



# SURGICAL PATIENT EDUCATION:

Transformation  
to a system  
that supports  
full patient  
participation

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**A** patient's wife sits at the bedside in the hospital, vigilant and ready to assist in the care of her husband following his colorectal surgery. However, she is uncertain what she should be watching for or what she should be doing to help her husband's recovery. He is discharged the next day with brief instructions about postoperative recovery, including the care of the colostomy. The couple is anxious about home management but told that the home health nurse will come the next day and do the necessary wound and ostomy teaching.

The potential problems with this scenario are evident. The patient and family are lacking the education, skills training, and competence to manage continued recovery post-discharge.

Though major emphasis has been placed on education for health professionals as a method to improve patient safety, there has been less emphasis on standardized education for patients and patients' families. More than 100 studies have identified that patient education, skills training, and psychosocial support result in significant improvement in surgical outcomes.<sup>1-3</sup> Despite the positive results from the patient education research, the national emphasis on patient safety and the government initiatives and standards—identifying that patients have the right and responsibility to participate in health care decisions<sup>4,5</sup>—there has been minimal progress toward implementing standardized educational approaches to support full patient participation. Patients continue to come to the experience of having an operation with limited education to support informed decision making and full participation; they often leave the hospital with minimal skill acquisition for task execution and without the required knowledge to prevent decision errors.<sup>6-9</sup>

Patients are discharged early and full participation in care is expected, yet there is limited training or validation of skills, and patients are often left to rely only on their memory as they continue their recovery at home. The critical role of the patient as an integral member of the surgical team is essential to achieve transformation to a safer health care system.

## ACS vision and goals

The American College of Surgeons is at the forefront to build organizational support for change by implementing a patient education program that strengthens the healing relationship and empowers patients with the skills and knowledge needed for full participation in care. As identified in the Institute of Medicine report, *Crossing the Quality Chasm: A New Health Care System for the 21st Century*, health care should be safe, effective, patient-centered, timely, efficient, and equitable.<sup>4</sup> Applied to patient education, safety is enhanced when patients can anticipate what is likely to happen and have the skills needed for decision making and providing self-care. An effective program is evidence-based and provides the necessary information to patients so that they can make informed decisions. Patient-centered education provides patients and families with the knowledge and skills needed to help reduce their risks of complications and support them in clinical decision making, in particular, post-discharge. A timely approach provides patients with access to education when needed—for example, before meeting with the surgeon—so that they can intelligently discuss and understand the options presented and to reinforce skills training and self-management postoperatively. An equitable and efficient system is cost-effective and collaborative among practitioners, patients, and specialty groups, and offers quality patient education to all individuals regardless of practice setting or location.

Recognizing the pivotal role of patients in the context of systems-based practice and patient safety, a new patient education program was officially launched in December 2004. The goals of the program are to help patients and their families become fully informed about the operation with current evidence to guide them in their decisions and empower them with the knowledge and skills necessary to fully participate in their hospital care and continued care post-discharge. We aspire to change the way surgical patients are educated, to improve patient health literacy and participation, and to maximize patient safety while supporting health professionals with a source of patient education based on current scientific data.

The program supports patients with educational experiences designed to meet a variety of learning styles and abilities. Education will occur through active engagement of the patient in the learning experience. The cognitive domain will be addressed through print, e-learning, and interactive education. Patient education will include the full spectrum of cognitive elements such as knowledge, decision making, and visualization and mental rehearsal of skills. Skills acquisition will be based on principles of contemporary surgical education. Skills training kits will provide didactic instruction; a clear description of the skill or task to be performed; and, most importantly, the opportunity for guided learning, including practice and demonstration of the skill, assessment of knowledge, and feedback on performance.<sup>10</sup> The final stage of learning—care provided by the patient or family—will be assessed through a variety of patient outcome measures. The science of patient education will advance through a system structured for outcomes analysis and continued quality improvement.

An ACS Patient Education Advisory Committee (see box, this page) was appointed to design

and implement a comprehensive patient education program. The first meeting of the advisory committee was in June 2005. Members bring extensive experience as leaders in the area of surgical education along with diversity in specialties, regions, and years in practice. In addition, the members are committed to educating patients so patients can partner with surgeons in management of their care and the transformation to a safer health care system.

### Program planning

Curriculum planning for the patient education program began with a comprehensive needs assessment. The assessment included a review of current standards and guidelines, an analysis of the informed consent and surgical patient education literature, a review of patient education material currently available through professional surgical specialty organizations, implementation of a national survey of surgeons and surgical nurses of current patient education and informed consent practice, and expert consensus of leaders in surgery.

The review of current informed consent guidelines and surgical patient education guidelines included material from the Joint Commission for Accreditation of Health Care Organizations—*Guidelines for Ambulatory Surgery Patient and Family Education and Planning Your Recovery*<sup>11,12</sup>—the *Patient's Bill of Rights*,<sup>5</sup> and informed consent guidelines published by the American College of Surgeons and the American Medical Association (AMA). (See Figure 1, page 14.) The guidelines outline the rights and responsibilities of patients to participate in their care and emphasize that patients must be given sufficient information to make decisions and to take responsibility for self-management activities.<sup>13</sup>

A review of national and international professional surgical organizations' Web sites was completed as part of the needs assessment of the patient education program. Professional health care organizations and associations are called to set the standard for excellence and commit to improving the system through the use of the best available evidence. They have a key role in their ability to change the culture and disseminate

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information to patients and professionals. The purpose of the assessment was to determine (1) was patient education material available; (2) did the patient information meet the minimal criteria as listed in the Patient Bill of Rights—that is, procedure description, risks, and benefits; and (3) did the patient information meet the complete standards provided by the ACS for surgical informed consent and patient education, which includes a description of what to expect during and following hospitalization. Only six of the 59 surgical specialty organizations currently have

complete patient education materials that meet the ACS guidelines for informed consent. Clearly, this represents an opportunity for collaboration and improvement.

Current practices were assessed through a national survey developed and implemented by the ACS Division of Education. The survey was completed by a random convenient sample of 363 surgeons and 820 perioperative nurses in the spring/summer of 2005. The purpose of the survey was to determine the availability of quality patient education materials in surgi-

Figure 1: Guidelines for patient education

<b>Guidelines for Ambulatory Surgery Patient and Family Education (Joint Commission, 2005)</b>	<b>Planning Your Recovery, A Speak Up Safety Initiative. (Joint Commission, 2005)*</b>	<b>Guidelines for Informed Consent (ACS)</b>
<p>Improve patients' understanding of their assessed needs, options for procedures and anesthesia, and the anticipated risks and benefits of treatment;</p> <p>Encourage patient participation in decision making about care;</p> <p>Increase the likelihood that patients will follow their preoperative and post-procedure instructions;</p> <p>Maximize patient self-care skills;</p> <p>Enhance patient participation in continuing care<sup>11</sup></p>	<p>Condition information</p> <ul style="list-style-type: none"> <li>• When patient should feel better</li> <li>• Return to and special instructions for daily activities</li> <li>• Degree of assistance</li> <li>• Signs and symptoms to watch for</li> <li>• Home set-up</li> <li>• Professional person to call after leaving hospital</li> </ul> <p>Medication information</p> <ul style="list-style-type: none"> <li>• Full list with written directions</li> <li>• Food or drink you should avoid</li> <li>• Side effects, including dizziness or confusion, which could lead to falls or forgetfulness</li> </ul> <p>Follow-up care</p> <ul style="list-style-type: none"> <li>• Physical exercise</li> <li>• Wound care directions</li> <li>• Use of special equipment</li> <li>• Follow-up tests and visits and transportation coverage</li> <li>• Insurance review to determine what will be covered</li> <li>• Home care services or assisted living<sup>12</sup></li> </ul>	<p>Nature of illness and course of no treatment</p> <p>Operation description</p> <p>Estimated risks of mortality and morbidity</p> <p>Complications</p> <p>Benefits</p> <p>Expectation during and post hospitalization</p> <p>Alternative treatments including nonoperative<sup>14,15</sup></p>

\*Upon patient request, these guidelines must be provided, in writing, in a language they can understand.

cal practice, determine the needs of surgeons and perioperative nurses, and determine how the ACS can support and enhance the area of informed consent and patient education. The results identified that the most frequently used methods by surgeons for informed consent were oral review followed by oral review with hand-drawn images. Only 46 percent of surgeons had print material for the majority (greater than 50%) of their procedures. Significant findings of the study included overwhelming support for the ACS to develop easily accessible quality patient education materials with more than 94 percent of surgeons and surgical nurses indicating that it would be helpful for the ACS to develop education and informed consent materials in various formats. The need for patient skills education was very evident. Only 19.5 percent of surgeons and surgical nurses provided patients with any skills education materials and only 33.5 percent provided any opportunity for patients to demonstrate or practice skills required for surgical recovery (see table, this page).

These results are noteworthy because skills training produces the largest effect on reducing complications in surgical patients.<sup>1-3</sup> There was a significant increase in the availability of patient education, skills education, and informed consent materials when hospitals and clinics had an active patient education committee.

A literature review on informed consent in surgery and surgical preoperative and postoperative education confirmed gaps in the content and method of delivery. An analysis of 540 consent forms from 157 randomly selected U.S. hospitals identified that 96 percent of informed consent surgical forms indicate the nature of the procedure, but only 26 percent included procedure, risks, benefits, and alternatives, and 14 percent

provided adequate information to aid the patient with decision making.<sup>16</sup> Evaluations of surgical leaflets identified only 14 percent that were considered suitable for content, 10 percent that met readability standards (eighth-grade level), and none that provided interactive learning simulation.<sup>17,18</sup>

Gaps were also evident during audiotaped surgical encounters. A review of 1,057 encounters of general and orthopaedic surgery identified that only 9 percent of the encounters met the criteria required for the patients to be fully informed about their surgical procedure.<sup>19</sup> Furthermore, assessment of patient understanding and any offering of psychosocial support were rarely provided by physicians during medical encounters.<sup>20-25</sup> These outcomes are noteworthy considering professionalism and humanistic communication skills are core competencies for physicians,<sup>26</sup> and patient-centered communication increases patient and physician satisfaction, improves clinical outcomes, and decreases the likelihood of malpractice litigation.<sup>9,25,27-31</sup> The use of informed consent guidelines by surgeons significantly improved the thoroughness and process of all informed consent categories with patients, including assessment of patient understanding and psychosocial support.<sup>32</sup>

A review of surgical patient education literature identified significant improvements in patient outcomes (such as length of stay, satisfaction, and compliance with activities) when content was delivered using methods where patients could see the skill performed—skills training, coping empowerment, and psychosocial support. The more robust studies that included all three domains had the largest improvement in all measured areas.<sup>1-3</sup> Skills training produced the largest effect on preventing complications.

#### Availability of patient skills education:

Response of the ACS and the Association of periOperative Registered Nurses, Inc.

	Surgeon	Nurse	Surgeons/ nurses
Material available to visualize skills	16%	23%	19.5%
Material available for patient to practice skills	26%	41%	33.5%

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Patient outcomes improved across all settings and populations when the information was provided in writing, used pictures, and emphasized the patient's role in coping.

Timing and usefulness of education are also important elements to surgical patients. Patients expressed concerns that the admission day was confusing and fatiguing, and identified processing educational information on that day as "too much." A frequent patient request was to obtain information at least one to three weeks in advance of surgery.<sup>33</sup> Patients identified the need for more practical information at discharge. The requests included greater knowledge of their condition, more information about medications, how to manage activities of daily living, how to perform treatments or skills, what complications to anticipate and how to manage them, and support on interpersonal communications—that is, how to discuss their surgery and home care with family and others.<sup>34,35</sup> Most information provided at discharge was delivered verbally, with only 50 percent of patients receiving any information in writing.<sup>7</sup>

Expert consensus was the final needs assessment strategy for the patient education program. The ACS Patient Education Advisory Committee served as this group of experts. At the first meeting, members were provided information from various sources. Members shared their commitment to focus on patient-centered care, to empower patients, and to address a broad variety of educational levels. The following objectives were developed by the committee:

1. Create patient education resources in various formats to address the knowledge and skills of patients and provide guidance to patients regarding reliable information from the currently available resources. Material will include informed consent guidelines, preoperative and postoperative education, skills education, and discharge instruction. The electronic materials would be available on the ACS Web site.

2. Provide for ease of access and consistent information to all health professionals.

3. Establish national guidelines for patient educational materials and skills training in the preoperative and postoperative setting, with emphasis on the transfer of the requisite knowledge and skills to patients and their families.

4. Develop and evaluate innovative patient education modules, which are interactive and patient-centered and evaluate knowledge and skills performance.

#### Program implementation

*ACS patient education Web site (www.facs.org/patienteducation/)*. Patients and their families frequently turn to the Internet or the lay press for education, only to be exposed to information that is often inaccurate and inadequate to provide the education necessary to assist with decision making. The ACS patient education Web site was developed in collaboration with ACS Communications staff and has been designed to provide reliable patient education from current available resources. Collaboration is being pursued with the surgical professional specialty organizations that currently have material that meets ACS guidelines for informed consent and input from various programs in the College. The Web site contains patient and professional resources from the National Institutes of Health (NIH), the National Library of Medicine, National Practice Guidelines, and surgical and medical specialty organizations. Examples of educational material on the Web site include the following:

- Disease information from the NIH on disease description and management, tests, symptoms, injuries, and surgeries, many with illustrations
- Collaborative surgical information from the ACS and surgical specialty organizations arranged alphabetically by disorder; all surgical content meets the ACS informed consent guidelines
- Medications resources from the NIH drug information site that includes information on prescription and over-the-counter medications and herbs and supplements—drug information includes action; side effects; precautions; administration considerations including dietary, age, disease, and missed dose considerations; storage; emergency; and brand names
- Test and laboratory information from the NIH consumer health information site, including information on the purpose, preparation, and interpretation of the results
- NIH Interactive Education–X-Plain Interac-

tive provides easy-to-understand, animated, and audible tutorials on 80 procedures or conditions

- Cancer information links are provided to the American Cancer Society, National Comprehensive Cancer Network, and Collaborating to Conquer Cancer (C-Change)
- Medical library (PubMed)
- Surgeon locator links patients directly to the ACS Find a Surgeon site
- Pain-management resources: includes The

American Society of Anesthesiology, American Pain Foundation, and COMPASS postoperative pain management resources

- Surgical Practice Guidelines from the National Guidelines Clearinghouse

*Patient education print and e-learning material.* Clear guidelines have been established by the Joint Commission for ambulatory surgical and hospitalized patients on informed consent, patient and family education, home care, and communica-

tion. Patients must be given sufficient information to make decisions, to take responsibility for self-management activities, to be involved in decisions, and to be educated to improve individual outcomes. A content analysis of several interactive patient education and risk-management commercial products was completed by the ACS Patient Education Advisory Committee and the ACS Advisory Councils. Following the review, it was determined that the available products in surgical patient education did not address the various goals of the committee.

Under the guidance of the ACS Patient Education Advisory Committee and the ACS Advisory Councils, print and e-learning materials are in development. All patient education material is being developed to meet the needs of persons with low health literacy and slow readers as well as to provide resources for patients with high health literacy. Content experts are involved in the development and review of the material. Educational and instructional design consultants, and the guidelines from the Centers for Disease Control and Prevention for creating easy-to-read print materials, are being used for development of materials.

Figure 2: Sample ACS patient education material

**The Condition**  
Cholecystectomy is the surgical removal of the gallbladder. The operation is done to remove the gallstones that cause swelling and block the gallbladder and the liver.

What are the common symptoms?  

- Sharp pain in the upper right part of the abdomen that may go to the back
- Low fever
- Nausea and feeling bloated
- Jaundice (yellowing of the skin)

**Treatment Options**  
**Surgery**  
 Laparoscopic cholecystectomy – the gallbladder is cut free and removed with instruments placed into 4 small slits in the abdomen.  
 Open cholecystectomy – the gallbladder is removed through an incision on the right side of the abdomen.  
**Non Surgical**  

- Stone retrieval
- Oral dissolution therapy

 For gallstones without gallbladder swelling:  

- Watchful waiting
- Diet changes
- Increased exercise
- Herbal medicine

**Patient Education**  
 This education is to help you be informed about your operation and empower you with the skills and knowledge needed to participate in your care.  
**Team Care**  
 Information that will help you further understand your surgery and your role in healing.  
**Education is provided on:**

- What is Cholecystectomy
- Common Symptoms
- Treatment Options
- Options to Surgery
- Surgical Techniques
- Benefits of Surgery
- Possible Complications
- Expectations
  - Preparing for Your Surgery
  - Anesthesia
  - Day of Surgery
- Your Recovery

**Risks of Not Having Surgery**  
 The symptoms may get better but can return if left untreated.

**Benefits of Surgery**  
 Gallbladder removal will relieve pain and in most cases stop gallstones from coming back.

**Risks of Surgery**  
 Your surgeon will do everything possible to decrease any risks. Possible complications include puncture of the intestine, bleeding or bile leaking into the abdomen, fever, liver injury, infection, numbness, raised scars, or hernia at the incision and death.

**Expectations**  
**Before your operation** - the most common test to check for gallstones is an abdominal ultrasound. Your surgeon will ask about your health history and home medications. The anesthesiologist will meet with you to talk about anesthesia options and pain control.  
**The day of surgery** - you will not eat or drink for 4 hours before the operation. Most often you will take your normal medication with a sip of water.  
**Your Recovery** - with no complications you are usually discharged home in 24 hours for a laparoscopic procedure and in 2-3 days for an open procedure. Call your surgeon if you are in severe pain, have stomach cramping, a high fever, your skin turns yellow or there is odor and increased drainage from your incision.

AMERICAN COLLEGE OF SURGEONS  
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 PATIENT EDUCATION  
*Partners in Your Surgical Care*  
**Cholecystectomy**  
 BEING INFORMED ABOUT YOUR CHOLECYSTECTOMY OPERATION  
 (Surgical Removal of the Gallbladder)

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(See Figure 2, page 17). The first page is designed to capture the reader's attention and provide an overview of essential content. It also supports the slow reader with limited health literacy. The document then proceeds to more in-depth education and includes sections such as "Keeping You Informed," which provides a summary of the statistics and current evidence to support clinical decisions. "Reducing Your Risks" identifies patient participation and outlines how patients can actively reduce their risks and enhance recovery.

Patients are an integral part of system improvement. All ACS print and Web-based material will have a patient evaluation component to assess the validity of instruction and to determine if current information matches the patient experience and advances the science of surgical patient education. Investigational Review Board approval has been sought to obtain input from nonmedical individuals of various ethnic and educational levels on the usefulness of the new material. Interactive education will also be developed. The committee recognizes the need for quality print and Web-based material and also the need to update the current patient education material offered by the ACS.


*Surgical skills patient education.* Creating an educational experience that provides the learner with the opportunity to practice is essential for meeting the objective of responsibility for self-management of care. This goal can be achieved through simulations that give the learner the opportunity to learn, develop, and practice skills. Planning is under way for collaboration with surgical specialty organizations, instructional design specialists, and curriculum experts to develop a standardized template for interactive patient skills education. Train-the-trainer activities will be developed as part of this program. An equitable system provides access to high-quality education to all surgical patients.

*Informed consent guidelines.* Informed consent is basic to fostering open communication and trust in the surgeon-patient relationship. The *Agency for Healthcare Research and Quality: Evidence Report/Technology Assessment* identifies that incomplete consent is a significant patient safety issue.<sup>36</sup> While the ideals for informed consent are pure, the process is often

ineffective and inconsistent.<sup>16</sup> Improper informed consent is also cited in 40 percent to 60 percent of all liability lawsuits, and the majority of liability cases involve issues of poor communication.<sup>37,38</sup> Standard guides for informed consent specific to the procedure significantly improve thoroughness of information presented and assessment of patient understanding.<sup>32</sup> The ACS is in negotiation with several commercial groups regarding procedure-specific informed consent documents.

*Standards for patient education.* The ACS has a long-standing commitment to patient safety. The Patient Education Advisory Committee recognizes the importance of patient education derived from evidence-based medicine, skills acquisition, and patient participation as a major strategy to improve patient safety. A statement confirming the importance of patient education was needed to promote awareness of the critical role of patients as integral members of the surgical team. The committee has developed the first draft of an ACS Statement on Principles of Patient Education for the ACS Board of Regents. The statement supports providing patients with the education and skills necessary to contribute effectively in their own care, and affirms the commitment of the ACS to its mission of improving the care of the surgical patient.

The interdependent relationship among patients, surgeons, and health care systems must be considered when designing educational programs on improving patient safety. The ACS is uniquely positioned to address the learning needs of patients and to facilitate a change in the culture to include the patient as an integral member of the surgical team. This change requires implementation and evaluation of patient education and skills acquisition along with train-the-trainer activities to support practitioners with patient skills education. Standardization and enhancement of patient education, discharge instruction, and surgical practice guidelines will provide the necessary infrastructure to support the entire surgical team to reduce complication and improve patient outcomes.

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