THE RESPONSIBILITY OF PATIENT EDUCATION AS PERCEIVED BY PROFESSIONAL NURSES, PHYSICIANS AND HOSPITAL ADMINISTRATORS

By

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CHAPTER I

INTRODUCTION

The actual practice of patient education is an old concept. Recent factors have developed to bring about an awareness of the need for proper planning, coordination, and evaluation of this form of education. These factors included: the presence of an increased number of chronic diseases along with the available treatment; the need for documentation of treatment outcomes along with problem-oriented medical records and discharge planning; consumers becoming more aware through the informed consent procedure of their health conditions; and evidence of patient education activities not being coordinated by the hospital staff (Lee and Garvey, 1977). In order to meet the standards of patient care evaluation according to the 1975 Joint Commission on Accreditation of Hospitals, there must be evidence which shows the patient to have a knowledge of his/her health status, level of functioning and self-care after discharge (Lee and Garvey, 1977).

Without the existence of clearly defined roles for each staff member, as defined in the various job descriptions, duplication of effort, gaps in patient care, and resentments among the health care staff can result (American Hospital Association, 1979). Equally important is how the various health professionals view their roles in regard to patient education.

Statement of the Problem

Within the Ponca City service area, the perceptions of the various health professionals relative to the responsibility for patient education were noy known.

Need for the Study

The success of patient education lies in the understanding of who is responsible for the planning, implementing, and evaluation of each specific program.

In order to achieve an understanding of the various group's perceptions, an assessment of the major groups responsible, at the present time, for patient education is needed. Since nursing has the patient care responsibility 24 hours a day, rather than a few minutes as compared with the other departments, it has become evident to some that most of the responsibility for patient education should fall on the nursing staff. However, the question remains if patient education should be solely the responsibility of the nursing staff, or can certain areas of teaching be shared or delegated to other personnel? Some physicians are also reluctant to give up this responsibility they have had for so long. Hospital administrators must see to it that patient education is carried out in order to receive accreditation for their hospital. The opinions of all three groups need to be assessed to achieve success in a patient education program.

Purpose of the Study

The purpose of this study was to identify opinions from three groups within the Ponca City service area: nurses, physicians, and

hospital administrators, to assess their perceptions of the responsibility for patient education.

Questions

The following research questions were explored for the Ponca City service area:

1. What areas of patient education does the physician view as being solely the responsibility of the physician?

2. What areas of teaching does the professional nurse view as his/her responsibility?

3. What areas of patient education can be delegated or shared by other personnel?

4. What areas of patient education does the hospital administrator view as specific to the various professional groups?

Limitations

This study was conducted within the following limitations:

1. The nurses and physicians receiving the opinionnaires were from the Ponca City and Blackwell area. The hospital administrators receiving opinionnaires were from hospitals within a 125 mile radius.

2. Since no distinction is made on the local level in relation to academic preparation of the registered nurse as far as job responsibility, no distinction will be made in this study to determine the differences in the perceptions of the nurses according to their level of education.

Assumptions

This study was conducted with the following assumptions:

1. A random sampling included nurses from various job positions and responsibilities.

2. The physicians included in the sampling were those from various specialties as well as general practice.

3. The hospital administrators included those from varying types of control of operations and size of facilitlies.

Definitions

The following definitions are furnished to provide a clearer and more concise meaning of the terms used in this study:

Joint Commission on Accreditation of Hospitals (JCAH) - That agency which a hospital can voluntarily seek to evaluate the quality of patient care within an institution. Accreditation is granted following a careful evaluation of compliance to the guidelines as set forth by the commission.

Hospital Administrator - The individual employed in each hospital setting who is responsible and answers directly to the Board of Trustees of each institution. The top most position of management within the hospital setting.

Patient Education - The teaching skills and the imparting of information to assist a person in returning to or maintenance of an optimum level of wellness. This includes actively involving the patient from the planning stage to the evaluation process.

Physician - Those who are distinguished by the initials M.D.

(medical doctor) following their name regardless of any specialty above that of general practitioner.

Professional Nurse - Those who have completed the academic requirements of the State Board, have successfully passed the State Board Exam, and are allowed to use the initials R. N. (registered nurse) following their names.

Organization of Study

Chapter I introduced the study, presenting the problem, need for study, purpose of study, questions, limitations, assumptions, and definitions of terms. Chapter II includes a review of directly and indirectly related literature concerning patient education terminology, role conflict, values-clarification, coordination and evaluation of effectiveness. Chapter II reports the methodology used in this study including the development of instruments, selection of subjects, collection of data and analysis of data. The findings from this study are presented in Chapter IV. Chapter V includes a summary of the findings, conclusions and recommendations based on the findings.

CHAPTER II

REVIEW OF LITERATURE

The review of literature was conducted to determine what information was available that related, either directly or indirectly, to patient education responsibility. This chapter reviews literature which related to: (1) patient education: terminology, (2) role conflict, (3) values-clarification, (4) coordination, and (5) evaluation of effectiveness.

Patient Education: Terminology

The words patient education are often used interchangeably with the words health education, patient teaching, patient counseling, patient information, and patient communication and occassionally with such terms as self-care, compliance education, self-management, and behavior modification (Squyres, 1980). However, a specific definition is available. Patient education is a "planned combination of learning activities designed to assist people who are having or have had experience with illness or disease in making changes in their behavior conducive to health" (Green, Kreuter, Partridge, and Deeds, 1979, p. 7). These activities are not limited to those taking place in a hospital setting but also educational activities outside clinics, offices, and agencies as well.

Perhaps the greatest distinction needs to be made between patient information and patient education (Redman, 1978). There are programs which simply make available to patients information through the use of pamphlets, video tapes, or instruction sheets. Education on the other hand is a process which actively involves the patient from the planning stage through the evaluation phase as he/she learns to cope with the prevailing health problem. Based on the use of this process, the behavioral change becomes measureable.

Role Conflict

Physicians and nurses were once considered to be the primary health care providers. With the increase of medical knowledge and technology, other health professionals have become trained to carry out these new procedures, such as dietitians, respiratory therapists, and clinical pharmacists. Each of these professionals consider patient education to be an important part of their respective roles (Bernheimer, 1980).

Bernheimer (1980) cited instances in which territorial boundaries had to be overcome when she was employed as a coordinator of patient education in a large metropolitan hospital. She was consistently met with such remarks as "You are on our turf." Most frequently the conflict came from the nursing department and occurred as a result of having entered into a domain of practice which was traditionally considered for nursing only.

An exercise on role conflict was designed and administered to 42 nurses, 18 health educators, six physicians and nine other professionals at a Symposium on Patient Education (Bernheimer, 1980). The eight question exercise had the same multiple choice responses to each of the questions.

The choices were: clinical pharmacist, dietitian, health educator, nurse, patient, physician, physical therapist, social worker, or others. Two responses were called for using the above choices according to: (a) status quo (the way it is now) and (b) the way you think it should be. In answer to the question, "Determining the amount of information a patient needs to know about his/her medical status is best done by . . ." the majority stated "the patient," while they all agreed that the physicians are currently making these decisions. Four questions related to the responsibility for assisting with compliance to regimen, and assessing readiness to learn, counseling and a prescribed regimen and specifically on a drug regimen. Again the nurse and physician were named as the ones who are doing the teaching currently. However, health educators, patients, and pharmacists (on the latter question) were named as those who should have these responsibilities (Bernheimer, 1980). So the conclusion drawn was, not only were the other professionals entering the territory, but also the patients are seen as taking an active part in their own health education.

Values-Clarification

How an individual's values affect his/her behavior is illustrated in a film shown entitled "What You Are, Is Where You Were, When" (Massey, 1976). In short, it described the various historical happenings of each decade since the early 1900's. Comparisons of these happenings are then related to the values that an individual is developing at that particular stage of life. Likewise, physicians and nurses who are trained or practicing in their respective fields at the time when they had the total responsibility for patient care find it

difficult to give up a part of that role.

At the same Symposium on Patient Education, Bernheimer (1978) also distributed to the same group of participants an exercise on values-clarification. This time the participants were asked to respond by agree, disagree, or undecided. A sample of the nine questions asked were:

1. Like other aspects of patient's treatment, I believe patient education should be based on a physician's order.
2. I feel that, if a patient does not comply with his/her regimen, I have somehow failed.
3. Patients are more likely to accept medical advice when it comes from their doctors.
4. To be an effective patient educator, it is more important to be an educator than a clinician (Squyres, 1980, pp. 187-188).

To question number one the physicians were evenly divided in their responses between agree and disagree, while other health professionals disagreed. Most professionals did not feel responsibile for the patient not complying with his/her own regimen. Nurses were more in disagreement with question number four, while physicians were evenly divided in their responses. As a whole the responses illustrated differences in values both within and among the groups of health professionals (Bernheimer, 1980).

Coordination

A search of literature revealed numerous articles which emphasize the need for the establishment of a Patient Education Committee. This committee usually consisted of a physician, a chairman, and members from the medical staff, surgical staff, nursing service, and library service. Ad hoc members included personnel from the other health services. The main responsibility of the committee was to evaluate patient

education materials and programs. Other responsibility included: determining and recommending policies by which patient education will be achieved, determining patient education priorities, approving patient education programs for specific patient education activities.

Another commonality found in the review of literature was the need to appoint a patient education coordinator. The American Hospital Association has gone into great depth to produce a manual entitled "Implementing Patient Education in the Hospital." In this manual the coordinator's role is defined; committees are explained; assessment and plan of action are discussed; policies, procedures, and job descriptions outlined; as well as financing information. The final chapter lays out the means of designing a patient education program for a specific population (American Hospital Association, 1979).

Evaluation of Effectiveness

It is said by those who evaluate hospitals for accreditation, "If it isn't documented, it hasn't been done." They cite this as being a weak point within the patient education process. The documentation of patient teaching activities gives evidence as to the effectiveness of the program it shows the extent of patient compliance.

One study by Adom and Wright (1982) which demonstrated program effectiveness as viewed by nurses and patients was a result of a hospital-sponsored inservice education workshop on patient teaching. Through the use of two 21-item satisfaction questionnaires--one for the patient and one for the nurse--and a teaching record to document what was taught and whether or not it was learned, a pre-operative opthalmology program was evaluated. The study revealed interesting

discrepancies between the responses obtained from the nurses and from the patients. While over one-half of the nurses prefer individual teaching, only one-third of the patients preferred this type of teaching. When using group teaching the nurses strongly believed the patients profited from the peer interaction while two-thirds of the patients failed to voice the same feeling. One hundred precent of the nurses felt all the teaching prepared the patients for surgery while only 68 percent of the patients felt so (Adom and Wright, 1982).

Areas of the study which did show a high degree of agreement included: feeling comfortable about asking questions, being best prepared for surgery by group teaching, opportunity given for asking questions in group teaching, less anxious due to sharing of feelings and support, and combined teaching (use of both individual and group) best prepared the patient for self-care following hospitalization (Adom and Wright, 1982).

The final phase of this study was evaluation of the patient teaching record. It was found that only 95 percent of the teaching content data were recorded and only 75 percent recorded information regarding the patient's achievement or non-achievement of objectives. It was also noted that the assessment section was seldom used with ten percent recording this data elsewhere on the form. One recommendation as a result of this study was the suggestion that all prospective and newly employed nurses be made aware of group teaching being a position requirement. This would necessitate orientation and supportive supervision during the time of new employment (Adom and Wright, 1982).

Summary

Past research has revealed the problems encountered and the professional resistances involved. Recommendations included:

1. Each institution should select a committee to consolidate all patient education efforts.

2. Whenever possible, an Educational Coordinator should be employed to coordinate, support, and instruct staff personnel on the total process of patient education.

3. Assessment of professional attitude toward patient education responsibilities.

4. Orientation programs should include expectations of patient teaching, with instruction on appropriate documentation of the patient teaching record.

CHAPTER III

METHODOLOGY

The purpose of this study was to identify opinions from three groups within the Ponca City service area: nurses, physicians, and hospital administrators to assess their perceptions of the responsibility for patient education. The methodology included selection of subjects, development of the instruments, collection of data, and analysis of data.

Selection of Subjects

A random sampling of 27 nurses from the two local hospitals, nurse instructors, health departments, and physician offices was selected. Twenty-four local physicians were also selected at random from both general practice and specialty areas. A list of all Oklahoma hospitals affiliated with the American Hospital Association was obtained and ten hospital administrators from hospitals within a 125 mile radius of Ponca City were selected with an effort made to include hospitals of various sizes and classification (American Hospital Association, 1982).

Development of the Instruments

The instruments used for the collection of data were designed by the researcher after reviewing three of the opinionnaires. These

three opinionnaires had been used previously for data gathering in other localities. Two of these are referred to in Chapter II (Bernheimer, 1980). The third was administered to a group of local physicians in Florida (Sutherland, 1980). The opinionnaire for nurses and physicians contained the same 17 items with "yes" or "no" responses. A space was provided following each response to allow for additional comments in regard to their response or lack of response. This opinionnaire was field-tested by three local nurses and two physicians to solicit comments and suggestions in regard to the clarity and conciseness of the instrument. The opinionnaire was revised to allow for the appropriate suggestions according to their relevance to the research questions to be explored in this study. A copy of the final opinionnaire is included as Appendix A in this study.

Ten items were then selected from the nurse/physician opinionnaire to be included in the second instrument for hospital administrators. These items also related to the research question to be explored in this study. A local hospital administrator was interviewed to determine the relevance of this study and appropriate revisions made. A copy of this opinionnaire is included as Appendix B in this study.

Collection of Data

During the first week of February 1983, the researcher contacted 16 nurses by telephone to solicit their participation in this study. The other 11 nurses were contacted personally. All 27 nurse's opinionnaires were delivered in person by the researcher. The 24 physician opinionnaires were likewise delivered to their offices and personal contact was made with the physician or his receptionist. The ten hospital

administrators' opinionnaires were mailed directly to their hospital address. Each of the 61 opinionnaires were accompanied by a cover letter (see Appendix C) and a stamped, self-addressed envelope. The researcher's name and address also appeared at the end of each opinionnaire.

A tabulation was maintained and at the end of one week, 80 percent of the hospital administrators had returned their opinionnaires and 75 percent of the the nurses' and physicians' opinionnaires had been received. At the end of two weeks, 80 percent of the opinionnaires had been returned. No further contact was made. During this two week period in February, the responses were recorded on a master tabulation sheet to determine the frequency of each "yes" and "no" response as each opinionnaire was received. Additional comments were copied to determine similarities and pertinent remarks.

Analysis of Data

To analyze the data collected, the researcher tabulated the frequency of each "yes" and "no" response from each of the three groups. The percentages of each "yes" and "no" responses were then calculated from each of the groups. Tables were then constructed to show the comparison of the percentages obtained from the three groups' responses to each question on the opinionnaire.

Summary

The opinionnaire was constructed in an effort to assess the professional attitudes of those individuals involved daily in patient education activities. The goal of this assessment was to determine how

the responsibility of patient education can be carried out in the most effective and efficient manner. The results of the assessment follow in Chapter IV.

CHAPTER IV

PRESENTATION OF FINDINGS

This chapter presents the findings of the study by first giving a brief explanation of the populations assessed and the percentage of returns. The questions from the opinionnaires are then organized into sections according to how they relate to the research questions to be answered by this study. The following sections are discussed:

1. Response rate and demographic characteristics.
2. Perceptions of the priority/need for patient education.
3. Perceptions of physician responsibility.
4. Perceptions of nurse responsibility.
5. Perceptions of areas of delegated or shared responsibility.
6. Perceptions of areas specific to other professional groups.
7. Summary.

Response Rate and Demographic Characteristics

The number of professional nurses to return the opinionnaires included 13 nurses working at Saint Joseph Medical Center in Ponca City, Oklahoma, three nurses from Blackwell Memorial Hospital in Blackwell, Oklahoma, four nurses working in physician offices, one director of nursing in a nursing home, one from obstetrical/gynecological private practice, one in-home health services, one nursing instructor and one school nurse. One person did not fill out the demographic information.

A breakdown by response rate is presented in Table I.

The nurses employed in hospitals worked in medical units, renal dialysis units, infection control, childbirth instruction, nursing education and nursing administration. The years of nursing experience ranged from two years to 37 years with an average of 13.2 years. Of the 27 opinionnaires sent, 26 were returned for a percentage return of 96.2.

Of the 24 opinionnaires sent to physicians, 20 were returned for a percentage return of 83.3. The physician's years of experience ranged from five years to 44 years with an average of 19.3 years. There were six in general practice, three in family practice, two in internal medicine, three in obstetrical/gynecological practice, one surgeon, one orthopedist, one opthamologist, one urologist and one pediatrician. One person refrained from giving any demographic information.

Of the 10 hospital administrators who received opinionnaires, eight responded for an 80 percent return rate. Only four responded to the demographic information which showed the years in hospital-related experience to range from two to 30 years for an average of 20.3 years. The years as hospital administrator ranged from two to 19 for an average of 8.8 years experience. The size of the hospitals assessed ranged from a bed capacity of 19 to 314. All were within a 125 mile radius of Ponca City. The means of control included those which were non-governmental (not for profit), non-federal (state and local) and investor-owned hospitals.

TABLE I

RESPONSE RATE AND DEMOGRAPHIC CHARACTERISTICS

	Nurses	Physicians	Hospital Administrators
Number to receive opinionnaires	27	24	10
Number of returned opinionnaires	26	20	8
Return percentage rate	96.2	79	80.0
Average years of professional experience	13.2	19.3	24.1
Number of speciality areas represented	15	8	NA

Perceptions of Priority/Need for Patient Education

Question one on both opinionnaires (see Appendixes A and B) asked, "Should patient education be a part of the patient's total treatment plan?" In two groups, the nurses and hospital administrators, 100 percent responded "yes." All physicians responded "yes" with the exception of one physician who responded with the comment, "depends on the diagnosis." Another physician answered "yes" but also added the same comment. One physician commented that most education should be "simple and written." Two nurses commented that the patients expect and deserve this education. These data are presented in Table II.

The responses to question 17 on the Physician/Nurses Opinionnaire are presented in Table III. Question 17 asked, "In view of the present health manpower shortage, on a scale of one to 10 (with one being low and 10 being high) what priority of patient care is patient education?" Values ranged from means of 3.5 to 10 from the nurses and three to 10 from the physicians. Only one physician did not respond. These responses were further calculated with the nurses' responses showing a mode of eight and a median of seven and a mean of 6.64. The administrators were not asked this question, therefore no responses are given.

Question 10 of the Hospital Administrators' Opinionnaire asked, "Is there a need for hospitals to provide facilities and instructors for group instruction for out-patients and/or families?" The results are reported in Table IV. Seven (87.5 percent) responded "yes" and one (12.5 percent) refrained from answering specifically but rather commented "could be." One commented "if the need is there and unmet, then hospitals should do that they can to meet the need." Another qualified the "yes" response

TABLE II

RESPONSES TO QUESTION CONCERNING PATIENT EDUCATION AS PART OF THE TOTAL TREATMENT PLAN BY STUDY GROUP

Response	Nurses N=26		Physicians N=20		Hospital Admin. N=8	
	N	%	N	%	N	%
YES	26	100	19	94.7	8	100
NO	0	0	0	0	0	0
NO RESPONSE			1	5.3		

TABLE III

MEASURES OF CENTRAL TENDENCY OF PERCEIVED PRIORITY OF PATIENT EDUCATION BY NURSES AND PHYSICIANS

	Nurses N=26	Physicians N=19
Mean	8	5
Mode	8	7
Median	7.25	6.64

TABLE IV

RESPONSES TO QUESTION CONCERNING NEED TO PROVIDE PATIENT EDUCATION SERVICES BY HOSPITAL ADMINISTRATORS

Response	Hospital Administrators N=8	
	N	%
YES	7	87.5
NO	0	0
NO RESPONSE	1	12.5

by commenting "if staffing is available to carry it out."

Question 15 on the Physician/Nurse Opinionnaire related to the previous question by asking "Is there a need for more patient/family education activities on an out-patient/community basis?" All 23 (100 percent) nurses responded "yes." Fifteen (75.0 percent) physicians responded "yes." Three (15.3 percent) said "no" and two (10 percent) did not respond. These results are presented in Table V. The comments all related to the need for follow-up education following hospitalization when the stress of confinement is less.

Perceptions of Physician Responsibility

Question 16 on the Physician/Nurse Opinionnaire was asked in response to question 15 regarding out-patient/community education. If individuals responded "yes" to the need for more education on this basis, they were asked "If, so, is this type of patient/community activity the physician's responsibility?" Seven nurses responded "yes," 17 responded "no," and two refrained from answering. Results are reported in Table VI. All comments related to this being a shared responsibility with other health professionals. Twelve physicians viewed this area as being their responsibility, five responded "no" and three did not answer. Again, the comments related to a combined effort. One physician who responded "yes" commented, but it is difficult to get physicians to accept this responsibility because they don't get paid for it."

Question 11 on the Physician/Nurse Opinionnaire and question four on the Hospital Administrators Opinionnaire asked "Are there specific areas of patient teaching you view as solely the responsibility of the physician?" The responses as illustrated in Table VII were divided

TABLE V

RESPONSES TO QUESTION CONCERNING NEED FOR MORE EDUCATION ON OUTPATIENT/COMMUNITY BASIS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	26	100	15	75
NO	0	0	3	15
NO RESPONSE	0	0	2	10

TABLE VI

RESPONSES TO QUESTION CONCERNING RESPONSIBILITY FOR OUTPATIENT/COMMUNITY EDUCATION BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	7	26.9	12	60
NO	17	65.3	5	25
NO RESPONSE	2	7.7	3	15

TABLE VII

RESPONSES TO QUESTION CONCERNING PHYSICIAN RESPONSIBILITY BY GROUPS

Response	Nurses N=26		Physicians N=20		Hospital Administrators N=8	
	N	%	N	%	N	%
YES	8	30.7	14	70	4	50.0
NO	18	69.2	6	30	4	50.0
NO RESPONSE	0	0	0	0	0	0

with eight (30.7 percent) nurses responding "yes" and 18 (69.2 percent) responding "no." Fourteen (70 percent) physicians responded "yes" and six (30 percent) responded "no." The hospital administrators were divided with four (50 percent) "yes" and four (50 percent) "no" responses. All participants responded to the question. Individual comments also expressed concern that the physician should be responsible in the areas of education regarding surgical procedures and risks, critical or acute cases, and those with difficult diagnoses. Other comments supported education as a team effort.

Those responding "yes" to the previous question were asked in question 12 on the Physician/Nurse Opinionnaire and question five on the Hospital Administrators Opinionnaire to indicate "which of the following areas are specifically physician responsibilities: planning, assessment, implementation, documentation, evaluation and other?" The information related to these areas is presented in Table VIII. Nine physicians checked the area of evaluation as being their sole responsibility. This was followed by seven naming assessment, four naming planning, three each naming implementation and documentation, and two naming "other." The comments in regard to marking "other" were related to the physician being responsible for prognosis, follow-up, chemotherapy and radiation therapy in cancer patients. Five nurses marked evaluation as a physician responsibility, two each marked planning, assessment and documentation while one marked implementation and other. Again those comments in regard to "other" related to prognosis and follow-up activities. Three hospital administrators viewed assessment as a physician responsibility, two marked evaluation and planning, and one marked implementation and documentation.

TABLE VIII

RESPONSES TO QUESTION CONCERNING SPECIFIC AREAS OF PHYSICIAN RESPONSIBILITY BY GROUP

Response	Nurses N=10		Physicians N=12		Hospital Admin. N=5	
	N	%	N	%	N	%
Planning	2	20	4	33.3	2	66.7
Assessment	2	20	7	58.3	3	100.0
Implementation	1	10	3	25.0	1	33.3
Documentation	2	20	3	25.0	1	33.3
Evaluation	5	50	9	75.0	2	66.7
Other	1	10	2	16.6	0	0

Question two on the Physician/Nurse Opinionnaire asked, "Should patient education require a written order by the attending physician?" Two (7.7 percent) nurses viewed this order necessary while 24 (93.3 percent responded "no." However, 12 (60 percent) physicians felt that a written order was necessary. Six (30 percent) responded "no" and two (10 percent) refrained from answering. Responses to this question are found in Table IX. One person commented: "Should be at discretion of individual physician." Other comments acknowledged that there are "exceptions," "depends on the type of education," and "if it is required then education will be done."

Responses to question three are presented in Table X. Question three on the Physician/Nurse Opinionnaire asked, "Should patient education be included as a standing order unless ordered otherwise?" To this question 21 (80.7 percent) nurses responded "yes," three (11.5 percent) responded "no" and two (7.7 percent) did not answer. Comments ranged from not feeling any order was necessary, to feeling if patient education was a standing order it would be carried out more often. The physicians were almost evenly divided with 10 (50 percent) responding "yes" and nine (45 percent) responding "no." One (5 percent) physician did not answer, but commented "M.D. or employee should do it."

Perception of Nurse Responsibility

Question 13 on the Physician/Nurse Opinionnaire and question six on the Hospital Administrators Opinionnaire asked, "Are there specific areas of patient teaching you view as being solely the responsibility of the nurse?" Numbers are presented in Table XI. Ten (38.5 percent) nurses responded "yes" and 16 (61.5 percent) responded "no." Again,

TABLE IX

RESPONSES TO QUESTION CONCERNING REQUIREMENT FOR WRITTEN ORDER BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	2	7.7	12	60
NO	24	92.3	6	30
NO RESPONSE	0	0	2	10

TABLE X

RESPONSES TO QUESTION CONCERNING REQUIREMENT FOR STANDING ORDER REQUIREMENT BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	21	80.7	10	50
NO	3	11.5	9	45
NO RESPONSE	2	7.7	1	5

TABLE XI

RESPONSES TO QUESTION CONCERNING PERCEPTIONS OF SPECIFIC NURSE RESPONSIBILITY BY GROUP

Response	Nurses N=26		Physicians N=20		Hospital Administrators N=8	
	N	%	N	%	N	%
YES	10	38.5	12	60	5	62.5
NO	16	61.5	8	40.	3	37.5
NO RESPONSE	0	0	0	0	0	0

the comments related to "team involvement." Twelve (60 percent) physicians responded "yes" and eight (40 percent) responded "no." The hospital administrators responded with five (62.5 percent) marking "yes" and three (37.5 percent) marking "no."

Question 14 and question seven followed the previous question by asking, "if so, indicate which of the following areas are specifically nursing responsibilities: planning, assessment, implementation, documentation, evaluation, other." As illustrated in Table XII, ten nurses viewed planning and assessment as specific areas, eight viewed implementation, seven documentation and six evaluation. Twelve physicians marked documentation, eight marked planning and implementation, four marked assessment and evaluation. One physician named additional areas of "colostomy care; diabetic diet; paraphenalia; medication, if complicated; difficult children; and disease." Four hospital administrators viewed implementation and documentation as specific nursing responsibilities, three marked planning and evaluation, while two marked assessment.

Perceptions of Areas of Delegated or Shared Responsibility

Question two on the Hospital Administrators Opinionnaire and question four on the Physician/Nurse Opinionnaire asked "Should a hospital have a patient education committee to develop and maintain policies, priorities, and activities of patient education?" Responses presented in Table XIII show that 23 (88.5 percent) nurses responded "yes," two (7.6 percent) responded "no" and one (3.9 percent) refrained from answering. Those responding "no" commented that patient teaching is a

TABLE XII

RESPONSES TO QUESTION CONCERNING SPECIFIC AREAS OF NURSE RESPONSIBILITY BY GROUP

Area	Nurses N=10		Physicians N=12		Hospital Administrators N=5	
	N	%	N	%	N	%
Planning	10	100	8	66.6	3	60
Assessment	10	100	4	33.3	2	40
Implementation	8	80	8	66.6	4	80
Documentation	7	70	12	100	4	80
Evaluation	6	60	4	33.3	3	60
Other			1	8.3	0	0

TABLE XIII

RESPONSES TO QUESTION CONCERNING PATIENT EDUCATION COMMITTEE BY GROUP

Response	Nurses N=26		Physicians N=20		Hospital Administrators N=8	
	N	%	N	%	N	%
YES	2	88.5	13	65	4	50
NO	2	7.6	7	35	2	25
NO RESPONSE	1	3.9	0	0	2	25

part of all nursing care and regulated by nursing, and committees tend to "talk and not do." Thirteen (65 percent) physicians responded "yes" and seven (35 percent) responded "no." Only one physician commented, "this could be referred to the executive committee." Four (50 percent) hospital administrators responded "yes," two (25 percent) responded "no" and two (25 percent) did not respond. Those administrators opposed or not responding commented that, "it depends on the size of the hospital," and one did not favor adding another committee if the objectives could be accomplished without one.

Responses to question five are presented in Table XIV. Question five on the Physician/Nurse Opinionnaire and question three on the Hospital Administrators Opinionnaire asked, "should there be one person within the hospital setting to coordinate patient education activities?" Twenty-two (84.6 percent) nurses responded "yes" with only three (11.5 percent) responding "no." One person (3.9 percent) did not check a response but rather commented, "what about vacations, etc., sometimes bad if everything revolves around one person." Nineteen (95 percent) physicians favored having a coordinator while one (5 percent) did not. His comment was, "this separates the patient from the M.D." Five (62.5 percent) hospital administrators responded "yes," two (25 percent) responded "no," and one (12.5 percent) did not respond. Again concern was related to the size of the hospital. One further comment mentioned the "tendency to let the coordinator do the teaching rather than the nurse instructing as appropriate."

Question six on the Physician/Nurse Opinionnaire asked, "are formal patient care conferences between the physician and nurses important for planning individual patient teaching needs?" Responses to this question are presented in Table XV. Twenty (76.9 percent) nurses

TABLE XIV

RESPONSES TO QUESTION CONCERNING PATIENT EDUCATION COORDINATOR BY GROUP

Response	Nurses N=26		Physicians N=20		Hospital Administrators N=8	
	N	%	N	%	%	%
YES	22	84.6	19	95	5	62.5
NO	3	11.5	1	5	2	25.0
NO RESPONSE	1	3.9	0	0	1	12.5

TABLE XV

RESPONSES TO QUESTION CONCERNING PATIENT CARE CONFERENCES BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	20	76.9	10	50
NO	5	19.2	9	45
NO RESPONSE	1	3.9	1	5

viewed these conferences important, five (19.2 percent) did not, and one (3.9 percent) refrained from answering. The physicians were more evenly divided in their responses with ten (50 percent) responding "yes," nine (45 percent) "no," and one (5 percent) not responding. Both groups commented about formal patient care conferences not being realistic, but rather informal planning should take place on an individual basis.

Question seven on the Physician/Nurse Opinionnaire asked "Do you prefer patient teachng on a one-to-one basis?" The data are presented in Table XVI. Twenty-four (92.2 percent) nurses responded that they prefer this type of teaching, one (3.9 percent) did not, and one (3.9 percent) did not respond. The comments were regarding the feeling that patients learn more and feel more concern is shown in a private setting, therefore more can be accomplished and the person teaching has a better understanding of the learning that has taken place. Sixteen (80 percent) physicians preferred this type teaching, two (10 percent) did not and two (10 percent) did not respond. Three physicians qualified their responses by commenting "sometimes," "depends on the situation," and "occassionally."

Question eight on the Physician/Nurse Opinionnaire asked "Do you prefer group teaching for patient education?" Responses are shown in Table XVII. Six (23.1 percent) nurses responded "yes," 18 (69.2 percent) responded "no" and two (7.7 percent) did not respond. The comments from those responding "no" were concerned that patients feel like they are just one of a number and are afraid they will ask a "dumb" question. Those responding "yes" felt this type teaching to apply to the giving of more general information, such as following childbirth and diabetes instruction. Five (25 percent) physicians responded that they

TABLE XVI

RESPONSES TO QUESTION CONCERNING ONE-TO-ONE TEACHING BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	24	92.2	16	80
NO	1	3.9	2	10
NO RESPONSE	1	3.9	2	10

TABLE XVII

RESPONSES TO QUESTION CONCERNING GROUP TEACHING BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	6	23.1	5	25
NO	18	69.2	12	60
NO RESPONSE	2	7.7	3	15

preferred this type of teaching, 12 (60 percent) responding that they did not, and three (15 percent) did not respond. Again comments were much the same as for the previous question--it depends on the situation.

The data from question nine are presented in Table XVIII. Question nine on the Physician/Nurse Opinionnaire asked, "is a combination of one-to-one and group teaching needed in most health problems?" Twenty-one (80.7 percent) nurses responded "yes," three (11.5 percent) responded "no," and two (7.7 percent) did not respond. The nurses commenting felt that more patients could be reached by having the group teaching as a follow-up to the one-to-one instruction. Eleven (55 percent) physicians preferred the combination plan, while seven (35 percent) did not, and two (10 percent) did not respond.

Question 10 on the Physician/Nurse Opinionnaire asked, "are pamphlets, brochures, instructional sheets, films, and other informational tools appropriate in some instances of informal teaching?" Responses to question 10 are illustrated in Table XIX. All of the 26 (100 percent) and 20 (100 percent) physicians responded "yes" in favor of using these informational tools. Two nurses commented by saying, "visual aids are always helpful, especially if the patient keeps them as a resource for future reference" and "you need guidelines and tools to help."

Perceptions of Areas Specific to Other Professional Groups

Question nine on the Hospital Administrators Opinionnaire asked, "are there specific areas of patient teaching you view as being the responsibility of professionals other than the physician and the nurse?"

TABLE XVIII

RESPONSES TO QUESTION CONCERNING COMBINATION TEACHING BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	21	80.7	11	55
NO	3	11.5	7	35
NO RESPONSE	2	7.7	2	10

TABLE XIX

RESPONSES TO QUESTION CONCERNING USE OF INFORMATIONAL TOOLS BY NURSES AND PHYSICIANS

Response	Nurses N=26		Physicians N=20	
	N	%	N	%
YES	26	100	20	100
NO	0	0	0	0
NO RESPONSE	0	0	0	0

Responses to this question are presented in Table XX. All eight (100 percent) responded "yes." Question 10 followed by asking "If so, which of the following professionals do you feel could share in the patient teaching process: pharmacist, dietitian, health educator, physical therapist, social worker, and other?"

Seven hospital administrators marked pharmacist, eight marked dietitian and physical therapist, and six marked social worker and health education. Two of the hospital administrators added additonal professionals such as respiratory therapists, occupational therapists, x-ray technicians, and pastoral care workers. This information is presented in Table XXI.

Summary

The 17 item opinionnaire received from 26 professional nurses, who came from various educational and occupational backgrounds, and 20 physicians who had various specialties and years of experience, has been compiled to determine the perceptions of these professionals regarding patient education responsibility. Likewise, the 10 item opinionnaire received from eight hospital administartors has been compiled to determine their perceptions of the physician/nurse responsibility in patient education as well as the responsibility of other professional groups.

TABLE XX

RESPONSES TO QUESTION CONCERNING RESPONSIBILITY OF OTHER PROFESSIONALS BY HOSPITAL ADMINISTRATORS

Response	Hospital Administrators N=8	
	N	%
YES	8	100
NO	0	0
NO RESPONSE	0	0

TABLE XXI

RESPONSES TO QUESTION CONCERNING SHARED RESPONSIBILITIES OF SPECIFIC PROFESSIONAL GROUPS BY HOSPITAL ADMINISTRATORS

Group	Hospital Administrators N=8	
	N	%
Pharmacist	7*	87.5
Dietitian	8	100
Health Educator	6	75
Physical Therapist	8	100
Social Worker	6	75
Other	2	25

*Numbers reflect more than one response per person.

CHAPTER V

SUMMARY, CONCLUSIONS, AND RECOMMENDATIONS

This chapter summarizes and discusses the results of the study. A summary of the study and findings presented in Chapter IV is first discussed, followed by the researcher's conclusions based on these findings. The final part of this chapter discusses the recommendations for practice and further studies.

Summary of the Study

The problems encountered in the practice of patient education center around the preceptions of health professionals regarding whose responsibility it is to plan, assess, implement, document, and evaluate the teaching process. The purpose of this study was to identify opinions from three groups within the Ponca City service area: nurses, physicians, and hospital administrators to assess their perceptions of the responsibility for patient education.

The population for the study was area nurses and physicians as well as hospital administrators within a 125 mile radius of Ponca City. Opinionnaires were sent out to 61 persons. Fifty-four individuals returned their opinionnaires for an overall return rate of 85.5 percent.

The items on the opinionnaire to which the participants responded either "yes" or "no" corresponded to the research questions to be answered by this study. Briefly stated these are:

1. What areas of patient education does the physician view as being solely the responsibility of the physician?

2. What areas of teaching does the professional nurse view as his/her responsibility?

3. What areas of patient education can be delegated or shared by other personnel?

4. What areas of patient education does the hospital administrator view as specific to the various professional groups?

To establish a background for the need and priority of patient education, the participants were asked if education should be a part of the total treatment plan. All participants but one responded "yes" to this questions. However, when the nurses and physicians were asked in another question to rate the priority of patient education on a scale of one to 10, with 10 being the highest priority, more nurses rated it higher priority than did the physicians. Most nurses also commented that they felt patient education to be an inseparable part of patient care. All nurse participants responded affirmative to the need for more outpatient/community patient/family education. Seventy-five percent of the physicians saw this need. Hospital administrators favored seven to one the opinion that the hospital should provide the facilities and instructors for the outpatient education.

A distinct disagreement is seen in the opinion of the nurses and physicians regarding specific areas of patient teaching as being solely the responsibility of the physicain. In fact, almost the same percentage of nurses (69 percent) responded "no" as physicians (70 percent) responded "yes." The administrators disagreed among themselves with half daying "yes" and the other half saying "no." As for specific areas

of physician responsibility, those who responded "yes" to the previous question, showed some similarities of response. The nurses placed most emphasis on the physicians being responsible for evaluation. The physicians likewise gave most emphasis on the physician being responsible for evaluation followed closely by assessment. The hospital administrators gave most emphasis to assessment followed equally by evaluation and planning.

Included in the areas of physician responsibility were two questions regarding written and standing orders. While the physicians were two to one in favor of patient education requiring a written order, the nurses were opposed one to 10. Making patient education a standing order, unless ordered otherwise, showed the physicians more evenly divided in their responses while 80 percent of the nurses favored this requirement. In another question within this category, over half of the physicians felt responsible for outpatient/community education, while two-thirds of the nurses viewed this as a combined responsibility with other health professionals.

Again there were differing opinions regarding there being specific areas of patient teaching solely the responsibility of the nurse. More hospital administrators and physicians than nurses acknowledged this viewpoint. As for specific areas of nurse responsibility, as perceived by those who responded "yes" to the previous question, the nurses strongly favored planning and assessment followed in order of importance by implementation, documentation, and evaluation. The physicians saw documentation as most important followed by planning and implementation equally. Less importance was placed on assessment and evaluation as a nursing responsibility by the physicians. The hospital administrators

viewed documentation and implementation as specific areas of nursing responsibility followed by planning and evaluation. Again, they placed less emphasis on assessment.

Areas of responsibility which should be shared or delegated were assessed by the asking of seven questions. A larger percentage of nurses than physicians favored the hospital having a patient education committee to develop and maintain policies, priorities, and activities of patient edcuation. Only one half of the hospital administrators favored having a committee. All three groups strongly favored having one person within the hospital setting to coordinate patient education. The nurses strongly favored having patient care conferences with the physicians evenly divided for and against these conferences. The method of teaching strongly favored one-to-one instruction as opposed to group teaching. Nurses also felt that a combination of one-to-one and group teaching was sometimes needed, while only one half of the physicians shared this view. The feeling of all respondents was unanimously in favor of using such informational tools as films, pamphlets, brochures, and instructional sheets.

The hospital administrators were asked to respond to two questions regarding the need and the role of other professionals in patient education. All felt that there were specific areas of patient teaching that were the responsibility of other health professionals. All listed the dietitian and physical therapist, one did not include the pharmacist, and two omitted the health educator and social worker. Two administrators listed additional professionals; occupational therapist, respiratory therapist, x-ray technicians, and pastoral care workers.

Summary of Findings

The following list includes the findings of the study as perceived by the participants of the Ponca City service area:

1. Patient education should be a part of the patient's total treatment plan.

2. There is a need for more patient/family educational activities on an outpatient/community basis.

3. Hospitals should provide the facilities and instructors for outpatient education.

4. The responsibility for outpatient education should be shared by all health professionals.

5. The physician should be responsible for the assessment and evaluation phases of patient education.

6. The nurses should be responsible for the planning, implementation and documentation phases of patient education.

7. A patient education committee should be established to develop and maintain policies, priorities, and activities of patient education.

8. There should be one person within the hospital setting responsible for coordinating patient education activities.

9. Informal patient care conferences should be held between the physician and nurses.

10. Patient teaching should be on a one-to-one basis for the most part.

11. Informational tools such as films, pamphlets, brochures, and instructional sheets should be available for teaching and giving to the patient.

12. Other health professionals such as dietitians, physical therapists, and pharmacists should share in the responsibility for patient teaching according to their specialty areas.

Conclusions

Although there were some distinct areas of differing opinions between the three groups assessed from the Ponca City area, there were also some positive commonalities of perceptions which can serve as the ground work for putting together a successful patient education program. The majority of the physicians showed acceptance in letting the nurses be responsible for planning, implementing, and documenting the patient teaching process. The nurses on the other hand showed preference for teaching as a standard order with the physician responsible for assessment and evaluation.

Recommendations

The following recommendations for practice are based on the results of the study. It is recommended that:

1. The hospital administrators could assist by encouraging other health professionals to enter into the teaching process according to their individual area of expertise. The administrators could also assist by establishing a committee to serve in establishing and maintaining guidelines of educational practice and having one person responsible for coordinating the teaching process.

2. A hospital committee should be designated to develop and maintain the policies, priorities, and activities of patient education.

3. One person within the hospital setting should be designated

to coordinate patient education activities.

4. Informal patient care conferences should be held to determine the physician's assessment of a patient's individual educational needs.

5. Follow-up evaluation conferences should be held before discharge to determine further educational needs on an outpatient basis.

6. Orientation of nursing personnel should include instruction in planning, implementing, and documentation of patient education.

7. The Patient Education Committee should review instructional materials to be made available for the patient.

8. The Patient Education Committee should determine if patient education should be on a written or standing order basis.

Further Study

The following areas related to patient education could be explored for further study:

1. Nurses and physicians could be asked to give their perceptions of how other health professionals can be included in the patient teaching process.

2. The other health professionals could be asked their perceptions of how they can be included in the patient teaching process.

3. A study of patient teaching problem areas could be explored.

4. A study of the community's health care needs could be assessed.

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APPENDIXES

APPENDIX A

PHYSICIAN/NURSE OPINIONNAIRE

We would like your opinion regarding the responsibility for Patient Education. Please respond by checking the appropriate response according to your feelings. Space is provided following each response if you would like to further comment on your response.

1. Should Patient Education be a part of the patient's total treatment plan? ( ) Yes ( ) No

   Comments____

2. Should Patient Education require a written order by the attending physician? ( ) Yes ( ) No

   Comments____

3. Should Patient Education be included as a standing order unless ordered otherwise? ( ) Yes ( ) No

   Comments____

4. Should a hospital have a Patient Education Committee to develop and maintain the policies, priorities, and activities of Patient Education? ( ) Yes ( ) No

   Comments____

5. Should there be one person within the hospital setting to coordinate Patient Education activities? ( ) Yes ( ) No

   Comments____

6. Are formal patient care conferences between the physician and nurses important for planning individual patient teaching needs? ( ) Yes ( ) No

   Comments____

7. Do you prefer patient teaching on a one-to-one basis?

   ( ) Yes ( ) No

   Comments____

8. Do you prefer group teaching for Patient Education?

   ( ) Yes ( ) No

   Comments____

9. Is a combination of one-to-one and group teaching needed in most health problems? ( ) Yes ( ) No

   Comments____

10. Are pamphlets, brochures, instructional sheets, films, and other information tools appropriate in some instances of informal teaching? ( ) Yes ( ) No

    Comments____

11. Are there specific areas of patient teaching you view as being solely the responsibility of the physician?

    ( ) Yes ( ) No

    Comments____

12. If so, indicate which of the following areas are specifically physician responsibilities:

    ( ) planning
    ( ) assessment
    ( ) implementation
    ( ) documentation
    ( ) evaluation
    ( ) other

    Comments____

13. Are there specific areas of patient teaching you view as being solely the responsibility of the nurse? ( ) Yes ( ) No

    Comments____

14. If so, indicate which of the following areas are specifically nursing responsibilities:

( ) planning
( ) assessment
( ) implementation
( ) documentation
( ) evaluation
( ) other

Comments____

15. Is there a need for more patient/family education activities on an outpatient/community basis? ( ) Yes ( ) No

Comments____

16. If so, is this type of patient/community activity the physician's responsibility? ( ) Yes ( ) No

Comments____

17. In view of the present health manpower shortage, on a scale of 1 to 10 (with 1 being low and 10 being high), what priority of patient care is Patient Education? (Please place an X on the following scale.)

1____10
2 3 4 5 6 7 8 9

Name (optional)______________________________

Profession______________________________

Years in profession______________________________

Current position/specialty______________________________

Please return to:

Melva Whitlock
736 Edgewood
Ponca City, OK 74601

APPENDIX B

HOSPITAL ADMINISTRATORS OPINIONNAIRE

We would like your opinion regarding the responsibility for Patient Education. Please respond by checking the appropriate response according to your feelings. Space is provided following each response if you would like to further comment on your response.

1. Should Patient Education be a part of the patient's total treatment plan? ( ) Yes ( ) No

   Comments____

2. Should a hospital have a Patient Education Committee to develop and maintain the policies, priorities, and activities of Patient Education? ( ) Yes ( ) No

   Comments____

3. Should there be one person within the hospital setting responsible for coordinating Patient Education activities? ( ) Yes ( ) No

   Comments____

4. Are there specific areas of patient teaching you view as solely the responsibility of the physician? ( ) Yes ( ) No

   Comments____

5. If so, indicate which of the following areas are specifically physician responsibilities:

   ( ) planning
   ( ) assessment
   ( ) implementation
   ( ) documentation
   ( ) evaluation
   ( ) other

   Comments____

6. Are there specific areas of patient teaching you view as solely the responsibility of the professional nurse?

( ) Yes ( ) No

Comments________________________________

7. If so, indicate which of the following areas are specifically nursing responsibilities:

( ) planning
( ) assessment
( ) implementation
( ) documentation
( ) evaluation
( ) other

Comments________________________________

8. Are there specific areas of patient teaching you view as being the responsibility of professionals other than the physician or the nurse? ( ) Yes ( ) No

Comments________________________________

9. If so, which of the following professionals do you feel could share in the patient teaching process:

( ) pharmacist
( ) dietitian
( ) health educator
( ) physical therapist
( ) social worker
( ) other

Comments________________________________

10. Is there a need for hospitals to provide facilities and instructors for group instruction for outpatients and/or families? ( ) Yes ( ) No

Comments________________________________

Name (optional)________________________________

Years of experience (hospital related)________________

Years of experience (as hospital administrator)________

Please return to: Melva Whitlock, 736 Edgewood, Ponca City, OK 74601

APPENDIX C

COVER LETTER

February 3, 1983

Dear

Would you please take a few minutes to complete the attached form which consists of some general questions about Patient Education? The information will be of great value to me as I am in the process of gathering information from physicians, nurses, and hospital administrators concerning how they individually perceive the responsibility of Patient Education. This information will be used in writing my thesis for a Master's degree from Oklahoma State University.

I can think of no one more qualified to assist in this study than those who professionally confront this phase of health care.

I am enclosing a self-addressed stamped envelope, and would appreciate your prompt return of the opinionnaire.

Sincerly yours,

Melvin Whitlock, R.N.

MW/vk

VITA

Melva Dowell Whitlock

Candidate for Degree of

Master of Science

Thesis: THE RESPONSIBILITY OF PATIENT EDUCATION AS PERCEIVED BY PROFESSIONAL NURSES, PHYSICIANS AND HOSPITAL ADMINISTRATORS

Major Field: Occupational and Adult Education

Biographical

Personal Data: Born in Eureka, Kansas, September 15, 1936, daughter of C. M. and Ruth Dowell.

Education: Graduated from Shidler High School, Shidler, Oklahoma in May, 1954; received Associate degree in Applied Science in August, 1969 from Odessa College in Odessa, Texas; received Bachelor of Science in Education degree from Central State University in May, 1978; completed requirements for Master of Science degree at Oklahoma State University in May, 1983.

Personald Experience: Staff Nurse at Odessa Medical Center, Odessa, Texas in 1969; Office Nurse for J. L. Robins, M.D. in Plainview, Texas, 1970-1972; Instructor/Coordinator of Practicel Nursing Programs at Pioneer Area Vocational-Technical School, Ponca City, Oklahoma, 1973-1980; Nurse Educator at Saint Joseph Medical Center, Ponca City, Oklahoma, 1980-1982; Office Nurse for Mark Palmer, M.D., Ponca City, Oklahoma, 1982 to present.

Professional Organizations: National League for Nursing Education Committee of the American Cancer Society; National Association of Medical Assistants.