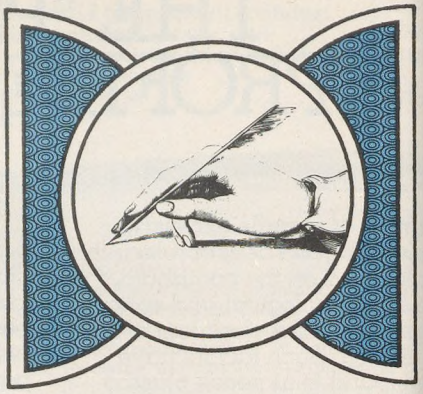
Letters to the Editor



The Journal welcomes Letters to the Editor; if found suitable, they will be published as space allows. Letters should be typed double-spaced, should not exceed 400 words, and are subject to abridgment and other editorial changes in accordance with journal style.

Effectiveness of Patient Education

To the Editor:

I am concerned that Dr. Webb's article on the lack of effectiveness of patient education *(Effectiveness of patient education and psychosocial counseling in promoting compliance and control among hypertensive patients. J Fam Pract 10: 1047, 1980)* may be regarded as a significant argument against the devotion of care delivery resources toward patient education, in the name of cost effectiveness. The discussion and conclusions dealt with some qualifications and limitations of the study, but several key aspects were omitted from consideration.

No data were given regarding the baseline pill count compliance rates and post-intervention rates. The most critical compliance indicator was lumped with pill bringing behavior—a desirable, but certainly secondary behavior. How much room for improved compliance was there, and how much improvement occurred in each group by pill count? Also unmentioned in the methods section is an explanation of how pill count compliance was entered into the combined bringing-and-consuming rating for visits where the patient did not bring his/her medication.

No mention is made of the number of blood pressure measurements taken on each visit. At least two, and preferably three readings per visit, ideally separated by at least a minute, are necessary to minimize variability of individual blood pressure over time during a visit, and intra- and inter-observer variability in blood pressure measurement performance.[1] Also, one wonders why diastolic blood pressure only was reported on, with ample evidence in the Framingham Study[2] and others indicating the equal or greater importance of control of systolic blood pressure.

A major educational point is that the once-a-month frequency of intervention, while probably adequate for follow-up reinforcement, is suboptimal for the initial facilitation of significant changes in knowledge, attitudes, or behavior in most target areas. A fertile area for research in family practice is the def-

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inition of optimal intervals for initial and follow-up education efforts, especially in the area of chronic diseases and disease risk factors.

Most importantly, it seems that the opportunity for demonstrating significant lowering of blood pressure by any intervention was very seriously undermined by more than one half (52 percent) of the subjects in the "uncontrolled hypertension" study having pretreatment baseline diastolic blood pressures of 90 mmHg or lower. The effective "n" actually is closer to 59, rather than 123—probably too small to demonstrate significant effects when distributed among three intervention groups.

I applaud Dr. Webb's efforts to examine critically some important questions in the swampy patient education process. It is almost impossible to do faultless research in this area, but good progress is being made toward more effective strategies and techniques.

Regarding Dr. Geyman's editorial about patient education,[3] I would like to add two practical recommendations for improving patient's memory and understanding of health education. Both of them are used by only a small minority of physicians, I suspect, due to time considerations, but if used more routinely, might be time-efficient in the long run. Both would probably add appreciably to the quality of care our patients receive.

1. Write down your recommendations legibly on a sheet of paper (possibly specially printed with a checklist format) for the patient to take home.

2. Take a minute or two to question the patient about his understanding (requiring specific answers, not yes or no responses), his attitudes about your recommendations (acceptance, misgivings, rejection), and his intended behavioral changes.

I suspect that poor or nonexistent documentation of patient education efforts in the medical record is a prime roadblock to the long-term continuity of such efforts. Terse catch phrases in the Plan section of progress notes can sustain educational content and process toward favorable patient education outcomes.

Michael A. Crouch, MD
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References

1. Schwartz MS: A design for the collection, processing, and analysis of hypertension data. Bull NY Acad Med 52: 735, 1976
2. The Framingham Study: An epidemiological investigation of cardiovascular disease. Bethesda, Md, National Heart Institute, 1968
3. Geyman JP: How effective is patient education? J Fam Pract 10:973, 1980

The preceding letter was referred to Dr. Webb who responds as follows:

I appreciate Dr. Crouch's comments. Pill counts and pill bringing behavior were included with diastolic blood pressure to provide a multi-dimensional measure of compliance. However, pill counts and

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pill bringing as isolated measures are less valid, and blood pressure is the most definitive test of the effectiveness of intervention. Accordingly, baseline data were collected only for diastolic blood pressure. Diastolic blood pressure was recorded by both the nurse and the physician at each visit, and averaged.* The diastolic parameter was chosen because diastolic blood pressure is generally considered to be more closely correlated with organ damage.[1]

It is incorrect to conclude that over half (52 percent) of the sample had diastolic blood pressures of 90 mmHg or lower. The baseline blood pressure was an average of the readings at the two visits prior to intervention. At least one of these was greater than 90 mmHg and, based on chart review, all patients had at least a one-year history of poorly controlled hypertension. My study focused on long-term, uncontrolled hypertensive patients which is, afterall, the population most in need of improved compliance. The results should not be generalized to other groups of patients, particularly to newly diagnosed patients. The three, monthly, hour-long intervention sessions failed to demonstrate a positive effect. Rather than speculating on the advantages of even more frequent intervention, I prefer to look to other avenues to improve compliance as proposed in the discussion section of my paper.

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*See Reference No. 25: Webb P: The relative effectiveness of patient education and psychosocial counseling in promoting compliance and control among hypertensive patients, thesis. University of Miami, Miami, Fla, 1978

Reference

1. Thorn GW, Adams RD, Braunwald E, et al (eds): Harrison's Principles of Internal Medicine, ed 8. New York, McGraw-Hill, 1977, pp 188, 1305-1307, 1318