to present a logical, tenable solution to this problem, the tasks outlined were those of identifying and analyzing (1) patient education activities and philosophies in small hospitals, (2) the demonstrated value of hospital patient education, and (3) issues and trends concerning methods and feasibility of providing patient education in the small hospital. The identification of these was made through comparison of data provided in related literature. Analysis of each area was accompanied by the application of existing knowledge and reflective thinking to arrive at the various positions or judgments presented in this report. Attempts were made to maintain a logical, critical, and unbiased approach in reaching judgments which culminated in the conclusions of this study. These conclusions constituted a philosophical concept of patient education in the small hospital.

Following a review of related literature and subjective analysis of the problem, the following hypothesis was induced: The philosophical and humanitarian tenets upon which small hospitals provide service demand the provision of maximal patient education which is integrated into routine patient care regimens. The

development of logical and defendable conclusions in the resolution of the problem of this study comprised the testing of this hypothesis. As indicated previously, one aspect of testing the hypothesis was also related to its power to generate further thinking about the problem.

Current Patient Education Activities in Small Hospitals. . . Are These Sufficient?

Although definitive data concerning the extent of patient education activities conducted in small hospitals was unavailable, an assessment of this was made through observations, general discussions with personnel of such facilities, and review of related literature. It was apparent that some degree of patient learning occurs in all hospitals. Unfortunately, however, planned patient education was often a hit-or-miss operation. Few small hospitals conducted educational activities with written goals and objectives for the patient and/or family during hospitalization.

The President's Committee on Health Education substantiated this assessment concerning hospital patient education. Victor Weingarten, writing about the findings of this committee, stated well the status of hospital patient education in the early 1970's and the potential of this component of health care. Weingarten made the following remarks, which are excerpts from his presentation at the Will Rogers Conference on Health Education held June 22-23, 1973, at Saranac Lake, New York:

> We found very little effective health education of patients in hospitals, and yet we found that this might be one of the really teachable moments when both the

> patient and his family are more susceptible to advice. . . On patient readmission, where there was effective patient and family education at the time of illness, compared with control populations which were not given any education, the readmission rates are substantially reduced where there is effective health education. Health education is not now a reimbursable cost under either Medicare or Medicaid or under Blue Cross or any other insurance, and so of the 7,000 hospitals in the United States, we could not find more than four that were doing what we would consider an effective job of patient education.[1]

The recent American Hospital Association Survey of Inpatient Education indicated that hospitals are just beginning to provide coordinated patient education activities. Results show that out of the 6,000 community, nonfederal, short-term general hospitals surveyed, only approximately 175 hospitals employ a full-time patient education coordinator. The probability that small hospitals are among this group is extremely low. The results also show that responsibility for patient education in the less-than-100-bed size hospitals was assigned to the director or assistant director of nursing. Nurses in these two positions were also responsible for staff education. Obviously, these nurses would have little time to devote to patient education activities due to their primary nursing administration duties.[2]

As a result of this lack of patient education, Lesparre states, "much of what the hospital patient learns or 'picks up' in the way of information is misinformation and is not in the least

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[1]Victor Weingarten, "Report of Findings and Recommendations of the President's Committee on Health Education," Health Education Monographs, II, No. 1, (1974), 15.

[2]Elizabeth A. Lee and Jeanne L. Garvey, "How is Inpatient Education Being Managed?" Hospitals, LI, No. 1, (June 1, 1977), 75-78.

relevant to his health. . .it may even be detrimental. . ."[3] McNerney shared similar views, "some doctors do not want their patients to get information from any source except themselves, and more often than not these are the same doctors who tell their own patients little or nothing and evade questions whenever they can."[4] Such situations can only detract from efforts to provide optimal health care in small hospitals or any other health service facility.

There are often reasons, however, for this apparent frailty of small hospitals in the area of patient education. Small hospitals were observed to be located frequently in small communities, especially rural communities. Such communities have traditionally lacked adequate health professionals, which contributed to heavy patient loads and tight schedules for these communities' physicians. Often, these physicians could not afford to spend the required time in responding adequately to the patient's educational needs. Physicians' lack of time and regard for patient education was also addressed in the previously mentioned findings of the President's Committee on Health Education as follows:

> Most of the physician groups told us that with the exception possibly of pediatricians and obstetric and gynecological specialists, most doctors don't have the time, inclination,

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[3]Michael Lesparre, "The Patient as Health Student," Reprint from Hospitals, XLIV, (March 16, 1970), 1.

[4]Walter J. McNerney, "The Missing Link in Health Services," Journal of Medical Education, L, (January, 1975), 20.

incentive, or belief in health education to do much of a job of patient education.[5]

Likewise, the nursing personnel in these small hospitals have had unique problems that constituted obstacles in providing patient education. In the hospital of 100 beds or smaller size, the nursing personnel usually had responsibility over a variety of areas due to the limited scope of the operation. For example, the director of nursing service may have had responsibility for maintaining supplies, coordination of staff development and inservice training. This size facility was apparently not able to afford to have someone charged with specific responsibility for patient education. This situation was especially apparent in small hospitals experiencing financial problems, as many were due to low occupancy rates. In 1973, short-term hospitals of the 6- to 24-bed size had an average occupancy nationwide of only 49.7 percent; those with 50 to 99 beds had a 66.2 percent rate.[6]

A typical patient in the small hospital had little voice in the way care was delivered to him. He lacked the technical knowledge to criticize things that were being done to him. He may have grumbled, of course, but unlike a customer in a store, he usually could not move his business to another hospital, especially if he was in a small, rural hospital that was the only one in the community.

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[5]Victor Weingarten, "Report of Findings and Recommendations of the President's Committee on Health Education," Health Education Monographs, II, No. 1, (1974), 15.

[6]U.S. Department of Health, Education and Welfare, Public Health Service, Health Resources Administration, Trends Affecting the U.S. Health Care System, DHEW Publication No. HRA 76-14503, (January, 1976), 318.

Technically, this patient was the customer of the hospital, but he had little choice over his care. Unlike other institutions in our free enterprise system, the hospital's customers have had little concern about the prices charged for their care. Since most patients had some type of health insurance coverage such as Blue Cross, Medicare, and Medicaid, many did not seriously consider the costs for services rendered to them.

The combination of the above considerations has created a very passive patient. Hopkins stated, "For many, many years we have thought of the patient as being passive to the point that he is not capable of participating in his own health care."[7] Hopkins further suggests that one of the ways to alleviate the health manpower shortage, which is an acute problem of many rural communities with small hospitals, is to use the "untapped resource--the patient"[8] through effective patient education.[9]

Traditionally, the physician has been viewed as the patient's ombudsman, which has further contributed to a passive patient. However, patients have not always found physicians to be adequate ombudsmen. In response, many larger hospitals added to their staffs special representatives to act as liaison between the hospital and the patient.[10]

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[7]Carol Hopkins, "Patient Education: A Part of Quality Health Care?" The Journal of the Arkansas Medical Society, LXXI, No. 7, (December, 1974), 231.

[8]Hopkins, p. 231.

[9]Hopkins, p. 231.

[10]Joel Chase, Martin Ames, and Mitchell Rabkin, "Dial C-A-R-E for Instant Response," Hospitals, XLVIII, No. 6, (March 16, 1974), 62-64.

The scarcity of writings on patient education in the small hospital corresponded with an apparent limited patient education activity in small hospitals. It was surmised, however, that incidental patient education occurred through routine care and patient-professional interactions. It was further surmised that in small hospitals patients with chronic conditions such as diabetes and colostomies, requiring specific patient instruction, may have received this instruction by means including volunteers, consultants, or referrals to large hospitals or specialty clinics.[11]

The writings concerning patient education and an analysis of the above assessment of patient education in the small hospital produce assumptions that limited patient education in these facilities was related to a lack of understanding of its effectiveness and of how to provide this aspect of patient care. Many physicians, nurses, and health administrators apparently paid lip service to patient education but, obviously, were not convinced that this component of patient care should receive priority consideration.[12, 13, 14] It seemed logical to assume that these health professionals would have given patient education higher priority if they had been adequately informed concerning its numerous advantages, including cost-

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[11]Lee and Garvey, pp. 75-78.

[12]McNerney, p. 19.

[13]Elizabeth Hahn Winslow, "The Role of the Nurse in Patient Education," Nursing Clinics of North America, XI, No. 2, (June, 1976) 213-214.

[14]Robert W. Jamplis, "The Practicing Physician and Patient Education," Hospital Practice, X, No. 10, (October, 1975), 93.

effectiveness and successful approaches to providing it as demonstrated in recent studies.

Need for Hospital Patient Education

As indicated earlier in this paper, patient education has been shown by numerous studies to hold significant potential for reducing morbidity, mortality, health care costs, and medical malpractice litigation of patients in the nation's hospitals. Certainly, these benefits should have constituted incentives for health professionals to have vigorously explored this potential. It was unfortunate that an activity which had potential for affecting the welfare of humanity through reductions in disease and deaths would have required any further exploration beyond that already provided patient education. One would have assumed that the health care delivery system would quickly incorporate hospital patient education into its functions due to the humanitarian benefits alone. However, a basic element of our health care system was its financing. The reality of the system forced the consideration of economics of providing health services including hospital patient education. The legal aspects of health care were also demanding increased consideration as medical malpractice suits became more frequent and as insurance coverage increased in cost and became more difficult to obtain. It was for these reasons that promotion of hospital patient education has been accompanied with consideration of benefiting factors beyond those of reductions in morbidity and mortality.

The desirability of hospital patient education was somewhat difficult to substantiate in quantifiable terms relating to reductions

in health costs. Studies have shown, however, the cost-effectiveness of patient education through means including reductions in the length of hospitalization required, fewer readmissions to hospitals, and avoidance of complications.[15]

Goldstein and Miller reported a program of information to diabetic patients in a county hospital setting in southern California that reduced the annual rate of admissions to approximately one in five. The authors stated that emergency room visits were reduced by fifty percent, and a potential cost-savings of between $1.7 million and $3.4 million was projected. It was estimated that with 4.4 million diabetics in this country, a one-day reduction in average days of hospitalization would reduce costs by $660 million annually if such special information programs were instituted nationally.[16]

Healy published an article in 1968, reporting that teaching appropriate bed exercises and techniques to patients before their operations resulted in 135 of 180 patients being discharged three to four days earlier than had been expected. According to the report, only 3 of 140 similar patients who received no teaching went home early.[17]

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[15]Lawrence W. Green, "The Potential of Health Education Includes Cost Effectiveness," Hospitals, L, No. 9, (May 1, 1976), 57-61.

[16]Jack Goldstein and Leona V. Miller, "More Efficient Care of Diabetic Patients in a County Hospital Setting." The New England Journal of Medicine, (June 29, 1972), 1388-1891.

[17]Kathryn M. Healy, "Does Preoperative Instruction Make a Difference?" American Journal of Nursing, LXVIII, (January, 1968), 62-67.

Hernandez and Hackett reported a study of patient compliance with therapy among patients with recurring peptic ulcers. The authors found that many of these patients believed that acid came from foods and, because of this belief, they did not take antacids between meals or at night. The study concluded that the patients who were most likely to follow doctor's orders were those who understood the reasons for their treatment.[18]

Levine and Britten reported that at the Tufts New England Medical Center instruction and practice in self-infusion for hemophiliacs cut average inpatient days for a group of such patients from 432 to 42. They also reported that outpatient visits per patient were decreased from 23 to 5.5, and total costs per patient went down forty-five percent.[19]

Lindeman and Aernam wrote about a program of structured teaching of ventilatory function to preoperative patients that resulted in significantly increased ability of patients to deep breathe and cough postoperatively. It was contended that this program caused a significant reduction of the length of hospital stay for such patients.[20]

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[18] M. Hernandez and T. P. Hackett, "Problem of Non-Adherence to Therapy in the Management of Duodenal Ulcer Recurrences," American Journal of Digestive Diseases, VII, (December, 1962), 1047-1060.

[19] Peter H. Levine and Anthony F. Britten, "Supervised Patient Management of Hemophilia," Annals of Internal Medicine, LXXVIII, (1973), 195-202.

[20] Carol A. Lindeman and Betty Van Aernam, "Nursing Intervention with the Presurgical Patient--the Effects of Structured and Unstructured Preoperative Teaching," Nursing Research, (July-August, 1971), 319-332.

If the cost-effectiveness incentive for the small hospital to implement or expand patient education activities was not sufficient, what one might assume as being an effective stimulus was outlined in the Accreditation Manual for Hospitals of the Joint Commission on Accreditation of Hospitals. This publication was widely recognized as representing the philosophies of various health professionals for optimal patient care services and facilities in hospitals. Patient education was specifically emphasized in numerous sections of this manual of hospital standards as evidenced by the following excerpts:

1. The patient has the right to communicate with those responsible for his care, and to receive from them adequate information concerning the nature and extent of his medical problem, the planned course of treatment, and the prognosis. In addition, he has a right to expect adequate instruction in self care. . .[21]

2. . . .criteria (concerning evaluation of professional services) shall include expected patient outcomes, such as. . .demonstrated knowledge of the patient concerning his health status, level of functioning, and self-care after discharge.[22]

3. The medical record shall contain evidence of the patient's informed consent of any procedure or treatment for which it is appropriate.[23]

This latter subject of informed consent placed a large responsibility on the hospital and its staff relative to patient education. Patient education was recognized as an essential part

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[21]Joint Commission on Accreditation of Hospitals, Accreditation Manual for Hospitals, (1976), 24.

[22]Joint Commission of Accreditation of Hospitals, p. 27.

[23]Joint Commission on Accreditation of Hospitals, p. 95.

of the process of informed consent in order to insure protection of the patient's rights.[24] The American Hospital Association has included in its "Patient's Bill of Rights" the following concerning informed consent and patient education:

> 1. 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 reasonable 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. . .[25]
>
> 2. The patient has the right to receive from his physician information necessary to give informed consent prior to the start of any 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.[26]

In summary, considerations which were found to support optimal patient education in small hospitals include (1) concern for the welfare of humanity and fulfillment of health professionals' responsibility in this regard, (2) ethical-legal aspects of patients' rights and the philosophical tenets upon which health care was

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[24]J. F. Monagle, "Ethical-Legal Considerations of Informed Consent," Hospital Progress, LV, No. 58, (September, 1974), 58.

[25]American Hospital Association, A Patient's Bill of Rights, (February 6, 1973), 1.

[26]American Hospital Association, p. 1.

provided by hospitals and affiliated health professionals, and (3) the potential cost savings to patients, insurance companies and governmental programs such as Medicare and Medicaid. As health professionals became sensitive to these considerations and, subsequently, more aware of the need to have an informed patient, it became apparent that planned patient education activities in hospitals will be required. Patients were being increasingly charged with responsibility for contributing to their own health care. It was obvious that individual patients should be educated regarding their illness and its treatment, as well as preventive care and maintenance of health.

It was apparent that a definite trend toward preventive care and health maintenance existed in the nation's health care delivery system. The Health Maintenance Act of 1973 initiated new patterns of health care which emphasized prevention and health maintenance through patient education and periodic screening. Health maintenance organizations increased in numbers in recent years and received greater recognition as models for health care of the future.[27, 28, 29, 30]

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[27]Lowell S. Levin, "The Layperson as the Primary Health Care Practitioner," Public Health Reports, XC, No. 3, (May-June, 1976), 206.

[28]Virginia Li Wang, et. al., "An Approach to Consumer-Patient Activities in Health Maintenance," Public Health Reports, XC, No. 5, (September-October, 1975), 449.

[29]Irving S. Shapiro, "HMO's and Health Education," American Journal of Public Health, LXV, No. 5, (May, 1975), 469.

[30]Lester Breslow and Anne R. Somers, "The Lifetime Health Monitoring Program," The New England Journal of Medicine, CCXCVI, No. 11, (March 17, 1977), 601.

This trend toward prevention and health maintenance was also evidenced by the ten national health priorities outlined in the National Health Planning and Resources Development Act of 1974. Three of these priorities were as follows:

1. The development of medical group practices (especially those whose services are appropriately coordinated or integrated with institutional health services), health maintenance organizations (HMOs), and other organized systems for the provision of health care.[31]

2. The promotion of activities for the prevention of disease, including studies of nutritional and environmental factors affecting health and the provision of preventive health care services.[32]

3. The development of effective methods of educating the general public concerning proper personal (including preventive) health care and methods for effective use of available health services.[33]

Another indication of the trend toward prevention and health maintenance was the recent enactment of the National Consumer Health Information and Promotion Act of 1976. This law provided the establishment of the new Office of Health Information and Health Promotion in the Office of the Assistant Secretary for Health, Department of Health, Education and Welfare. Included as a function of this office was the coordination of the operation of a national clearinghouse on

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[31]National Health Planning and Resources Development Act of 1974, 88 Stat. 2225 (1975), 42 U.S.C. 300k (1975), 4.

[32]National Health Planning and Resources Development Act of 1974, p. 4.

[33]National Health Planning and Resources Development Act of 1974, p. 4.

health information, promotion, and prevention activities.[34]

Means of Providing Hospital Patient Education

The preceding analyses of the issues concerning the need for patient education in the small hospital set the stage for examination of some of the issues concerning the methodology of hospital patient education. It was realized that the patient education issues outlined in a quotation from Robert Johnson earlier in this report could have each required indepth research involving scientific inquiry which was beyond the scope of this study. However, a general analysis of some of the issues concerning methods of providing hospital patient education was deemed appropriate.

A variety of approaches to providing health education to hospital patients were being utilized primarily by larger hospitals across the nation. Patient education activities in hospitals ranged from ultra-sophisticated programs involving education prescriptions, clinical health educators, and television assisted instruction, to education provided only when the patient asked, and in terms which he often could not understand. Educational activities directed toward meeting the learning needs of patients and achieving optimal benefits of this aspect of health care were prevalent in hospitals with planned patient education programs. Various elements of such programs described in the literature were investigated as part of the analyses of issues which related to the following aspects of hospital patient

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[34]National Consumer Health Information and Health Promotion Act of 1976, 90 Stat. 695 (1976), 42 U.S.C. 300u (1976), 6.

education: planning, management, methodologies, materials, evaluation, and financing. The most recent data available on hospital patient education were provided by the American Hospital Association's recent Survey of Inpatient Education. These data formed the bases for the discussion of the issues which follow.

Planning. The issues concerning the planning of hospital patient education seemed to involve the following basic questions: What should serve as sufficient stimuli for the initiation of a hospital patient education program? Who should be involved in the planning? How should the scope of the program be determined?

The first question relates to the benefits of patient education which were discussed in previous sections of this chapter. The participants of the 1976 Patient Education Workshop reported the following stimuli or contributing factors for initiation of patient education programs with which they were affiliated:

> . . .the program began with a concerned physician, board member, or administrator who was responding to outside stimuli. The impetus included (1) new demands for patient discharge planning, (2) funding available from Regional Medical Programs (RMP) or other federal sources, (3) professional contact with an educator and reading of the literature, and (4) the requirement in the medical-nursing audit part of the Joint Commission of Accreditation of Hospitals' (JCAH) review criteria.[35]

The second question of who should plan patient education was addressed in many of the descriptions of hospital patient education programs provided by the literature. Most programs began with early

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[35]U.S. Department of Health, Education and Welfare, Center for Disease Control, Bureau of Health Education, Patient Education Workshop: Summary Report, (1976), 1.

involvement of representatives of hospital administration, the medical staff, nursing staff, and other patient contact health professionals in the hospital. In many hospitals multi-disciplinary committees performed the patient education planning function.

Consideration of the third question of determining the scope of a patient education program related to the hospital's size and its resources. As assessment of a hospital's current and potential patient education activities would have been involved. The patient education planning committee or other hospital committee which served the patient education planning function usually guided this assessment.

Management. The primary questions contained in the issues relating to the management of the hospital patient education program appeared as follows: Who should set the policies for programs? How should patient education activities be coordinated? Should patient education be a managed function or left totally as the responsibility of individual health professionals?

It could have been argued that the policies for a patient's education program were the sole responsibility of that patient's physician. However, the concept of hospital-wide, planned patient education with broad policies to cover patients appeared to be a more valid argument. This latter policy mechanism was supported by hospital accreditation standards which stressed planned patient education and procedures for peer review to assure quality patient care. This peer involvement thus extended responsibility for a patient's care beyond the absolute, sole responsibility of a single physician. Considering this fact of peer responsibility, the

establishment of a patient education committee was defendable.

Coordination of patient education seemed to be an extensive undertaking in view of varied patient contact by numerous health personnel who each in some way provide education. The issue was complicated further when it was realized that most patients were not in the hospital sufficient time to obtain optimal knowledge concerning their respective condition. Apparently, these were some of the reasons that hospitals began to employ health educators to coordinate hospital-wide patient education and provide education services to inpatients and outpatients. In many hospitals, this patient education coordination function was the responsibility of the nursing department.

Coordinated hospital patient education certainly appeared to be much more effective than the sporadic attempts of individual health professionals to educate patients concerning their conditions. This organized approach seemed to provide the degree of accountability to justify reimbursement of the hospital for this aspect of patient care.

Methodologies. Various approaches to conducting patient education were described as ranging from the one-on-one type to sophisticated group sessions including elaborate audio-visual materials. The issue of which methods are more effective does not lend itself to resolution to the extent that a solution would fit all types of patients and apply to all institutions. The choice of teaching methods to be employed obviously needed to remain the discretion of the individual health professional. It was clear that more research

was needed in the area of evaluation of patient education methodologies.

Materials. The amount and diversity of patient education materials were found to be extensive. These included numerous pamphlets, booklets, video cassettes, films, instructional guides on specific diseases, and audio cassettes. A single clearinghouse for patient education materials was apparently not available. Sources of patient education materials included a variety of voluntary health organizations such as the heart and lung associations, governmental health agencies, individual hospitals, health education programs in colleges and universities, and commercial suppliers. The issues concerning patient education materials appeared to center upon the relative cost-effectiveness of the various types of these materials. The need for more research in this area of patient education materials was apparent.

Evaluation. Questions requiring long term research concerning the overall evaluation and cost-effectiveness of organized hospital patient education programs were found to be longstanding. Since this area of patient care has just recently been provided through organized approaches, sufficient time has not lapsed to adequately research these questions. Discussions of evaluation of hospital patient education related to nearly all aspects of this subject, for example: evaluation of patient education planning, management, methodologies, and materials. It was apparent that the questions of reimbursement of hospital patient education could only be attempted after questions of evaluations were resolved. Green has written articles which

addressed patient education evaluation both on the overall program level and at the level of individual patient education activities.[36, 37, 38] Green's studies in this area appeared to be more numerous than other researchers who investigated patient education evaluation.

Financing. The issues concerning the financing of hospital patient education centered upon the question of whether direct reimbursement of this service should be provided through various health insurance programs such as Blue Cross, Medicare, and Medicaid. These issues have been recently analyzed as evidenced by the formal patient education statements of various national health organizations which support reimbursement of hospitals for patient education services. The outcome of these efforts has led to the reimbursement of some hospitals for these services through regular daily room charges. This method of hospital patient education financing was endorsed by the participants of the Patient Education Workshop conducted in 1976, by the federal Bureau of Health Education.[39] The participants

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[36]Lawrence W. Green, "The Potential of Health Education Includes Cost Effectiveness," Hospitals, L, No. 9, (May 1, 1976), 57-61.

[37]Lawrence W. Green, David M. Lavine, and Sigrid Deeds, "Clinical Trials of Health Education for Hypertensive Outpatients: Design and Baseline Data," Preventive Medicine, IV (1975), 417-425.

[38]Lawrence W. Green, "The Potential of Health Education Includes Cost Effectiveness," Hospitals, L, No. 9, (May 1, 1976), 57-61.

[39]U.S. Department of Health, Education and Welfare, Center for Disease Control, Bureau of Health Education, Patient Education Workshop: Summary Report, (1976), 2-3.

of this workshop agreed that the method of payment for patient education services should be as follows:

1. When the educational services are part of normal good patient care which would include patient orientation to the health care setting, developing an understanding about the illness condition, and how to manage the therapeutic regimen, the charges for these services should be a part of the total daily bed rate.

2. When a patient's condition requires special educational services beyond the routine care, the patient should have the option of "elective education;" this would be a specific additional charge. This is most likely to occur with therapeutic regimens which require changes in lifestyle and hence needing a more extensive educational plan.

3. In the outpatient settings, the educational services would be identified in the clinic charges as part of a total visit fee or as an extra depending upon the nature of the service.[40]

It was evident that the matter of financing was of paramount importance to the initiation or expansion of hospital patient education activities. Without clear mechanisms of reimbursement for patient education, hospital officials seemed generally unimpressed with the need for this aspect of patient care. The challenge of informing officials of small hospitals concerning the value of patient education and possible avenues for financing was apparent.

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[40]U.S. Department of Health, Education and Welfare, Center for Disease Control, Bureau of Health Education, p. 11.

Chapter IV

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

The hypothesis of this research has been substantiated. The philosophical and humanitarian tenets upon which small hospitals provide service clearly support the provision of maximal patient education which is integrated into routine patient care regimens. This substantiation was provided through identification and analysis of hospital patient education issues and philosophies as reported in the literature.

This concluding chapter presents a concept of patient education in the small hospital. The outlined concept is based upon the findings of this research and reflects the conclusions and tested hypothesis of this philosophical study. This concept of hospital patient education was intended to serve as a resource for officials of small hospitals pursuing the establishment of a hospital-wide patient education program or expansion of existing patient education activities. It was also purposed that this study generate further thinking by health professionals of small hospitals concerning the provision of planned health education to their patients.

The need for an integrated system of patient education in the small hospital in confirmed. Patient education's potential for improving the effectiveness of hospital services has been demon-

strated by numerous research in recent years. As has been assessed in this study, the impetus for hospital patient education has been primarily provided by accreditation groups, consumer movements, federal legislation and health programs, and health professionals' national organizations. Health professionals have generally recognized the importance of patient education; however, due to a number of factors, they have often failed to provide this component of patient care. These factors were essentially their apparent lack of time and not being acquainted with effective approaches to providing this important element of patient care. This proposed concept of an integrated system of patient education in the small hospital is intended to assist in this regard.

Patient education should be planned activity with as many aspects of patient care in the small hospital as possible. This element of patient care should have evaluation procedures for general accountability purposes and to justify payment for these services by health insurance programs and federal programs such as Medicare and Medicaid.

An approach to an integrated system of patient education in the small hospital is proposed to include the following:

1. Policy statement (philosophy) on patient education approved by the hospital's board of trustees. This policy should describe the total scope of hospital's patient education responsibility.

2. Patient education committee. This should be an interdisciplinary committee composed of various hospital departments. The purposes of this committee should include the review of ongoing

patient education activities and policy and procedures determination. In very small hospitals this committee function could be combined with another committee such as the patient care committee.

3. Patient education center. In an effort to establish a greater identity for patient education, it is suggested that an area in the hospital be designated as the patient education center. This center would serve as a patient education classroom for ambulatory patients, contain a library of various patient education materials and equipment, and serve as an office for the patient education coordinator and staff. Since many small hospitals usually have unoccupied beds, it may be feasible to convert a patient room for this purpose.

4. Patient education coordinator. The hospital's patient education activities should be coordinated by a health professional who is proficient in educational techniques and methodology and has adequate knowledge of clinical patient care to perform in this capacity. Many larger hospitals have had success with employing nurses with training in educational techniques. Others have had similar success in using health educators in these positions. Smaller hospitals that may not be able to afford a full-time patient education coordinator may find it feasible to share a patient education coordinator. For example, two or three small hospitals in the same general geographic area may each wish to employ this person on a part-time basis. This approach would enable the hospitals to avail themselves of specialized health education skills that they otherwise might not be able to afford. Another option would be for a smaller hospital

to obtain consulting patient education coordination from an affiliated larger hospital or one that is located in the same geographic area. This patient education coordinator would be responsible for planning and managing the hospital's patient education activities in conjunction with and upon approval by the hospital's patient education committee. This person would also maintain appropriate patient education resources and provide inservice instruction to other health professionals and hospital volunteers to stimulate and improve their patient education interests, capabilities, and activities.

5. Patient education materials and equipment. Numerous health education materials have been available from voluntary health organizations, pharmaceutical companies, governmental health agencies, and professional organizations such as the American Hospital Association. Many of the materials have been available at little or no cost. Patient education materials have also been available from commercial suppliers. In the event that a small hospital could not afford as many of these as desired, options might include the sharing of patient education equipment and materials with another hospital or group of hospitals through a consortium type of agreement. A multi-facility patient education consortium could have tremendous potential for extensive services for patients as well as community health education services. Should the small hospital be located in proximity of a college or university, there may exist potential for establishing affiliations between the two for patient education activities. Many institutions of higher education have health education materials and equipment which might be used in hospital patient education. This

potential may be especially good if the educational institution conducts nursing and health education programs. These educational institutions would probably respond favorably to a small hospital's request for affiliation in this regard due to the possible availability of clinical learning experiences for health education students. This affiliation might also have potential for expansion into joint activities to assist the small community hospital to become truly a community health education center, offering courses in areas such as first aid, personal health, and consumer health. The hospital's role and function as a community health education center would benefit from coordination with other health education resources available in the community such as the local health department, comprehensive mental health centers, and voluntary health organizations. A specific community health education activity in which the small hospital might engage is operation of a "health education by telephone" service. Such services providing three- to five-minute, taped health education messages are widely available from many larger hospitals. This service might be provided by the small hospital through donations from local businesses or community organizations. Assistance in answering and the playing of requested tapes could possibly be provided by members of the hospital auxiliary or other volunteers. Such a service would be utilized by patients as well as the community's general public.

6. Patient education regarded as an integral part of patient care. This would be the crux of an integrated system of hospital patient education. It could only be optimally effective when patient education is considered an essential aspect of care to individuals

in each stage of being a patient, including: pre-admission, admission, inpatient, pre-discharge, and outpatient. As such, activities to meet the patient's health education needs would be as significant as perhaps meeting his nutritional or basic hygiene needs. The hospital's reimbursement of these significant patient education activities could justifiably be provided through including charges for these in the computation of the patient's room rate. A separate patient education fee might be charged patients with special health education needs such as diabetic patients. Each health professional having direct patient contact would need to gain an appreciation for the effectiveness and working knowledge of methods of patient education. The effect of this high regard for patient education and implementation of integrated patient education activities would reflect health professionals' concern for the patient's total health needs as opposed to their concern for a single physiologic function. Patient education activities in this integrated system would consist of informal, impromptu health instruction accompanying each patient treatment and service. More importantly, however, planned patient education programs with written objectives specific to each patient would be required. In many cases, these planned patient education programs would be based on an "education prescription" written by a physician for his patient. Concurrent evaluation of planned patient education activities for each patient would be essential.

In conclusion, small hospitals have potential for assuming a new and exciting air of patient concern and services through patient education. The impact of this potential can be tremendous if this

potential is fully sought. As a result of this study, this investigator concludes that sufficient evidence exists to justify a small hospital's active pursuit of the development of an integrated system of hospital-wide patient education. This justification is evident in the patient education philosophies and related humanitarian concerns identified and in the benefits of hospital patient education as demonstrated by previous research in terms of reducing mortality, morbidity, health care costs, and medical malpractice suits. Planned patient education with written goals and objectives should be included in the services provided by the small hospital. This planned patient education function should be part of a total system of patient health education which is integrated into all aspects of the hospital's treatment services. It has been shown that viable approaches to providing patient education on this scale are applicable to the small hospital. Further, expectations of agencies which review hospital services to assure quality and growing expectations of the public support the small hospital's provision of maximal patient education.

In addition to the implementation of integrated systems of patient education in small hospitals, this investigator further recommends that demonstration funding be sought by a group of small hospitals and an affiliated health education program in a college or university to operate a hospital patient education consortium as suggested above. This funding is potentially available from the federally authorized health systems agencies which have demonstration funds for such activities. Numerous additional sources for such

funding might exist from government agencies, voluntary health organizations and philanthropies.

APPENDIX

Appendix

ADDRESSES OF ORGANIZATIONS WITH FORMAL STATEMENTS CONCERNING PATIENT EDUCATION

Health Education: Role and Responsibility of Health Care Institutions, 1975. S010 - Single copy free
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

A Patient's Bill of Rights, 1975. S009 - Single copy free
American Hospital Association
840 North Lake Shore Drive
Chicago, IL 60611

White Pater: Patient Health Education
Available from Health Care Services
Blue Cross Association
840 North Lake Shore Drive
Chicago, IL 60611

Professional Statements

The American Nurses Association has published "The Professional Nurse and Health Education," available from the American Nurses' Association, 2420 Perching Road, Kansas City, Missouri 64108.

The American Society of Hospital Pharmacists has a statement on the "Pharmacist Conducted Patient Counseling," available from the American Society of Hospital Pharmacists, 4630 Montgomery Avenue, Washington, D.C. 20014

The American Medical Association's statement on patient education can be obtained from the AMA's Department of Health Education, 535 North Dearborn Street, Chicago, IL 60610.

The Society for Public Health Education in 1973, adopted a "Position in Support of a National Health Education Program," available from the Society for Public Health Education, Inc., 655 Sutter Street, San Francisco, California 94102.

Appendix (continued)

Other National Organizations and Agencies with Significant Patient Education Activities and Interests

Office of Health Information and Health Promotion
Public Health Service
U.S. Department of Health, Education and Welfare
Washington, D.C. 20201

National Center for Health Education
Suite 2564
44 Montgomery Street
San Francisco, California 94104

Health Education Information Retrieval System
Division of Health Education
Johns Hopkins University School of Hygiene and Public Health
615 North Wolfe Street
Baltimore, MD 21205

Bureau of Health Education
Center for Disease Control
Public Health Service
U.S. Department of Health, Education and Welfare
Atlanta, Georgia 30333

American Public Health Association
1015 Eighteenth Street, N.W.
Washington, D.C. 20036

BIBLIOGRAPHY

BIBLIOGRAPHY

1. Books

Englehart, Max D. Methods of Educational Research. Chicago: Rand McNally, 1972.

Joint Commission on Accreditation of Hospitals. Accreditation Manual for Hospitals, Chicago: Joint Commission on Accreditation of Hospitals, 1976.

National Commission on Community Health Services. Health is a Community Affair. Cambridge: Harvard University Press, 1967.

Peitchinis, Jacquelyn A. Staff - Patient Communication in the Health Services. New York: Springer, 1976.

Pohl, Margaret L. The Teaching Function of the Nursing Practitioner. 2d ed. Dubuque: Wm. C. Brown, 1973.

Redman, Barbara Klug. The Process of Patient Teaching in Nursing. St. Louis: Mosby, 1968.

2. Statements, Papers, and Special Publications

American Hospital Association. "Advisory Statement on American Hospital Association's Role in Consumer Health Education." 1973 Annual Report. Chicago: American Hospital Association, 1973.

American Hospital Association. "Commercial Suppliers of Patient Education Materials." Chicago: American Hospital Association, 1976. (Mimeographed.)

American Hospital Association. "Guides For Implementing Patient Education Programs in Hospitals." Chicago: American Hospital Association, 1976. (Mimeographed.)

American Hospital Association. "Patient Education Resource List," Chicago: American Hospital Association, 1976. (Mimeographed.)

American Hospital Association. "Policy Statement on the Role and Responsibilities of Hospitals and Other Health Care Institutions in Personal and Community Health Education," 1973 Annual Report. Chicago: American Hospital Association, 1973.

American Hospital Association. "Statement: A Patient's Bill of Rights." Chicago: American Hospital Association, 1973. (Mimeographed.)

American Hospital Association. "Statement on Health Education: Role and Responsibility of Health Care Institutions." Chicago: American Hospital Association, 1974. (Mimeographed.)

American Hospital Association. "Statement on Right of the Patient to Refuse Treatment." 1973 Annual Report. Chicago: American Hospital Association, 1973.

American Hospital Association. "Sources of Patient Education Videotape Programs." Chicago: American Hospital Association, 1976. (Mimeographed.)

American Hospital Association. "Survey of Inpatient Education--Preliminary Report." Chicago: American Hospital Association, 1977. (Mimeographed.)

American Medical Association. "Statement on Patient Education." Chicago: American Medical Association, 1975. (Mimeographed.)

American Nurses' Association. "The Professional Nurse and Health Education." Kansas City: American Nurses' Association, 1975. (Mimeographed.)

American Society of Hospital Pharmacists. "Statement on Pharmacist-Conducted Patient Counseling." Washington: American Society of Hospital Pharmacists, 1976. (Mimeographed.)

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

Johnson, Robert L. "National Update on Health Education." Paper presented at the Conference on Patient Education in the Primary Care Setting, Madison, Wisconsin, April 19, 1977.

Shields, Dale E. "The Time for Responsibility and Accountability in the Health Field." Paper presented at the 1975 National Health Forum, Lake Buena Vista, Florida, March 17-19, 1975.

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

3. Periodicals

Adair, Lois. "Patient Education," Patient Aid Digest, (January-February, 1976), 17-19.

"A Guide to Shared Educational Services," Hospitals, IL (August 16, 1975), 95-98.

Bartlett, Marjorie H., and Thomas C. Meyer. "Patients Receive Current, Concise, Health Information by Telephone," Hospitals, L (February 16, 1976), 79-82.

Bartlett, Marjorie H., and Wilma R. Lewis. "Closing the Health Information Gap in a University Student Community by Telephone Access to Taped Health Messages," The Journal of the American College Health Association, XXIV (June, 1976), 301-306.

Bhanumathi, Patinhara P. "Nurses' Conception of 'Sick Role' and 'Good Patient' Behavior: A Cross-Cultural Comparison," International Nursing Review, XXIV, No. 1 (Issue No. 211), 20-24.

Breslow, Lester, and Anne R. Somers. "The Lifetime Health-Monitoring Program," The New England Journal of Medicine, CCXCVI, No. 11 (March 17, 1977), 601-608.

Bryan, N. E. "Every Nurse a Teacher," Australian Nurses' Journal, IV, No. 1 (July, 1974), 31-33.

Chase, Joel, Martin Ames, and Mitchell Rabkin. "Dial C-A-R-E for Instant Responses," Hospitals, XLVII, No. 6 (March 16, 1974), 62-64.

Choi-Lao, Agnes T. H. "Three Patient Conferences," Nursing Papers, VII, No. 3 (Fall, 1976), 15-24.

Cole, Raymond. "The Need for Education of the Subject in Clinical Research," Journal of the American Osteopathic Association, LXXIV (April, 1975), 760-764.

Czarnik, Patti, and John Phillips. "Patient Education," Medical Group Management, XXIII, No. 4 (July-August, 1976), 12-14.

Davenport, Rachel R., and others. "Dietitians, Nurses Teach Diabetic Patients," Hospitals, XLVII (December 1, 1974), 81-82.

Engle, Veronica. "Diabetic Teaching," Nursing 75, (December, 1975), 17-24.

Etzwiler, D. D. "Current Status of Patient Education," Journal of American Medical Association, CCXX (April 24, 1972), 583-586.

Evans, M. W. "An Introduction to Health Education in Hospitals," Nursing Mirror, (October 10, 1974), 49-50.

Fralic, Maryann F. "Developing a Viable Inpatient Education Program--A Nursing Director's Perspective," Journal of Nursing Administration, (September, 1976), 30-36.

Frerichs, Johanna M. "A Comprehensive Approach to Teaching Cardiovascular Surgical Patients," Cross-Reference (American Hospital Association), V, No. 10 (November, 1975), 1-4.

Fuhrman, Ruth R., and Margaret McWilliams. "Consumer Management Program Aims for Total Health Education," Hospitals, L, No. 16 (September, 1976), 86-89.

Fylling, Carelyn P., R.N., and Donnell D. Etzwiller, M.D. "Administrative Reviews: Health Education," Hospitals, XLIX (April 1, 1975), 95-98.

Goldstein, Jack, and Leona V. Miller. "More Efficient Care of Diabetic Patients in a County Hospital Setting," The New England Journal of Medicine, (June 29, 1972), 1388-1891.

Green, Lawrence W. "Constructive Consumerism," Health Education, VI, No. 6 (November-December, 1975), 3-7.

Green, Lawrence W., David M. Levine, and Sigrid Deeds. "Clinical Trials of Health Education for Hypertensive Outpatients: Design and Baseline Data," Preventive Medicine, IV (1975), 417-425.

Green, Lawrence W. "Evaluation and Measurement: Some Dilemmas for Health Education," American Journal of Public Health, LXVII, No. 2 (February, 1977), 155-161.

Green, Lawrence W. "The Potential of Health Education Includes Cost Effectiveness," Hospitals, L, No. 9 (May 1, 1976), 57-61.

Hassell, Jean, and Eva Medved. "Group Audiovisual Instruction for Patients with Diabetes," Journal of the American Dietetic Association, LXVI (May, 1975), 465-470.

Healy, Kathryn M. "Does Preoperative Instruction Make a Difference?" American Journal of Nursing, LXVIII (January, 1968), 62-67.

Hellman, Sandra. "The Health Educator--A Resource for Nurses," Supervisor Nurse, (September, 1976), 18-22.

Herje, Pat Angvik. "The Ambulatory Clinic Patient as a Learner," Biomedical Communications, II, No. 3 (November, 1975), 20-23.

Hernandez, M., and T. P. Hackett. "Problem of Non-Adherence to Therapy in the Management of Duodenal Ulcer Recurrences," American Journal of Digestive Diseases, VII (December, 1962), 1047-1060.

Hitt, David H. "Reinbursement System Must Recognize Real Costs--Part I," Hospitals, LI, No. 1 (January 1, 1977), 47-53.

Hitt, David H. "Reinbursement System Must Recognize Real Costs--Part II," Hospitals, LI, No. 2 (January 16, 1977), 69-77.

Hopkins, Carol. "Patient Education: A Part of Quality Health Care?" The Journal of the Arkansas Medical Society, LXXI, No. 7 (December, 1974), 231-232.

Horwitz, I. "Television Provides Patient Education," Hospitals, (January 16, 1972), 56-58.

Inui, Thomas S., Edward L. Yourtee, and John W. Williamson. "Improved Out-comes in Hypertension After Physician Tutorials," Annals of Internal Medicine, LXXXIV, No. 6 (June, 1976), 646-651.

Jamplis, Robert W. "The Practicing Physician and Patient Education," Hospital Practice, X, No. 10 (October, 1975), 93-99.

Kohles, M. Therese. "Education and Training Support Quality Assurance," Hospitals, XLVIII, No. 19 (October 1, 1974), 149-153.

Lee, Elizabeth A., and Jeanne L. Garvey. "How is Inpatient Education Being Managed?" Hospitals, LI (June 1, 1977), 75-82.

Lesparre, Michael. "The Patient as Health Student," Reprint from Hospitals, XLIV (March 16, 1970), 1-5.

Levin, Lowell S. "The Layperson as the Primary Health Care Practitioner," Public Health Reports, XCI, No. 3 (May-June, 1976), 206-210.

Levine, Peter H., and Anthony F. Britten. "Supervised Patient Management of Hemophilia," Annals of Internal Medicine, LXXVIII (1973), 195-202.

Lindeman, Carol A. and Betty Van Aernam. "Nursing Intervention with the Presurgical Patient--The Effects of Structured and Unstructured Preoperative Teaching," Nursing Research, (July-August, 1971), 319-312.

Long, Medeleine, and others. "Hypertension--What Patients Need to Know," American Journal of Nursing, LXXVI, No. 5 (May, 1976), 765-770.

McCool, Barbara P. "The Hospital: An Educational System," Hospital Progress, LVI, No. 7 (July, 1975), 67-71.

McNerney, Walter J. "The Missing Link in Health Services," Journal of Medical Education, L (January, 1975), 11-23.

Monagle, J. F. "Ethical-Legal Considerations of Informed Consent," Hospital Progress, LV, No. 58 (September, 1974), 58-61.

Morreau, Lanny E. "Behavior Change Through Patient Education and Contracting," Journal of the Medical Society of New Jersey, LXIII, No. 1 (November, 1976), 991-994.

Nordberg, Beatrice, and Lynelle King. "Third-Party Payment for Patient Education," American Journal of Nursing, LXXVI, No. 8 (August, 1976), 1269-1271.

Nuttleman, Doris G. "Development of the Role of Nurse Health Educator in a Private Ob/Gyn Medical Practice," Journal of Obstetrical and Gynecological Nursing, (September-October, 1976), 49-52.

Ogden, Horace G. "Health Education: A Federal Overview," Public Health Reports, XCI, No. 3 (May-June, 1976), 199-205.

Okel, Benjamin B., and Hank Holderfield. "Tel-Med--An Experiment in Patient Health Education," Journal of the Medical Association of Georgia, LXIII (September, 1974), 369-370.

Ravich, Ruth, and others. "Hospital Ombudsman Smooths Flow of Services and Communication," Hospitals, XLIII (March 1, 1969), 56-61.

Reader, George G., ed. "Proceedings of the Will Rogers Conference on Health Education," Health Education Monographs, II, Supplement 1 (1974), 1-105.

Richards, Ruth F., and Howard Kalmer, eds. "Patient Education," Health Education Monographs, II, No. 1 (Spring, 1974), 1-92.

Riemensnider, Dick K., and Ruth F. Richards. "Providing Supportive Information to the Patient in Isolation," Hospitals, LI (June 1, 1977), 103-106.

Roccella, Edward J. "Potential for Reducing Health Care Costs by Public and Patient Education," Public Health Reports, XCI (May-June, 1976), 223-225.

Rosenberg, Stanley, and Beatrice A. Judkins. "Federal Programs Make Education An Integral Part of Patient Care," Hospitals, L, No. 9 (May 1, 1976), 62-65.

Schlesinger, A. David. "Annual Administrative Reviews: Health Education," Hospitals, XLVII (April, 1973), 137-139.

Schopp, Mary Lou. "Patient Education: Brink of a Boom," Group Practice, (September-October, 1974), 32-35.

Shapiro, Irving S. "HMO's and Health Education," American Journal of Public Health, LXV, No. 5 (May, 1975), 469-473.

Silverman, Mark E., and Donnah Lamitina. "Improved Patient Care Through Patient Education," Journal of the Medical Association of Georgia, LXV, No. 4 (April, 1976), 111-113.

Simmonds, S. K. "President's Committee on Health Education," Hospitals, XLVII (March 1, 1973), 54-59.

Sly, R. Michael. "Evaluation of a Sound-Slide Program for Patient Education," Annals of Allergy, XXXIV, No. 2 (February, 1975), 94-97.

Society for Public Health Education. "New Definitions: Report of the 1972-73 Joint Committee on Health Education Terminology," Health Education Monographs, No. 33 (1973), 67.

Somers, Anne R. "Consumer Health Education-To Know or To Die," Hospitals, L, No. 9 (May 1, 1976), 52-56.

Swezey, Robert L., and Annette M. Swezey. "Educational Theory as a Basis for Patient Education," Journal of Chronic Disease, XXIX (1976), 417-422.

"Telephone is a Health Instrument," Modern Health Care, III, No. 3 (March, 1975), 55-56.

"The Physician's Role in a Hospital's Patient Education Program," Public Health Reports, XCII, No. 3 (May-June, 1976), 271-275.

The Wall Street Journal [New York], April 25, 1977.

Ulrich, M. R., and K. M. Kelley. "Patient Care Includes Teaching," Hospitals, XLVI, No. 59 (April 16, 1972), 59-63.

Wang, Virginia Li, and others. "An Approach to Consumer-Patient Activities in Health Maintenance," Public Health Reports, XC, No. 5 (September-October, 1975), 449-454.

Ward, Graham W. "How Misconceptions Deter Maintenance," Urban Health, VI, No. 4 (June, 1977), 28-29.

Weinstein, Milton C., and William B. Stason. "Foundations of Cost-Effectiveness Analysis for Health and Medical Practices," The New England Journal of Medicine, CCIVC, No. 13 (March 31, 1977), 716-721.

Welbert, Robert T., and Donald A. Dee. "Experience in an Organized Patient Education Program," Journal of the American Pharmaceutical Association, XVI, No. 8 (August, 1976), 450-452.

Wenger, Nanette. "Patient and Family Education After Myocardial Infarction," Postgraduate Medicine, LVII, No. 7 (June, 1975), 129-134.

Wenslow, Elizabeth Hahn. "The Role of the Nurse in Patient Education," Nursing Clinics of North America, XI, No. 2 (June, 1976), 213-214.

Young, Marjorie A. C. "Review of Research and Studies Related to Health Education Practice (1961-1966) Patient Education," Health Education Monographs, No. 26 (1968), 1-64.

Young, Marjorie A. C. "Review of Research and Studies Related to Health Education Practice (1961-1966) Program Planning and Evaluation," Health Education Monographs, No. 27 (1968), 1-85.

Zimering, S., and D. J. McTeran. "The Role of the Clinical Health Educator," Health Education Monographs, IV, No. 3 (Fall, 1976), 266-275.

4. Government Publications

National Consumer Health Information and Health Promotion Act of 1976, 90 Stat. 695 (1976), 42 U.S.C. 300u (1976).

National Health Planning and Resources Development Act of 1974, 88 Stat. 2225 (1975), 42 U.S.C. 300k (1975).

U.S. Center for Disease Control, Atlanta. Patient Education Workshop: Summary Report, Center for Disease Control, Bureau of Health Education, (1976).

U.S. Department of Health, Education and Welfare, HEW News, (November 9, 1976).

U.S. Department of Health, Education and Welfare. Trends Affecting the U.S. Health Care System, DHEW Publication No. HRA 76-14503. [Washington: Government Printing Office, 1976.]

U.S. Department of Health, Education and Welfare, Public Health Service, Center for Disease Control, Bureau of Health Education. Focal Points, (July, 1977).

U.S. Department of Health, Education and Welfare, Public Health Service. Forward Plan for Health. FY 1977-81, DHEW Publication No. (OS) 76-50024. [Washington: Government Printing Office, 1975.]

U.S. Department of Health, Education and Welfare, Public Health Service. Forward Plan for Health. FY 1978-82, DHEW Publication No. (OS) 76-50046. [Washington: Government Printing Office, 1976.]

U.S. Department of Health, Education and Welfare, Public Health Service, Health Resources Administration. Papers on the National Health Guidelines: Baselines for Setting Health Goals and Standards. DHEW Publication No. 76-640. [Washington: Government Printing Office, 1976.]