A Survey of Verbal Communications to Clinic Patients Related to their Health Problem

Dorothy Kuester

Follow this and additional works at: https://scholarsrepository.llu.edu/etd

Part of the Nursing Commons

Recommended Citation
Kuester, Dorothy, "A Survey of Verbal Communications to Clinic Patients Related to their Health Problem" (1962). Loma Linda University Electronic Theses, Dissertations & Projects. 630.
https://scholarsrepository.llu.edu/etd/630

This Thesis is brought to you for free and open access by TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works. It has been accepted for inclusion in Loma Linda University Electronic Theses, Dissertations & Projects by an authorized administrator of TheScholarsRepository@LLU: Digital Archive of Research, Scholarship & Creative Works. For more information, please contact scholarsrepository@llu.edu.
A SURVEY OF VERBAL COMMUNICATIONS TO CLINIC PATIENTS
RELATED TO THEIR HEALTH PROBLEM

by

Dorothy Kuester

A Thesis in Partial Fulfillment
of the Requirements for the Degree
Master of Science in the Field of Nursing

June, 1962
I certify that I have read this thesis and that in my opinion it is fully adequate, in scope and quality, as a thesis for the degree of Master of Science.

Ruth M. White, Chairman
Ruth M. White, M.S., Associate Professor of Nursing

Winifred Edwards
Winifred Edwards, M.A., Associate Professor of Nursing and Sociology

Betty Trubey
Betty Trubey, M.S., Associate Professor of Nursing
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. THE PROBLEM AND DEFINITION OF TERMS USED</td>
<td>1</td>
</tr>
<tr>
<td>The Problem</td>
<td>1</td>
</tr>
<tr>
<td>Statement of the Problem</td>
<td>1</td>
</tr>
<tr>
<td>Need for the Study</td>
<td>2</td>
</tr>
<tr>
<td>Purpose of the Study</td>
<td>2</td>
</tr>
<tr>
<td>Assumptions</td>
<td>3</td>
</tr>
<tr>
<td>Limitations of the Study</td>
<td>3</td>
</tr>
<tr>
<td>Method of the Study</td>
<td>4</td>
</tr>
<tr>
<td>Definition of Terms</td>
<td>5</td>
</tr>
<tr>
<td>Summary</td>
<td>6</td>
</tr>
<tr>
<td>II. GROWING INTEREST IN PATIENT EDUCATION</td>
<td>7</td>
</tr>
<tr>
<td>Personnel Who Teach</td>
<td>8</td>
</tr>
<tr>
<td>The Nurse and Student of Nursing</td>
<td>8</td>
</tr>
<tr>
<td>The Physician and Medical Student</td>
<td>12</td>
</tr>
<tr>
<td>Overlapping in Teaching</td>
<td>13</td>
</tr>
<tr>
<td>Research Related to Patient Teaching</td>
<td>14</td>
</tr>
<tr>
<td>Patients Who Listen</td>
<td>16</td>
</tr>
<tr>
<td>Summary</td>
<td>19</td>
</tr>
<tr>
<td>III. METHOD OF GATHERING DATA</td>
<td>21</td>
</tr>
<tr>
<td>Setting for the Study</td>
<td>21</td>
</tr>
<tr>
<td>Admittance of Patients</td>
<td>21</td>
</tr>
<tr>
<td>Selecting the Sample</td>
<td>22</td>
</tr>
<tr>
<td>Development of the Work Sheet</td>
<td>23</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>PAGE</td>
</tr>
<tr>
<td>---------</td>
<td>------</td>
</tr>
<tr>
<td>Observations of Communications</td>
<td>26</td>
</tr>
<tr>
<td>Summary</td>
<td>28</td>
</tr>
<tr>
<td>IV. FINDINGS, ANALYSIS, AND INTERPRETATION OF DATA</td>
<td>29</td>
</tr>
<tr>
<td>Analysis and Interpretation of Information Given</td>
<td>31</td>
</tr>
<tr>
<td>Nature of Illness</td>
<td>32</td>
</tr>
<tr>
<td>New Tests</td>
<td>33</td>
</tr>
<tr>
<td>Test Results</td>
<td>34</td>
</tr>
<tr>
<td>Medicines</td>
<td>36</td>
</tr>
<tr>
<td>Diet</td>
<td>37</td>
</tr>
<tr>
<td>Home Treatment</td>
<td>37</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>39</td>
</tr>
<tr>
<td>Prognosis</td>
<td>39</td>
</tr>
<tr>
<td>Statistical Analysis and Interpretation of the Levels of Explanation</td>
<td>41</td>
</tr>
<tr>
<td>Statistical Comparison Between Initial and Later Visits as It Affected Information Given to Return Patients</td>
<td>43</td>
</tr>
<tr>
<td>Analysis of the Medical Personnel's Contributions of Information to Patients about Their Health Problems</td>
<td>46</td>
</tr>
<tr>
<td>Summary</td>
<td>48</td>
</tr>
<tr>
<td>V. SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS</td>
<td>51</td>
</tr>
<tr>
<td>Summary</td>
<td>51</td>
</tr>
<tr>
<td>Conclusions</td>
<td>56</td>
</tr>
<tr>
<td>Recommendations</td>
<td>56</td>
</tr>
<tr>
<td>CHAPTER</td>
<td>PAGE</td>
</tr>
<tr>
<td>-------------------</td>
<td>------</td>
</tr>
<tr>
<td>BIBLIOGRAPHY</td>
<td>59</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>66</td>
</tr>
</tbody>
</table>
LIST OF TABLES

<table>
<thead>
<tr>
<th>TABLE</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Frequency and Level of Explanation Given to Clinic Patients on Nature of Illness</td>
<td>32</td>
</tr>
<tr>
<td>II. Frequency and Level of Explanation Given Clinic Patients on Diagnostic Tests</td>
<td>35</td>
</tr>
<tr>
<td>III. Frequency and Level of Explanation Given to Clinic Patients on Therapy</td>
<td>38</td>
</tr>
<tr>
<td>IV. Frequency and Level of Explanation Given to Clinic Patients on Diagnosis and Prognosis</td>
<td>40</td>
</tr>
<tr>
<td>V. Chi Square for Significance on Level 1 Explanations as Compared to Levels 2 to 3</td>
<td>42</td>
</tr>
<tr>
<td>VI. Comparison of Frequency of Explanations According to Number of Patient Visits to Clinic</td>
<td>45</td>
</tr>
<tr>
<td>VII. Frequency and Percentage of Verbal Communications with Fifty Patients by Various Personnel</td>
<td>48</td>
</tr>
<tr>
<td>FIGURE</td>
<td>PAGE</td>
</tr>
<tr>
<td>--------</td>
<td>------</td>
</tr>
<tr>
<td>1. Percentage of Actual and Possible Verbal Communications with Fifty Clinic Patients by Various Clinic Personnel</td>
<td>47</td>
</tr>
</tbody>
</table>
CHAPTER I

THE PROBLEM AND DEFINITION OF TERMS USED

In recent years much emphasis has been given to the importance of informing the patient concerning his disease, explaining how his symptoms relate to his disease, and describing what course the disease is expected to take. In medical literature doctors are increasingly pointing out their duty to give information to the patient. Nursing educators have stressed for years that a nurse is a teacher, and this has been a part of their philosophy in educating students of nursing and directing their other varied activities.

The public has ready access to health information in daily newspapers and popular weekly magazines, as well as through the media of television and radio. This has changed the patient-doctor relationship during the last few decades. Fifty years ago the doctor gave little information and the patient expected little; today the modern patient wishes information, and the doctor and the nurse feel obligated to supply this information. The question that follows is, what information is being communicated to the patient in certain specific settings.

I. THE PROBLEM

Statement of the Problem

What verbal information do return patients receive concerning selected aspects of their health problems while making a return visit to a selected clinic in an urban outpatient department? Who of the
clinic personnel is involved in communicating this information to patients?

Need for the Study

In a recent nursing research workshop "the members recognized that there was a need for more patient-oriented research."¹ The observation is made that "Nursing studies in the past have focused upon the nurse as a practitioner rather than upon patient-oriented studies of nursing."² This study focuses on the patient in the clinic setting to observe information he is given while seeking professional help.

The information the patient is told concerning "the nature of his problem, the mechanism and significance of his symptoms," and the course of the illness may make the difference between a poor therapeutic result and "many years of comfortable and productive life, and whether or not a person cooperates to the extent required."³ There is a need then to discover what information is communicated to the patient in a busy outpatient clinic to help him understand his disease, the treatment for it, and the facts that will help him to cooperate more fully with the physician.

Purpose of the Study

It was the purpose of this study to observe the extent to which certain aspects of verbalized health information were included in the

²Ibid.
³A. Carlton Ernstone, "Explaining to the Patient--A Therapeutic
communications to return patients by clinic personnel. Another purpose of the study was to observe the depth of information included in communications to patients and to observe who of the clinic personnel were most involved in informing patients. It was expected that if omissions were found in information given to patients, these omissions could be the basis for implementing a more comprehensive plan of health education and teaching for patients.

Assumptions

For the purpose of this study it was assumed that:

1. Patient teaching would occur during the observation period and not immediately previous to or following this period.

2. All patients would benefit from the deepest levels of explanation in selected aspects of their health problem if information was communicated to them on this level.

3. There would be variations in the amount of information communicated by the different medical personnel of the clinic.

4. Different patients would need varied amounts of information.

Limitations of the Study

1. The aspects of health information to be noted in this study were limited to those centering around the patient's health problem such as explanations on the nature of the illness, diagnosis, prognosis, and therapy. Because of the limited scope of the study, health maintenance and rehabilitation were areas omitted.

2. Only return patients ages fifteen and over were included in this study.

---

3. Another limitation of this study was the inability of the observer to be completely objective in evaluating information to be placed in the various depth levels of explanation.

4. No attempt was made to evaluate the learnings that took place within the patient as a result of the communications verbalized to these fifty patients.

5. No attempt was made to equate the depth level of explanation and the intellectual level of the patient.

**Method of the Study**

The descriptive survey was the method chosen for the study. Observations were made of the verbal communications directed to patients by all clinic personnel. Observations were made from the time the patient was called to see the doctor in an examining room until the patient made his appointment with the appointment clerk and left the clinic. Only return patients were observed in this study, and each patient was observed only once.

The general medicine clinic of an urban hospital's part-pay outpatient department was chosen because it had patients with varied diagnoses and there was no formal health teaching program in this clinic. Also, there were large enough numbers of patients in attendance at this clinic to give the quantity of patients needed for this study.

A work sheet was used by the non-participant observer to record the selected aspects of health information given to the patient. The effectiveness of this work sheet was checked by observing five patients going through the clinic. After this the work sheet was revised and used as a guide in collecting data during the remaining observations.
After the raw data had been collected on the work sheet, they were used in the final tabulations and analyses of the study.

II. DEFINITION OF TERMS

The following terms had these specific meanings in this study.

**New patient.** A new patient was one who was making a first visit to the general medicine clinic or who had been absent from the clinic for over a year so that a new appraisal of his health condition had to be made.

**Return patient.** A return patient was one who had an appraisal of his health condition in a selected clinic as a new patient and was making any one of a number of consecutive follow-up visits for medical supervision.

**Outpatient department.** An outpatient department was that area of medical services in connection with a hospital in which ambulatory patients received diagnostic, therapeutic and preventive medical care. It was divided into many clinics, each treating patients coming under a specialized area of medicine.

**General medicine clinic.** The general medicine clinic was one of the specialized clinics of the outpatient department to which patients were referred when their diagnosis indicated they needed the services of an internal medicine specialist.

**Clinic personnel.** Those persons employed in general medicine clinic and those volunteering services in their speciality in medicine were defined as clinic personnel. The following were included: internal medicine specialists, residents, senior medical students, graduate nurses and an appointment desk clerk.
Health problem. Health problems were defined as those objective and subjective symptoms that are perceived by the patient as causing cessation or interference with normal activities, and for which the patient is seeking relief by enlisting professional help.

Depth of information. The depth of information was that degree of information both cumulative and of specific detail which distinguished it from other levels in its own category of health knowledge.

Verbal information. Facts, data and explanations spoken orally were called verbal information.

III. SUMMARY

The purpose of this study was to observe the verbalized information which patients received concerning their health problem while making a visit to a selected clinic in an urban part-pay outpatient department. Further, it was noted if explanations were detailed or superficial and who of the clinic personnel were involved in imparting this information.

Certain assumptions were made relative to the study. Limitations were noted with respect to the scope and content of the study, and various terms were defined in a specific way for this study.

The survey method was used for the study, and data were collected, analyzed and interpreted by a non-participant observer with the use of a work sheet. From this information conclusions and recommendations were drawn.
CHAPTER II

GROWING INTEREST IN PATIENT EDUCATION

The concern for informing the patient about his health problem has been gaining emphasis in recent years. The population in the United States is aging; every year there are increasing numbers of older people. People in the older age groups tend to have more chronic diseases. Many of these patients with chronic diseases are being cared for by their physicians on an outpatient basis. These patients will be able to better cooperate with the physician if they are given adequate information, hence there is increasing need for thorough teaching of patients in the outpatient department.

Another trend seen today in medical practice is for the physician to continue his education until he becomes a specialist. Many patients today are being treated by specialists whose main concern is with one system of the body. There are fewer patients today who have a family physician to care for their ills, whose physician understands everything about them, including family background as well as medical history. Thus, a patient being treated in the outpatient department today needs to be completely informed because he often has no close family physician to whom he can feel free to turn if problems should arise.

In 1954 Lucile Petry Leone recognized this trend when she aptly stated "for informed meeting of the doctor's and nurses' therapeutic expectation, the patient is given more information than he was given
Formerly the patient was content to trust the physician and be satisfied with his treatment without explanation. Today many patients wish detailed explanations of what is causing their disease and how the treatment will help them, because they have somewhat informed themselves by reading health columns in newspapers and popular journals. The task of interpreting medical facts to patients comes within the scope of the activities of all the members of the medical team as they meet the patient in varied situations.

I. PERSONNEL WHO TEACH

The Nurse and Student of Nursing

In nursing literature there is agreement that the nurse has a responsibility to teach patients. Statements that clearly indicate this thinking are the following: In Brown's report on nursing she points to the ideally educated nurse as having a "preparation in the art of teaching health to persons, whether sick or well and whether individually or in groups." Ackerman indicates "whatever her special role, a nurse is, to some degree, an educator. She may never teach a class, but she will be called upon daily to share her knowledge with patients, friends, and relatives." Skinner not only emphasizes that there is nothing new in the nurse being a teacher of patients, but


3Lois R. Ackerman, "Help from the Health Educator," Nursing Outlook, 7:218, April, 1959.
she says "her role as a teacher is gradually assuming greater importance."4

Many organized plans for teaching patients finds the nurse sharing in the responsibility with other members of the medical team. In such areas as rehabilitating the tuberculosis patient, these programs have been reported on by Wandelt, Kressler, and Daniels and Tagliaubue.5,6,7 In some areas of industrial health the graduate nurse has assumed the total responsibility for health teaching as in the programs outlined by Alexander and Decgan.8,9

For some years in the education of nursing students the development of skills in teaching patients has been included. Cross writing in 1942 shows how her students' experiences in teaching groups in public health can be carried over into hospital nursing.10 She gives examples of items discussed with various patients by students of nursing. Johnson reports on a project developed in their hospital


5Mabel A. Wandelt, "How Should We Teach the Tuberculosis Patient?" Nursing Outlook, 3:444-447, August, 1955.


which was an outgrowth of students' interest in teaching patients how to care for their colostomies.\textsuperscript{11} This same philosophy is exhibited in modern textbooks.\textsuperscript{12}

... It is the nurse who, in her thoughtful discussions with the patient, can best clarify these pronouncements and lend them appropriate emphasis. Her advice regarding matters of general health and hygiene, as well as the problems of immediate concern, if communicated skillfully and patiently, will make lasting impressions on the patient and secure his complete cooperation.\textsuperscript{13}

Of more interest to this study is the emphasis given the students' work of teaching patients in the outpatient department. Lennon indicates a desire for students to develop an awareness of patient teaching possibilities in the various clinics. "To educate the patient as to the nature of the disease... and to develop in the student an appreciation of her responsibility in teaching patients how to carry out preventive measures"\textsuperscript{14} are examples of the objectives stated. More recently Sholtis and Bragdon have stated a similar objective "to adapt the teaching of the patient and his family to their specific health needs"\textsuperscript{15} as a part of the students' education. These objectives have found a practical application as Shafer and Tschida state the

\begin{itemize}
  \item \textsuperscript{11}Jean E. Johnson, "Students Teach Their Patients," \textit{Nursing Outlook}, 2:319, June, 1954.
  \item \textsuperscript{14}Mary Isadore Lennon, \textit{Teaching in the Outpatient Department}, New York: G. P. Putnam's Sons, 1954, p. 98.
  \item \textsuperscript{15}Lillian A. Sholtis, and Jeane Sherburn Bragdon, \textit{The Art of Clinical Instruction}, Philadelphia: J. B. Lippincott Company, 1961, p. 132.
\end{itemize}
details of their plan to give senior students an experience in patient teaching within a group discussion setting.\textsuperscript{16}

There is over-all agreement found in nursing literature to indicate that the nurse has a responsibility to teach patients and to assist future nurses, the nursing students, to develop this skill whether in the hospital, health department, outpatient department or in industrial nursing. These findings are well stated by Fisher who lists as a prominent feature of the outpatient department teaching of patients.\textsuperscript{17} Windemuth says, "It may not be too far afield to say that nursing care is teaching in the outpatient department."\textsuperscript{18}

The nurse reads in her journals that she is to teach, she has been taught how to teach, but does she teach? The paradox of this situation appears in two recently reported investigations centered in the outpatient department. Malone, Berkowitz and Klein, in gaining responses to cartoons concerned with situations in the outpatient department from ninety nurses who worked there, found only two of the 90 nurses anticipated that they would be expected to teach patients; only eight indicated there was a need for more teaching in the outpatient department. The nurse "is exhorted to teach patients, but she finds that, by their behavior, neither the physician nor the supervisor expects or encourages her to do so."\textsuperscript{19} With the present organization


\textsuperscript{17}Mercedes M. Fisher, "Outpatient Departments Have a Long Way to Go," \textit{American Journal of Nursing}, 61:56, January, 1961.


\textsuperscript{19}Mary Malone, Norman H. Berkowitz, and Malcolm W. Klein,
in many outpatient departments it is pointed out that it is humanly impossible for her to do so because a nurse "cannot teach every patient, assist three to eight doctors, and administer the clinic all at the same time." 20

In her interviews with forty patients from the University of California outpatient department, Kaplan asked patients if adequate explanations were given them. In their replies the patients always referred to the physician as the source of information but never the nurse. Although all patients gave positive responses concerning their relationships to nurses, they did not think it one of her duties to explain medical facts to them. 21 This seems to indicate that nurses were not greatly involved in teaching patients.

The Physician and Medical Student

Physicians in various responsibilities have felt that teaching the patient about his problem is important. It is clearly established by Gregg in his article by saying, "education of patients regarding medical problems is one of the duties of the physician." 22 The same concern for putting this principle across to medical students is voiced by Brant when he speaks of the comprehensive care for the

---


20 Malone, loc. cit.


patient as a total person. He and Kutner conducted interviews in their teaching hospital to see if this concept was being implemented by students and physicians in their university teaching hospital.

Overlapping in Teaching

If the nurse, the doctor, the medical student, and the student of nursing are going to interpret medical information to the patient, the question arises, who should tell what. In the medical literature there seems to be a conflict of opinion as to the areas to be covered by the different medical personnel.

Areas specifically pointed out for nurses and students of nursing are the giving of home care instructions, which might include “interpretation of the doctor’s orders,” making referrals, and giving instructions and demonstrations on procedures to be carried out at home. They may also give explanations “related to the patient’s physical condition” and of the expected activities surrounding taking diagnostic tests and treatments.

Although nurses may prepare patients for tests, some feel that “it is not the nurse’s prerogative to interpret the meaning or usefulness of the tests in reference to diagnosis.”

Prognosis and diagnosis


25 Ibid., p. 423.

and the explanations of these are thought by some to be the exclusive right of the doctor or medical student; however, Ernstene would give the physician a much larger responsibility. He would include explanations on "the nature of (the medical) problems, the mechanism and significance of his symptoms, and the course the illness may be expected to follow."27

Brant and associates after their investigation outlined ten specific areas of health teaching for the surgical patient.28 Their opinion was that these areas were to be covered by staff physicians, medical students, and other doctors contacting the patient. From these writings it would seem that there is overlapping of interests in teaching the patient. This might indicate that where there are different organizational plans, different responsibilities will be delegated to different groups of medical personnel. Inherent in this is also the danger that aspects of health teaching may be omitted for the patient unless all understand the work of the others.

II. RESEARCH RELATED TO PATIENT TEACHING

A number of recent research projects have centered about the problem of information given to patients. A number of these were conducted at New York Hospital by investigators from the Cornell Medical Center. Seligmann and associates developed a questionnaire to discover the level of knowledge of clinic patients related to the

27Ernstene, loc. cit.

ten most common diseases. This they felt could be a base line for teaching the patient. Their findings indicate that the patients knew only 55 per cent of the thirty-six questions asked about the disease. Having more than one of the diseases did not increase their knowledge.

The next step was to see if the physicians working in this outpatient department thought the patient should know the questions asked him, and how much the physician expected that the patient would know. "Eighty-one per cent of all doctors had an over-all tendency to underestimate patients' knowledge." The doctors agreed the patient should know only 32 per cent of the information in the questionnaire.

Reader, heading another section of the research project, reports on the findings from interviewing new clinic patients concerning what they liked or disliked in a doctor and what they expected from a clinic visit. An interesting discovery was that "patients seemed to have a need for explanations of their condition by the physician who cared for them and yet made no particular effort to obtain this information by direct questioning." How much time does an internist spend telling his patients about preventive health measures was the question of research by


32 Ibid., p. 94.
Doctors Dowling and Shakow. The group of sixty-seven internists and twelve general practitioners who participated indicated they spent 26 per cent of their time in health education of a preventive nature and 19 per cent in instruction concerning the patient's illness.

III. PATIENTS WHO LISTEN

The interest in teaching health by individuals from the medical sciences seems to be paralleled by the interest of the general public who are potential patients. In a recent survey it was found that 37 per cent of the people questioned reported that they read all the health news they could find. Medical news ranked third in the ten categories given, showing a larger reading public than sports, comics, and crime.

The few patients who have written concerning their experiences in the hospital feel they have not received the information about their health problem that would have given them assurance and understanding. Jones states emphatically, "Your enquiries into the reason for certain procedures, or the type of medication you are ordered to take, are treated coldly." She felt intelligent people should be informed about their condition so they could work as a team with the medical group. Russell expresses much the same feeling. "There are many other instances of needless mystery in hospital procedures. . . . The

---


patient takes his pill, and does not question. But he always wonders what he's taking and what it's supposed to do for him. Can he not be told?" 36 "Somehow the questions you have as a patient bring forth evasive answers or receive no answers at all" 37 Larsen says of her experience as a patient. These patients who have expressed themselves indicate a desire for more information than they had received.

Is the clinic patient satisfied with the information he receives in the outpatient department? The investigations centered in the outpatient department reported in the literature give only clues as to the patients' reactions on this topic. There is no research on this specific question. Kaplan, when analyzing reasons for broken appointments in a hospital medical outpatient department, discovered some clues as to the patient's feeling on this subject. When asked whether clinic personnel explained enough to them, 23 out of the 40 patients interviewed said "yes", and 17 said "no." "The important things about which explanations were desired were the examination procedures, the laboratory findings, treatment, and medications." 38 Patients expressed dissatisfaction with doctors who were abrupt in answering their questions or gave no answers. As mentioned previously, Reader and associates found patients feeling a need for explanations concerning their illness, but not expecting doctors to meet this need. 39

38 Kaplan, op. cit., p. 37.
39 Reader, Pratt, and Mudd, op. cit., p. 94.
Another means of identifying patient interest in health knowledge came by checking on the number of health pamphlets asked for by patients of nurses in clinic waiting rooms. There was ample evidence of patient's interest in a variety of health topics.\(^40\)

Even though the patient may express a desire to learn, there are other factors which would prevent his effective use of the facts and information he hears while at the clinic. Five important factors related to patient learning are discussed by Skinner and Derryberry. There must be a motivation within the individual and he must take an active part in his learning. The patient's background, past and present, and the attitudes of his own group will cause him to select only certain information from what he hears, sees, and feels. Finally, he will act only when he sees that these actions are a part of his individual goals. Speaking in a more general vein, these authors recognized that many symptoms that brought people to an outpatient department were life crises and at these times "barriers to learning are lowered."\(^41\) If, however, this crisis became too great a threat to personal security, it could produce anxiety which would interfere with learning. Cassady and Altrocchi were in agreement with these findings about anxiety as related to pre-surgical patients in their investigation.\(^42\) A moderate degree of anticipatory fear could best be alleviated by complete


information, whereas extremely high or low degrees of fear had to be dealt with differently. Windermuth, after discussing many of the above factors related to patient learning, says, "the evident fact that the patient has made the effort to come to the clinic indicates that he has a need—biological, psychological, or social—which he consciously or unconsciously wishes to have satisfied."\(^4^3\) This need may be partially satisfied with information given by the nurse if she is alert to her opportunity.

Another investigator was interested in finding out if patients understood the words used in giving them medical advice. Collins worked out a list of twenty words commonly used by dietitians, doctors, and nurses in prenatal clinics.\(^4^4\) She interviewed a hundred patients to find their understanding of these words. Most patients understood fourteen of the twenty words, but six words gave them special problems. Eighty per cent missed the meaning of these. This indicates the care needed in choosing simple words in health education and the necessity of knowing the patient's background.

**IV. SUMMARY**

From a review of the literature related to patient teaching in the outpatient department, it was found that in theory patient teaching was considered a major responsibility of nurses and students of nursing. In actual practice nurses in outpatient department clinics were doing very little teaching, but were usually engaged in administrative

\(^4^3\)Windermuth, *op. cit.*, p. 106.

activities. A few physicians have written expressing a conviction that physicians are responsible for adequately informing their patients. In one large university hospital an investigation was done to see what physicians felt patients should know concerning ten common diseases. The physicians thought the patients should know only 82 per cent of the information, but they had a tendency to underestimate the patients' level of information. Other physicians found in a survey that considerable amount of time is spent by the internist doing health teaching and informing the patient about his disease.

Patients exhibited dissatisfactions when they were not given information they desired concerning their disease condition in the setting of both the hospital and outpatient department. Investigation showed patients do not ask questions because they felt they would not be given answers by their physicians. The potential patient (the general reading public) is spending much time reading medical news in newspaper columns and other periodicals.

It was found that the need for medical assistance that brings the patient to the clinic is an indication of learning readiness. His action of coming to the clinic reveals internal motivation to secure information about his health problem.
CHAPTER III

METHOD OF GATHERING DATA

The method of study chosen was the descriptive survey which, as Hillway states, "attempts usually to describe a condition or to learn the status of something and, whenever possible, to draw valid general conclusions from the facts discovered." The technique of research was observation with the use of a work sheet.

I. SETTING FOR THE STUDY

The general medicine clinic of the outpatient department was selected for this investigation because it seemed typical of many of the clinics in organization, the patients had varied diagnoses, and a sufficient quantity of patients were in attendance to give the number needed in a sample for this study. This part-pay clinic was attached to a large urban private hospital whose clinical facilities were used by the school of medicine and the school of nursing in a private university.

Admittance of Patients

The outpatient department is organized to give medical assistance to ambulatory patients with health problems within a certain financial eligibility range. Assignment of the patient to any one of the many clinics was determined by the doctors in admitting clinic. The basis

---

of eligibility depended upon the urgency of the medical problem and its degree of teaching value.

After being accepted in the admitting clinic, the applicant was sent to register as a clinic patient. At this time someone in the business office of the clinic evaluated their ability to pay for medical care. Evaluation was made on the basis of their income, financial liabilities, number of dependents, and previous medical expenditures to determine what percentage of their care at the clinic they would be expected to pay. All patients in the clinic were on a part-pay basis.

With registration complete the patient was now ready for an appointment to a specific clinic. Patients who were assigned to general medicine clinic would usually have a tentative diagnosis that would ordinarily be treated by an internal medicine specialist.

**Selecting the Sample**

The number of patients in this study was set at fifty because it was thought this would provide a large enough sample to provide data concerning the information patients were receiving from various clinic personnel in general medicine clinic.

Return patients rather than new patients were observed for two reasons, the first reason being the desirability of including diagnosis as one of the aspects of the health problem. Often new patients in this clinic could not be told their diagnosis. On these first visits physicians often could not confirm a diagnosis because diagnostic tests were in process and test results were not yet recorded. To include the aspect of diagnosis, which was important health knowledge
to patients, it seemed better to observe return patients. It was also found that within the time limits of the investigation it would not be possible to include new patients. It took approximately four to five hours to observe one new patient and only thirty to forty-five minutes to observe a return patient.

Because of the organization of the clinic, the patients observed were selected in the following manner. All names of medical students who were seeing patients for that day were put on slips of paper and the names shaken up in a box and one chosen. The patients being seen by this student were then observed for that clinic period. This procedure facilitated observing from one to four patients in a morning. Each senior medical student saw a different group of patients, thus a different group of patients were chosen by lot to be observed each clinic period.

II. DEVELOPMENT OF THE WORK SHEET

To facilitate observations in the clinic a work sheet was developed for use in gathering data.* The general categories of information that were included in the data were: (1) information about the nature of the illness, (2) explanations about new tests, (3) interpretations of test results, (4) information on drugs, (5) information on diet therapy, (6) information on home treatments, (7) diagnosis, and (8) prognosis.

---


*See Appendix A.
From a review of available literature it was found that these aspects of health knowledge were all mentioned as areas of legitimate importance for patients. Gregg, Reader, and Gay all mention the need for the patient to have "a detailed and intelligent explanation of his medical problem" given him by his physician. Windemuth includes this type of information as a part of the teaching function of the nurse in the outpatient department, as does Burton for the work of the nurse in the hospital.

Equally important for the patients' understanding, says Streeter, is information about "diagnostic examinations and therapeutic treatments." Skinner agrees with her that this information can be supplied by the nurse. Although the nurse may not be the first to explain test findings, she can reinforce the instructions and interpretations of the physician.

---


6Ibid.


Perhaps the most delicate and difficult of explanations comes in the realm of diagnosis and prognosis, especially if malignancies are found. "It is generally agreed that the person to share diagnosis and prognosis with the patient is the doctor, and that it is within his discretion to decide how much the patient should be told."\(^1^2\) Under these circumstances "the nurse must accept and help the patient understand whatever explanation the physician has given."\(^1^3\) There also seems to be general agreement that physicians owe the patient an explanation of the probable consequences of his disease condition.\(^1^4,1^5\)

Instruction related to health maintenance and rehabilitation were omitted because of the limited scope of this study.

These eight aspects of information were incorporated into a work sheet for use in making the observations. It was tested by use in observing five patients making visits to general medicine clinic. Revisions were made and the revised work sheet was then used for gathering data on the fifty patients included in this study.


\(^{1^4}\) Ernstene, *op. cit.*, p. 1112.

\(^{1^5}\) Brant, *op. cit.*, p. 1006.
III. OBSERVATIONS OF COMMUNICATIONS

Observations with the use of a work sheet was the technique used to conduct this survey. All observations on the fifty patients were done by one graduate nurse observer.

Before collection of data began, permission for observation in the clinic was obtained by an interview and letter to the hospital administrator.* He in turn relayed the request to the physicians in charge of the medicine clinic, who gave their permission. The observer had discussed the possibility of doing a study in the clinic with the nurses before the study began, but no formal explanations were given as to the nature of the study as the observations were begun.

The observations were made by following the patient as he was called by the senior medical student to the examining room, then staying with the patient at all times that he was in the presence of clinic personnel. After the medical student interviewed the patient and made necessary examination, he left the room to care for other patients until specialists and residents were available for consultation. The patient was observed again when the consultant and medical student saw the patient to finalize on his continued therapy. The patient was then followed as he made his return appointment at the appointment desk, where he saw the nurse or desk clerk and left the clinic. The observation ended at this point.

The observer found it was usually unnecessary to explain her presence to senior medical students except to say she wished to

*See Appendix B.
follow patients with him that day in order to gather data for writing a master's thesis. Most seniors took pains to explain details of the diagnosis to the observer feeling this was her primary interest. It seemed clear to the observer that they were unaware of the real nature of the investigation and therefore they were not influenced to increase the quantity or quality of information given to patients. Three seniors and two specialists asked concerning the topic of the study and were told the investigator was listening to questions patients asked while in the clinic. This brief statement seemed to be a satisfactory answer. Three of these inquiries were made after the observations were completed and only two came previous to the observation.

The observer was dressed in the regular uniform of the graduate nurse and was introduced by the senior medical student at the time he introduced himself to the patient. Some added such a remark as "she is one of our nurses in the clinic" or "she will be with us today." The observer carried a check sheet in a journal and usually sat behind the medical student and took notes as he made notes on the patient's chart. The medical student and the patient were usually closer to each other than the nurse and this kept the nurse from being involved in the conversation. Non-involvement of the nurse was enhanced by the nurse's keeping her eyes lowered to the check sheet for note taking if the patient wished to include her in the conversation.

However, note taking was not done in the presence of the consultants after it was noted once that the consultants exhibited signs of uneasiness from this procedure. Since the consultant was
in the room usually only three to five minutes, notes were made immediately after leaving their presence.

Beginning on August 28, 1961, observations were made in general medicine clinic on Monday, Tuesday, and Thursday of that week, three days of the next week, and on Fridays of the months of October, November, and December. Observations were concluded in 1962 on four Fridays in January and three in February until a total of 50 patients were observed.

IV. SUMMARY

The descriptive survey was the method chosen for this study that had its setting in the general medicine clinic of an urban part-pay outpatient department. Observations with the use of a work sheet was the technique of research. One graduate nurse conducted all fifty of the observations as a non-participant observer.

From a review of literature it was found that certain areas of information were consistently mentioned as subjects to be discussed with the patient. Among these were information on the causes of illness, a statement of prognosis and diagnosis, and details related to test findings and treatments. These subjects were included in a work sheet that was tested in observing five clinic patients, revised and used for gathering data on the fifty patients included in this study.
CHAPTER IV

FINDINGS, ANALYSIS, AND INTERPRETATION OF DATA

Fifty patients were observed in the general medicine clinic of an urban part-pay outpatient department during the times they were in the presence of clinic personnel to find out what they were learning about their health problems and who communicated this to them. These patients showed varied and interesting backgrounds.

The age range of the patients included ages 17 through 82 with an average age for the group of 54. The patients according to their ages could be further grouped in this way:

<table>
<thead>
<tr>
<th>Age Bracket</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 - 24</td>
<td>3</td>
</tr>
<tr>
<td>25 - 44</td>
<td>7</td>
</tr>
<tr>
<td>45 - 64</td>
<td>24</td>
</tr>
<tr>
<td>65+</td>
<td>16</td>
</tr>
</tbody>
</table>

Thirty-four of the patients were women and sixteen were men. Half the patients were of Caucasian descent, eighteen were Negroes, six were from Spanish-American ancestry, and one was of Oriental background.

A study of the socio-economic background of the patients disclosed that very few were employed outside the home. Six of the patients worked as janitors or "domestics," ten others worked in factories or as day laborers, and one man owned a small business. Seventeen classified themselves as housewives. Eight were retired or receiving compensations of different kinds, six were unemployed, and two were dependents within a family group.
Thirty-seven patients were born in the United States. The remainder were born outside the United States; five in Mexico, two in Poland, and one each in the countries of Ecuador, Guatemala, Hungary, Italy, Sweden, and China.

Twelve patients were being treated for hypertension, seven for diabetes mellitus, four for arteriosclerotic heart disease, three for post-myocardial infarcts, two for duodenal ulcers, and two for coronary insufficiency, and each of the others had a different diagnosis.* Since these patients were in the older age bracket, they tended to have more than one diagnosis, only a third had a single diagnosis; however, the diagnosis used in describing these patients was the condition for which the patient was receiving care during the current visit.

Observations were made of these fifty patients making return visits to the general medicine clinic of an urban part-pay outpatient department. These observations were made for the purpose of discovering what information was communicated verbally to patients about their health problems by the various personnel of the clinic. These communications were divided into eight aspects of health knowledge: (1) nature of illness, (2) new tests, (3) test results, (4) medicines, (5) diet, (6) home treatments, (7) diagnosis, and (8) prognosis. These factors were found from a review of the literature to be topics medical personnel believed were beneficial when interpreted to patients.

In order to evaluate whether the explanations were cursory or of a detailed nature, each aspect was graded arbitrarily by the

*See Appendix C.
observer for increasing depth of explanation on a scale of 0, 1, 2, and 3. An explanation on the 0 level indicated the patient received no information, but the amount and depth of information increased from levels 1 through 3. This scale for rating each of the eight aspects is explained in connection with analysis and interpretation in this chapter.*

The fifty patients were further divided into groups depending on the number of visits they had made to the clinic. They were grouped as those making visits 1-3, 4-9, and 10 or over. This was done to see if patients making initial visits received more information than patients making repeated visits to the clinic.

Analysis was also made as to who of the clinic personnel was most involved in verbalizing health information to patients.

I. ANALYSIS AND INTERPRETATION OF INFORMATION GIVEN

Three aspects of health knowledge—"Nature of the Illness," "Prognosis," and "Diagnosis"—applied to all fifty patients. Only twenty-four patients had new tests ordered for them the day they were observed. Only thirty-three of the patients had test results on their charts which could have been explained to them. Only seven patients were not on drug therapy, so the category of "Medicines" applied to forty-three of the patients.

Fourteen patients had a diagnosis which the physician felt would not usually call for diet therapy. Thus these were not candidates for

*See Appendix D.
information in the area of diet. This left only thirty-six patients who would have benefited by an explanation of their diet.

As a basis of computing the percentages of information verbalized to patients, the total number of patients for which this category was pertinent was used. Using these totals, percentages were worked out for the quantity of information given to this sampling of patients on the four levels of explanation as given above.

**Nature of Illness**

Fifty per cent of the return patients received no explanations about the characteristics of their illness. Of the 50 per cent who did receive explanations, 14 per cent received it on level 1, 30 per cent on level 2, and 6 per cent on level 3 as shown in Table I.

**TABLE I**

<table>
<thead>
<tr>
<th>Nature of Illness (50)</th>
<th>Level of Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>T</td>
</tr>
<tr>
<td></td>
<td>25</td>
</tr>
</tbody>
</table>

T - Total of patients
( ) - Number of patients in category

The following guide was used in rating the level of information for this aspect:

0—No item on the nature of the illness was discussed.
1--The causative agent was discussed.

2--The causative agent was discussed and related to a host factor or environmental factor.

3--The cause of the disease was discussed with the patient and was related to two of the following: a host factor, or an environmental factor, whether physical, biological or social.

An example of level 1 of explanation came as the senior medical student told a lady that the discoloration she was experiencing on her legs resulted from a poor "blood return" to the heart. This left "blood deposits out in the tissue" which caused discoloration.

A level 2 of explanation was given to communications in which a diabetic patient was told that diabetes means there is too much sugar in the urine, and much more important than this, there is too much sugar in the blood. In some people the urine does show the true picture of the degree of diabetes but the blood sugar is a better gauge. Level 2 gave the patient more information and in greater detail.

More information or greater details would have been called for if the communications were to be classified on level 3. A specialist gave this level of information to a patient with "black-out spells" when she explained how the causative agent could be the result of a "head injury" or personal health habits, or "emotional strain," thus relating his problem to the causative agent plus a host and an environmental factor.

**New Tests**

Of the twenty-four patients who were asked to have a test performed before returning to the clinic, all patients received
explanations. Of this 100 per cent, 50 per cent were given on the 1 level, 20.8 per cent on the 2 level, and 29 per cent on the 3 level. This is shown in Table II.

The levels of information for new tests were described as follows:

0---Patient was told a test is to be taken with no name given.
1---The test name was given and the patient was told where to go or how the test will be administered.
2---The test name was given and the patient was told where to go, and given preliminary pre-test instructions, or told the purpose of the test.
3---The test name was given and at least three things were explained to the patient, where to go for the test, preliminary instructions, and the purpose of the test.

Since these were return patients with previous testing experience, it is interesting to note that all of them still received information, but only 30 per cent were told the purpose of the test.

Test Results

Table II gives the percentages on test results. It shows 33.3 per cent of the thirty-three patients receiving no verbal communications concerning test results on their charts. Of the two-thirds who did have verbalized explanations, 39.7 were on the 1 level, 24.2 were on the 2 level, and 3 per cent on the 3 level.

The following guide was used in rating the level of information for test results:

0---No explanation was given the patient of recorded test results.
An explanation was given indicating that the test results were normal or not normal.

The test results were explained as being normal or not normal plus an explanation related to one additional factor in level 3.

The test results were explained to the patient as being normal or not normal plus relating the results to two of the following factors: physiology, anatomy or chemistry of the disease problem.

### TABLE II

<table>
<thead>
<tr>
<th></th>
<th>Level of Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>T</td>
</tr>
<tr>
<td>New Tests (24)</td>
<td>0</td>
</tr>
<tr>
<td>Test Results (33)</td>
<td>11</td>
</tr>
</tbody>
</table>

T - Total of patients
( ) - Number of patients in category

Thirteen of thirty-three patients were told that the test results revealed a normal or abnormal condition. Eight patients were given additional details, i.e., "your blood sugar test shows too much sugar, you must not be keeping on your diet," or "you are staying around the same number on your blood thinning," thus receiving a 2 level explanation. One patient was given the maximum level of
explanation when details of physiology and chemistry were related to specific findings on the test.

Medicines

The aspect of drug therapy was applicable to forty-three return patients. Only one patient, or 2.2 per cent, received no explanation about the medicine they were taking as seen in Table III. More patients received a 2 level explanation (51.2 per cent) than either a 1 level with 27.9 per cent, or a 3 level with an 18.6 per cent. Information on how to take their medicines was given to twelve patients. The 2 level which included communications on how to take their medicines and either its expected results or side effects was the most popular level of explanation. Twenty-two patients were included here. Eight patients received more information and were given a level 3 explanation.

The following guide was used in rating the level of information for medicines:

0--Medicines were not discussed.
1--Information was given on administration of the drug.
2--Information was given on any two of the items in level 3.
3--Information was given on administration of the drug, its purpose, its side effects, or what to do if side effects appear.

This larger number of patients receiving information on medicines may have been because the physicians realized their patients were not being supervised as they took their medicines at home, so more careful explanations were given them. However, this study could not prove
this because it did not measure the reasons why medical personnel gave information to patients.

**Diet**

Diet communications were pertinent for thirty-seven of the patients, as shown in Table III. No explanations of a dietary nature were given to 8.3 per cent of the patients. Of the 91.3 per cent who received explanations, 45.4 per cent were given information on level 1, 24.3 per cent were given on level 2, and 21.6 per cent on level 3.

The following guide was used in rating the level of information for diets:

0—Diet was not discussed.

1—Patient was instructed either as to type of diet or items of food related to the patient's health.

2—Patient was instructed as to type of diet or food item that had an effect on his health and details were given related to physiology or chemistry.

3—Patient was sent with a diet referral for consultation with a dietitian.

It was noted that most patients received information on diet, but it was also noted that approximately half of the patients received the information on the first level.

**Home Treatment**

Only nine of the patients were instructed to do certain home treatments. The guide that was followed in rating the levels of information were as follows:

0—Nothing was discussed with the patient on his home treatment.
1—The patient was told a certain treatment should be done at home.

2—Two of the items in level 3 were discussed with the patient.

3—The patient was told a certain treatment should be carried out at home, detailed information was given on how to do this treatment, and its expected results or purpose was explained.

TABLE III
FREQUENCY AND LEVEL OF EXPLANATION GIVEN TO CLINIC PATIENTS ON THERAPY

<table>
<thead>
<tr>
<th>Medicine (43)</th>
<th>Level of Explanation</th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>T</td>
<td>%</td>
<td>T</td>
<td>%</td>
<td>T</td>
</tr>
<tr>
<td>Medicines</td>
<td>1</td>
<td>2.2</td>
<td>12</td>
<td>27.9</td>
<td>22</td>
</tr>
<tr>
<td>Diet (37)</td>
<td>3</td>
<td>8.3</td>
<td>17</td>
<td>45.4</td>
<td>9</td>
</tr>
<tr>
<td>Home Treatments (9)</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>22.2</td>
<td>2</td>
</tr>
</tbody>
</table>

T - Total of patients
( ) - Number of patients in category

The types of treatments ordered and explained to patients which were rated as level 3 were "hand exercises" for rheumatoid arthritic hands, postural drainage for clearing the lungs in bronchiectasis, and an activity program for Parkinsonian rigidity. Included in these explanations were statements about the purpose of the treatment, how it was to be done, and the name of the treatment. This maximum level of explanation was given to 55.5 per cent of the patients in this
category, as presented in Table III. Level 2 explanations were given to two patients, and two patients received a level 1 explanation. It was in this category that patients received the highest percentage of explanations on level 3.

**Diagnosis**

In this sampling of return patients, shown on Table IV, 26 per cent heard nothing about their diagnosis during the clinic visit when they were observed. Sixty-four per cent were told the name of their health problem, which constituted a level 1 explanation. Eight per cent received a 2 level explanation, and 2 per cent a level 3 explanation.

The following guide was used in rating the level of information concerning diagnosis:

0—No specific name was given to the health problem of the patient.

1—The health problem of the patient was named.

2—The health problem of the patient was given a name, and one other explanation was given relating it to either physiology or anatomy.

3—The health problem of the patient was given a name and related to both factors in level 2.

**Prognosis**

In the category of prognosis, 32 per cent of the patients received no information, 42 per cent were informed on level 1, 18 per cent on level 2, and 8 per cent on level 3. The following guide was used in rating the levels of information for prognosis:
0--Prognosis was not discussed.

1--The patient was told he was making progress toward recovery, or he was not doing well.

2--The patient was told the expected course of his disease and some other detail of residual effects, or duration of the disease.

3--The patient was informed on all items in level 2.

TABLE IV

FREQUENCY AND LEVEL OF EXPLANATION GIVEN TO CLINIC PATIENTS ON DIAGNOSIS AND PROGNOSIS

<table>
<thead>
<tr>
<th></th>
<th>Level of Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>T</td>
</tr>
<tr>
<td>Diagnosis (50)</td>
<td>13</td>
</tr>
<tr>
<td>Prognosis (50)</td>
<td>16</td>
</tr>
</tbody>
</table>

T - Total of patients
( ) - Number of patients in category

When considering all eight categories, there seemed to be a lack of information or explanation in the categories of "Nature of Illness," "Test Results," and "Diagnosis" and "Prognosis." It is possible that the low percentage of patients being informed about "Nature of Illness," "Diagnosis," and "Prognosis" might be a result of the medical student finding in his interview with the patient a degree of understanding already present. Medical personnel may have been conscious of the number of previous visits the patient had made and therefore have
consciously given less information feeling the patient was already informed. The data from this study could not measure this factor. Another factor that may have been present is the difficulty experienced by doctors in verbalizing health information on a level understandable to the patient, so they may have elected to give less information.¹ There may also be a feeling by some doctors that patients do not need extensive explanation and that only a very minimum is essential.

II. STATISTICAL ANALYSIS AND INTERPRETATION OF THE LEVELS OF EXPLANATION

The eight aspects of the patients' health problems were divided into four levels: 0, no explanations; 1, a small amount of explanation with increasing amounts on the 2 and 3 levels. Were the frequencies with which explanations were given on level 1, as compared to the combined 2 and 3 levels, significant, or was it due to chance? To find the answer to this question, the chi-square was used to compare information given on level 1 with that given on level 2 and 3 combined. This statistical analysis would have told whether there was significance in the number of cursory explanations as compared to those of greater depth.

Because of the small number of frequencies in the category of "Home Treatments," it was necessary to omit it from the calculations. "New Tests" and "Diet" would show no significance because there was an exact number of frequencies 12 and 12, and 17 and 17 on level 1, as compared to the combined levels of 2 and 3. (See Table V.)

## TABLE V

**CHI SQUARES FOR SIGNIFICANCE ON LEVEL 1 EXPLANATIONS AS COMPARED TO LEVELS 2 TO 3**

<table>
<thead>
<tr>
<th>Categories</th>
<th>( \chi^2 )</th>
<th>Significance at 5 per cent</th>
<th>Frequency of Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td><strong>Level 1</strong></td>
</tr>
<tr>
<td>Nature of Illness</td>
<td>5.72</td>
<td>*</td>
<td>7</td>
</tr>
<tr>
<td>New Tests</td>
<td>--</td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Test Results</td>
<td>0.73</td>
<td></td>
<td>13</td>
</tr>
<tr>
<td>Medicines</td>
<td>8.4</td>
<td>*</td>
<td>12</td>
</tr>
<tr>
<td>Diet</td>
<td>--</td>
<td></td>
<td>17</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>19.7</td>
<td>*</td>
<td>32</td>
</tr>
<tr>
<td>Prognosis</td>
<td>1.88</td>
<td></td>
<td>21</td>
</tr>
</tbody>
</table>
In the area of explanations on the "Nature of Illness," it was found there was a significance at the 5 per cent level that it was probably not due to chance that there were more explanations on the detailed levels than on the cursory level. This same trend was observed in regard to "Medicines" where a significance at the 5 per cent level was found, indicating the larger number of explanations on the detailed levels was probably not due to chance.

In the category of "Diagnosis" there was a significant trend at the 5 per cent level for explanations to be given at the 1 level as compared to levels 2 and 3 combined. It was probably not due to chance that information was verbalized more frequently on level 1.

The frequency with which explanations were given on "New Tests," "Test Results," "Diet," and "Prognosis" was probably due to chance, as no significance was revealed.

There is a probability that in all categories with a larger sample these degrees of significance would change. This is especially true where smaller frequencies were reported, as in the cases of "Nature of Illness," "Test Results," and "Diagnosis."

III. STATISTICAL COMPARISON BETWEEN INITIAL AND LATER VISITS AS IT AFFECTED INFORMATION GIVEN TO RETURN PATIENTS

One factor that had a possibility of affecting depth of information verbalized to patients was the number of visits they had previously made to the clinic. It is conceivable that patients making their first to third visits might have more explanations given them as compared to patients making their fourth to ninth return visits,
or tenth and later visits. The patients were divided into Groups I, II and III according to whether they were making their first to third visit to the clinic, their fourth to ninth visit, or tenth or more visit.

These groupings were arrived at arbitrarily to see if patients making initial visits to the clinic received more information than those making later visits. This grouping gave numbers large enough for comparison by the use of chi-square, which is a statistical tool for comparing more than two groups. In this grouping there were 21 patients in Group I, 16 in Group II, and 13 in Group III. "Home Treatments" had to be omitted from this part of the analysis because it still did not give large enough numbers in each group.

Using the \( \chi^2 \) as a statistical measure of difference, it was found there was a significant difference at the 5 per cent level in the category of "Diagnosis." The difference in the frequency with which this type of information was verbalized to patients was probably not due to chance. There was a significant trend to give more information to Group I who were making initial visits to the clinic than to Group II and Group III who had made repeated visits.

This same trend was noted in explanations on "Nature of Illness," with frequencies of explanation running 12, 9, and 4 for Groups I, II, and III; and in "Medicines" with frequencies running 17, 14, and 11; and in "Prognosis" with the frequencies running 15, 10, and 9 for the same groupings. These data are presented in Table VI. However, as was

\[2\text{Huldah Bancroft, Introduction to Biostatistics, New York: Harper and Brothers, 1959, p. 131.}\]
<table>
<thead>
<tr>
<th>Categories</th>
<th>Group I (1-3 visits)</th>
<th>Group II (4-9 visits)</th>
<th>Group III (10+ visits)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nature of Illness</td>
<td>12</td>
<td>9</td>
<td>4</td>
</tr>
<tr>
<td>New Tests</td>
<td>6</td>
<td>8</td>
<td>10</td>
</tr>
<tr>
<td>Test Results</td>
<td>7</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>Medicines</td>
<td>17</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Diet</td>
<td>11</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>18</td>
<td>13</td>
<td>6</td>
</tr>
<tr>
<td>Prognosis</td>
<td>15</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>
previously noted these trends were not statistically significant.

In the categories of "New Tests," "Test Results," and "Diet," the frequencies that were observed on the different groups of patients were probably due to chance.

There is a probability that in all categories with a larger sample these degrees of significance would change.

IV. ANALYSIS OF THE MEDICAL PERSONNEL'S CONTRIBUTIONS OF INFORMATION TO PATIENTS ABOUT THEIR HEALTH PROBLEMS

A part of the information desired from this study concerned those of the clinic personnel who gave the information. It was also interesting to note the possibility the patients had for learning information from the various personnel. The analysis of this area of the data revealed that the patients had the greatest possibility of verbal contact with the senior medical student and the desk clerk. These contacts reached 100 per cent possibility for senior medical students and 96 per cent possibility for the appointment clerk. The next highest possibility was 74 per cent for the specialist in internal medicine, and the resident with 26 per cent. The nurses had the fewest opportunities for communication with patients. Only 8 per cent of the patients came in possible verbal contact with the nurse. (See Figure 1.)

The fifty patients who had a 100 per cent possibility of hearing explanations about their health problems received 100 per cent responses from senior medical students. The explanations by other personnel were less, with 36 per cent from specialists, 14 per cent from
FIGURE 1

PERCENTAGE OF ACTUAL AND POSSIBLE VERBAL COMMUNICATIONS WITH FIFTY CLINIC PATIENTS BY VARIOUS CLINIC PERSONNEL
residents, 12 per cent from desk clerks, and 4 per cent from nurses.

These findings were consistent with the approximate time spent by senior medical students, specialists, residents, nurses and desk clerks in contact with patients. Senior medical students spent approximately a half hour or more time with each patient in examination and interview, whereas the resident and specialist saw the patient at the end of the clinic visit for a brief consultation. The nurse and desk clerk had an even briefer period of time with the patient as he made his return appointment before he left the clinic.

There was a total of 271 verbal communications given to the fifty patients by all clinic personnel, as presented in Table VII. Of these 74.1 per cent were given by senior medical students, 14.3 per cent by specialists, 8.4 per cent by residents, 2.2 per cent by the appointment clerk, and 0.7 per cent by the nurse. These findings are in line with the percentages previously discussed in this section.

**TABLE VII**

**FREQUENCY AND PERCENTAGE OF VERBAL COMMUNICATIONS WITH FIFTY PATIENTS BY VARIOUS PERSONNEL**

<table>
<thead>
<tr>
<th>Frequency of Communication by</th>
<th>Specialists</th>
<th>Residents</th>
<th>Medical Students</th>
<th>Nurses</th>
<th>Clerk</th>
</tr>
</thead>
<tbody>
<tr>
<td>T %</td>
<td>T %</td>
<td>T %</td>
<td>T %</td>
<td>T %</td>
<td>T %</td>
</tr>
<tr>
<td>39</td>
<td>14.3</td>
<td>23</td>
<td>8.4</td>
<td>201</td>
<td>74.1</td>
</tr>
<tr>
<td>2</td>
<td>0.7</td>
<td>6</td>
<td>2.2</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

T - Total communication

**V. SUMMARY**

An analysis and interpretation of the data gathered from observing fifty return patients in an outpatient department was made (1) to see
what information was verbalized to them on eight aspects of their health problems, and (2) to further evaluate which of four depth levels of explanation—0, 1, 2, or 3—was most frequently communicated to them. A comparison (3) was made by dividing the fifty patients into three groups according to whether they were making their first to third visit, fourth to ninth, or tenth and over visits to see if this affected the information they received. Lastly, (4) the data were analyzed to see who of the clinic personnel coming in contact with the patient was most involved in communicating information to patients.

When the data on the information given to fifty return clinic patients were analyzed, it was found that the eight aspects under consideration did not equally apply to all patients. These differences were taken into consideration when percentages were computed.

The data revealed the highest percentages given to patients in areas of "New Tests," 100 per cent; "Medicines," 97.7 per cent; "Diagnosis," 74 per cent; and "Diet," 91.3 per cent. Lower percentages were observed in communications on "Prognosis," 68 per cent; "Test Results," 66.6 per cent; and only 50 per cent on "Nature of Illness."

An analysis with chi-square for a significant difference in explanations given on a 1 level, as compared to 2 and 3 levels combined, indicated a probable significant trend toward giving a more detailed explanation in the area of "Medicines," and "Nature of Illness." A probably significant trend toward the 1 level was noted in "Diagnosis," and all other categories showed no significance. The frequency of communications in these other categories was probably due to chance.

The fifty patients were divided into groups depending on whether they were making their first to third visit, Group I; fourth to ninth
visit, Group II; or ten or more visits, Group III. These three groups were compared with the use of the chi-square to see if there was a significant difference in the frequency with which information was given to these three groups. The category of "Diagnosis" was the only one showing a probable significant difference. There was a trend towards giving more information when patients were making initial return visits than on later visits. However, since all the frequencies involved relatively small numbers a larger sampling might show different findings.

As to who was most involved of the medical personnel in giving information, the senior medical student came first. These students communicated information to all fifty patients, the specialists to 36 per cent of the patients, the residents to 14 per cent, the desk clerk to 12 per cent, and the nurse to 4 per cent. This was consistent with the approximate time spent in verbal contact with the various clinic personnel.
CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

I. SUMMARY

The general reading public today takes considerable interest in medical knowledge pertaining to their personal health. Medical personnel seem to feel a certain responsibility to inform the patient about his health problem. This stems from the treatment of increasing numbers of patients with chronic diseases who can cooperate better with medical personnel if they are well informed. Both outpatient department and hospital patients, who have expressed themselves, desire to know about their illness, the reasons for tests ordered, and what their treatments and medicines should do for them.

With this background of need and interest, it was the purpose of this study to see what information concerning their health problems was communicated to return patients in the general medicine clinic of a part-pay urban outpatient department, and who of the clinic personnel were involved in verbalizing this information.

The method chosen for the study was the descriptive survey, using the technique of observation with a check sheet. The eight categories on the check sheet, (1) nature of illness, (2) new tests, (3) test results, (4) medicines, (5) diet, (6) home treatment, (7) diagnosis, and (8) prognosis, were decided upon after a review of literature revealed that nurses and physicians felt this type of information would be beneficial when explained to patients. Each category of information was further broken down in four levels of
explanation starting with 0 for no information and increasing in depth and detail with levels 1 through 3.

The data were analyzed (1) for the percentage and frequency of information being verbalized in the eight categories for the fifty patients, (2) for the significant difference between information given on level 1 explanations as compared to the combined levels of 2 and 3, (3) for the significant difference in the amount of information given when comparing the patients divided into three groups according to whether they were making initial or return visits to the clinic, (4) for the percentage of involvement in instruction by the various personnel of the clinic.

When the data on information verbalized to the fifty return patients were analyzed to place it in different levels, it was found that all patients could not be included in all eight categories. There were twenty-four patients who could have benefited from information on new tests ordered, and thirty-three on test results; forty-three from therapy information on medicines, nine on home treatments, and thirty-seven on diet. Information on the nature of illness, diagnosis, and prognosis was pertinent for all fifty patients.

The number of patients for which the information was pertinent in each category was then used as a basis for computing the percentage of information given to patients in each category. The different categories then showed 50 per cent of the patients receiving information on "Nature of Illness," 100 per cent on "New Tests," 66.6 per cent on "Test Results," 97.7 per cent on "Medicines," 91.3 per cent on "Diet," 100 per cent on "Home Treatments," 74 per cent on "Diagnosis," and 68 per cent on "Prognosis."
After the data were analyzed, it was found that for the fifty patients seen, there appeared to be a lack of information or explanation in the categories of "Nature of Illness," "Test Results," and "Diagnosis" and "Prognosis." It is possible that the low percentage of patients hearing information about "Nature of Illness," "Diagnosis," and "Prognosis" might be a result of the medical student finding in his interview with the patient a degree of understanding already present. Medical personnel may have been conscious of the number of previous visits the patient had made and therefore have consciously given less information, feeling the patient was already informed. Another factor that may have been present is the difficulty experienced by doctors in verbalizing health information on a level understandable to the patient, so they may have elected to give less information.

In the area of "Test Results" it would seem that there were gaps in information on interpretation of test results. Thirty-three and a third per cent of these patients had test result reports on their charts, but no explanation was given.

It would seem that patients were generally kept informed concerning the areas "New Tests," "Medicines," "Diet," and "Home Treatments." Patients received 100 per cent information on "New Tests," and "Home Treatments," 97.7 per cent in "Medicines," and 91.3 per cent in "Diet." However, in the areas of "New Tests," "Diet," and "Home Treatments," there was not a significant number of these patients who received information on the depth levels of explanation. It was a matter of chance as to whether a patient received cursory or detailed information. It would seem then that these patients, although receiving some information, could have received it at a greater depth level.
This was not true in the category of "Medicines" where a probable significant number of patients received their information on the depth levels. This may have been due to the physicians' realizing their patients were not being supervised as they took their medicines at home, so more careful explanations were given them.

In the area of "Diagnosis" there was found a significant difference in the number of patients receiving information on the cursory as compared to the depth level. Again, this may have been due to the medical personnel's knowing the patient was making a return visit and therefore assuming that the patient did not need the information. It may also have been due to the small frequencies in this category. A larger sample could possibly change the probable significance noted here. Since complete objectivity of the observer could not be attained, it may have been due to subjective evaluations in gathering and classifying data.

The fifty patients were divided into groups according to the number of visits: Group I--first to third return visits; Group II--fourth to ninth visits; and Group III--tenth and over. There was a trend for Group I to receive more information than Group II, and Group II than Group III in the categories of "Nature of Illness," "Medicines," "Diagnosis" and "Prognosis." However, only in regard to "Diagnosis" was there a probability that this was not due to chance. Patients making return visits were apt to receive increasingly less information in these categories. Again, this may have been due to chance because of the small numbers observed. It may have been due to the medical personnel's conscious knowledge of the number of previous visits
made by the patient; however, there was no way to measure this from
the data.

"New Tests," "Test Results," and "Diet" all showed a greater
frequency of explanations on the later groups than on Group I, where
patients were making their first or second visit. This may have been
due to the specific findings on tests that medical personnel felt
needed emphasis at that time, or the ordering of a new test with which
the patient was unfamiliar or the finding that a patient was not
following a specific diet, thus requiring depth of explanation. There
is no satisfactory explanation from these data as to why this occurred.

The senior medical students were the segment of the clinic
personnel who were most involved in verbalizing information to return
patients. The amount of verbalization of information decreased in
order with the specialists, residents, desk clerk, and nurse.

Since the clinic has as a primary function providing learning
opportunities for medical students, it is expected they would have
more time given them to interview and examine the patient than other
personnel. This gave more opportunity for verbal contact. The consul-
tants, either specialists or residents, seemed to prefer the student's
explaining health data to the patient and only added interpretations as
they felt it necessary. This would preclude fewer explanations by them.

The nurses of the clinic were generally involved in administration
and clerical types of activities which gave them very little contact
with the patient. Perhaps this accounts for their lack of explanations
to patients.

The appointment clerk had next to the highest opportunities for
verbal contact with the patients and next to the lowest incidence of
giving information. This was probably a result of her lack of background from which to impart information and her job requirements not including explanations of this nature.

II. CONCLUSIONS

As a result of this study it was concluded:

1. That the information communicated to patients by medical personnel seemed to cluster about the aspects of therapy where the physician seemed to feel a need to communicate with the patient to enhance his role as a therapist. Other aspects may have received less communication because of the physician's self concept as a diagnostitian who determines diagnosis and prognosis without patient understanding.

2. That patients in this selected clinic were better informed concerning aspects of therapy than aspects related to an understanding of the nature and diagnosis of their health problems; however, further study is needed for clarification as to the amount of information needed and the adequacy of this information for the patient.

3. That in this selected clinic of the outpatient department the job description does not require the nurse to carry the major role of patient educator.

III. RECOMMENDATIONS

After the data in this investigation were analyzed and reviewed, the following recommendations were made for areas of further research:

1. That a longitudinal investigation be done to see if a group of patients followed over a period of time in an outpatient department received information on all areas of their health problems.
2. That a similar investigation be carried out in other speciality clinics to see if the results were the same as those found in this study.

3. That follow-up investigations be made to answer questions raised by the present study.
   a. Why do medical personnel give the information they elect to give?
   b. Why was there a probably significant difference in some areas of health information and not in others?
   c. Would these probable significant differences in trends toward giving information be the same in a larger group of patients, if new patients had been included in the investigation, and if two observers had participated in the study?
   d. Do factors such as language barriers, type of diagnosis, or the educational level of patients influence information given to patients?
   e. What comprehension do clinic patients have of the information communicated to them?
   f. What changes in patient behavior and attitudes are instituted because of the information heard in the outpatient department?
   g. Are patients satisfied with the amount of information they hear in the outpatient department?

The following recommendations were made for implementing the information gathered from this study:

1. That clinic personnel be alerted to the areas where there are seeming gaps of knowledge, so that steps can be taken to better
inform patients concerning these aspects of their health problems.

2. That the outpatient department administrators give study to a reorganization of the clinic to give nurses more opportunity for contact with patients in the utilization of their teaching skills.
BIBLIOGRAPHY
SELECTED BIBLIOGRAPHY

A. BOOKS


B. PUBLICATIONS OF LEARNED SOCIETIES

C. PERIODICALS


Brauer, Paul H. "Should the Patient Be Told the Truth?" *Nursing Outlook*, 8:672-676, December, 1960.


Wandelt, Mabel A. "How Should We Teach the Tuberculosis Patient?" Nursing Outlook, 3:444-447, August, 1955.


Zimmerman, Mortimer W. "Instruction Cards Allay Patients' Fears," Modern Hospitals, 90:59-61, April, 1958.

D. UNPUBLISHED MATERIALS

APPENDICES
APPENDIX A
**WORK SHEET FOR COMMUNICATION OBSERVATIONS**

<table>
<thead>
<tr>
<th>Patient Identification No.</th>
<th>Age</th>
<th>Sex</th>
<th>Diagnosis</th>
<th>Occupation</th>
<th>Extraction</th>
<th>Place of Birth</th>
</tr>
</thead>
</table>

### NATURE OF ILLNESS

<table>
<thead>
<tr>
<th>Causative Agents</th>
<th>P*</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Host Factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Environmental Factors</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### THERAPY

<table>
<thead>
<tr>
<th>Medicines</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Diet</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Treatment</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DIAGNOSTIC TESTS

<table>
<thead>
<tr>
<th>Test ordered</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Purpose</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Mechanism</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Instructions</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition named</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Details of diagnosis</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### DIAGNOSIS

<table>
<thead>
<tr>
<th>Condition named</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### PROGNOSIS

<table>
<thead>
<tr>
<th>Expected course of disease</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Duration of Illness</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Residual effects</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*P - indicates the personnel who gave the information

Letters indicate the personnel giving information:
S-Specialists  R-Resident  M-Senior Medical Student  N-Nurse  C-Clerk
Mr. Raymond L. Pelton, Administrator  
White Memorial Hospital  
1720 Brooklyn Avenue  
Los Angeles 33, California  

Dear Mr. Pelton:

As a method of gathering data for my master's thesis in nursing, I plan to observe contacts between patients and other clinic personnel (nurses, doctors, interns, etc.). The thesis is concerned with aspects of health teaching in the outpatient department. I plan to observe approximately forty patients in the General Medicine Clinic. With your permission, I would plan to do the observations during the next three months.

The studies done at New York Hospital, participated in by Dr. George G. Reader, director of the comprehensive care and teaching program at Cornell Medical Center, stimulated my interest in conducting a similar study at the White Memorial Clinic. The results of this study would be available as a bound thesis at the library. A copy of the summary and conclusions will be sent you if you so desire.

Sincerely yours,

Dorothy Kuester

DK: jk
Diagnoses of the Fifty Patients

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hypertension</td>
<td>12</td>
</tr>
<tr>
<td>Diabetes</td>
<td>7</td>
</tr>
<tr>
<td>Arteriosclerotic Heart Disease</td>
<td>4</td>
</tr>
<tr>
<td>Post-Myocardial Infarct</td>
<td>3</td>
</tr>
<tr>
<td>Duodenal Ulcers</td>
<td>2</td>
</tr>
<tr>
<td>Coronary Insufficiency</td>
<td>2</td>
</tr>
</tbody>
</table>

There was only one patient having each of the following diagnoses: congestive heart failure, sinus bradycardia, aortic and mitral stenosis, bronchiectasis, Laennec's Cirrhosis, Parkinson's Disease, anxiety reaction, esophageal diverticulitis, rheumatoid arthritis, psychiatric syncope, gout, lupus erythematosus, erythema nodsum, angina, chronic ulcerative colitis, chest lesion, diarrhea, pernicious anemia, osteoarthritis, and asthma.
APPENDIX D
ASSESSMENT VALUES FOR LEVELS OF EXPLANATION

Nature of the Illness

0—No item on the nature of the illness was discussed.
1—The causative agent was discussed.
2—The causative agent was discussed and related to a host factor or environmental factor.
3—The cause of the disease was discussed with the patient and related to two of the following: a host factor or an environmental factor (physical, biological or social).

New Tests

0—Patient was told a test was to be taken with name of test not given.
1—The test name was given and the patient was told where to go or how the test will be administered.
2—The test name was given and the patient was told where to go, and given preliminary pre-test instructions, or told the purpose of the test.
3—The test name was given and at least three things are explained to the patient, where to go for the test, preliminary instructions, and the purpose of the test.

Test Results

0—No explanation was given the patient of recorded test results.
1—An explanation was given indicating that the test results were normal or not normal.
2--The test results were explained as being normal or not normal plus an explanation related to one additional factor in level 3.

3--The test results were explained to the patient as being normal or not normal plus relating the results to two of the following factors: physiology, anatomy, or chemistry of the disease problem.

**Medicines**

0--Medicines were not discussed.

1--Information was given on administration of the drug.

2--Information was given on any two of the items in level 3.

3--Information was given on administration of the drug, its purpose, its side effects, or what to do if side effects appear.

**Diet**

0--Diet was not discussed.

1--A type of diet or items of food was discussed with the patient and related to his health.

2--A type of diet or food item that had an effect on his health was discussed with the patient and details were given related to physiology or chemistry.

3--The patient was sent with a diet referral for consultation with a dietitian.

**Home Treatment**

0--Nothing was discussed with the patient on home treatment.
1—The patient was told a certain treatment should be done at home.
2—Two of the items in level 3 were discussed with the patient.
3—The patient was told a certain treatment should be carried out at home, detailed information was given on how to do this treatment, its expected results or its purpose.

**Diagnosis**

0—No specific name was given to the health problem of the patient.
1—The health problem of the patient was named.
2—The health problem of the patient was given a name, and one other explanation was given relating it to either physiology or anatomy.
3—The health problem of the patient was given a name and related to both factors in level 2.

**Prognosis**

0—Prognosis was not discussed.
1—The patient was told he was making progress toward recovery or he was not doing well.
2—The patient was told the expected course of his disease and some other detail of residual effects or duration of the disease.
3—The patient was told the expected course of his disease, and details as to the length of its duration and the residual effects if any.
A SURVEY OF VERBAL COMMUNICATIONS TO CLINIC PATIENTS
RELATED TO THEIR HEALTH PROBLEM
by
Dorothy Kuester

An Abstract of a Thesis
in Partial Fulfillment of the Requirements
for the Degree of Master of Science
in the Field of Nursing

June, 1962
ABSTRACT

The purpose of this study was to see what information concerning eight aspects of their health problems was communicated to return patients in the General Medicine Clinic of a part-pay urban outpatient department, and who of the clinic personnel were involved in verbalizing this information.

The descriptive survey was chosen as the method of study, using the observation technique with a work sheet. The eight categories of the work sheet were decided upon by a review of literature. These were broken down into four levels beginning with no information or slight information and progressing to greater depth and detail.

The data was analyzed (1) for the percentage and frequency of information being verbalized in the eight categories for fifty return patients, (2) for the significant difference between information given on the cursory level as compared to the combined deeper levels, (3) for the significant difference in the amount of information given when comparing patients grouped according to the numbers of visits the patients had previously made to the clinic, (4) for the percentage of involvement by the various personnel of the clinic.

One hundred per cent of the patients to whom the category applied heard information on "New Tests," and "Home Treatments," 97.7 per cent on "Medicines," and 91.3 per cent on "Diet." Fifty per cent of all the patients heard information on "Nature of Illness," 74 per cent on "Diagnosis," 68 per cent on "Prognosis," and 66.6 per cent on "Test Results."
There was a probable significant difference at the 5 per cent level in the amount of information communicated to patients on the different levels in the areas of "Nature of Illness," "Medicines," and Diagnosis." These tended toward the depth level on "Nature of Illness" and "Medicines," and the cursory level on "Diagnosis."

Conclusions based on data analysis indicated a lack of knowledge being communicated on "Nature of Illness," "Test Results," "Diagnosis," and "Prognosis" with 26 per cent or more of the patients receiving no information. Patients were more frequently informed on "New Tests," "Diet," and "Home Treatments." Patients were informed most completely about "Medicines."

It is a matter of chance as to whether return patients making initial visits to the clinic would receive more health information than on later visits except in the category of "Diagnosis." A probable significant number of patients will receive more information on initial visits than on later return visits.

The senior medical students were most involved in communicating health knowledge to all patients. The nurses, who were generally occupied in administrative and clerical duties, communicated the least amount of information.

After reviewing the analysis of data, it was recommended that follow-up investigations be made to discover the reasons for many of the questions raised by trends seen in the data, that the outpatient department be reorganized to give nurses more opportunity for patient teaching contacts, and that clinic personnel be alerted to supply information where omissions in information were observed in the data.