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Review Article

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Analyzing Patient Education in Croatia and America

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Introduction

Patient education is broadly accepted as a necessary tool to improve health outcomes, self-management, and medication adherence. However, there are still issues surrounding the practice of patient education, and further research is needed on verbal versus written education, and on how to tailor education to a patient's specific literacy and cultural context [1,2].

By analyzing hospitals in the USA and in Croatia, this review aims to illustrate and compare patient education in two different healthcare systems, outline benefits and shortcomings of each system, and clarify further research opportunities. This will be accomplished through the examination of case reports from the Hospital for Special Surgery (HSS) in New York City, Harborview Medical Center in Seattle, and the Hospital of Obstetrics and Gynecology in Zagreb. These three institutions all provide expert care to their communities while aiming to adequately inform patients of their ailments [3].

Some common strengths of patient education noted in each of these three institutions include: physicians clearly explaining procedures and recovery in advance, and a strong willingness to listen to patients.

To mention just a few shortcomings: in the New York City HSS Spine Surgery Department, the core issue blocking adequate patient education was the short appointment time. The Neurosurgery Clinic at Harborview's main problem in patient education was the speed at which surgeons explained different pathologies and the challenging professional verbiage used. Furthermore, patients would occasionally hear contradictory statements from fellow and attending surgeons. In the Hospital of Obstetrics and Gynecology in Zagreb, hospital personnel expressed different priorities, which could lead to patients feeling inundated and confused.

One patient in Harborview, a man in his early 40s, had suffered a stroke. When asking why he had experienced a stroke, his question was left majorly unanswered (perhaps because it is an unanswerable question). Furthermore, when asking about any scars that would be left after his double bypass, the doctors were confused why this would be an important question, and were a bit dismissive. The second patient who suffered trigeminal neuralgia was met with complex verbiage and a quick pace of explanations by the doctors. Also, the fellow doctor came in before the attending, and he said that the decompression material used would be a fat graft while the attending asserted that they would be using Teflon felt. These differences may not seem important to the doctors, but to the patient there is importance in these details.

In HSS, the doctor had only fifteen minutes to go through all of the imaging, answer any questions, and explain further steps. One patient with lumbar stenosis had a fellow recommend decompression while the attending surgeon recommended fusion. Again, this resulted in patient confusion. Another patient with cervical myelopathy and lumbar stenosis had no cervical symptoms, so she was unclear why she required cervical surgery first–the doctor had to rush an explanation without having enough time for further questions.

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In the Hospital of Obstetrics and Gynecology in Zagreb a patient was given separate instructions by anesthesiologists, nurses and doctors. She was scheduled for a dermoid cystectomy and the head nurse told her to not eat for 24 hours beforehand, while the doctor said do not eat for 12 hours beforehand. Another patient with chocolate cyst removals had a rushed postoperative explanation (during rounds) regarding infertility. Such a delicate subject should ideally have more time for conversation, but sometimes it is impossible.

These three hospitals, in two different countries with two different healthcare systems, share similar problems in patient education. The key issues are that (1) patients may receive information from many different healthcare providers, who (2) tend to overwhelm patients with information, and who (3) sometimes use technical terminology, confusing many patients. Future research should assess which forms of communication lead to the best patient understanding, identify a streamlined approach so patients receive information from 1-2 key stakeholders, and train medical personnel to speak colloquially with all patients.

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