

PATIENTS' AND NURSES' PERCEPTIONS OF THE NURSE'S TEACHING ROLE
AS RELATED TO TEACHING PERCEIVED, LEARNING AND SATISFACTION

by

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ABSTRACT

A Role interactionist and perception theory perspective formed the theoretical framework for identifying the relationship between the nurse's teaching role and perceived teaching by nurses, perceived patient learning, and patient satisfaction with care from both patient and nurse perspectives.

A convenience sample of 28 nurses and 30 patients from one medical and one surgical unit participated in this correlational, descriptive study by completing this investigator's Nurse's Teaching Role Scale, the Nurse's Teaching Scale, the Patient Learning Scale, and Risser's Satisfaction with Educational Relationship Subscale.

Independent t-tests revealed no differences between patients' and nurses' perceptions of the total nurse's teaching role. However, a significant difference ($p < .05$) was found in the Role Subscale results, with patients expressing a less favorable view of the nurse's role. Patients scored higher than nurses on the Learning Scale, with no difference found in the Teaching Scale scores. Results on the Satisfaction Scale demonstrated patients perceived themselves consistently more satisfied than did nurses. As predicted, a significant, positive relationship was found between perceptions of the nurse's teaching role and teaching behaviors and satisfaction with care for patients; however, not for nurses. Differences in patient-nurse perceptions have clinical, practice and research implications.

CHAPTER 1

INTRODUCTION

Health of mind and body is so fundamental to the good life that if we believe men have any personal rights at all as human beings, then they have an absolute moral right to such a measure of good health as society and society alone is able to give them. (Aristotle as cited in Beland and Passos, 1975, p. 53)

Statement of the Problem

For many years, patient education within the acute care setting has been considered a desirable component of health care. Recently, however, a variety of factors are causing an increased emphasis on patient teaching as a priority issue in the delivery of quality patient care.

A major factor contributing to this emphasis on increased patient education is the patient himself. In this age of consumerism, patients are becoming more knowledgeable in health matters and are subsequently demanding more information about their treatment management and goals. Many of these patients are part of a rapidly growing population who live with chronic disease and must be knowledgeable partners in their treatments to obtain successful disease control.

The Patient's Bill of Rights (American Hospital Association, 1972) has also emphasized the patient's right to be informed in health-related matters. The Bill of Rights' tenth point speaks to the belief that the patient has the right to expect the hospital will provide a mechanism whereby he is informed by his physician, or a delegate of the

physician, of his health care requirements following discharge. Likewise, the concept of including patient education as a component of the acute care package is strongly supported throughout the 1980 Joint Commission of Accreditation of Hospitals' standards which stated in the Nursing Service Standard IV interpretation that patient education and patient/family knowledge of self care shall be given special consideration in the nursing care plan (Joint Commission on Accreditation of Hospitals, 1980). The President's Committee on Health Education concluded that patients have an inalienable "right to know" the status of their health, the nature of an existing health problem, available community resources, what they can do to achieve and maintain an optimum state of health as well as prevent future recurrences of illness (U.S. President's Committee on Health Education, 1971).

A further stimulus for the inclusion of patient education as an integral part of health care is the concept of third-party reimbursement for teaching. The White Paper published by Blue Cross Insurance found that a patient education program, integrated into the routine services of an institution, offers the potential for both cost containment and improved quality of patient care. The paper made final recommendations that Blue Cross Insurance Plans should encourage health care institutions to establish and operate programs in patient education and should support such programs through the existing payment mechanism (White Paper, 1974). Although insurance companies currently do not routinely reimburse for patient education, a trend toward this practice is evidenced by insurance payments to several institutions for patient education services rendered (Nordberg, 1977).

Many positive outcomes have been demonstrated as a result of carefully planned patient education. Lindeman and Van Aernam (1971) designed an experimental study to determine the effects of structured versus unstructured preoperative teaching. The sample, consisting of patients admitted for non-emergency surgeries, included an experimental and control group of 126 and 135 patients, respectively. It was found that patients receiving structured preoperative teaching could post-operatively cough and deep breathe better, resulting in a significantly reduced hospital stay. Similarly, Hood and Murphy's (1978) experimental study showed that discharge teaching reduced patient non-compliance in taking prescribed medications. Based on a sample of 192 in-patients, 83.7% who received discharge teaching demonstrated total compliance, in contrast to 67.9% of patients who did not receive teaching. Meyers (1964) demonstrated that decreased stress and fewer misconceptions were created for patients who experienced an unfamiliar diagnostic procedure when they were given information with which they could structure their experience. Using an experimental design, the researcher communicated in different ways to three sample groups of 72 hospitalized patients. Patients receiving structuring communication which carefully described the unfamiliar procedure experienced significantly less tension during an unfamiliar procedure than the other two groups. A study of 81 cholecystectomy patients by Johnson et al. (1978) evaluated the contributions of instruction in a specific coping strategy and two types of informational interventions on subjective and objective indicators of recovery from surgery. It was found that instruction in coping activities, description of sensations, and description of events all

were found to decrease negative moods for patients who were fearful before surgery. Length of hospitalization was, likewise, significantly reduced in patients given a description of typical sensations. The literature revealed that educational intervention can improve the quality of care and reduce hospital stay (Egbert, 1964; Miller and Goldstein, 1972; Rosenberg, 1971, etc.).

The need for patient education is clear; nurses can meet many of these needs as patient education is an integral part of nursing care. The concept of patient education as a component of quality nursing care and a professional responsibility is supported throughout the nursing literature. As early as 1937, A Curriculum Guide for the National League of Nursing Education stated, "the nurse is essentially a teacher and an agent of health in whatever field she may be working" (National League for Nursing Education, 1937, p. 42). Kreuter (1957) identified teaching as a part of good nursing care, as did Abdellah et al. (1960), who conceptualized nursing care as helping to restore self-help. Baden (1972, p. 563) wrote, "patient teaching is a professional responsibility of nurses and one of our most independent functions."

The nurse practice acts of several states now designate patient teaching as a function of nursing. Consequently, patient teaching is becoming a legal responsibility as well as a moral and professional one (Narrow, 1979). In addition, the American Nurses' Association's (1973) Standards of Practice provide a clear focus on the nurse's role in patient education in which teaching is included as a function of the practitioner in private duty, general duty, public health, occupational health, and office nursing.

Much of the literature reflects dissatisfaction with the teaching done by nurses. In 1953, Streeter found no teaching programs organized in any of eight large U.S. hospitals. The data were secured by interviewing 19 nurses who were employed as directors, supervisors, head nurses, or staff nurses. The open-end question interview indicated the majority of nurses felt their patients received inadequate teaching (Streeter, 1953). Wynn's (1967) exploratory study of 400 heart patients demonstrated that 50 percent of the patients had unwarranted emotional distress and invalidism. Using an exploratory interview technique, it was found that inadequate explanation of the disease and inadequate planning for rehabilitation were major factors in this outcome. Many other authors have written of health teaching by nurses as being inadequate (McAuthur, 1959; Skipper, 1965; Olivia, 1948; Linehan, 1966; Pender, 1974; Leighton, 1976; Williams, 1978).

Donabedian (1969) pointed out that patients and providers of health care services may differ significantly in their perceptions of what quality care is, and to what extent it is present. Likewise, it is reasonable that patients and nurses hold different perspectives of patient teaching and, more specifically, the role of the nurse in facilitating that teaching.

One of the ways in which patient education can improve is when the desires of patients are compatible with those of professional nurses caring for them. An understanding of patients' perceptions of the nurse's teaching role may provide a stimulus for changing both teaching and learning behaviors for the purpose of improving patient education outcomes.

A study of patients' perceptions would be incomplete without the nurses' perceptions of their role in education. With this information, better insight may be gained into teaching behaviors as they relate to patient learning.

In summary, as the benefits of patient education are increasingly being recognized, many health-related organizations are striving to further this concept. However, in considering the identified gaps in the current teaching by nurses, it is timely to evaluate aspects of that teaching. A study to determine if patients and nurses perceive the nurse's teaching role as valid will lend valuable information necessary to define better methods of patient education.

Purpose of Study

The purpose of this study was twofold: 1) to determine if specific measures of patients' and nurses' perceptions of the nurse's role as a teacher differ significantly; and 2) to identify the relationship of nurses' and patients' perceptions of the nurse's teaching role to perceived patient teaching, learning accomplishment, and patient satisfaction with care.

Conceptual Hypotheses

Based on the stated purpose of the study, the conceptual hypotheses are:

1. The nurses' and patients' perceptions of the nurse's teaching role will differ significantly.
2. The patients' perceptions of the nurse's role as a teacher will relate to the patients' perception of teaching by nurses, amount

of perceived patient learning, and satisfaction with care in a correlational relationship.

3. The nurses' perception of the nurse's role as a teacher will relate to the nurses' perceptions of teaching by nurses, amount of perceived patient learning, and patient satisfaction with care in a correlational relationship.

Significance of the Problem

The literature has revealed a growing concern over the need for increased patient education in the acute care setting. In light of this, it became crucial to evaluate and seek ways to increase the quantity as well as improve the quality of current patient teaching. Nurses, as least in theory, have always been expected to teach patients, although patient education in many places has been unstructured, casual, and inconsistent (del Bueno, 1978). In evaluating and suggesting methods to improve patient education, it becomes important to consider nurses' and patients' perceptions of the nurse as a teacher, as they may impact significantly on teaching and learning behaviors. The results of this study may suggest areas in which nurses can alter their behavior to achieve better patient education.

Potential benefactors to improved patient education would be interested in attempts to determine ways in which patient education can be made more effective. Improvement of patient education would be of interest to the following:

1. Nursing service administrators who are concerned with providing quality nursing care that encompasses all phases of the health-illness spectrum.
2. Nurses as providers of care, as only through evaluation of current practice can the practitioner determine ways to improve teaching methodologies.
3. Health care consumers who are concerned with the most efficient and effective health care.

Conceptual Framework

In examining patients' and nurses' perceptions of the role of the nurse in patient teaching, the conceptual framework contains a role interactionist and perception theory perspective. Figure 1 presents a diagrammatic representation of the conceptual framework. The diagram illustrates the concept that perceptions of the nurse's role relate to perceptions of teaching done, perceived patient learning, and satisfaction with care. Although in actual practice teaching precedes the variables of learning and satisfaction, this model reflects teaching as correlated with the variables of learning and satisfaction with care. The diagram is a general model that will be operationalized from both the patients' and the nurses' view. Specifically, the model demonstrates:

1. Nurses' perceptions of the nurse's teaching role relate to nurses' perceptions of teaching performed, patient learning, and satisfaction with care.

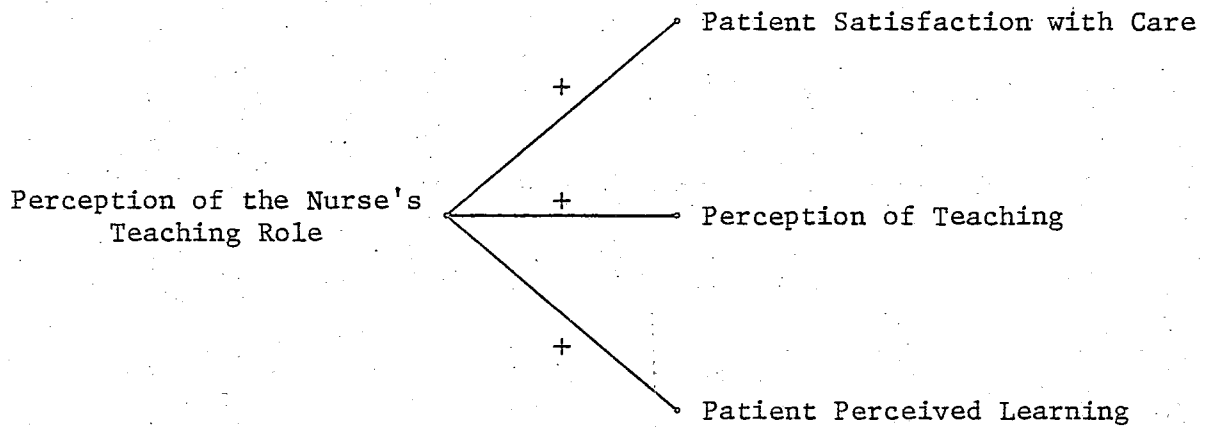


Figure 1. Conceptual Model for Both Patients' and Nurses' Perceptions.

2. Patients' perceptions of the nurse's teaching role relate to patients' perceptions of teaching performed, patient learning, and satisfaction with care.

The interactionist states that role is: "more than a prescription for the expected behavior of a person occupying a given position. Role is a constellation of behaviors that emerges out of interaction between self and other, that constitutes a meaningful unit, and is the consistent expression of the sentiments, values, and/or goals that govern or provide direction for that interaction" (Turner as cited in Eyres, 1972, p. 28).

Role interactionist theory does not discard the belief that structure influences behavior within the context of the social system, rather it holds that structure alone does not account for, nor can it predict, how persons will act in a set of specified circumstances (Cottrell, 1969). This concept allows the theory to better account for the wide variations in behaviors which take place within complex social structures. Davis (1948, p. 90) defined role as "how the individual performs in a given position as distinct from how is supposed to perform." The role then is the manner in which a person actually carries out the requirements of his position." The individual decides what he wishes to do, and how he will do it in response to external and internal clues (Conway and Hardy, 1978). Translated for this study, the delivery and receiving of health care, specifically patient education, is dependent on the performance and interpretation of a number of roles.

Patients hold definite expectations of nurses, their behavior, and the way they interact with patients in delivering care. In turn, individuals occupying the role of a nurse hold expectations for their own role enactment (Hinshaw, 1978). Incongruity in these role expectations can create conflict among individuals and retard their ability to function together effectively. In situations of role conflicts, the quality of health care delivered can be greatly decreased and patient satisfaction with care greatly reduced (Hinshaw, 1978). "In order to counteract the negative consequences from incongruity in role perceptions, understanding and predictions of the various sets of expectations are necessary" (Hinshaw, 1978, p. 274).

The second supporting concept for the study framework is adopted from perception theory. Perception relates to what is taken in through the senses and refers to the process which occurs between sensing and thinking, usually involving symbolic and emotional responses (Carter, 1976). Frandsen (1961) viewed perception as an attachment of meaning to, an awareness of, or an interpretation of a stimulus. Perception as described by Knutson (1965) is that man tends to act in terms of what he knows, expects, or hopes that action to yield; how any man behaves with respect to any situation tends to be in accord with how he perceives or defines that situation. Thus, the way in which patients perceive the nurse will affect behavior and subsequent learning. Hinshaw (1978, p. 273) further stated that "perceptions towards the performance of roles are subjective phenomena, learned from cultural and social experience." The many variables affecting perceptions of roles may help

account for the variety of successes and failures seen in patient education.

Pohl emphasized the need to recognize the importance of perception in the patient education process. She stated, "individual differences in perception and unrecognized errors in perception constitute a serious problem in the process of learning" (Pohl, 1968, p. 8).

In summary, an evaluation of patients' and nurses' perceptions of the nurse in a teaching role should provide insight into ways patients and nurses perceive and behave in the patient educational (teaching-learning) process. In this study, it is recognized that the role interactionist theory is a precursor to the perception theory. The conceptual framework blends the role interactionist and perception perspectives as they focus on perception of the nurse's role, perceived teaching, perceived learning, and satisfaction with care. The link between the concepts has been well-established. Role perceptions and expectations influence the interpretation of the stimulus (teaching) and behaviors (learning). In addition, incongruency in role expectations leads to decreased quality of care and reduced patient satisfaction with care. It is valid that both patient and nurse perceptions be considered, because only when evaluation of a health care service includes both patients' and nurses' perceptions will a more realistic picture of nurses and nursing care be obtained (Risser, 1975).

Definition of Terms

For the purpose of this study, the following definitions will be used:

1. Perception -- A direct acquaintance with anything through the senses. The link between the stimulus and the environment, and a person's response to the stimulus and the environment.
2. Role -- Behaviors and expectations culturally defined for relationships and positions occupied in various social structures.
3. Patient Teaching -- Activities by which the nurse assists the patient in understanding and applying knowledge about health and illness. Teaching includes providing factual information, assisting the patient in clarifying his thinking related to his health problem, or the instructing in a manual or intellectual skill (Redman, 1972, p. 7).
4. Patient Learning -- The acquisition of new knowledge, attitudes, and/or behaviors that promote the patients' abilities to care for themselves.
5. Satisfaction with Care -- The degree of congruency between a patient's expectations of ideal nursing care and his perception of the real nursing care he receives.

Assumptions

1. Patients who have been cared for by a nurse have formed opinions relative to the role of the nurse.
2. Nurses caring for patients have formed opinions relative to the role of the nurse.
3. Perceptions of patients and nurses are measurable.

4. Similar groups of patients have similar perceptions; however, some perceptions remain unique to the individual.
5. Nurses must attend to both common and unique patient perceptions.

CHAPTER 2

REVIEW OF THE LITERATURE

Although the literature frequently cites the teaching role of the nurse as significant, very few studies have addressed role as a determining factor in the success or failure in the patient educational process. This review of the literature focuses on patients' and nurses' perceptions of the role of the nurse, perceptions of teaching and learning, and satisfaction with care.

Patients' Perceptions of the Teaching Role of the Nurse

Since the hospital is considerably unlike other social systems people encounter, it seems safe to assume that most people enter it with a great deal of role ambiguity. Patients are uncertain as to their expectations for themselves as well as others, and many appear to be searching for the means of clarifying mutual expectations to decrease the uncertainty (Christman, 1967).

One of the earliest studies that revealed patients' perceptions of the role of the nurse was conducted by Linehan (1966), demonstrating that patients generally do not view nurses as legitimate teachers. Linehan interviewed a convenience sample of 443 patients with a wide range of diagnoses, ages, and occupations in a 250-bed hospital to determine their perceptions of how nurses met their learning needs.

Using an open-end question interview schedule of 44 questions, Linehan explored the patient's knowledge of his illness and questions the patient might have. Although 51 percent of the patients stated they had no questions, comments relative to the nurse's teaching role were numerous and revealing: "Nurses are not allowed to answer"; "Just ask the doctor, don't bother the others, they don't know"; "I believe nurses are told not to answer you -- one nurse will tell you one thing and another something else." In spite of the critical comments about the nurse's teaching role, there were many favorable comments about the excellent nursing care given and the high caliber of the nurses (Linehan, 1966, p. 1069).

Pender (1974) studied health information received by 162 randomly selected, medical and surgical patients. Interviews with patients indicated that the majority of patients (85.2 percent) received information about their health problems during hospitalization, mostly from their physicians, although a small number received information from a nurse.

Physicians and nurses were perceived as providing patients with equal opportunity to ask questions if they so desired. Topics most frequently discussed were diagnosis, treatment type, and treatment procedure. However, 105 patients said they received the most helpful information from the physician, while only 24 received it from the nurse. Patients taught by nurses indicated a need for significantly more information than patients taught by physicians.

Packard and Van Ess (1969) studied the effects of patients' varying perceptions of the role of the nurse and subsequent learning

behaviors. Using a conceptual framework from role theorists, the researchers hypothesized that the probability of the occurrence of desired behavior is heightened when an appropriate psychological set is aroused. One method of arousing and maintaining it is through classification of social roles. The study subjects were 102 postpartum in-patients at a large midwestern medical center. Subjects were randomly assigned to three different groups as they entered the postpartum unit. Experimental group I was taught preventative nutrition by diet selection in an informal atmosphere with the nurse clarifying her role as the teacher and the patient's role as a student. Group II was taught informally without role clarification, while group III served as a control. No formal tool was used, although instruction variables were controlled. The teaching time was limited to two minutes with no visual aids, no question and answer sessions, or preplanned time arranged with patients. The nutrition information given was the same for both groups, although the introductory and closing remarks varied. Results showed a significant change at the .05 level in diet selection (learning) in both informal and role-delineated groups. It was found that the experimental group receiving the role-delineated teaching demonstrated a greater selection of suggested foods, with this behavior being maintained for a longer period of time (Packard and Van Ess, 1969).

A study of Sisk et al. (1965) was designed to explore what chronically ill ambulatory patients expected of nurses and their comprehension of the role of nurses in caring for them. Sixty-two patients answered a questionnaire relevant to the study's dimensions. Questionnaire statements were categorized in relation to six nursing needs:

physical, psychological, social, spiritual, teaching, and health team. The majority of these 62 patients agreed that meeting physical needs was the primary role of the nurse, with teaching considered the least important.

Skipper (1965) used a semistructured technique to interview 86 hospitalized patients. The researchers found that patients frequently refused to ask nurses questions related to their illness because they rarely received satisfactory answers. Thus, nurses were often perceived as not having the authority to communicate this type of information to the patient.

In evaluating the patient's perception of the role of the nurse, it has been identified that the nurse's helpfulness is a significant dimension of the teaching role. The nurse helps the ill person cope with present problems, conceptualize problems realistically, perceive participation in an experience, face emerging problems, envisage alternatives, and test new patterns of behavior, as well as communicate, socialize, and find meaning in illness (Russell, 1963). Russell's ideas were stated without an explanation of the research tool utilized. These goals appear similar to those of patient teaching because, "the boundary between education and psychotherapy often overlap. It can be seen that within the general teaching goal of effecting changes there are a number of interpersonal techniques" (Redman, 1976, p. 11).

Skipper (1965) found that being person-oriented versus task-oriented when providing patient and family information about hospitalization encouraged patient learning. These authors also observed that frequently patients hesitate to ask questions, complain or ask for

services because they feared a negative reaction, particularly from nurses. This becomes an important consideration because perceived rejection by health care personnel can become a barrier to the use of any knowledge the individual may have (Redman, 1976, p. 36). Other patients' in Skipper's (1965) study stated they hesitated to ask questions because they sensed the nurse was always in a great hurry. One patient said, "If you want to tell her something, she won't listen to you; she is on her way out, a patient senses that" (Skipper, 1965, p. 69).

A study by Leighton (1976) demonstrated the importance of the patient's perception of the nurse's helpfulness in teaching. In interviewing 100 mothers of children with congenital heart defects, a significant majority placed a higher value on receiving information than nurses did with imparting it. Many patients complained that the staff lacked warmth and friendliness and failed to respond appropriately to their expectations and concerns. One mother made this comment: "Parents get angry when they feel every nugget of information has to be chased all over the hospital and pried loose. We get a dehumanizing, shoved around feeling because information is not given freely and we don't know what is going on" (Leighton, 1976, p. 76). Skipper, Tagliacozzo, and Mauksch (1964) studied communication needs of 86 patients using a semistructured interview technique. The patients, a small sample of a large private hospital, were between 40 and 60 years old with major disease categories of cardiovascular and gastrointestinal disorders. Patients expressed a desire for information from nurses but also found the interpersonal communication to be just as important. For

most patients, communication bolstered the patients' trust and helped them to cooperate. Without this psychological preparation, many patients expressed fear and anxiety over forthcoming events.

Bille (1977) studied the effectiveness of two approaches to patient education. Twenty-four patients hospitalized for the treatment of a myocardial infarction were subjected to two different teaching methods. Although this study demonstrated no significant difference between structured and unstructured teaching methodologies, the final analysis suggested a warm, interpersonal relationship may be a predictor variable in patient compliance.

In addition to perceptions of the nurse's role and nurse's helpfulness, an additional significant dimension in the patient's perceptions of the nurse's teaching role is the nurse's knowledge. Redman (1976, p. 115) wrote, "that to a varying extent, the teacher-learner relationship is one between authority and a subordinate, or is one between two equals. In some segments of American society, young women are viewed as subordinate in knowledge to most men and older women."

Hinshaw and Oaks (1978) studied patients' expectations of nurses in defining quality nursing care. Nine patients from a general medical-surgical unit comprised the sample population. Using the measurement technique of magnitude estimation, the subjects estimated the strength or intensity of their subjective responses to a set of social stimuli (the nurses). Their results showed that 1) providing personalized care, 2) competency in technical skills, and 3) cooperation with others positively influenced patients' perceptions of quality nursing care.

Significantly, nurses' professional knowledge was estimated to have a negative relationship to quality care for patients.

Dodge (1963) evaluated the patient's perceptions regarding the importance of being given information by their nurses. Findings at two metropolitan hospitals were based on a convenience sample of 208 patients with a variety of diagnoses. Both nurses and patients agreed that it was relatively important for nurses to give patients information regarding their illness and medications. These correlations were found to be statistically significant at the .05 level. Results also suggested that young female patients in general attribute more importance to receiving information from the nurse than the older patient. In addressing the issue of teaching patients, Dodge (1963, p. 76) noted that "lack of information when the patient wants it may increase his anxieties, make him less satisfied with care or make him dislike his doctor and nurse."

Nurses' Perceptions of the Teaching Role of the Nurse

It may well be that identified teaching inadequacies by nurses may be related to the nurses' perceptions of nurses in the teaching role. Although there have been only a few attempts to isolate nurses' perceptions of nurses in a teaching role, much insight into this question can be gained in reviewing the literature on nurses' activities and views on patient teaching.

Pohl (1965) has most extensively studied nurses' teaching activities by mailing a questionnaire to a randomized sample of 1,500 registered nurses (R.N.'s). The investigation was undertaken to obtain

information to describe the present teaching role of the nurse, to clarify what this role should be, to determine the appropriate scope and limitations of the nurse's teaching, and to point out the implication of the findings relevant to the preparation of the practitioner for her teaching role. Results showed that, generally, nurses are involved in a variety of teaching activities depending on their work settings. Although the majority of nurses believed teaching is as important as other aspects of their work, there was a widely reported lack of clarity in the nurses' concepts of teaching. A large proportion of the nurses also expressed much confusion in understanding their teaching role. Significantly, 37.2 percent (107 nurses) did not answer the questionnaire, stating they gave direct nursing care but did not teach.

Streeter (1953) investigated the teaching nurses were carrying out in medical-surgical units of eight general hospitals in a large metropolitan area. The data were obtained by interviewing 19 nurses employed in positions from staff nurses to directors. Since interviews indicated that all areas of the nurse's teaching were considered to be inadequate, an attempt was made to determine the factors which interfered with effective teaching. The factors most frequently mentioned were: lack of time, lack of knowledge about content and basic teaching methods, inability to teach, poor communication among the health team, lack of support, and the nurse's lack of responsibility in assuming the function of a health teacher.

Axford and Cutchen (1977) were interested in instituting a change in nurses' teaching behaviors in a rural, 90-bed acute care hospital. A questionnaire evaluating beliefs about patient teaching was

completed by all registered nurses. In general, patient teaching was viewed positively by the nursing staff. The negative responses indicated that some nurses felt it was the doctor's role to explain all care while others were uncertain about what they could, or could not, tell patients. Major factors that were resisting forces for teaching behavior changes were identified as: lack of knowledge, lack of belief that it benefits patient care, fear of an increase in work, belief that teaching was not sanctioned, and a discomfort with the role of the nurse as a teacher.

Palm (1971) undertook a descriptive study to determine whether nurses give top priority to patient teaching over physical care, supportive emotional care, and liaison activities in the nurse-patient relationship. The study was formulated on the hypothesis that informal teaching at the bedside is an independent nursing function but many nurses show confusion and inconsistency in this role.

The written instrument for this study was constructed with 22 vignettes of nonemergency situations of direct nursing care in the medical-surgical clinical area in which patients presented with learning needs. One hundred fifty-one registered nurses who were giving direct nursing care in the medical-surgical area in one large private hospital completed the instrument. Validity was determined, and split-half reliability yielded a coefficient of reliability of 0.76.

Results of the study demonstrated that 89 nurses, or 59 percent, assigned top priority to the patient education category. Thirty percent of the nurses ranked the teaching response second, 8 percent ranked it third, and 3 percent ranked it fourth.

The Chi-square test was used to determine if there were any relationships between college education, unit of assignment, or work shift and the priority that nurses gave to patient teaching. It was found that nurses without college education gave higher priority to patient teaching than nurses with higher education. No significant relation was found between the unit of assignment and the priority given to teaching. Similarly, nurses working on different shifts did not demonstrate a significant difference in the priority given to teaching.

Palm was of the opinion that nurse clinicians and educators need to examine their effectiveness in the teaching role during incidental and informal patient contacts. "A determination of whether teaching is given top priority in the nursing role by nurses is essential before effective patient teaching in the clinical area can be expected" (Palm, 1971, p. 675).

Other authors have written about the same subject. Powell (as cited in Winslow, 1976) showed that the majority of nurses questioned about teaching myocardial infarction patients agreed that nurses should be and were teaching patients; however, they themselves were not personally teaching patients. Aiken (1970, p. 1917) wrote, "there are vast areas of patient education left untouched by nurses. Partly this may be true because of our limited perception of the role of the nurse as a teacher."

Perceptions of the nurse's knowledge as a component of the nurse's teaching role have been addressed in the literature. Redman (1976) noted that it is not unusual for student nurses and older nurses to view themselves as subordinate in knowledge and social status to the

clients for whose learning they are responsible. Further, this "perception may incline nurses to assume that patients are in such a strong position that they need no teaching, or even if one sees evidence that they do, to be afraid to approach them" (Redman, 1976, p. 115).

Pohl's (1965) research found that a major reason nurses cited as affecting their teaching was inadequate preparation. One-third of the total group reported they had no preparation for the teaching they were doing, about one-fifth reported adequate preparation, while one-fourth offered suggestions for improving the teaching preparation they had.

Salmond (1978) analyzed the barriers to patient teaching within one large agency that supported both inpatient and outpatient departments. The analysis revealed that nurses lacked needed teaching skills and were, therefore, uncomfortable with initiating teaching plans. This was found to be especially true on the general medical-surgical units where, due to the great variety of case loads, nurses must possess multiple knowledge and skills for effective teaching of all patients.

In addition, helpfulness has been identified as a major component of the nurse's teaching role. Davis and Eichorn (1963) identified the use of information as a controlling power and a factor that affects teaching behavior. "Knowledge about a patient's disease and treatment is a commodity useful in controlling the health practitioner-patient relationship. Giving this knowledge to patients may help them to dispute the physician's or nurse's authority" (Davis and Eichorn, 1963, p. 243).

Sarorsi (1968) charged that nurses' fear of patients taking over their treatment may have contributed to nursing clinging to a role that limited client participation. The author saw nursing clinging to mother

surrogation, in which it is assumed that the patient is not really a person but a child -- regressive, dependent, egocentric, helpless, anxious, lacking in understanding, withdrawn from adult responsibilities, unable to make decisions, and preoccupied with symptoms and illness. Such beliefs tended to limit the nurse's helpfulness in providing the patient with information relevant to his illness.

The study by Hinshaw and Oaks (1978) previously cited also studied nurses' definers of quality care based on eight characteristics derived from the professional nursing literature. A study population of nine registered nurses from a general medical unit was utilized for this study. A test-retest procedure was used to estimate intrasubject reliability. With each subject being interviewed twice in 72 hours, an alpha level of $p < .05$ demonstrated no significant differences between the two sets of judgments. Results demonstrated that of the eight characteristics three relationships were predicted correctly. The cure function of competency in technical skills, the professional characteristics of demeanor, the the care function of providing information were empirically estimated to influence quality care positively for nurses.

Perceptions of Teaching and Learning

Very few studies were found that defined role perceptions as influencing perceived teaching and learning. This is an unfortunate gap, as "very little seems to be known about the general effectiveness of health teaching and about subsequent retention of health knowledge and attitudes" (Redman, 1976, p. 107).

Dodge (1969, p. 503) stated that, "people respond to a situation according to the way they perceive it, and the particular responses they make are responses that they consider appropriate to it." Similarly, Zimbardo and Ebbesen (1970) pointed out that persuasion is more successful if the persuader has high credibility based on expertise and trustworthiness.

Atwood, Puffenbarger, and Hinshaw (1980) investigated staff nurses' and patient/significant others' perceptions of patient preparedness for discharge. The contents of the Likert-type scale plus open-ended question instrument were determined by a "marriage of clinical hunches and recommendations reported in the literature in lieu of firm research findings" (Atwood et al., 1980, p. 1). The tool is divided into three major dimensions: type of client, substantive topic and, significant to this study, the satisfied informed client. The third dimension was comprised of two subscales, the Satisfied with Care subscale and the Informed Recipient subscale. Based on a sample of 15 patients' and 21 nurses' completed questionnaires, the Informed Recipient subscale resulted in a coefficient alpha of .86 and .81 for nurses and patients, respectively. This research demonstrated that patients and nurses generally rated patients as satisfactorily informed, indicating that perceived learning occurred.

Clark (1967) studied the perceived teaching and learning of the patient with coronary occlusion about his disease and its therapy. The author reported that a post-hospital questionnaire demonstrated patients had retained approximately 44 percent of that knowledge which was generally accepted to be necessary for adequate management of their

disease. Of this retained knowledge, 30 percent was perceived as being taught by the physician, with 0.6 percent being contributed by the nurse in the hospital setting.

As noted previously, Packard and Van Ess (1969) researched the effect of patients' perceptions of the role of the nurse relative to subsequent learning. Their findings indicated that desired behavior changes (learning) occurred when the nurse clarified her teaching role.

Buckley (1963) conducted a study exploring patient expectations of personalized care. Of the 78 inpatients utilized, 53.8 percent expected information from the nurses about schedules and routines, 59 percent thought nurses should explain medication effects, and 61.5 percent wanted information about nursing care procedures. Of these expectations, 75.1 percent were fulfilled.

Allen (1970) interviewed 25 patients who had undergone cerebral angiography, pneumoencephalography, or myelography to determine what information they had received prior to the test and what information they would give to future patients undergoing the same test. From 14 to 25 of the patients felt information about pre-sedation, the reason for the test, use of local anesthesia, the amount of pain to be expected, the part of the body involved, the time involved, possible reactions to the contrast media, expected patient cooperation, equipment and position used, and post-procedure care would all be useful. Five of these topics had been discussed with only one to six patients, while 11 to 20 patients had received teaching on the remaining items.

In their study of hospital patients' knowledge of the drugs they received, Marks and Clark (1972) found that patients had little

information about their medications. The majority of patients with drug knowledge were pleased to have it and would have liked more information. Patients ranked physicians as giving the most general information, while nurses were ranked the lowest.

Patient Satisfaction with Nursing Care

Very few studies speak directly to patient satisfaction with their nursing care relative to perceptions of the teaching role of the nurse and perceived teaching. However, the need to develop defensible methods and procedures to measure the effects of nursing care on the client's health/illness status is well-documented (Bloch, 1975; Hasselmeyer, 1962; Johnson, Johnson, and Dumas, 1970; Johnson and Martin, 1975; Majesky, Nishio, and Brester, 1978).

Aydelotte and Turner (1973) stated what the nurse does for the patient and how she does it has a marked influence on the way a patient responds to illness. That a causal relationship may exist between the care the nurse provides for a patient and the patient's recovery is of paramount importance to nursing.

Risser (1975) developed an instrument to measure patient satisfaction with nurses and nursing in the primary care setting. The author believed that evaluation of health care services from the patient's point of view takes on additional significance when the implications of perception theory are considered. Risser's tool consisted of three dimensions of nursing: intra-interpersonal, trusting relationship, and educational relationship. The questionnaire was submitted to two sequential trials during the study for a total sample of 138

patients. In both trials, the patients were most satisfied with the nurse's function in the technical-professional area and least satisfied with the nurse's behavior in the educational relationship dimension. With the highest possible mean score being 5.0, patients scored means of 2.5 and 2.2 on the Educational Relationship subscale. The author theorized two possible explanations for the patient's lack of satisfaction expressed in the educational relationship area: 1) nurses in ambulatory settings do not consistently function as patient teachers, and 2) patients do receive some information from the nurses but still want more.

Ullery (1979) administered the Risser tool to 40 patients in evaluating patient satisfaction on a team and primary nursing care unit. Results showed high satisfaction with the educational relationship. Patients scored means of 4.2 and 4.8 on the primary and team nursing care units, respectively.

Williams (1978) investigated families' perceptions of nursing care in relation to overall satisfaction with nursing care. The author administered an adaptation of the Risser tool to 30 family members of patients admitted to the intensive care unit. Three groups of 10 relatives each were formed. The Control Group received the usual informal verbal explanations from the nursing staff in the intensive care unit. Experimental Group I received the usual informal verbal explanations from the nursing staff plus the instructional booklet developed by the researcher. Experimental Group II received the usual informal verbal explanations from the nursing staff and the booklet and, in addition, the researcher sat down and read the booklet to the relative. Each

section was explained and questions raised by the relative were answered, thus providing both verbal and written instruction to the group. The F-test for homogeneity of variance was used for analysis of questionnaire responses. Similar to Risser's results, all three groups had more favorable perceptions of nurses in the technical-professional area than in the educational relationship or trusting relationship areas. With the highest possible mean score being 5.0, all scores expressed a relatively high degree of satisfaction with nursing care. "It is important that the family members perceive the nurses as being skillful and interested in the patient. The nurse's method of explaining tests and procedures to the family may influence this perception, with positive perceptions expressed as greater satisfaction with nursing care" (Williams, 1978, p. 306).

Atwood and Hinshaw (1977) have further tested and developed the Risser tool in two separate studies in the acute care setting. The researchers used a basic before-after multiple indicators design to assess the impact of a change in staffing patterns on patients. Risser's (1975) scale for determining patient satisfaction with three aspects of nursing care was administered to a total of 38 patients in two separate samples. Reliability coefficients in Sample I ranged from .80 to .89 for the three subscales, and from .64 to .82 in Sample II. Internal consistency tests for both samples showed moderate to strong correlations, indicating the three subscales measured a common phenomenon.

A modified Risser (1975) tool was again tested in Hinshaw and Atwood's (1979) Care Comfort Survey. Using a similar before-after,

multiple-phase design, outcome changes in nursing staff and patients were evaluated. The sample of 309 randomly selected patients completed the tool. Results demonstrated the total scale had an internal consistency of .99 with the Educational subscale demonstrating an internal consistency of .88.

When Tagliacozzo (1965) interviewed patients to determine their satisfaction with nursing care in hospitals, 81 percent of the patients stressed the importance of personalized care; 81 percent emphasized personality attributes of the nurse; 45 percent expected prompt, efficient services; and, significant to this study, only 29 percent mentioned specifically that they expected knowledge and technical skills from the nurse. Many patients felt hesitant to express apprehension or dissatisfaction to nurses or physicians, with 68 percent of the sample reporting withholding of desires, fears, and criticism.

In summary, the review of the literature revealed patients and nurses hold a variety of perceptions of the role of the nurse. Characteristics comprising the nurse's teaching role have been identified as general role, knowledge, and helpfulness. Much pertinent research has been completed on teaching and learning demonstrating the patient's general desire for information. However, the majority of studies showed that patients did not perceive the nurses as contributing significantly to this information. In reviewing patient satisfaction with nursing care, a majority of patients expressed satisfaction with nursing care based mainly on nurses' technical skills and physical care measures.

CHAPTER 3

METHODOLOGY

In this chapter are described the research design, the setting, the population and sample, variables, limitations, data gathering instruments, and data collection.

Research Design

A correlational descriptive design was utilized to evaluate and compare the following operational hypotheses:

1. The patients' and nurses' perceptions of the nurse's role, knowledge, and helpfulness will differ significantly.
2. There will be strong, positive correlations between patients' perceptions of the nurse's teaching role (role, knowledge, and helpfulness) as relating to his own perceptions of the nurse's teaching, his learning, and his satisfaction with the nurse-patient educational relationship.
3. There will be strong, positive correlations between the nurses' perceptions of the nurse's teaching role (role, knowledge, and helpfulness) as relating to her own perceptions of the nurse's teaching, the patient's learning, and the patient's satisfaction with the nurse-patient educational relationship.

The Setting

This study was conducted in a 550-bed, acute care, community hospital located in the southwestern United States. Two out of 22 units were selected for the study because of the following matching factors: each is a 37-bed, adult unit; both have been newly constructed and operational for approximately 18 months; and each utilizes a team nursing assignment methodology.

The Population and Sample

Two distinct populations have been identified in this study. The nurse population comprised all Registered Nurses (R.N.'s) working in the acute care setting on the two medical-surgical units. The patient population consisted of adult medical-surgical inpatients on the two units.

A convenience sample of 15 patients and 14 nurses from each of the two units comprised the study sample. The following criteria were utilized to select the nursing and patient participants for this study. Nurses were selected according to the following criteria:

1. Licensed as a Registered Nurse by the Arizona State Board of Nursing.
2. Employed on the study unit for a period of 30 days prior to the testing.
3. Literate in English and English-speaking.
4. Willing to answer a questionnaire regarding their perceptions of the nurse's teaching role.
5. Working on the most active shifts (days and evenings).

6. Attending the staff meeting where the research study and questionnaire were introduced.

Patients were selected according to the following criteria:

1. Hospitalized in the study unit a period of two to three days prior to testing.
2. Diagnosed with either a medical or surgical problem.
3. Eighteen years of age or older.
4. Mentally alert and oriented.
5. Literate in English and English-speaking.
6. Willing to answer a questionnaire regarding their perceptions of the nurse's teaching role.

Variables

Characteristics of the nurse sample considered as variables were: age, original nursing education, highest degree held, length of time employed as a R.N., and shift worked. These variables are significant to consider in that Palm (1971) found that nurses without college education and older nurses tended to give much higher priority to patient teaching than younger nurses with higher education. Palm also found no correlation between the priority nurses gave to patient teaching and years of nursing experience, unit of assignment, and shift assignment. Research by Pohl (1965) demonstrated that certain characteristics of nurses with high teaching activities included: one-to-five years' experience, basic collegiate nursing preparation, college work beyond the basic preparation, and some courses in teaching. It is

significant to note the discrepancy between Palm's and Pohl's findings on the teaching activities of nurses with and without college educations.

Characteristics of the patient sample considered as variables were: age, sex, medical or surgical diagnosis, and education. Research suggests there are individual differences in patients' desires for information. Dodge (1963) found that young, female patients were found to attribute more importance to nurse-patient communication for information than the older patient. As most of these young females were on the postpartum obstetric unit, the author felt this finding was related to the "well" patient's as opposed to the "sick" patient's desire for information. Well-educated patients demonstrated a significant difference in desire for information from the nurse than the poorly educated patient. For example, patients who had been educated beyond high school wanted information relating to time for goals and chances for recovery. The patients with less than a high school education were concerned about what the prescribed care would do for them, with little interest in the details of care. Surgical patients were more concerned with activity restrictions and success of care, while medical patients wanted to know about their medications and self-care. Pender (1974) found similar results with relation to the patient's education. The higher the patient's educational level, the more likely he was given an explanation of his treatment,

Limitations

The following limitations were recognized in this study:

1. The data were collected in a single facility.

2. The patient sample was not randomly selected; therefore, generalizations can be made to the theoretical but not to a larger population.
3. The nursing sample was not randomly selected; therefore, generalizations can be made to the theoretical framework but not to a larger population.
4. The nurses' patient load was not consistently equal on both units.
5. The teaching activities of any given nurse on the unit may have significantly influenced the patients' responses about all nurses on the unit.

Data Collection Instruments

There were four operational measures: perception of the nurse's teaching role was measured by this author's Nurse's Teaching Role Scale; teaching and learning were evaluated with tools adapted from Atwood et al. (1980); while satisfaction with care was measured by the Educational Relationship Subscale of the Risser (1975) tool. Figure 2 illustrates the operational model of the conceptual framework (Figure 1) in demonstrating hypothesized scale and subscale relationships.

Data from each scale were evaluated by examination of the means, ranges, and standard deviations. The t-test of significance was used on each scale to determine if significant differences existed between patient and nurse perceptions. "The t-test is the statistic used to test the chance of probability of a difference between the means of two small samples" (Phillips and Thompson, 1967, p. 273).

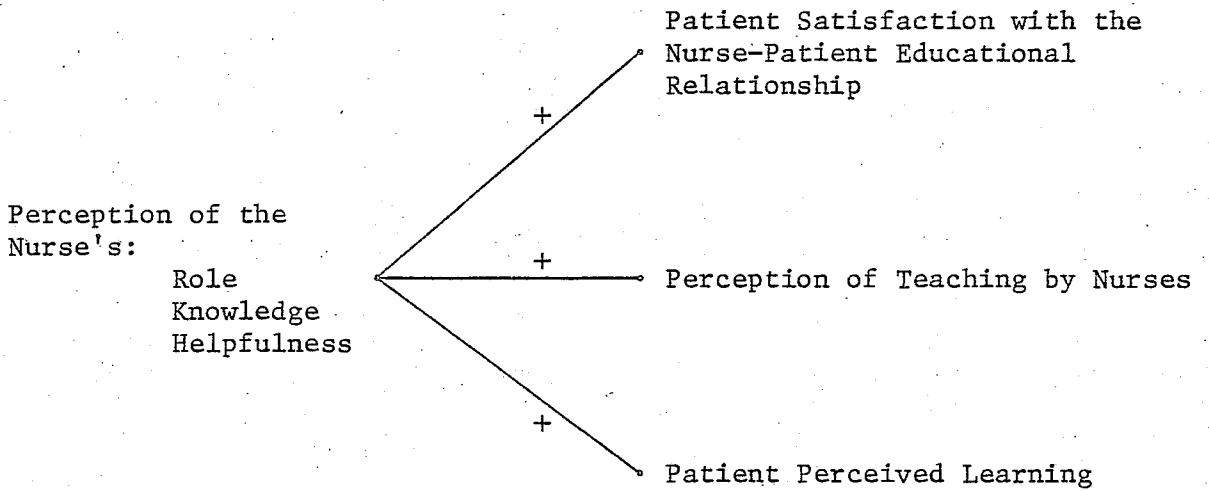


Figure 2. Operational Model for Both Patients' and Nurses' Perceptions.

Total scores on the Nurse's Teaching Role Scale were correlated with the total scores on the Teaching and Learning and Satisfaction with Nursing Care Scales using the Pearson product-moment correlation coefficient. The correlation coefficient is used to provide a numerical indicator of the magnitude of the relationship between two sets of data. The Pearson product-moment correlation coefficient is used to evaluate the strength of a linear relationship when the data can be expressed as interval scale scores (Fox, 1966).

Estimates of face, content, and construct validity and reliability were determined for each scale. Face validity was assessed by the investigator's evaluation of the tools based on the review of the literature and her personal clinical experiences. A formal panel of three judges with expertise in research, patient education, and clinical patient care was assembled to determine content validity. The panel evaluated instrument items individually with minimal criterion agreement set at 67 percent. The degree to which the content was predicted to index the intended construct provided a measure of construct validity. Since prior to the study it was unknown whether patients' and nurses' perceptions were the same concept, separate validity and reliability estimates were made for each instrument.

Prior to actual data collection, the instruments were pretested with a convenience sample of 5 patients and 5 nurses in the same institution and on similar, but not identical, units to those in the full study. The pilot study was done: 1) to detect any problems with the directions or language of the questionnaire, 2) to obtain an estimate of the time needed to complete the four tools, and 3) to assess the

adequacy of item range and variance. Minor revisions were made based on comments from the pilot sample. Tools are displayed in Appendices A and B.

Nurse's Teaching Role Scale

The investigator designed a structured questionnaire to obtain information about the patients' and nurses' perceptions of the nurse's role as a teacher. There were two forms to the tool, one completed by the nurse and one by the patient. "The Likert method was chosen due to its relative ease of administration and scoring, potential reliability with relatively few items, and relationship to behavioral criteria" (Risser, 1975, p. 46).

"A Likert-type attitude scale is a summated scale consisting of a series of statements or items to which the subject is asked to react along a continuum" (Palmer, 1965, p. 100). The scale results in the conversion of qualitative facts into a quantitative series. It is used to make discriminations of degree rather than quality (Palmer, 1965). Likert found that scores based on this method correlated .99 with the more complicated system of normal deviate weighting of categories (Likert, 1932).

A five-point, Likert-type, agreement-disagreement scale was chosen for the continuum. The options included: strongly agree (5 points), agree (4 points), undecided (3 points), disagree (2 points), and strongly disagree (1 point). Numerical values were reversed for negatively phrased items. All responses were treated as interval data

as though the distances between them were equal and the weights uniform for all items (Palmer, 1965).

The content area was defined prior to construction of the scale based on the literature review. Three specific aspects of the nurse's teaching role were focused on: 1) role of nurses, 2) knowledge of nurses, and 3) helpfulness of nurses. Statements for item construction were based on the review of the literature and the researcher's personal experience. Research reported by Linehan (1966), Skipper (1965), Streeter (1953), Pohl (1965), and Redman (1976) was used extensively in item development.

The scale consists of 15 items, five related to each of the three chosen areas. Items were equally divided between positive and negative statements and distributed randomly throughout the questionnaire. The Role Subscale items were 2, 4, 7, 10, and 13; Knowledge items were 1, 5, 9, 11, and 15; with items 3, 6, 8, 12, and 14 comprising the Helpfulness Subscale.

Estimates of Validity and Reliability -- Patients. Patient scores on the Role Subscale showed 8 of 10 inter-item correlations met the criterion of .30-.70 and ranged from .06 to .64 (Table 1). In addition, all five subscale items comfortably met the item to subscale criterion of $r = .60-.80$. Consistent with these results, the standardized alpha level was .77, with a minimal criterion level of acceptance at .70. Internal consistency measures were moderately high which, when coupled with content validity support, provided moderately strong support for construct validity.

Table 1. Patient Item Means, Standard Deviations, Item Correlations, and Alpha Scores for the Role, Knowledge, and Helpfulness Subscales of the Nurse's Teaching Role Scale.

Subscale	Item	Item Means	Item Standard Deviation	Inter-Item Correlations (.30-.70)		Alpha (Standardized) (.70)
				Item	Scale Mean	
Role	2	3.6	1.26	8/10	.40	.77
	4	3.7	1.09			
	7	3.2	1.23			
	10	3.3	1.33			
	13	4.1	.73			
		$\bar{x} = 3.6$				
Knowledge	1	4.0	1.02	3/10	.13	.42
	5	3.4	1.21			
	9	4.1	.57			
	11	3.6	1.17			
	15	4.4	.49			
		$\bar{x} = 3.9$				
Helpfulness	3	4.3	.89	5/10	.23	.60
	6	4.5	.51			
	8	4.3	.45			
	12	3.2	1.08			
	14	3.9	1.15			
		$\bar{x} = 4.0$				

The Knowledge Subscale was somewhat weaker with 3 of 10 acceptable inter-item correlations. The correlations ranged from a low of .03 to a high of .64. None of the items were found to meet the item to subscale criterion. The coefficient alpha was found to be the lowest of the subscales at .42. Predictably, a deletion of specific items did not raise this alpha level. Internal consistency was low with relatively weak construct validity support for the Knowledge Subscale.

The Helpfulness Subscale showed individual inter-item correlations ranging from $-.00$ to $.47$ with half meeting the criterion level. However, none of the items met the acceptable item to subscale level. Item 12 had a $-.00$ correlation with item 8. Deletion of item 12 raised the alpha level only slightly to $.62$, from the original standardized alpha of $.60$. This alpha reflects low to moderate internal consistency. Likewise, construct validity estimates are modest.

The Helpfulness Subscale correlated with the Role and Knowledge subscales at $r = .74$ ($p = .001$) and $r = .65$ ($p = .001$, respectively). The Knowledge and Role subscales correlated at $r = .58$ ($p = .002$), meeting the acceptable level of subscale to subscale intercorrelations of $.50$ -. $.60$. The subscale to total scale intercorrelations were acceptable but somewhat higher than the expected range of $.60$ to $.70$, with intercorrelations of: Helpfulness, $.90$; Knowledge, $.81$; and Role, $.92$ (Table 2). Total scale estimates of internal consistency were relatively low.

Estimates of Validity and Reliability -- Nurses. The nurses' results on the Role Subscale showed individual inter-item correlations

Table 2. Patient Correlation Coefficients and Probability Levels between the Subscale Scores and Nurse's Teaching Role Scale Total Scores. -- N = 30.

Subscale	Nurse's Teaching Role		Total Score
	Knowledge	Helpfulness	
Role (n = 27)	.58 (p = .002)	.74 (p = .001)	.92 (p = .001)
Knowledge (n = 28)		.65 (p = .001)	.81 (p = .001)
Helpfulness (n = 28)			.90 (p = .001)

ranging from $-.01$ to $.69$, with fewer than half meeting the criterion level of $.30$ to $.70$ (Table 3). One item met the item to subscale criterion of $r = .60-.80$, i.e., item 7 $r = .64$. Consistent with the foregoing, the standardized alpha of $.65$ did not meet the criterion. Item 10 had a zero correlation with item 4. Deletion of either of the items did not change the alpha level noticeably. Internal consistency was low to moderate with modest construct validity support for the Role Subscale.

On the Knowledge Subscale, only 3 of 10 inter-item correlations met the acceptable levels with ranges from $-.00$ to $.56$. Further, none of the items met the acceptable item to subscale level of correlation. The standardized alpha on this subscale was $.63$, reflecting a low to moderate internal consistency. Construct validity estimates for the Knowledge Subscale are also modest.

Of the three subscales, the Helpfulness Subscale appeared to be the weakest. Inter-item correlations ranged from $-.08$ to $.36$, with only one correlation meeting the criterion level. Likewise, none of the items met the item to subscale criterion. Predictably, the alpha of $.18$ was not noticeably raised with the deletion of any of the items. Internal consistency and construct validity measures were low on the Helpfulness Subscale.

Findings demonstrated Role and Helpfulness subscales correlated at $r = .39$ ($p = .040$), with Helpfulness and Knowledge correlating at $r = .56$ ($p = .002$). Role and Knowledge correlated at $r = .36$ ($p = .060$). Thus, the Helpfulness and Knowledge correlation was the only one to meet the criterion level. The Role, Knowledge, and Helpfulness subscales

Table 3. Nurse Item Means, Standard Deviations, Item Correlations, and Alpha Scores on the Role, Knowledge, and Helpfulness Subscales of the Nurse's Teaching Role Scale.

Subscale	Item	Item Means	Item Standard Deviation	Inter-Item Correlations (.30-.70)		Alpha (Standardized) (.70)
				Item	Scale Mean	
Role	2	4.3	.75	4/10	.28	.65
	4	4.2	.76			
	7	4.0	.82			
	10	4.2	.90			
	13	4.5	.71			
		$\bar{x} = 4.3$				
Knowledge	1	3.8	.69	3/10	.26	.63
	5	3.9	.48			
	9	3.5	.86			
	11	4.0	.72			
	15	4.2	.51			
		$\bar{x} = 3.9$				
Helpfulness	3	4.5	.50	1/10	.04	.18
	6	4.3	.62			
	8	4.2	.50			
	12	3.4	.95			
	14	3.8	.89			
		$\bar{x} = 4.0$				

intercorrelated with the total score at .78, .80, and .77, respectively, approximating the desirable subscale to scale range of .60 to .70 (Table 4). Two of the three nurse subscales showed low to moderate estimates of internal consistency and construct validity, with one subscale, Helpfulness, rated low. This contrasts with patient results which demonstrated the Role Subscales was moderately strong with the Knowledge and Helpfulness subscales estimated at low to moderate. Thus, total scale estimates indicated moderate internal consistency.

Teaching and Learning Scales

To determine perceptions of teaching done by nurses and perceived learning by patients, a structured questionnaire was designed by the investigator. There were two forms of the tool, one completed by the nursing staff and one by the patients. Currently, there are no valid, reliable instruments available in the literature specific to

Table 4. Nurses' Correlation Coefficients and Probability Levels between the Subscale Scores and the Nurse's Teaching Role Scale Scores. -- N = 28.

Subscales	Nurse's Teaching Role		Total Score
	Knowledge	Helpfulness	
Role (n = 28)	.36 p = .060	.39 p = .040	.78 p = .001
Knowledge (n = 28)		.56 p = .002	.80 p = .001
Helpfulness (n = 28)			.77 p = .001

general patient perceived teaching and learning variables. Therefore, tool development was structured from the researcher's experience and clinical hunches. Topic dimension was adapted from the Atwood et al. (1980) Patient Preparedness for Discharge Instrument. Based on specific, vital aspects of almost any patient's care, content area was divided into four dimensions: medications, treatments, diet, and knowledge about illness. Each scale consisted of 10 items related to each of the four dimensions selected. Each item had five options, which were scored by the equal-appearing interval method via Likert-type, summated rating scales. Items were equally divided between positive and negative statements and distributed randomly throughout the questionnaire. The Teaching Scale consisted of items 18, 20, 22, 24, 27, 28, 30, 32, 33, and 35; while the Learning Scale included items 16, 17, 19, 21, 23, 25, 26, 29, 31, and 34.

Estimates of Validity and Reliability -- Patients. On the Teaching Scale, 34 of 45 inter-item correlations met the acceptable criterion with a wide range of $-.26$ to $.89$ (Table 5). Three of the scale items were found to meet the acceptable item to scale standard with a total range of $.38$ to $.88$. The alpha was high at $.88$. Predictably, the alpha was not noticeably changed with the deletion of any items. Thus, internal consistency was judged to be moderately high with moderately strong construct validity support based on tool generation and internal consistency.

Patient scores on the Learning Scale showed individual inter-item correlations ranging from $-.39$ to $.75$ with 23 of 45 items meeting

Table 5. Patient Item Means, Standard Deviations, Item Correlations, and Alpha Scores for the Teaching and Learning Scales.

Scale	Item	Item Means	Item Standard Deviation	Inter-Item Correlations (.30-.70)		Alpha (Standardized) (.70)
				Item	Scale Mean	
Teaching	18	3.4	1.16	34/45	.42	.88
	20	3.3	1.10			
	22	2.8	1.13			
	24	3.7	1.00			
	27	3.2	1.30			
	28	3.4	1.16			
	30	3.2	1.07			
	32	3.0	1.15			
	33	3.1	1.24			
	35	2.8	1.07			
		$\bar{x} = 3.1$				
Learning	16	3.8	.89	23/45	.31	.82
	17	3.4	1.17			
	19	3.8	.91			
	21	3.6	1.01			
	23	4.0	1.02			
	25	3.2	1.23			
	26	3.6	1.07			
	29	3.8	.89			
	31	3.8	1.19			
	34	4.1	.46			
		$\bar{x} = 3.8$				

the criterion level. In reviewing items to subscale correlations, three met the acceptable standard from a range of .23 to .62. The standardized alpha on this scale was .82, reflecting moderately high measures of internal consistency. Construct validity estimates were also moderately strong.

Estimates of Validity and Reliability -- Nurses. The nurse Teaching Scale was somewhat weaker than patient results with 27 of 45 acceptable inter-item correlations (Table 6). The correlations ranged from a low of $-.00$ to a high of $.72$. Half of the items with a total range of $.32$ to $.83$ met the item to scale criterion level. Item 24 had a $-.00$ correlation with item 18. Deletion of either item did not raise the alpha appreciably from the original standardized alpha of $.86$. This alpha reflects a relatively strong internal consistency with concomitant, strong construct validity support.

Scores on the Learning Scale demonstrated inter-item correlations of $-.20$ to $.66$ with only 16 of 45 items meeting the criterion level. Consistent with these results, none of the items ranging from $.20$ to $.55$ reached the item to subscale standard. The alpha level was $.75$, reflecting moderate internal consistency measures. Construct validity measures are estimated to be moderate.

The Teaching Scale proved to be fairly strong with both patient and nurse internal consistency and construct validity measures estimated to be moderately high. Results demonstrated the Learning Scale to be somewhat weaker in comparison to the Teaching Scale. Validity and reliability measures from the patient scores were strong with nurse

Table 6. Nurse Item Means, Standard Deviations, Item Correlations, and Alpha Scores for the Teaching and Learning Scales.

Scale	Item	Item Means	Item Standard Deviation	Inter-Item Correlations (.30-.70)		Alpha (Standardized) (.70)
				Item	Scale Mean	
Teaching	18	3.5	.76	27/45	.37	.86
	20	2.9	1.05			
	22	3.5	.99			
	24	3.4	.80			
	27	3.5	.76			
	28	3.3	.80			
	30	3.1	.91			
	32	3.5	.76			
	33	3.5	.86			
	35	2.2	.63			
			$\bar{x} = 3.3$			
Learning	16	2.8	1.02	16/45	.23	.75
	17	2.5	.95			
	19	2.5	.76			
	21	2.5	.76			
	23	2.9	.82			
	25	1.9	.59			
	26	2.6	.98			
	29	3.5	.65			
	31	2.5	.95			
	34	3.4	.76			
		$\bar{x} = 2.7$				

results demonstrating modest internal consistency and construct validity estimates.

Patient Satisfaction with Care Scale

One of the three subscales of the Risser (1975) instrument was used to measure patients' satisfaction with nurses and nursing care. The instrument fulfills the criteria for face and content validity and also provides some evidence of construct validity. Each of the tool's three subscales possesses a reliability coefficient greater than its correlation coefficient with another subscale. In Risser's trial II, Cronbach's (1951) reliability coefficients for the technical-professional, educational relationship, and trusting relationship were .64, .82, and .82, respectively. This is in contrast to the intersubscale correlation coefficients which were .59, .81, and .65, respectively. The high intersubscale correlation suggests treatment of all items as one scale, with three subdivisions of content areas of the same attitude. This is based on the statistics obtained from the second trial in which the homogeneity ratio of the combined 25 items was .302, with the reliability coefficient of .91 (Risser, 1975).

As discussed in the review of the literature, Hinshaw and Atwood (1979) have extensively tested the Risser (1975) tool in the acute care setting. The first testing of the tool demonstrated reliability coefficients for the three subscales to be .80 to .89 in sample I and .64 to .82 in sample II. Internal consistency tests for both samples indicated moderate to strong correlations (Atwood and Hinshaw, 1977). In the second testing by the researchers, the tool had a theta coefficient of

.99 with the Educational Relationship Subscale, demonstrating an internal consistency of .88 (Hinshaw and Atwood, 1979).

The tool used in this study was the Educational Relationship Area Subscale, consisting of seven items. The instrument consisted of a five-point, Likert-type rating scale with options from strongly agree to strongly disagree. The Educational Relationship Area refers to information exchange between patient and nurse, including such activities as answering questions, explaining, and demonstrating (Risser, 1975, p. 47). Items, 36, 37, 38, 39, 40, 41, and 42 comprised this scale.

Estimates of Validity and Reliability -- Patients. Patient scores on the Satisfaction with Care Scale showed 13 of 21 inter-item correlations met criterion with a range of $-.09$ to $.67$. Interestingly, only 2 of the 7 items met the acceptable item to scale level from a range of $.30$ to $.78$ (Table 7). The standardized alpha level was $.77$, demonstrating strong moderate internal consistency and construct validity for this well-tested subscale.

Estimates of Validity and Reliability -- Nurses. The Satisfaction with Care Scale was somewhat weaker with 6 of 21 acceptable inter-item correlations. The correlations ranged from a low of $-.09$ to a high of $.57$. There were no items that met the item to subscale criterion from a total range of $.12$ to $.53$. Predictably, the standardized alpha level was $.61$. This alpha reflects a moderately low internal consistency. Likewise, construct validity estimates are modest.

In comparing patient and nurse scale results, the nurses' scale was demonstrated as the weaker of the two. The alpha of the nurse scale

Table 7. Patient and Nurse Item Means, Standard Deviations, Item Correlations, and Alpha Scores on the Satisfaction with Care Scale.

	Item	Item Means	Item Standard Deviation	Inter-Item Correlations (.30-.70)		Alpha (Standardized) (.70)
				Item	Scale Mean	
Patient	36	4.0	.75	13/21	.33	.77
	37	3.9	1.02			
	38	4.0	.70			
	39	3.5	.90			
	40	4.0	.75			
	41	3.7	1.00			
	42	3.3	1.19			
		$\bar{x} = 3.8$				
Nurse	36	3.6	.76	6/21	.18	.61
	37	3.8	.69			
	38	3.6	.70			
	39	2.3	.80			
	40	2.6	.75			
	41	2.8	.75			
	42	2.5	.81			
		$\bar{x} = 3.1$				

was lower than the patient scale, as well as all other measures of internal consistency and construct validity.

Patient and Nurse Profile

Background information about the study subjects was recorded on a patient/nurse profile sheet attached to the questionnaire. Patient charts were used to verify or supplement this information. The patient and nurse profiles are displayed in Appendices A and B, respectively.

Data Collection

Patients' Data

Patients hospitalized on the selected medical and surgical units were approached after the second or third day of hospitalization and asked to participate in the study. The investigator explained that responses about their perceptions of the nurse would be helpful in planning future care. Patients were told that participation was voluntary and should they choose not to participate, their care would in no way be affected. Those individuals who agreed to participate were informed that they would be giving their consent by responding to the statements on the questionnaire. They were told their names would remain confidential and would not appear on the questionnaire. Participants were assured all data would be used for the stated purpose of the study. Data were collected until the sample size was met. The investigator was available to answer any questions during the completion of the questionnaire.

Nurses' Data

The nursing personnel on the two units were approached at a unit staff meeting and asked to participate in the study. They were told the investigator was interested in ascertaining their perceptions of the role of the nurse. Nurses were told participation was voluntary and if they chose not to participate their employment would in no way be affected. Those individuals who agreed to participate were informed they were giving their consent by responding to the statements of the questionnaire. They were told their names would remain confidential and would not appear on the questionnaire. Participants were assured all data would be used for the stated purpose of the study.

Protection of Human Rights

This study was submitted to the Human Subjects Committee of The University of Arizona and also to the Department of Staff Development and Research at the clinical facility used in this study. Only individuals who consented to participate in this study were used. The purpose of this study was explained to each person, including the right to ask questions or to withdraw from the study at any point without consequence. The confidentiality of the information obtained was assured by assigning each person a code number only.

CHAPTER 4

PRESENTATION OF DATA

Described in this chapter are the characteristics of the sample, patients' and nurses' perceptions of the nurse's teaching role, nurse's teaching and patient's learning, and satisfaction with care. Statistical analysis of the data and findings related to the hypotheses are also included. The criterion level for statistically significant differences was set at .05. Substantive significance was viewed at the .10 level due to the early developmental stage of the instruments and the model (Atwood, 1980).

Characteristics of the Sample

Patients

The patient sample consisted of 30 patients, 15 from the surgical unit and 15 from the medical unit. Data collected from the patient sample included age, education, sex, and medical or surgical diagnosis. The investigator contacted 36 patients; however, 4 patients on the medical unit and 2 patients on the surgical unit refused to participate in the study. Patients gave similar responses in refusing to participate, explaining they were too tired, too sick, or just not interested. Eighteen (60%) were hospitalized with a medical diagnosis, while 12 (40%) were hospitalized with a surgical diagnosis. The subjects'

average age was 56.6 years, with a range of 22 to 82 years (Table 8). The sex of the patients was close to being equally divided, with 13 females (43.3%) and 17 males (56.7%). The level of the patients' education ranged from 5 to 21 years, with a mean of 12.5 years. The majority of patients (80%) were found to have completed 12 or more years of education (Table 9). No attempt was made to control the length of hospitalization, previous hospitalization, or specific diagnoses of any of the patient participants.

Nurses

The sample of nursing staff in this study consisted of 28 R.N.'s, 14 from the surgical nursing unit and 14 from the medical nursing unit. Data collected from the nurses included age, original nursing education, highest degree held, shift worked, and length of time employed as an R.N. The mean age of the study sample was 34.4 years, with a range of 22 to 57 years. Of all the R.N.'s, 53.6% were 30 years of age or younger (Table 10). Information about original nursing education revealed that one nurse started with an L.P.N. degree, 9 with A.D. degrees, 9 with diploma degrees, and 9 with baccalaureate degrees in nursing. In addition, information collected regarding highest degree showed 2 of the 28 nurses held a baccalaureate degree in a field other than nursing, while no nurses were found to have a degree beyond the baccalaureate level (Table 11). The distribution of nurses among the three different shifts was reflective of typical staffing patterns. Fourteen (50%) of the R.N.'s worked the day shift, 7 (25%) worked the evening shift, with the remaining 7 (25%) working the night shift. In

Table 8. Age of Patients. -- Standard deviation = 17.50; mean = 56.6.

	Age							Total
	21-30	31-40	41-50	51-60	61-70	71-80	Over 80	
Number	5	1	2	7	8	6	1	30
Percent	17	3	7	23	27	20	3	100

Table 9. Years of Education of Patients. -- Standard deviation = 3.33; mean = 12.5.

	Years of Education					Total
	5-8	9-11	12	13-16	Over 16	
Number	3	3	13	8	3	30
Percent	10	10	43.3	26.7	10	100

Table 10. Age of Nurses. -- Standard deviation = 10.52; mean = 34.4.

	Age							Total
	21-25	26-30	31-35	36-40	41-45	46-50	Over 50	
Number	3	12	3	4	1	1	4	28
Percent	10.7	42.8	10.7	14.3	3.6	3.6	14.3	100

Table 11. Highest Degree Held by Nurses. -- Standard deviation = .97.

	Highest Degree					Total
	AD	Diploma	BSN	BA	Other	
Number	9	8	9	2	0	28
Percent	32.1	28.7	32.1	7.1	0	100

reviewing the variable of the length of time employed as a R.N., 53.6% had worked less than five years, while 14.3% had been employed over 20 years (see Table 12).

Associated Variables in Relation to Scales

Patients

In order to assess the simple bivariant relationships between the tools and the other variables measured, data concerning patient age and education were correlated with the Nurse's Role Scale and Subscales, the Teaching, Learning, and Satisfaction with Care Scales. In addition, a t-test was used to determine if scale scores differed by sex and diagnosis of the patient. Although no significant relationships were found between test scores and the variables of age and education, a substantively significant difference was found with male patient results. Specifically, male patients were shown to perceive noticeably less learning by patients than females ($t = 1.98$, $d.f. = 13.68$, $p = .067$).

Table 12. Distribution of Nurses by Length of Time Employed as a R.N. -- Standard deviation = 1.23; mean = 2.8.

	<u>Length of Time Employed as a R.N.</u>					Total
	Less than 1 Year	1-5 Years	5-10 Years	10-20 Years	Over 20 Years	
Number	3	12	6	3	4	28
Percent	10.7	42.9	21.4	10.7	14.3	100

The t-test demonstrated patients with a medical diagnosis scored lower on the Learning Scale ($t = -2.43$, $d.f. = 19.03$, $p = .025$) than did patients with a surgical diagnosis. In addition, medical patients' scores on the Teaching Scale showed generally lower results than surgical patient scores ($t = 1.93$, $d.f. = 19.17$, $p = .068$). These scores show a general trend by medical patients to perceive less teaching by nurses and less learning by patients.

Nurses

The Pearson correlation coefficient was utilized to determine the relationship of the nurse variables of age, original nursing education, highest degree held, and length of time employed as a R.N. with each tool. An analysis of variance model was used with the categorical variable of shift worked. It was found that older nurses and nurses employed over a longer period of time scored significantly lower on the Role Subscale at $r = -.46$ ($p = .014$) and $r = -.39$ ($p = .044$), respectively. Also, nurses employed a longer time tended to score lower results on the Teaching Scale ($r = -.34$, $p = .082$), while nurses with higher education tended to perceive patients as learning less ($r = -.35$, $p = .014$). The variables of original nursing education and shift worked were not shown to impact on test scores.

In contrasting medical and surgical nurses, a t-test revealed significantly lower ($t = 2.24$, $d.f. = 25.09$, $p = .034$) scores by surgical nurses on the Teaching Scale. These results indicate surgical nurses perceived less teaching by nurses than did their medical peers. This is an interesting contrast to patient scores which indicated

surgical patients perceived more teaching by nurses and more learning by patients.

Nurse's Teaching Role Scale

Descriptive data were evaluated by examination of the means, ranges, and standard deviations on the total Nurse's Teaching Role Scale and each of the Role, Knowledge, and Helpfulness subscales. In addition, the t-test of significance was used to evaluate the first hypothesis which stated: The patients' and nurses' perceptions of the nurse's teaching role will differ significantly.

The Nurse's Teaching Role Scale contained 15 items designed to explore overall perceptions of the nurse's teaching role. A 60-point range of scores from 15 to 75 was possible, with higher scores indicating more favorable perceptions. Each of the three subscales contained 5 items designed to obtain information about perceptions of the nurse's role, knowledge, and helpfulness. A score range of 5 to 25 was possible for each subscale, with the higher scores indicating more favorable perceptions of each subscale dimension.

Patients

On the Nurse's Teaching Role Scale, patients scored a mean total score of 57.7 and item mean of 3.9. The empirical range of 43 to 75 points represents the top half of the theoretical range. Patients scored lowest on the Role Subscale with scale and item means of 17.9 and 3.6, respectively, and a range of 11 to 25 points. There were three missing cases in the role analysis. It is not surprising patients scored lowest on this subscale in view of the many comments expressed

relative to the nurse's role. Patients stated: "The nurses are not allowed to tell me the results of my tests"; "I don't know if the nurses are trying to compete with the doctor or what, if they know the answer to everything they ought to be doctors"; "In my day, the nurses had to keep their mouth shut. I think the nurse has to do what the doctor tells them." The Knowledge Subscale showed patients scoring a scale mean of 19.6 and an item mean of 3.9, with a range of 16 to 25. The third subscale, Helpfulness, reflected the highest scale and item means of 20.1 and 4.0, respectively. Helpfulness seemed to be a very important quality in nurses as patients frequently commented on how helpful and nice the nurses were. Some stated: "The nurses are so wonderful, so sweet"; "This has been the friendliest gang of nurses, also the most helpful"; "The nurses will do anything for you." Table 13 presents data on the Nurse's Teaching Role Scale and each of the Role, Knowledge, and Helpfulness subscales.

Table 13. Patients' Mean, Standard Deviation, and Range Scores of Nurse's Teaching Role Scale and Role, Knowledge, and Helpfulness Subscales. -- N = 30.

Variable	Item Mean	Scale Mean	Standard Deviation	Range
Nurse's Teaching Role (n = 27-28)	3.8	57.7	7.84	43 to 75
Role (n = 27)	3.6	17.9	3.84	11 to 25
Knowledge (n = 28)	3.9	19.6	2.47	16 to 25
Helpfulness (n = 28)	4.0	20.1	2.34	15 to 25

Nurses

Nurses responded to the Nurse's Teaching Role Scale with a total scale and item mean score of 61.0 and 4.1, respectively, with a standard deviation of 5.28. Similar to patient findings, the total scale empirical range of 50 to 72 is representative of the top half of the theoretical range of 15 to 75. In contrast to patient results, nurses scored highest on the Role Subscale with a mean and standard deviation of 21.4 and 2.5, respectively. The item mean was 4.3. The Helpfulness and Knowledge subscales showed means of 20.1 and 19.5 and standard deviations of 1.71 and 2.20, respectively. Item means for the Helpfulness and Knowledge subscales were 4.0 and 3.9, respectively (Table 14).

Comparison of Results

A t-test was utilized to determine if significant differences existed between the patients' and nurses' scores on the Nurse's Teaching Role Scale and each of the Role, Knowledge, and Helpfulness subscales. The first hypothesis -- the patients' and nurses' perceptions of the nurse's teaching role will differ significantly -- was only partially supported. Perceptions were similar on the overall scale and on the Knowledge and Helpfulness subscales. However, data analysis revealed a significant difference of $< .001$ in the Role Subscale. Patients scored a mean of 17.9, with nurses scoring a mean of 21.4, indicating patients held a much less favorable impression of the nurse's role than did nurses (Table 15).

Table 14. Nurses' Mean, Standard Deviation, and Range Scores of Nurse's Teaching Role Scale and Role, Knowledge, and Helpfulness Subscales. -- N = 28.

Variable	Item Mean	Scale Mean	Standard Deviation	Range
Nurse's Teaching Role (n = 28)	4.1	61.0	5.28	50 to 72
Role (n = 28)	4.3	21.4	2.50	16 to 25
Knowledge (n = 28)	3.9	19.5	2.20	16 to 25
Helpfulness (n = 28)	4.0	20.1	1.71	17 to 24

Table 15. Mean Scores, Standard Deviations, t-Values, Degrees of Freedom (d.f.), and Probability of Nurse's Teaching Role Scale and Role, Knowledge, and Helpfulness Subscales of Nurses (Group I) and Patients (Group II).

Variable	Group	Item Mean	Standard Deviation	t-Value	d, f.	2-Tail Probability																										
Nurse's Teaching Role	I	4.1	5.28	1.80	49.0	.078																										
	II	3.8	7.84				Role	I	4.3	2.50	4.03	44.72	<.001	II	3.6	3.84	Knowledge	I	3.9	2.20	-.21	53.0	.838	II	4.0	2.47	Helpfulness	I	4.0	1.70	.06	56.0
Role	I	4.3	2.50	4.03	44.72	<.001																										
	II	3.6	3.84				Knowledge	I	3.9	2.20	-.21	53.0	.838	II	4.0	2.47	Helpfulness	I	4.0	1.70	.06	56.0	.950	II	4.0	2.38						
Knowledge	I	3.9	2.20	-.21	53.0	.838																										
	II	4.0	2.47				Helpfulness	I	4.0	1.70	.06	56.0	.950	II	4.0	2.38																
Helpfulness	I	4.0	1.70	.06	56.0	.950																										
	II	4.0	2.38																													

Teaching and Learning Scales

Patients' and nurses' perceptions of teaching done by nurses and perceived learning by patients was evaluated with the Teaching and Learning questionnaires. Means, ranges, and standard deviations of the scales were analyzed. In addition, patient and nurse scores were contrasted utilizing a t-test of significance. The Teaching and Learning scales each consisted of 10 items with a possible 40-point score range of 10 to 50. For each of the scales, higher scores indicated perceptions that the nurses taught a greater amount with the patients learning a greater amount.

Patients

Patients scored a total scale mean of 31.3 and an item mean of 3.1 on the Teaching Scale. The empirical range was 20 to 47, which represented a wide span of the theoretical range. A total of 7 missing cases were found in this scale. When questioned, patients stated they left items unanswered because they felt the nurse should not be teaching patients. Examples of the many comments included: "The nurses don't tell me those things and that's the way it should be"; "It [the scale] doesn't differentiate what a nurse and doctor do"; "It's the doctor's job to teach me about my medications." On the Learning Scale, patients scored a higher mean and standard deviation of 38.0 and 5.68, respectively, with an item mean of 3.8. The range was 26 to 49. Only 23 of a possible 30 cases were valid. Table 16 summarizes pertinent data.

Table 16. Patients' Mean, Standard Deviation, and Range Scores on the Teaching and Learning Scales. --
N = 30.

Variable	Item Mean	Scale Mean	Standard Deviation	Range
Teaching (n = 23)	3.1	31.3	8.28	20 to 47
Learning (n = 23)	3.8	38.0	5.68	26 to 49

Nurses

On the Teaching Scale, nurses scored a mean of 33.1, with a standard deviation of 5.90. Total scores ranged from 20 to 41, reflecting a middle distribution in the theoretical range of 10 to 50. The item mean was 3.3. Several nurses made comments about items on the scale relative to teaching behaviors. Nurses stated: "This would be nice, but most of us don't have the time"; "It doesn't matter if we make sure the patients know all these things as long as we get the charting done"; "I'd love to have the time, but it's impossible with all our admits and discharges." The nurses' total and item mean scores of 27.7 and 2.7, respectively, on the Learning Scale were much lower than patient results, as was the score range of 16 to 36. Table 17 details results.

Comparison of Results

In order to address the question, "What is the difference between nurse and patient scores on the Teaching and Learning scales?," a t-test was utilized to compare results. Examination of the Teaching

Table 17. Nurses' Mean, Standard Deviation, and Range Scores on the Teaching and Learning Scales. -- N = 30.

Variable	Item Mean	Scale Mean	Standard Deviation	Range
Teaching (n = 28)	3.3	33.1	5.90	20 to 41
Learning (n = 28)	2.7	27.7	6.19	16 to 36

Scale showed no significant difference between groups. In contrast, data analysis demonstrated patients scored significantly higher at $< .001$ on the Learning Scale than did nurses (Table 18).

Satisfaction with Care Scale

Patients' and nurses' perceptions of patients' satisfaction with their care was indexed by the Educational Relationship Subscale of the Risser instrument. The data obtained were evaluated by examination of the means, ranges, and standard deviations of the responses. The subscale consisted of 7 items with a possible 28-point score range of 7 to 35. A higher score indicated perceptions that the patient is more satisfied with his care.

Patients

Patients scored an empirical range of 19 to 34 points, which was strongly representative of the higher end of the theoretical range. The scale and item means for patients were 26.7 and 3.8, respectively (Table 19).

Table 18. Mean Scores, Standard Deviations, t-Values, Degrees of Freedom (d.f.), and Probability of Teaching and Learning Scales of Nurses (Group I) and Patients (Group II).

Variable	Group	Item Mean	Standard Deviation	t-Value	d.f.	2-Tail Probability
Teaching Scale	I	3.3	5.90	.87	48.0	.386
	II	3.1	8.28			
Learning Scale	I	2.7	6.10	-6.08	48.0	<.001
	II	3.8	5.68			

Table 19. Mean Scores, Ranges, Standard Deviations, t-Values, Degrees of Freedom (d.f.), and Probability of Nurses' (Group I) and Patients' (Group II) Perceptions of Patient Satisfaction with Care. -- N = 28-30.

Group	Item Mean	Scale Mean	Standard Deviation	Range	t-Value	d.f.	2-Tail Probability
I (n = 28)	3.1	21.7	3.35	15 to 29	-5.14	53.0	<.001
II (n = 30)	3.8	26.7	3.94	19 to 34			

Nurses

Nurse results demonstrated a somewhat lower range than patients of 15 to 29. Consistent with this, item and scale means were also lower at 3.1 and 21.7, respectively.

Comparison of Results

A t-test was used to determine results in addressing the question, "What is the difference between nurse and patient scores on the Satisfaction with Care Scale?" Data analysis revealed a significant difference at $< .001$ between patient and nurse responses. Patients perceived themselves consistently more satisfied than nurses thought they were (Table 19).

Relationships among Independent and Dependent Variables

In order to evaluate the second and third hypotheses, concerning relationships between the independent and three dependent variables, patient and nurse scores on the Nurse's Teaching Role and the Teaching, Learning, and Satisfaction with Care scales were each correlated using the Pearson product-moment correlation coefficients.

Patients

As predicted, the test of the patient model demonstrated a positive correlation between scores on the Nurse's Teaching Role Scale and the Teaching and Satisfaction with Care scales at $p = .003$ and $p = .001$, respectively. Although the correlation between the Nurse's Teaching Role and Learning scales was positive, the magnitude of the correlation was not found to be significant at $p = .117$ (Figure 3). Thus, the

Key: ——— Hypothesized correlations
 - - - Correlations among dependent variables

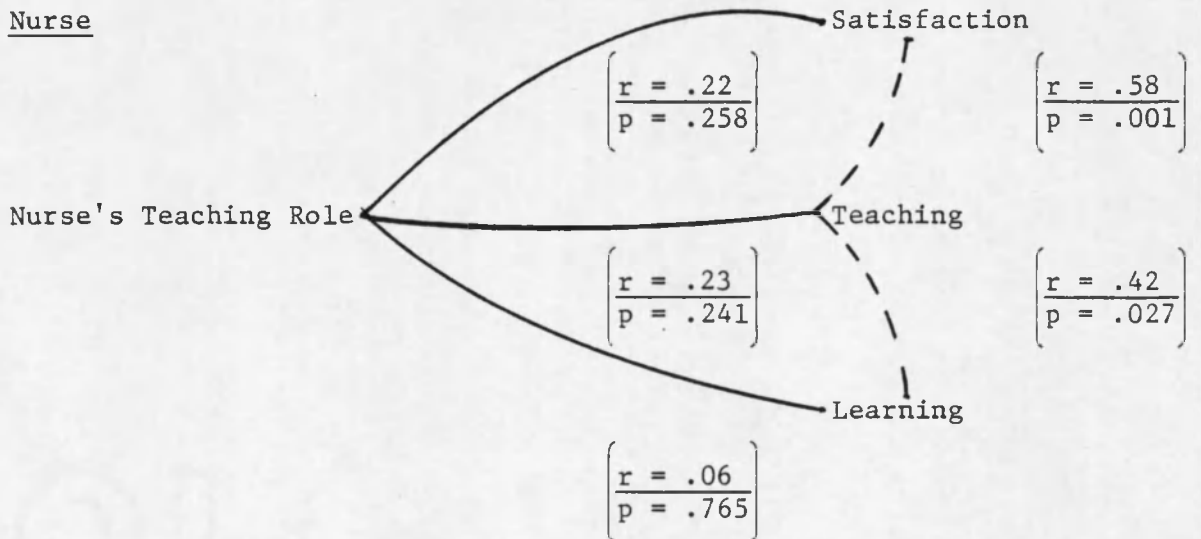
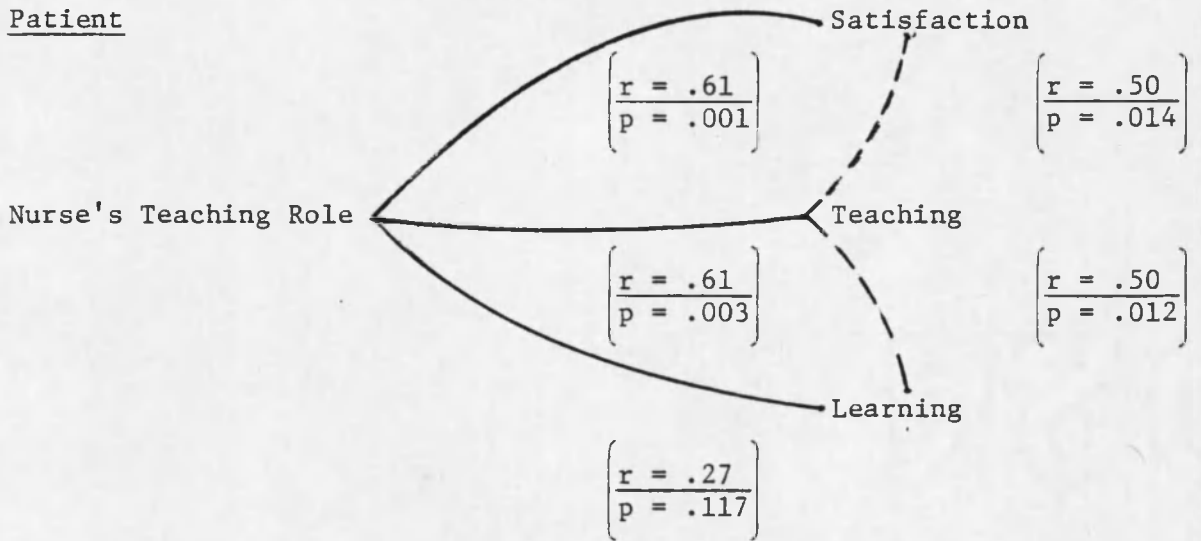


Figure 3. Patient and Nurse Correlation Coefficients of Nurse's Teaching Role Scale with Teaching, Learning, and Satisfaction Scales.

second hypothesis -- the patient perceptions of the nurse's role as a teacher will relate to the patients' perceptions of teaching by nurses, amount of perceived patient learning, and satisfaction with care in a correlational relationship -- was partially supported. It is of interest to note the Teaching Scale correlated moderately ($r = .50$) with the Learning and Satisfaction with Care scales at $p = .012$ and $p = .014$, respectively.

Nurses

In contrast to the patient model, data analysis showed no relationships among nurse scores. The Nurse's Teaching Role Scale correlated with the Teaching scores at $p = .241$, Learning at $p = .765$, and Satisfaction with Care at $p = .258$ (Figure 3). Although all of the scales correlated in the hypothesized direction, none of the coefficients were of sufficient magnitude to support the third hypothesis -- the nurses' perceptions of the nurse's role as a teacher will relate to the nurses' perceptions of teaching by nurses, amount of perceived patient learning, and patient satisfaction with care in a correlational relationship. Similar to the patient results, nurse scores demonstrated the Teaching Scale positively, moderately, and significantly correlated with the Satisfaction with Care and Learning scales at $r = .58$ ($p = .001$) and $r = .42$ ($p = .027$), respectively.

The significant and positive correlations between both the patient and nurse Teaching Scale and the Learning and Satisfaction with Care scales raises evidence for a higher common construct. However, validation for separate constructs is suggested by the moderate

correlations and the distinction nurses made between the Learning and Satisfaction with Care scales.

Summary

Although no significant difference was shown between the patient variables of age and education, patients with medical diagnoses scored lower than surgical patients on both the Teaching and Learning scales. In addition, males scores lower than females on the Learning Scale. Nurses employed over a longer time scored lower on the Role Subscale and Teaching Scale, while older nurses scored lower on the Role Subscale only. Results by medical nurses indicated they perceived more teaching than did surgical nurses. Nurses with higher degrees scored lower on the Learning Scale.

The t-test of significant revealed no significant differences between patients' and nurses' perceptions of the nurse's teaching role. However, a significant difference was found in the Role Subscale results with patients expressing a less favorable view of the nurse's role. In view of these results, the first hypothesis was partially supported.

The Teaching and Learning score results demonstrated a significant difference between patient and nurse test scores. Specifically, patients scored much higher on the Learning Scale, with no significant difference found in the Teaching Scale. Data analysis revealed a significant difference between patient and nurse response on the Satisfaction with Care Scale, with patients perceiving themselves consistently more satisfied than did nurses.

The second hypothesis was partially supported as shown by patient scores on the Nurse's Teaching Role Scale significantly correlating with the Teaching and Satisfaction with Care scales only. The third hypothesis was not supported as no significant correlations between the Nurse's Teaching Role Scale and the Teaching, Learning, and Satisfaction with Care scales were found in the nurses' scores.

CHAPTER 5

DISCUSSION OF FINDINGS, CONCLUSIONS, AND RECOMMENDATIONS

In this chapter, the results of the study are discussed in relation to the review of the literature and the conceptual framework. Conclusions and recommendations for nursing practice, education and research are also presented.

The study was designed to determine if specific measures of patients' and nurses' perceptions of the nurse's role as a teacher differ significantly. Secondly, the investigator attempted to identify the relationship of nurses' and patients' perceptions of the nurse's teaching role to perceived nurse's teaching, learning accomplishment, and patient satisfaction with care. Both nurse and patient perceptions were considered, because only when evaluation of a health care service includes both patient and nurse perceptions will a more realistic picture of nurses and nursing care be obtained (Risser, 1975).

The significance of this research is based on the importance of patient education. The literature has revealed a growing concern over the need for increased patient education in the acute care setting. In light of this, it becomes crucial to evaluate and seek ways to increase the quantity as well as improve the quality of current patient teaching. In evaluating and suggesting methods to improve patient education, it is

important to consider nurses' and patients' perceptions of the nurse as a teacher, as these perceptions may impact significantly on teaching and learning behaviors. Patients hold definite expectations of nurses, their behavior, and the way they interact with patients in delivering care. Likewise, those occupying the role of a nurse hold expectations for their own role enactment (Hinshaw, 1978). Although much research has been done on patient educational needs and teaching by nurses, no studies have directly related patient and nurse perceptions of the nurse's teaching role to teaching and learning behaviors and patient satisfaction with care. Previous studies have suggested perceptions of the nurse's teaching role may relate to both teaching and learning behaviors.

Methodology

To evaluate the responses of patients and nurses, a correlational descriptive design was used. A convenience sample of 15 patients and 14 R.N.'s from an adult medical and an adult surgical unit were included in the study. Each group was asked to complete four questionnaires. The tools included a Nurse's Teaching Role Scale, Teaching and Learning scales, and a Satisfaction with Care Scale.

Questionnaire responses were coded and analyzed by a computer. All results were reported by group, with subject names kept confidential. Means, ranges, and standard deviations were run on all scales and subscales. A t-test was used to determine if significant differences existed between patient and nurse responses on all scales. The criterion level for statistically significant differences was set at the

.05 level and .10 for substantive significance. Estimates of validity and reliability were also made for each scale. Continuous nurse variables of age, original nursing education, highest degree held, and length of time employed as a R.N. were correlated with test scores, while the analysis of variance model was used with the variable of shift worked. The patient variables of age and education were correlated with test scores and the variables of sex and diagnosis were evaluated by a t-test methodology.

Conclusions

The research hypotheses tested were:

1. The nurses' and patients' perceptions of the nurse's teaching role will differ significantly.
2. The patients' perceptions of the nurse's role as a teacher will relate to the patients' perceptions of teaching by nurses, amount of perceived patient learning, and satisfaction with care in a correlational relationship.
3. The nurses' perceptions of the nurse's role as a teacher will relate to the nurses' perceptions of the teaching by nurses, amount of perceived patient learning, and patient satisfaction with care in a correlational relationship.

The t-test of significant revealed no differences between patients' and nurses' perceptions of the nurse's teaching role. However, a significant difference at the $p < .001$ level was found in the Role Subscale results with patients expressing a less favorable opinion

of the nurse's role. In view of these results, the first hypothesis was partially supported.

The second hypothesis was partially supported as patient scores on the Nurse's Teaching Role Scale significantly correlated with the Teaching and Satisfaction with Care scales only. The third hypothesis was unsupported as no significant correlation between nurse scores on the Nurse's Teaching Role Scale and the Teaching, Learning, and Satisfaction with Care scales was found. Nurses expressed fairly strong teaching role identity; however, they suggested lack of time and expectations as reasons for perceived inconsistent teaching behaviors.

Several relationships were examined post hoc beyond the stated hypotheses. Teaching Scale scores were the same; however, a significant difference was demonstrated between patient and nurse responses on the Learning Scale with patients perceiving themselves learning a greater amount than nurses perceived. Data analysis showed a significant difference between patient and nurse test scores on the Satisfaction with Care Scale. Patients scored much higher, indicating a greater satisfaction with care.

Patients with a medical diagnosis were found to score lower on both the Teaching and Learning scales. In addition, there was a trend toward male patients perceiving they learned less than did female patients. Older nurses and nurses employed over a longer period of time scored significantly lower on the Role Subscale. In contrasting medical and surgical nurses, results showed surgical nurses scored lower on the Teaching Scale.

Relationship of Findings to the Literature Review

Associated Variables

Variables collected from the patient sample included age, sex, education, and medical or surgical diagnosis. Patient results showed no difference in test scores and the variables of age and education. This contrasts to results by Dodge (1963) and Pender (1974), who found that the higher the patient's educational level the more likely he was to be given an explanation of his treatment. Test scores did reveal that female patients tended to perceive they learned more than did male patients. Perhaps females learned more through increased communications with nurses as Dodge (1963) found young female patients attributed more importance to nurse-patient communication. In contrasting medical and surgical patients, it was found patients with a medical diagnosis scored lower on both the Teaching and Learning scales. These results may be attributed to the medical patient's different learning expectations and needs. Dodge (1963) found medical patients have a desire for information relative to medications and self-care, while the surgical patient is more interested in information about activity restrictions and success of care. Although confirmatory, the current findings are not conclusive because only one medical and one surgical unit were used in the study.

Age, original nursing education, highest degree held, shift worked, and length of time employed as an R.N. were variables assessed with the nurse sample. This study demonstrated older nurses and nurses employed over a longer period of time valued the nurse's professional

role as a teacher much less. Axford and Cutchen (1977) found nurses expressed a discomfort with the role as a teacher and indicated it was the physician's role to explain all care. Likewise, Pohl (1965) found the majority of nurses placed teaching as an important aspect of their work; however, many reported a lack of clarity in understanding their teaching role. The literature did not relate the reported lack of role clarity to the variables of age and length of time employed. Nurses employed a longer time tended to perceive nurses as teaching less. In addition, nurses with higher education generally perceived the patient as learning less. This study did not support the results of Palm (1971) and Pohl (1965), who reported the nurse's age and degree held were significant variables which strongly influenced teaching activities. Specifically, Palm (1971) found nurses without college education and older nurses tended to give much higher priority to patient teaching. Palm found no correlation between teaching activities and years of experience and shift worked. Pohl (1965) showed characteristics of nurses with high teaching activities included: one to five years' experience, collegiate nursing, some college work beyond basic preparation, and some courses in teaching.

In comparing medical and surgical nurses, results of this study showed medical nurses perceived significantly more teaching by nurses than did their surgical peers. These findings are interesting in view of the results showing medical patients perceiving less teaching by nurses and less learning by patients. It may be the medical nurses are teaching more in response to their patients' increased needs. No impact

on test scores was found with the variables of original nursing education and shift worked.

Nurse's Teaching Role Scale

This study revealed a significant difference between patients' and nurses' perceptions of the nurse's professional role, with patients expressing much less favorable impressions. Many items on the Role Subscale were left unanswered by patients. When questioned, patients expressed the belief that it was not the nurse's role to teach patients. These results support findings by Linehan (1966), Sisk et al. (1965), and Skipper (1965), where the nurse was perceived as not having the full authority or responsibility to function as a teacher. Nurses scored relatively high on the Teaching Role Scale; however, scores on the Teaching Scale were substantially lower with no significant correlation found between the two scales. These results appear to support findings by Powell (as cited in Winslow, 1976), who found nurses agreed they should be teaching patients, although they themselves were not personally teaching patients. As previously discussed, results from a study by Axford and Cutchen (1977) indicated nurses expressed a discomfort with the role as a teacher and indicated it was the physician's role to explain all care. Likewise, Pohl (1965) found the majority of nurses placed teaching as an important aspect of their work; however, many reported a lack of clarity in understanding their teaching role.

Patients and nurses both viewed the nurse favorably in knowledge and helpfulness measures, with many patients freely commenting about the importance of the nurse's helpfulness. Results by Skipper (1965) and

Leighton (1976) also showed patients placing a great deal of significance on whether or not the nurse was helpful. In their studies, they cited many instances where patients perceived the nurse as not being helpful. The importance of the nurse's helpfulness was also emphasized by Skipper et al. (1964) and Bille (1977), who reported patients expressed a desire for information from nurses. Consistent with that, they found interpersonal communication to be just as significant. Hinshaw and Oaks (1978) reported that patients indicated nurses' professional knowledge had a negative relationship to quality care for patients in contrast to the high knowledge ratings by patients in the current study. Also, when Tagliacozzo (1965) interviewed patients, only 29 percent mentioned specifically that they expected knowledge and technical skills from the nurse.

Relative to this study's results by nurses, Hinshaw and Oaks (1978) found nurses rated the function of providing information as significantly and positively influencing quality care. Nurses' high knowledge ratings in this study contrasted to findings by Pohl (1965), Redman (1976), and Salmond (1978), who related that nurses expressed a lack of essential knowledge and teaching skills.

Teaching and Learning Scales

Results from the Teaching and Learning scales showed patients and nurses perceived the nurse's teaching similarly, with scores indicating only a moderate amount of teaching by nurses. The literature revealed a general consensus that teaching by nurses is often inadequate. This perception has been cited in studies by Clark (1967), Dodge

(1969), Pender (1974), Streeter (1953), and Marks and Clark (1972). In contrast, Buckley (1963) found 75.1 percent of patient expectations of teaching by nurses were fulfilled. Also, Allen (1970) reported the majority of patients felt they had received adequate teaching on a specific procedure.

A very interesting finding in this current study was the difference in patient and nurse perceptions of patient learning. Nurses viewed the patients' learning as significantly less than did patients. These results could be related to several factors that include: patients received additional information from sources of which the nurses were unaware, patients were more knowledgeable than nurses perceived, results were related to a halo effect, or nurses were aware of how much there was to know in perspective to what the patients had actually learned. Likewise, patients knew how far they had come but not how much there was left to be learned. An additional suggestion would be that these results may have stemmed from a methodological problem in that true learning is much better measured by competency tests rather than pencil and paper questionnaires. Atwood et al. (1980) found patients rating themselves satisfactorily informed and, in contrast to this study, nurses also rated patients satisfactorily informed.

Results from the Learning Scale did not correlate with the Nurse's Teaching Role scores. This finding is quite different from research by Packard and Van Ess (1969) who found a strong positive correlation between the patients' perceptions of the nurse's teaching role and patient learning behaviors. It is important to note Packard

and Van Ess demonstrated their findings on competency based criteria rather than perceptions of learning as studied here.

Satisfaction with Care Scale

On the Satisfaction with Care Scale, with the highest possible item mean score being 5.00, patients scored an item mean of 3.8. These results are much higher than reported by Risser (1975), who found patients scored means of 2.5 and 2.2 on the Educational Relationship Scale in two separate trials. However, research by Ullery (1979) reported patient means of 4.2 for patients on a primary care unit and 4.8 for patients on a team nursing unit. Williams (1978) administered the tool to thirty family members of patients admitted to the intensive care unit. Results showed all family members expressed a relatively high degree of satisfaction with nursing care.

Relationship of Findings to the Conceptual Framework

A role interactionist and perception theory perspective were used to examine perceptions of the nurse's teaching role, teaching, learning, and satisfaction with care. The link between the concepts had been well-established. Role perceptions and expectations influence the interpretation of the stimulus (teaching) and behaviors (learning). The results of this study indicated patient perceptions of the nurse's teaching role are significantly related to perceived teaching and satisfaction with care. These results support the idea by Hinshaw (1978) that fulfilled role expectations can contribute to quality care and, specific to this study, satisfaction with care. Although results

showed a relationship of role perceptions to the stimulus (teaching), scores did not reflect a like relationship to behaviors (learning). That learning score results were not related to perceptions of the nurse's teaching role may be related to a variety of reasons, as previously discussed.

In contrast to patient results, nurse perceptions of the nurse's teaching role did not significantly relate to perceived teaching, patient learning, or satisfaction with care. Although the nurses expressed fairly strong teaching role identity, it did not correlate with perceived teaching behavior scores. Several nurses suggested restraints of time and expectations as reasons for these inconsistencies in the nurse's teaching. Inconsistencies between role and behavior were recognized by Davis (1948, p. 90) when he described role as "how the individual performs in a given position as distinct from how he is supposed to perform." Further, Conway and Hardy (1978) acknowledged the many factors affecting behaviors in their statement that the individual decides what he wishes to do, and how he will do it in response to external and internal clues. Although results suggest role perceptions were not actualized into behaviors, the concept of perception theory was partially supported by nurse results in that perceived teaching scores significantly related to perceived patient learning and satisfaction with care scores.

Recommendations

On the basis of this study, the following recommendations for nursing practice, research, and education are made:

1. Nurses need to be aware of the patient's perceptions of the nurse's role. They must be aware of the impressions they convey and attempt to present themselves as knowledgeable and legitimate patient educators.
2. Nurses must be aware of the importance patients place on their helpfulness, freely integrating this quality in teaching behaviors.
3. Nurses need to be alert to the possibility that medical patients may have greater or different learning needs than surgical patients.
4. Based on the discrepancy between patient and nurse scores on the Learning Scale, nurses must examine their own teaching behaviors, integrating their teaching with that of other health professionals.
5. Nurses must carefully assess the patient's learning throughout all phases of care. When possible, patient learning should be evaluated with competency based criteria.
6. Replicate the study in more than one hospital using a larger and randomized sample to obtain greater generalizability.
7. In order to decrease error, control for patients' acuity level and previous hospital experiences.
8. Further refine the Knowledge and Helpfulness subscales for a more accurate Nurse's Teaching Role Scale.
9. Administer the questionnaire immediately prior to the patient's discharge to better determine how teaching needs were met during hospitalization.

10. Investigate the patient's specific diagnosis as a possible factor in perceptions of the nurse's teaching role.
11. Potentially increase sensitivity of the measures by replicating the study with nurses answering questionnaires based on perceptions of themselves versus perceptions of nurses in general.
12. Compare responses of patients given structured patient teaching during hospitalization with the responses of patients given no planned teaching.
13. Further investigate the discrepancy between the nurses' perceived teaching role and actual teaching behaviors.
14. Replicate the study using competency based criteria to evaluate patient learning.

The findings of this study offer important contributions to current nursing practice, research, and education. In addition, with further testing and refinement, the instruments developed in this study will offer meaningful avenues to further the body of nursing knowledge.

APPENDIX A

PATIENTS' QUESTIONNAIRE

- I. Nurse's Teaching Role Scale (developed by Moore, this study):
 - A. Role Subscale: items 2, 4, 7, 10, and 13.
 - B. Knowledge Subscale: items 1, 5, 9, 11, and 15.
 - C. Helpfulness Subscale: items 3, 6, 8, 12, and 14.
- II. Teaching and Learning Scales (adapted from Atwood et al., 1980):
 - A. Teaching Scale: items 18, 20, 22, 24, 27, 28, 30, 32, 33, and 35.
 - B. Learning Scale: items 16, 17, 19, 21, 23, 25, 26, 29, 31, and 34.
- III. Satisfaction with Care Scale (Risser, 1975): items 36, 37, 38, 39, 40, 41, and 42.

Key to abbreviations:

D = diet

H = helpfulness

K = knowledge

L = learning

M = medications

R = role

T = teaching

T = treatments

Patients' and Nurses' Perceptions of the
Nurse's Teaching Role

You are being asked to voluntarily give your opinion on the statements in this questionnaire. The purpose of this study is to explore patients' perceptions of nurses' teaching. By responding to the questionnaire, you will be giving your consent as a willing participant in this study. All information will be treated confidentially and your name will not be on the questionnaire. Only the investigator and her research committee will have access to this information. You are free to ask questions of the investigator or to withdraw from the study at any time. You may choose not to answer some or all of the questions, if you so desire. Whatever you decide, your care will not be affected in any way.

Subject Number _____ Unit _____

Age _____ Sex _____

Circle Highest Education Completed:

Grade School 1 2 3 4 5 6 7 8

High School 9 10 11 12

College 1 2 3 4

Other _____

Diagnosis: _____

You had one or several contacts with the nurses who cared for you on this unit. For each of the questions, circle the one answer which best describes your situation on the unit.

PLEASE ANSWER ACCORDING TO YOUR SITUATION ON THIS UNIT.

I.

- (K+) 1. The nurses know the answers to my questions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R-) 2. Nurses are not allowed to explain things to me.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H+) 3. If I have a question, the nurses will help me get an answer.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R+) 4. The nurse should teach me about my medications.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K-) 5. I ask the doctor for information because nurses don't know the answers.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H+) 6. Just talking to the nurse makes me feel better.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R-) 7. It's not part of the nurse's job to explain to me about my illness.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H-) 8. Nurses get annoyed when I ask questions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K+) 9. The nurse really knows what she is talking about.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R-) 10. It's not the nurse's role to explain to me about my tests/procedures.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K-) 11. The nurse does not have a good understanding of my condition.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (H+) 12. The nurses give me information without my asking for it.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R+) 13. The nurse is a teacher to patients in many ways.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H-) 14. Nurses are too busy to spend time answering my questions.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K+) 15. The nurses were skillful in caring for me.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

II.

- (M/L+) 16. I know what medications I am taking in the hospital.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/L-) 17. I do not understand how to take care of my special treatments (i.e., dressings, exercises, care of tubes or bags, lifestyle changes, etc.).
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/T+) 18. The nurses have taught me what to expect in the future with my current condition.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/L+) 19. I understand the plans for my nutrition in the hospital.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/T-) 20. The nurses have not taught me the reason for taking each of my medications.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/L-) 21. I have unanswered questions about my diet in the hospital.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/T-) 22. The nurses have not told me what to expect from the tests/procedures in the hospital.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (K/L+)23. I understand the reason for my current condition.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/T+)24. The nurses helped me understand my diet in the hospital.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/L-)25. I am not sure of the side effects of the medications I am taking.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/L-)26. I have some unanswered questions about the reasons for my special treatments (i.e., dressings, exercises, care of tubes or bags, lifestyle changes, etc.).
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/T-)27. The nurses have not explained my current condition to me.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/T+)28. The nurses have taught me what I need to know about my medications.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/L+)29. I can probably manage my special treatments at home.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/T-)30. Nurses have not taught me about my current diet.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/L-)31. I have many unanswered questions about my current condition.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/T+)32. The nurses have explained when I should take my medications at home.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/T+)33. The nurse taught me the reasons for the procedures/tests done in the hospital.
 STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(K/L+)34. I understand the care involved with my illness.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(D/T+)35. The nurse explained to me how to prepare my diet at home.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

III.

(-) 36. Too often the nurse thinks you can't understand the medical explanation of your illness so she just doesn't bother to explain.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(+) 37. The nurse explains things in simple language.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(-) 38. The nurse asks a lot of questions, but once she finds the answer she doesn't seem to do anything.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(-) 39. I wish the nurse would tell me about the results of my tests more than she does.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(+) 40. It's always easy to understand what the nurse is talking about.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(+) 41. The nurse gives directions at just the right speed.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

(+) 42. The nurse always gives complete enough explanations of why tests are ordered.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

APPENDIX B

NURSES' QUESTIONNAIRE

- I. Nurse's Teaching Role Scale (developed by Moore, this study):
 - A. Role Subscale: items, 2, 4, 7, 10, and 13.
 - B. Knowledge Subscale: items 1, 5, 9, 11, and 15.
 - C. Helpfulness Subscale: items, 3, 6, 8, 12, and 14.
- II. Teaching and Learning Scales (adapted from Atwood et al., 1980):
 - A. Teaching Scale: items, 18, 20, 22, 24, 27, 28, 30, 32, 33, and 35.
 - B. Learning Scale: items 16, 17, 19, 21, 23, 25, 26, 29, 31, and 34.
- III. Satisfaction with Care Scale (Risser, 1975): items, 36, 37, 38, 39, 40, 41, and 42.

Key to abbreviations:

D = diet

H = helpfulness

K = knowledge

L = learning

M = medications

R = role

T = teaching

T = treatments

Patients' and Nurses' Perceptions of the
Nurse's Teaching Role

You are being asked to voluntarily give your opinion on the statements in this questionnaire. The purpose of this study is to explore nurses' perceptions of nurses' teaching. Completion of this questionnaire will indicate your consent as a willing participant in this study. All data will be treated with anonymity and confidentiality. Only the investigator and her research committee will have access to this information. You are free to ask questions of the investigator or to withdraw from the study at any time. You may choose not to answer some or all of the questions, if you so desire. Whatever you decide, your job will not be affected in any way.

Subject Number _____ Unit _____

Age _____

Circle Original Nursing Education:

LPN ADN Diploma BSN MS

Circle Highest Degree Held:

ADN Diploma BSN BA MS MA PhD

Circle Shift Worked:

7-3 3-11 11-7

Circle Length of Time Employed as Registered Nurse:

Less than 1 year

1-5 years

5-10 years

10-20 years

Over 20 years

When answering the following questions, please consider your present position on your unit only. Your response will be useful only if you are as honest as you can be. For each numbered item, circle one of the five answers.

PLEASE ANSWER ACCORDING TO YOUR SITUATION ON THIS UNIT.

I.

- (K+) 1. Nurses know the answers to patients' questions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R-) 2. Nurses are not allowed to explain things to the patients.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H+) 3. If patients have a question, nurses will help them get an answer.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R+) 4. Nurses should teach patients about their medications.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K-) 5. Patients ask the doctor for information because nurses don't know the answers.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H+) 6. Just talking to the nurse makes the patient feel better.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R-) 7. It's not part of the nurse's job to explain to patients about their illness.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H-) 8. Nurses get annoyed when patients ask questions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K+) 9. Nurses really know what they are talking about.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R-) 10. It's not the nurse's role to explain to patients about their tests/procedures.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (K-) 11. Nurses do not have a good understanding of patients' conditions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H+) 12. Nurses give patients information without their asking for it.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (R+) 13. Nurses are teachers to patients in many ways.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (H-) 14. Nurses are too busy to spend time answering patients' questions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K+) 15. Nurses are skillful in caring for patients.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

II.

- (M/L+)16. Patients know what medications they are taking in the hospital.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/L-)17. Patients do not understand how to take care of their special treatments (i.e., dressings, exercises, care of tubes or bags, lifestyle changes, etc.).
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/T+)18. Nurses teach patients what to expect in the future with their current condition.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/L+)19. Patients understand the plans for their nutrition in the hospital.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/T-)20. Nurses do not teach patients the reasons for taking each of their medications.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (D/L-)21. Patients have unanswered questions about their diet in the hospital.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/T-)22. Nurses do not tell patients what to expect from the tests/procedures in the hospital.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/L+)23. Patients understand the reasons for their current conditions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/T+)24. Nurses help patients understand their diets in the hospital.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/L-)25. Patients are not sure of the side effects of the medications they are taking.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/L-)26. Patients have unanswered questions about the reasons for their special treatments (i.e., dressings, exercises, care of tubes or bags, lifestyle changes, etc.).
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/T-)27. Nurses do not explain to patients about their current conditions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/T+)28. The nurses teach patients what they need to know about their medications.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/L+)29. Patients probably can manage their special treatments at home.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/T-)30. Nurses do not teach patients about their current diets.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (K/L-)31. Patients have many unanswered questions about their current conditions.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (M/T+)32. Nurses explain to patients when they should take their medications at home.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (T/T+)33. Nurses teach patients the reasons for the tests/procedures done in the hospital.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (K/L+)34. Patients understand the care involved with their illness.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (D/T+)35. Nurses explain to patients how to prepare their diets at home.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- III.
- (-) 36. Patients feel too often the nurses think the patients can't understand the medical explanation of their illness so they don't bother to explain.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (+) 37. Patients feel nurses explain things in simple language.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (-) 38. Patients believe nurses ask a lot of questions but once they find the answers they don't seem to do anything.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (-) 39. Patients wish the nurses would tell them about the results of their tests more than they do.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE
- (+) 40. Patients feel it's always easy to understand what the nurse is talking about.
STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (+) 41. Patients believe nurses give directions at just the right speed.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

- (+) 42. Patients feel nurses always give complete enough information of why tests are ordered.

STRONGLY AGREE AGREE UNDECIDED DISAGREE STRONGLY DISAGREE

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