

HISTORICAL OUTLOOK OF PATIENT EDUCATION IN AMERICAN HEALTH CARE

Objectives



After completing Chapter 2, the reader will be able to:

- Describe the development of patient education in health care.
- Identify the transition from health education to patient education in the health care system.
- Outline the contributions of various organizations to the development of health and patient education.

The Beginnings of Patient Education in the American Health Care System



Health and health care services in the United States have changed dramatically over the years. The American health care system has evolved from one symbolized by the country doctor with little, if any, training to one comprised of an incredibly complicated and sophisticated array of providers and institutions. The health care system today bears little resemblance to the health care services available in colonial America. During this time, epidemics of acute infectious diseases such as plague, cholera, typhoid, and smallpox struck entire communities and killed large numbers of the population. Many of these diseases were spread through impure food, contaminated water supplies, inadequate sewage disposal, and

the generally poor living conditions of the time. Public health programs such as sanitation, purification of water, quarantine, and hygiene leagues only were established in the late nineteenth century. These programs were effective in drastically reducing the morbidity and mortality caused by epidemics.

EARLY AMERICAN HEALERS AND PATIENT EDUCATORS

Patient instruction has been a part of health care since the first healer gave the first patient advice about treating his or her ailments.⁵ Patient and health education in general have been an intrinsic component of the caring process for centuries. In colonial America, patient education was totally dependent on local resources and local healers. Caring for the sick was based mostly around the home and family, although at that time there was little health care that could be provided at home. Most health care was palliative and long-term while the disease ran its course. In 1658, the first informal American hospital with six beds was opened in a small poorhouse supported by a church in New Amsterdam.⁶ This small hospital for the poor and the sick served approximately 1,000 inhabitants of Manhattan and is considered the forerunner of Bellevue Hospital in New York City.⁶ However, the first documented American hospital was the Pennsylvania Hospital founded in 1751 by Dr. Thomas Bond and Benjamin Franklin.⁶ The Pennsylvania Hospital cared for, and at the same time isolated, residents of Philadelphia who were sick, poor, and afflicted by mental illnesses.⁶ Later, in 1798, the passage of a nationwide act for the relief of sick and disabled seamen established a federal network of hospitals for the care of merchant seamen.⁶ This hospital network represents the foundation of today's U.S. Public Health Service as well as symbolizes the first official establishment of the American health education system.

THE FIRST DEVELOPMENT OF ORGANIZED HEALTH CARE

The American health care system started to become organized for the first time around the middle to late 1800s.⁶ During that time, community epidemics were still prevalent, with many Americans dying young from acute infections such as influenza and pneumonia. The first institutionalization of health care began around 1850 when the first large hospitals in New York (Bellevue Hospital) and Boston (Massachusetts General Hospital) began to flourish.⁶ However, growth in the hospital field was still very slow. Prior to the mid-1800s, health care primarily consisted of an unorganized collection of individual services functioning independently, with little or no relationship to one another.⁶ Hospitals were few in number, small in bed size, characterized by high mortality rates, and stigmatized as indigent care institutions whose role was to isolate the sick from the rest of society.⁶ The majority of people who became ill were not ready or willing to use the health care facilities of the 1800s. The inadequate sanitary conditions in these facilities were viewed by the public as the last resort to medical care. The hospitals were actually considered a final alternative before death.⁶ As a result, much of the care was still provided by members of the patient's family.

In regard to patient education in the 1800s, the health care provider's role was to teach the patient's family how to treat the patient at home and how to protect themselves from

the disease, especially when caring for infectious and contagious diseases.⁶ At that time, patient education was performed mostly by nurses and doctors. Nurses taught family members how to take care of the sick, proper sanitary precautions, and disease prevention. In addition, nurses who were in contact with the patient and patient's family more often than the doctor commonly were also able to interpret the doctor's instructions to the patient.⁷

THE SECOND DEVELOPMENT OF ORGANIZED HEALTH CARE

In 1900, the average life expectancy in the United States was 47 years, and the most common causes of death each year were various infectious diseases.⁶ During the beginning of the 1900s, the American health care system began to move forward with the introduction of the scientific method into medicine, symbolizing the second phase of development of the health care system.⁶ Scientific discoveries and advances played a central role in the growth of medical treatments and surgical practices. Powerful diagnostic tools started to be developed, and new vaccines and antibiotic medications came into use. Medical knowledge increased, as did technological improvements, bringing in new concepts of health care. During this time, the American Medical Association (AMA) sponsored medical schools, trying to improve the quality of medical education and strengthen the licensing requirements of medical doctors. Better medical education, coupled with more effective surgery and treatment practices, permitted better trained physicians and surgeons to increase their intervention in disease processes.⁶ As a result, patients' mortality rates decreased. Education programs in sanitation, immunization, and maternal and child health became important components of the U.S. public health system. These programs, taught by nurses, doctors, and other health care providers, created the U.S. health education system. The National League of Nursing Education described that in the 1900s, preventive and educational activities of public health nurses were considered to be the essential elements of public health work.⁶ The health education provided in the 1900s became a precursor to modern patient and health education.

THE THIRD DEVELOPMENT OF ORGANIZED HEALTH CARE

The third phase of development of the American health care system started after the Depression and World War II (WWII). The exceptional scientific accomplishments and the development of the civil rights movement after WWII resulted in profound changes in the country's health care delivery system. Before the war, most American physicians were still general practitioners. By 1960, 85% to 90% of medical graduates were choosing careers in specialty or subspecialty medicine.⁶ The egalitarian spirit of post-WWII society originated a new view about health care delivery. Health care became a fundamental right of all citizens, not merely a privilege. This change in attitude was financed by the rise of third-party payers that brought more and more Americans into the health care system.⁶ The social and organizational structure of health care concentrated on financing health, forming health insurance plans, and increasing the federal government's involvement in health care delivery services. The need for educating patients as part of organized health was growing.

The Introduction of Patient Education in the American Health Care System

During the third phase of development of the American health care system, infections started to be replaced by disabilities and chronic diseases such as rheumatic fever, tuberculosis, and diabetes as sources of health disorders.⁶ The military veteran population increased to 19 million individuals by the 1950s. More than 50,000 WWII veterans had tuberculosis.⁶ As a result, the Veterans Administration (VA) hospitals started to offer for the first time *selected patient education* as part of total patient care. The term *patient education* was first documented in literature in the 1950s in relation to the VA hospitals.⁷ In addition, public awareness of chronic diseases and disabilities increased. Moreover, the concept of health education expanded from disease prevention to management of chronic diseases and disabilities. For example, the National Tuberculosis Association started to teach patients and their families about the disease and its treatment as part of its public health service.⁷ Many programs teaching the public about specific chronic diseases such as this became available. These programs were supported and funded by the federal government. Health education and patient education concepts were used interchangeably. Nevertheless, patient education was provided sporadically and on a case-by-case basis. As a separate concept of care, patient education was in its developing stage.

INDIVIDUALIZED PATIENT EDUCATION

Still in the third phase of American health care development, private medical insurance companies like Blue Cross and Blue Shield began providing health care insurance to millions of middle-class citizens. In 1965, the U.S. government became involved in the financing of health care services with the passage of Titles XVIII and XIX of the Social Security Act, which created the Medicare and Medicaid plans, respectively. These programs were designed to pay for health care services for the medically needy, the aged, and the poor. Also, the concept of patient education evolved to focus on educating the patient to assume increased responsibility for maintaining personal health. Health care providers offered patient instruction for special patient groups who were treated for various diseases and disorders.⁷ This instruction was different from health education. Patient education went beyond disease prevention and focused on the patient fully understanding the disease and its treatment. Patients were becoming consumers of health care, having responsibilities and rights at the same time. Toward the end of the 1960s, the American Public Health Association formed a committee that recommended patient education become an organized health care activity.⁷ Patient instruction also had to be based on each patient's individual needs. In addition, the committee mentioned that the educational prescription for each patient should be included and remain as part of the patient's record.⁷ Historically, this represented the first mention of *individualized patient education* as an organized health care activity.⁷

In 1971, the Department of Health, Education, and Welfare officially introduced the new concept of patient education by describing in its publication *The Need for Patient Education* the requirement for a more specific, individualized form of patient education.⁷ This new

concept included teaching patients to stay healthy and providing individualized information about diseases and treatments. The publication also recognized the need for a formal approach regarding patient education that would concentrate on a continuous organized program instead of on a sporadic, incidental basis.

The Beginnings of Structured Patient Education in the American Health Care System

In the 1970s, patient education was officially included as part of organized health care in American hospitals. President Nixon appointed a committee to explore the feasibility of a public and private health education foundation.⁷ President Nixon's committee mandated, through the Department of Health, Education, and Welfare, that hospitals offer patient education to patients and families of patients.

PATIENT EDUCATION INCLUDED IN PATIENT'S BILL OF RIGHTS

President Nixon's committee also recommended that the American Hospital Association (AHA) had the obligation to provide educational programs for patients in hospitals or other health care institutions. These programs were required *to include all health professionals in patient education activities* in order to improve the quality of patient care, provide better utilization of outpatient facilities, and offer shorter lengths of stay and reduced health care costs.⁷ Through all these educational programs, patient education during the 1970s started to affect not only the welfare of the patient, but also the health care delivery system.

In 1973, the AHA published the first *Patient's Bill of Rights*, authorizing that patients should receive information in understandable terms that would enable them to make informed decisions about recommended treatments or procedures.⁶ Although the initial statement on a patient's rights did not specifically mention patient instruction, health care providers had to be able to explain the most important points of the diagnosis, treatment, and prognosis in terms the patient could understand. Consequently, patient education became the responsibility of the health care professional as well as the *patient's right*. Because patient education was recognized as a patient right and a necessary part of quality patient care, health professionals also were held legally liable for acts of omission or commission in regard to instructing patients and their families.⁶ For example, the first legal court ruling to substantiate this patient right was applied in Iowa in 1974.⁷ The court ruled that a physician who failed to advise a patient properly could be tried for negligence.

During the 1970s, patient education and health promotion were given increased recognition with the Canadian Lalonde Report of 1974 and the U.S. Surgeon General's *Healthy People* report of 1979.^{8,9} Both reports addressed the notion that individuals play an important part in modifying behaviors to sustain or improve their health. To legitimize patient education even more, in 1975 the House of Delegates of the AMA adopted a formal statement that made patient education an "integral part of high quality health care."^{7(p.28)} Although the AMA emphasized the role of the physician as the main education provider, other health

care professionals such as pharmacists, nurses, dietitians, dentists, and rehabilitation practitioners were also considered responsible for patient instruction.⁷

In 1976, following President Nixon's committee report, the National Consumer Health Information and Health Promotion Act was signed into law by President Ford.⁷ Consumer organizations became more alert to the possibility of increasing their right to receive quality products and services, including health care. Because of the consumer movement and the *Patient's Bill of Rights*, patients became more demanding about receiving information on their condition and treatment, and about becoming involved in decisions regarding their care.

PATIENT EDUCATION INCLUDED IN THE ACCREDITATION MANUAL FOR HOSPITALS

The reinforcement of patient education as a right and expectation of quality health care was specified in the 1976 edition of the *Accreditation Manual for Hospitals* published by the Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations).⁷ In the manual, patient education was expanded to include outpatient and inpatient services. The patient had the right to be informed of any technical procedure that needed to be performed, including the type of procedure, the reason for the procedure, and the person responsible for performing the procedure.⁷ Also, the manual solidified patient education as an entitlement. This required the health care provider to make available to the patient information about the patient's medical problem, the type of problem, the prognosis, and the necessary treatment to be implemented.

The 1980s provided rapid and dramatic changes for the health care industry. Regulatory and competitive pressures, in addition to rising costs and developing technologies, pushed health care providers, payers, and consumers into new behaviors.⁶ Providers behaved more defensively and payers behaved more aggressively, while consumers carried the burden of decreased public and private payer willingness to pay for health care services. This led to the business-imposed approach of managed care. For example, health maintenance organizations (HMOs), which were promoted in the 1970s as alternatives to fee-for-service medicine, began to introduce cost savings strategies limiting the utilization of medical services. Nevertheless, the largest benefit of managed care was that it forced the medical profession for the first time to think seriously about costs, encouraging greater attention to patients as consumers.



National Health Education Programs

The 1980s were the beginning of an era of cost containment and reorganization of the methods of financing and delivering health care. Health care trends concentrated on disease prevention and the promotion of healthful behaviors. These developments brought about much good in regard to the growth of *national health education* programs. As a result of this, and also following the U.S. Surgeon General's *Healthy People* report of 1979, the U.S. Public Health Service issued the *Healthy People 2000: National Health Promotion and Disease Prevention Objectives* report in September 1990.^{9,10} The document established specific goals

for health promotion, disease prevention, and health protection in 21 critical areas. *Healthy People 2000* also called for the creation of data and surveillance systems to track progress towards the goals and established national health care objectives for a nation-wide patient education initiative.¹⁰ In the U.S. health care industry, this document served as the basis for the development of state and community plans that laid the foundation for a national patient education agenda called *Healthy People 2010*.¹⁰ The same as its predecessors, *Healthy People 2010* was developed through a broad consultation process, built on the best scientific knowledge of the time and designed to measure health programs over time.¹⁰

TWENTY-FIRST CENTURY HEALTH EDUCATION PROGRAMS

The *Healthy People 2010* national initiative offers a powerful idea to provide health objectives in a format that enables diverse groups to combine their efforts and work as a team.¹⁰ *Healthy People 2010* can be considered a *contemporary national health education* or patient education road map to better health for all. The Healthy People Consortium consists of more than 400 national membership organizations, all state and territorial health departments, and key national associations of state health officials working to advance health. Individuals, groups, and organizations are encouraged to integrate *Healthy People 2010* into their programs, special events, publications, and meetings.

The U.S. Department of Health and Human Services issued an addition to *Healthy People 2010* called *Communicating Health: Priorities and Strategies for Progress*.¹⁰ This document enhances the two main goals of *Healthy People 2010*: to increase quality and years of healthy life and to eliminate health disparities by adding new action plans to American health care (Table 2.1).

The *Healthy People 2010* campaign supports health professionals such as physical and occupational therapists, providing improved, accurate, and understandable information to patients. Also, all rehabilitation providers are asked to encourage their patients to pursue healthier lifestyles and participate in community-based programs.

Table
2.1

Healthy People 2010 New Action Plans¹⁰

To improve all disease prevention.

To increase Internet access for specific populations.

To improve health literacy among policy makers and organizational leadership.

To increase research and evaluation of health communication activities.

In the 21st century, patient education and health education are continuously expanding and evolving areas recognized as essential components of modern health care. Patient education and public or health education programs are among the fastest growing components of health care in the United States. Currently, patient education and health education programs are available in almost every health care institution. Although no exact numbers are available, it is assumed that, since 1970, the number of health educators also has greatly increased. More health care professionals, including rehabilitation providers, are completing professional preparation programs as well as participating in training and workshop programs to develop skills in providing effective, high quality clinical patient education and health education. In addition, patients and clients are becoming well-informed health consumers. It is estimated that annually more than 70 million Americans use the Internet to search for medically related Web site information pertaining to their health.

Patient education is growing among health care providers as well as with patients. Patient education invites patients to participate in decision-making aspects of their care using a patient-centered approach to health care. In this Internet age, health care providers are being challenged to take a proactive role in helping their patients find and understand medical information provided on Web sites. Ultimately, the future of patient and health education is for health care providers to build their own digital libraries and Web sites. Clinical patient teaching and learning and health education programs will enhance health care environments, making them safer, more effective, patient-centered, efficient, timely, and equitable organizations.