Staff Nurses' Attitudes toward and Perceptions of their Role as a Patient Educator

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Abstract

A Patient Educator contributes to the health and wellness of patients. Nurses are identified among the persons responsible for patient education and many see nurses as having primary responsibility for patient education. Literature and studies have reported that nurses' attitudes toward and perceptions of their educator role affect their actual provision of patient education. A number of factors that affect nurses' patient education behaviors will be identified and discussed in this review of literature.
In recent years, cost containment, health promotion and early discharge have led patients to participate more in their own care at home. These patterns of care place greater emphasis on patient education for nurses because they spend more time with patients than other health care professionals.

**Patient Education Issues**

Patient teaching is not a new role for nurses. In the 1800s, Florence Nightingale noted the importance of teaching families about sanitation, cleanliness, and care of the sick (Bennett, 1975). In that era, sick people were cared for by their families. Nurses began to extend their services to education of families in health care. In 1900, Lillian Wald, who was a visiting nurse, developed a settlement house which was a forerunner of community centers to provide instruction programs for new mothers, children, and invalids. Patient education was provided by public health nurses at home and in the community setting. In the middle of the 20th century, outpatient departments of hospitals began to be identified as sites for health care teaching (Whitman, Graham, Gleit & Boyd, 1992).

The Blue Cross Association (1974) approved a White Paper on Patient Health Education, which served as a landmark for patient education. The White Paper presented guidelines for programs of patient education. Patient education was combined within the routine services of hospitals to provide cost containment and to improve the quality of patient care.

In 1975, the American Hospital Association (AHA) requested that hospital leaders plan, implement and document health education programs. In July of the same year, the AHA distributed "The Hospital Inpatient Education Survey" to 5770 community hospitals. Of these, 4670 (80.90%) of the hospitals returned the questionnaire. Fifty-seven percent of the hospitals reported that they had a formal health education program. Hospitals indicated that they had one or more health education programs, and 329 (12.75%) of them had specific hospital policies on patient education. In addition, nurses were frequently cited for their major position in initiating, planning, directing, and implementing patient education programs (Whitman, et al., 1992).

Nursing organizations have encouraged nurses to be responsible for health and illness teaching for many years. In 1975, the American Nurses' Association published a document entitled "The Professional Nurse and Health Education". It stated that the responsibility of the professional nurse is to teach health behaviors to the patient and family. In addition, the document stated that licensed practical nurses have the responsibility to reinforce what is being taught to patients and their families. Hence, in many health care institutions, patient education is included
In nurses’ job descriptions (Rankin & Duffy, 1983). The recent standards for accreditation of hospitals in the U.S.A. (JCAHO, 1994) have indicated criteria for patient education:

1. The patient and/or his/her family are provided with appropriate education and training to expand their knowledge of patient’s illness and treatment needs and to learn skills and behaviors that promote recovery and improve function.

2. The patient and/or, when appropriate, his/her family receive education specific to the patient’s assessed needs, abilities, and readiness, as appropriate to the patient’s length of stay.

3. Any discharge instructions given to the patient and/or, when appropriate, his/her family are provided by the organization to the individual responsible for the patient’s continuing care.

4. The organization plans and supports the provision and coordination of patient and family education activities and resources (p. 23-24).

Although such criteria or standards for patient education are not yet in place in hospitals in Taiwan, nursing is no less responsible for this aspect of total patient care. Therefore, perhaps there is an even greater need to emphasize these types of activities with development of appropriate standards in nursing education and practice.

Research reports identify patient education as a major nursing intervention in the clinical setting. For example, Stanton (1988) indicated a research finding that nurses perceive patient education as a vital part of their role. This indicates professional socialization. Much earlier, Henderson (1966), a nurse theorist and educator, had stated that improving the patients’ level of understanding and promoting their health are part of the nurses’ role. Now in hospitals and clinics, patient education is a vital nursing intervention to prepare patients for an optimal and uncomplicated course of therapy, surgery, recovery, effective self-care, and needed lifestyle changes. Patient education programs also assist the patients, nurses, and physicians in working to reach common goals (Robinson, 1991).

Patient education has become an important part of nurses’ responsibility and accountability. Nurses function as role models and should be experienced in management of their own health. This can also be an added reward of patient education (Robinson, 1991). If not nurses who are in such an ideal position, who else could provide information, follow-up instruction, and give feedback and reinforcement to patients (Haggard, 1989)?

**Patient Education Outcomes**

Nursing practice combines scientific knowledge, art, human interactions, and
communication skills in an unique way. It is constantly changing to solve problems in many areas (Rorden, 1987). Patient teaching presents changing needs and exciting challenges to nurses. Because patients need assistance with understanding their health situation, making health decisions and changing health behaviors, nurses need to provide patient education that produces quality patient care and is also cost-effective because of reduced readmissions (Ardnt & Underwood, 1990). The purpose of patient/family education is to help people gain abilities with which they can take greater responsibility for their own well-being (Rorden, 1987; Redman, 1993).

Simonds (1979) has explained patient education as the process of influencing patient behaviors, producing changes in knowledge, attitudes and skills, and the requirements to maintain and improve health. Patient education also has been defined by Bartlett (1985) as “planning learning experience using a combination of methods, such as teaching, counseling, and behavior modification techniques that influence patients’ knowledge and health behavior”(p. 323). Others indicate that the patients gain new skills and information and use new knowledge to maintain their own affairs (Rankin & Stallings, 1990). In patient education research, outcomes of patient education interventions are changes in knowledge and skills, attitudes, and behaviors of patients (Kruger, 1990; Oberst, 1989).

Knowledge and Skills

To enhance patients' knowledge, skills and self-care performance, patient education is the primary intervention used by nurses (Oberst, 1989; Hardway, Weatherly & Bonheur, 1993). For instance, Brown (1988) found that patient teaching brought positive outcomes in diabetic adults, because it increased patients’ knowledge and self-care behaviors.

Several studies have shown statistically significant effects of patient education. Barbarowicz, Nelson, DeBusk, and Haskell (1980) found that education programs for myocardial infarction (MI) patients produced a statistically significant (p < 0.001) increase in knowledge scores and satisfaction. McPhail (1982) prepared patients who were going to receive coronary artery graft surgery using a programmed instruction format for teaching. She found that all subjects (n = 6) had increased their knowledge test score at posttest. Lindsay, Jennrich, and Biemolt (1991) in a similar study, demonstrated that through using the programmed instruction booklet, the posttest scores of the experimental group of patients (n = 29) after MI were significantly higher than those of the control group (n = 30) on knowledge level about cardiac rehabilitation concepts. Many studies support the fact that patient education programs are effective in improving the patients' knowledge level and skills.

Attitudes and Behaviors
Attitudes or beliefs about illness and the efficacy of treatment or preventive methods are factors that explain or predict individuals' health behaviors. The Health Belief Model (HBM) was developed by Maiman and Becker (1974) to analyze the individual's motivation to act, and to explain health related behaviors in terms of subjective beliefs. The Health Belief Model focuses on the individual's cognition or perception of the present environment and events (Fleury, 1992). Because attitudes and beliefs of an individual lead to the person's behaviors, literature and studies have investigated patient education as related to changes in life-style, to the individuals' compliance/adherence to their preventative or treatment regimens, and to decreasing patients' stress or anxiety.

**Compliance/Adherence**

Nurses have contributed much to the changes in knowledge and skills of patients through patient education programs. Results and effects of patient education have been reported on compliance or adherence of patients to care regimens. In the past few years, several nursing scholars have reported that an interactive patient education approach is successful in influencing compliance of the patients to follow health care advice (Walton, 1988; Resnick, 1991; Pfister-Minogue, 1993).

Several studies have monitored the effects of patient education on adherence or compliance behaviors of patients. For instance, a study found that the advance of public education programs has improved patient adherence and also cost effectiveness (Caggiula & Watson, 1992). Penckofer and Llewellyn (1989) measured self-reported compliance with diet, smoking cessation and activity level at six weeks and one year after coronary artery bypass graft in sixty subjects. They found the experimental group's activities were more compliant than those of the control group at a statistically significant level ($p < 0.05$). According to Bartlett's study (1988), the outcomes of patient education are enhancement of self-management skills and improved adherence to the therapeutic regimen.

**Stress and anxiety**

Literature reports that patients have experienced certain degrees of stress when they are being prepared for procedures, undergo invasive examinations, or when procedures are extensive (Peterson, 1991; Murphy, 1993; Wilson, 1993; Larrivee, Davis & Maquire, 1992). For instance, Peterson (1991) in her study of patient anxiety before cardiac catheterization reported that giving patients information reduced their anxiety level. Murphy (1993) reported that patient teaching provided a positive outcome from a stressful event for those patients who experienced an endoscopic procedure. Patients can get benefits, such as a decrease in stress and anxiety and increased patient cooperation as a result of teaching about potentially painful procedures, such as uncomfortable diagnostic tests and invasive and distressing treatments.
**Life-style**

From the review of several studies, patient education is not only able to increase patient's knowledge, but also affects life style change. McCollum (1993) indicated that patient education programs provided a profound effect on management and life-style of asthma patients. Patient education as central to help treat and prevent foot disease in diabetic patients was reported by Harley (1993). Wilson (1993) reported patient teaching can eliminate or minimize the complications of ileoanal reservoir.

**Factors Influencing Patient Education**

Patient education is an inherent part of professional nursing practice. It plays an important role for individuals to achieve wellness, recovery from illness and to adapt to chronic disease (Wynne, 1989). It is generally agreed that the role of the nurse is to educate patients, but often, this is not carried out in reality. A variety of factors can enhance or interfere with the effectiveness of patient education, such as the characteristics of patients, situational factors, and characteristics of the educators. Generally, many investigators have put more attention on the characteristics of the patient and situational factors, but ignored the effects of individual variations among nurses who provide the patient education interventions (Oberst, 1989). This section will discuss the characteristics of nurses that interfere with or enhance the effectiveness of patient education.

**Nurses' Values, Attitudes and Beliefs**

Nurses are socialized into the values related to their professional, technical or vocational role. Values, attitudes, and beliefs are interrelated (Mueller, 1986). Rorden (1987) has indicated that if nurses have positive values, attitudes and beliefs toward patient education, then effective teaching is more likely to be provided. Research shows that if nurses perceive themselves as educators in patient teaching, they are more likely to be committed to teach patients and family members (Barrett, Doyle, Driscoll, Flaherty & Dombrowski, 1990).

**Nurses' Knowledge of Clinical Content**

The knowledge and skills of nurses will affect patient education outcomes (Rorden, 1987). Lack of knowledge about the content to be taught will lead to inadequate patient education (Randell, 1993). Studies reveal that lack of experience and knowledge will influence nurses' attitudes and perceptions of what information is given to patients and what type of information nurses believed should have been given (Schuster & Jones, 1982; Honan, Krsnak, Petersen & Torkelson, 1988). Ward and Faulker (1983) have indicated that a lack of knowledge of the effects of smoking will influence nurses' abilities to do effective health education with
these patients.

**Nurses' Knowledge of Teaching-Learning Principles**

A study of coronary care unit nurses (n = 18) knowledge of teaching/learning principles was done by Murdaugh (1980). A pretest was given before a course on teaching/learning principles. Results indicated that nurses did not have adequate knowledge of these principles. But after taking a course, posttest scores indicated that effective knowledge was gained in all of the previously deficient areas.

Although, nurses' high level of knowledge does not guarantee that patients can gain or learn more knowledge, it is often assumed that if the nurses have more knowledge, then more knowledge will be passed on to patients (Close, 1988). This is much more likely to happen if the nurse has appropriate knowledge of the principles of teaching and learning along with the clinical content knowledge and skills.

**Nurses' Teaching Skills**

A lack of teaching skills and a lack of utilizing teaching skills will impact on nurses' abilities to provide effective patient education. Boswell, Prichert, Lorenz, and Schlundt (1990) reported that effective patient education will be provided when nurses have enhanced their patient teaching skills. Gessner (1989) emphasized that "the better the teaching skill of nurses, the more likely patients are to learn" (p. 589). Perceptions of the patient teacher role also are associated to patient education.

**Prioritization of Patient Education in Relation to Nurses' Education, Area of Practice and Workload**

The priority that nurses place on the role of educator in providing patient teaching is an important aspect of practice. For instance, a stratified random sample (n = 1230) of staff nurses, nurses administrators (including head nurses and supervisors) and nurse educators were surveyed for their perceptions of their role as patient educator (Kruger, 1991). The researcher reported that the majority of nurses in the study perceived themselves as having primary responsibility for patient education, and 97% of the nurses believed that nurses' responsibility for patient education would be increased in the future. Nurses who had negative responses (3%, n = 23) referred to lack of time to provide patient education. Stanton's (1988) study showed that all nurses (n = 288) who participated in the study believed that patient education had a high priority in nursing practice, but time limitation and staff shortage were identified as interfering factors. Boyd, Cleary, Coomer, Cooper, Cosner, Cummins, Decell, Keper, Kirby, Sims, Van Den-Dries, and Wingate (1991) indicated that nurses who felt overworked failed to carry out an important aspect of the professional nurse—that of the patient educator.

There are many additional factors that influence nurses' role perceptions in
relation to patient education. Some of these include educational level, number of years in nursing practice and the area of clinical work (Rossow-Sebring, Carrieri & Seward, 1990; Lauer, Murphy & Powers, 1982; Barrett et al., 1990).

**Educational Level**

A study investigated the effect of educational level of 285 registered nurses' on their attitude toward discharge teaching (Caldera, Colangelo, DiBlasi, Garman, Kowalczuk, Murphy, Mason, Olson, Orr & Ouellette, 1980). The research findings pointed out that nurses with the baccalaureate degree tended to have higher responsibility for patient education and better awareness of professional standards. Other research revealed that nurses who have a higher education degree have more positive attitudes to patient education (Rossow-Sebring et al., 1992). Nurses with a baccalaureate degree (n = 37) demonstrated more nursing competence in this area than associate degree (n = 8) and diploma (n = 30) colleagues (Deback & Mentkowski, 1986).

Many nurses recognize that patient teaching is an important part of their role, but because of lack of preparation in providing patient education, patients' information needs are not met by patient teaching programs (Hockey, 1978; Elkind, 1982). Several authors acknowledge that the nurses' education fails in some ways to prepare them as patient educator (Hopps, 1983; Parker, Alkirees & Fackash Rosen, 1983). However, nurses in the 1990s have more awareness of the needs for good patient education than before. But because of lack of knowledge and skills, nurses do not provide adequate patient teaching (Noble, 1991).

**Work Experience**

Jennings and Muhlenkamp (1981) reported a study in which increased experiences of oncology nurses (n = 28) affected their positive perceptions of patient education. But Lauer et al. (1982) compared nurses' (n = 32) and patients' (n = 27) perceptions of the learning needs of cancer patients and found that the length of work experience of nurses did not correlate with their perception of which education items were important for patients.

**Area of Clinical Work**

Loch Palm (1971) found that of the medical-surgical nurses (n = 151) studied, 59% assigned top priority to patient education over other nursing care activities. Barrett et al. (1990) used a nonprobability sampling of 1355 RNs from every division in an institution and studied nurses' perceptions of their health educator role. With a 35% return rate (n = 468), they found that nurses who work in obstetrics and the general medical area perceived themselves as better at patient teaching than did those nurses in the intensive care unit, ambulatory clinic and emergency room.

In summary, variables that influence the nurse's providing education to
patients were identified in several studies and literature. These included values, attitudes and beliefs, knowledge of content and principles of teaching and learning, teaching skills and the workload time factor. The educational level, years of experience and clinical practice area were also related to nurses' ability and practice of patient education. These research reports provided the basis for the design of a study to measure nurses' perceptions of the patient educator role and their degree of perceived competence in patient education behaviors. The reports also serve as a basis for comparison of the findings of the proposed study with the independent variables of educational levels and work experience reported in other studies.
References


