

MULTIPLE PERCEPTIONS OF DISCHARGE PLANNING IN ONE URBAN HOSPITAL

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Since the advent of diagnosis-related groups (DRGs), advocacy groups have claimed that although hospital discharge planners perceive the discharge planning process as helpful, elderly patients and their families do not. This article explores how the discharge planning process was perceived by 40 discharge planners and 40 family caregivers. Planners greatly overrated caregiver influence and the amount and adequacy of information shared about posthospital health care, choice of discharge to home or nursing home, and time to decide. Caregivers perceived that nursing homes were forced on patients by social workers and physicians. DRGs, physicians, and hospital administrators appeared to pressure social workers to coerce mentally competent patients into nursing homes. Excessive concern by hospital staff about patient safety after discharge may override patients' rights to autonomy and self-determination, violating the NASW Code of Ethics. Implications for practice, policy, and future research are discussed.

Key words

caregivers
discharge planners
elderly patients
ethics
risk management

Since the advent of diagnosis-related groups (DRGs), elderly patients are discharged from hospitals "quicker and sicker." Advocacy groups have claimed that although hospital discharge planners perceive the discharge planning process as helpful, patients and their families do not. In fact, the social process of transferring patients from hospital to posthospital settings has received little systematic study. Participants' perceptions of the process have been studied even less.

This study sought to answer two questions: (1) How do discharge planners and family caregivers perceive their influence and the amount and adequacy of information, choice, and time in the discharge planning decision? (2) How do their perceptions differ and agree? Respondents' comments raise important issues that need to be considered in practice and public policy.

LITERATURE REVIEW

Studies on decision making in discharge planning have investigated patient participation (Coulton, Dunkle, Chow, Haug, & Vielhaber, 1988; Coulton, Dunkle, Goode, & MacKintosh, 1982) and social workers' perceptions of patient participation (Abrahamson, 1988). To date, no studies have conceptualized discharge planning as a social process of small-group decision making by elderly patients, family caregivers, and discharge planners. Participants' perceptions of the process are unknown. Three strategies for understanding the discharge planning process have been identified: (1) use of sociodemographic variables in measuring client characteristics and utilization of helping services (Asser, 1978; Kleinman, 1973), (2) examination of discharge planning and decision-making processes (Abrahamson, 1988; Coulton et al., 1982, 1988; Wetle, Levkoff, Cwikel, & Rosen, 1988), and (3) exploration of organizational responses to clients (Lefton & Rosengren, 1971; Pruitt, 1981).

Some investigators have found that the amount and adequacy of information, choice, time, and patient and caregiver influence in decision making during discharge planning may be insufficient (Abrahamson, 1988; Blazyk & Canavan, 1986; Coulton et al., 1982, 1988; Wetle et al., 1988). Indeed, participants involved in health care decisions may perceive the same process quite differently (Wetle et al., 1988). Adequate information about

posthospital care options, adequate time to make a decision, perceived choice of options, and influence in the decision enable patients to participate in the discharge planning process and cope with outcomes (Abrahamson, 1988; Coulton et al., 1982, 1988; Wetle et al., 1988).

METHOD

Setting

The sample was drawn from one 450-bed tertiary-care teaching hospital accredited by the Joint Commission on Accreditation of Healthcare Organizations and affiliated with two medical schools. Although the hospital was located in an urban area, the service area was predominantly suburban. Polish, German, Italian, Russian, French Canadian, Jewish, and Irish ethnic groups, as well as black and Hispanic groups, were represented in the towns served by the hospital. The population was predominantly middle, lower-middle, and working class.

Sample

Data were collected from 40 hospital discharge planners and 40 family caregivers. The study was originally designed to sample planners, caregivers, and hospitalized elderly patients, but the hospital denied approval to interview the patients.

High-risk elderly patients—those who were older than 70; living alone; or being treated for hip fracture, cardiovascular disease, stroke, cancer, or other serious condition—were identified for discharge planning by a computerized screening procedure. These patients were considered to be at risk for unmet posthospital needs and rapid readmission to the hospital without planning. Patients assessed as needing nursing home placement by physicians, hospital staff, or family were referred to the social work department; patients expected to return home with services were referred to the nurses in the home care department.

A sample of 40 triads each consisting of an elderly patient, a family caregiver, and a discharge planner was randomly selected. Because the hospital dealt with patients needing discharge planning as two separate groups, the sample was divided in half. After an arbitrary start date, 20 triads each were randomly selected from the social work and home care departments. Until the sample was filled, every other triad meeting two criteria—the patient was older than 65 and a family caregiver was in contact with a discharge planner—was asked by the investigator to participate in the study. *Family caregiver* was defined as the family member or friend with the most contact with the discharge planner.

For each triad, a dyad of caregiver–planner or former patient–planner was identified for inclusion in the study. The random sample consisted of 37 caregiver–planner and three patient–planner dyads. Each person contacted agreed to participate and completed all the interviews for a response rate of 100 percent. All four social workers and four nurses responsible for discharge planning for elderly patients in this hospital participated. The three former patients interviewed after discharge were reported by their caregivers to be the primary decision makers.

The mean age of patients was 80 years and of caregivers was 60 years. Caregivers were primarily white, lower-middle-class spouses and daughters of patients. Seventy-five percent of the 40 caregivers identified themselves as belonging to an ethnic group, primarily German and Polish in the social work subsample and Italian in the home care subsample. English was a second language for many patients and caregivers. Discharge planners were four master's- and bachelor's-level social workers and four bachelor's- and diploma-level nurses. All eight planners were white and middle class.

Survey Design

The survey questionnaire was developed through a literature review and consultation with experts. An interview instrument developed for measuring nursing home residents' perceptions of medical decision making aided in development (Wetle et al., 1988).

All participants were asked the same questions about their views of the discharge process. Each question was asked in an open-ended and closed-ended format. For example, the key questions about choice were

- Please tell me about the choice of post-hospital plans the discharge planner gave to the patient.
- In your opinion, would you say the choice of posthospital plans the discharge planner gave the patient were too many choices (more than the patient wanted), about the right number of choices (about what the patient wanted), too few choices (less than the patient wanted), or no choice?
- Please tell me about the choice of posthospital plans the discharge planner gave to the family caregiver.
- In your opinion, would you say the choices of posthospital plans the discharge planner gave the family caregiver were too many choices (more than the caregiver wanted), about the right number of choices (about what the

caregiver wanted), too few choices (less than the caregiver wanted), or no choice?

Data Collection and Analysis

Data were collected in a three-month period ending February 1, 1990. On completion of the discharge plan and before discharge, the investigator explained the study to caregivers and planners and obtained their written informed consent to participate. The investigator interviewed all caregivers and former patients in their home or workplace in person or by telephone and all planners in person. Interviews lasted about one to 1½ hours. All dyads were interviewed about one week postdischarge.

Frequencies and percentages to closed-ended questions were tabulated. Responses to open-ended questions were analyzed for content and recurrent themes.

FINDINGS

Perceptions of Information, Choice, Time, and Influence

More than half of the social work and nursing planners felt they had given patients a high level of information; however, the great majority of family caregivers felt patients had been given very little or no information (Table 1). Almost all of the planners felt they had given caregivers a high level of information; about half the caregivers felt they had been given very little or no information.

About half of the social work planners felt they had given a good number of choices to patients, and about half felt they had given a poor number (Table 2). The nursing planners, on the other hand, generally felt they had given a good number of choices. Nearly all of the caregivers felt patients had been given too few choices or no choice at all. Most planners felt they had given a good number of choices to caregivers,

but most caregivers felt they had been given too few choices or no choice at all.

Most planners felt that an adequate amount of time had been spent on the discharge process (Table 3). Most caregivers from the nursing dyads agreed, but most from the social work dyads disagreed.

Most patients were seen as having little influence in the discharge decision (Table 4). Only seven discharge planners felt the patient had exerted a high degree of influence, and in all of these cases the caregiver said the patient had minimal influence. The most striking difference in perceptions was in the relative influence of planners and caregivers in the decision-making process. For example, four social work planners felt they had a high degree of influence, but 14 planners felt the caregivers had a high degree of influence. Caregivers' perceptions were just the opposite; 13 caregivers attributed high influence to the social work planners, and only six attributed high influence to themselves. The same discrepancy is reflected in the nursing dyads.

The responses of the planners and caregivers to the open-ended questions were consistent with their responses to the closed-ended questions. One social work planner responded, "I always meet with patients and families and give them all the information and options for home care as well as nursing homes. We are advocates for patients, who are the primary discharge planning decision makers except when they are mentally incapacitated." Another social work planner commented of a particular patient, "It is safe, necessary for her to go to a nursing home."

Caregivers, on the other hand, said they were pressured, forced, badgered, or bullied by social workers and physicians to place patients' names on nursing home waiting lists as a hospital and Medicare requirement for high-risk patients needing care after

Table 1. Perceptions of Discharge Planners and Family Caregivers of Information Shared about Discharge Plans

Perceptions of Information DPs Gave about Plans	Social Work Dyads (N = 19)					Nursing Dyads (N = 18)				
	FC's Rating	DP's Rating				FC's Rating	DP's Rating			
		High	Low	High	Low		High	Low		
	n	%	n	%	n	%	n	%		
To patients	High	2	11	1	5	High	0	0	0	0
	Low	8	42	8	42	Low	10	56	8	44
To family caregivers	High	10	53	0	0	High	7	39	0	0
	Low	8	42	1	5	Low	11	61	0	0

NOTES: DP = discharge planner; FC = family caregiver; high = everything there is to know or a moderate amount of information about posthospital plans; low = very little information or no information about posthospital plans.

Table 2. Perceptions of Discharge Planners and Family Caregivers of the Choice of Discharge Plans

Perception about Choice of Plans DPs Gave	Social Work Dyads (N = 19)					Nursing Dyads (N = 18)				
	FC's Rating	DP's Rating				FC's Rating	DP's Rating			
		Good	Poor	Good	Poor		Good	Poor		
	n	%	n	%	n	%	n	%		
To patients	Good	1	5	0	0	Good	2	11	0	0
	Poor	8	42	10	53	Poor	11	61	5	28
To family caregivers	Good	4	21	2	11	Good	4	22	2	11
	Poor	8	42	5	26	Poor	11	61	1	6

NOTES: DP = discharge planner; FC = family caregiver; good = too many choices or about the right number of choices; poor = too few choices or no choice.

discharge. One caregiver recalled, "The social worker said, 'Well, you're going to have to send him to a nursing home. Be prepared to be a pauper.' I spat right back at her, 'I'm taking him home.'" Other caregiver comments included the following: "It seems if you don't do what they want you don't get any help." "A 15-minute group meeting of all concerned would have been helpful." "The social worker was helpful even though there was no choice of plans."

Caregivers' Perceptions of Coercion

The most negative comments about coercion came from family caregivers who felt that nursing home placement was forced on patients and that inadequate information about alternatives was given. Social work planners perceived that placement of high-risk patients in nursing homes would ensure their safe and prompt discharge, promote continuity of care, and protect the hospital against legal liability. Nevertheless, many caregivers were willing to take their relatives home.

Caregivers and patients perceived that coercion was exerted in the following ways:

- ❑ automatic referral of high-risk patients to the social work department for nursing home planning
- ❑ Medicare and hospital policy requirement of nursing home planning for high-risk patients
- ❑ provision of only limited information about home care
- ❑ the "denial of Medicare benefits process," in which patients and families were told that the patient would be discharged even if they did not accept the first nursing home bed available
- ❑ insistence that patients and caregivers accept beds in the worst homes when that is all that is available
- ❑ caregivers' perceptions that planners exerted more influence in the decision than they did
- ❑ inadequate assessment of patients' ability to return home
- ❑ inadequate time to plan a discharge to the home.

A 74-year-old patient with a hip fracture who lived alone said,

Table 3. Perceptions of Discharge Planners and Family Caregivers of Adequacy of Time to Decide the Discharge Plan

Perception	Social Work Dyads (N = 19)					Nursing Dyads (N = 18)				
	FC's Rating	DP's Rating				FC's Rating	DP's Rating			
		Good	Poor	Good	Poor		Good	Poor		
	n	%	n	%	n	%	n	%		
Adequacy of time	Good	7	37	0	0	Good	11	61	1	6
	Poor	10	53	2	11	Poor	6	33	0	0

NOTES: DP = discharge planner; FC = family caregiver; good = too much (more than was needed) or about the right amount of time; poor = too little (needed more time) or no time.

Table 4. Perceptions of Discharge Planners and Family Caregivers of Influence in the Discharge Plan

		Social Work Dyads (N = 19)						Nursing Dyads (N = 18)						
		DP's Rating						DP's Rating						
Influence Held	FC's Rating	High		Moderate		Low		High		Moderate		Low		
		n	%	n	%	n	%	n	%	n	%	n	%	
By discharge planner	High	3	16	5	26	5	26	High	0	0	2	11	10	56
	Moderate	0	0	0	0	3	16	Moderate	0	0	1	6	4	22
	Low	1	5	1	5	1	5	Low	0	0	0	0	1	6
By patient	High	0	0	2	11	0	0	High	0	0	0	0	2	11
	Moderate	0	0	0	0	0	0	Moderate	0	0	0	0	0	0
	Low	4	21	2	11	11	58	Low	3	17	2	11	9	50
By family caregiver	High	5	26	1	5	0	0	High	4	22	1	6	1	6
	Moderate	3	16	1	5	0	0	Moderate	3	17	0	0	0	0
	Low	6	32	2	11	1	5	Low	8	44	0	0	1	6

NOTES: DP = discharge planner; FC = family caregiver; high = high degree of influence; moderate = moderate degree of influence; low = low degree of influence.

I was barely out of anesthesia when the social worker approached me about putting my name on five nursing home lists. I thought the nursing home was being forced on me . . . that it was a departmental requirement. There was no way I was going to a nursing home. . . . I understand the department's need to have a backup plan, but no one assessed my ability to manage at home until I said I absolutely would not go to a nursing home. I have a lot of friends, but none of them were involved in discharge planning. To my amazement in a couple of days after surgery they found a bed for me in a nursing home. I wasn't told I could get physical therapy at home. I didn't know what was being done about a home care plan until the very end. This caused me a lot of stress. My blood pressure went up, and it aggravated my diabetes. Because I insisted on going home I was able to get physical therapy at home instead of in a nursing home. Now I'm doing fine.

Legally and ethically, competent patients cannot be forced into nursing homes if the risks and benefits of refusing placement are understood by them. All of the planners said they informed patients and caregivers of their right to refuse placement; none of the patients and caregivers said they were so informed. A significant and unexpected finding was that physicians and staff nurses frequently decided within 24 hours of admission whether the patient would be discharged to home or a nursing home and on that basis referred them to either the social work

or the home care department for planning. Although some planners reported family and patient influence in this referral decision, none of the caregivers reported any involvement until an assignment had already been made. Once a referral was made, the organizational separation of the two departments made crossing over their rigid boundaries very difficult. Planners reported collaboration, but caregivers found it difficult to gain access to information considered the province of the other department.

Caregivers reported difficulties negotiating systems of finance and service delivery of hospital and posthospital care during discharge. Trying to understand Medicare DRGs and Medicaid "spend-down" policies was difficult and time consuming and added to the crisis.

Language and Ethnicity

Most family caregivers and discharge planners agreed that patients requested and received little or no information, choice, and influence in the discharge decision, citing patients' poor mental and physical condition and preference that the family decide on the plan. Many planners also cited patients' language difficulties as a reason for lack of involvement in planning. Although 75 percent of the sample belonged to an ethnic group and English was the second language for most, the planners did not use the interpreters employed by the hospital with any of the patients and caregivers during discharge planning. One social work planner commented about an elderly patient, "She requested no information because there

was a language barrier.” Another said, “Although we have interpreters on staff, we generally use the family to interpret except in cases where there is obvious conflict about the discharge plan.”

Caregivers were more likely to cite ethnicity than language problems as the reason why they had little involvement in the process. One Polish caregiver commented about the minimal information requested by the patient from a social work planner, “I guess nobody talked to her because she’s Polish, and they figured she couldn’t speak English. She speaks some Polish and some English, but she doesn’t speak to people she doesn’t know.” Said one Italian caregiver, “I sat in his room four or five hours a day . . . nobody talked to me. . . . I didn’t ask for nothing and nobody told me nothing, I guess because of my accent.”

DISCUSSION

Why were there discrepancies between planners’ and caregivers’ perceptions of the quality and value of the information shared? Certainly pressure for early discharge exerted by prospective payment systems may encourage planners to overrate the amount and adequacy of information they give to caregivers. Such an overestimation perhaps served as a coping strategy that allowed planners to deal with intense job stress while still adhering to client-centered professional values. Language difficulties and cultural differences may have also contributed to differing perceptions. Planners may have excluded patients to save time, negotiating the discharge plan instead directly with caregivers. Whatever the reason, these data indicate that the discharge (nursing home) plan many clients received was not the discharge (home care) plan they wanted.

Ethics and Coercion

In discharge planning, two ethical principles may conflict: the principle of autonomy and self-determination, which holds that people have the right to make decisions that are voluntary and free from undue influence, and the principle of beneficence, which promotes the good of clients (Kane, 1988). Ethical dilemmas arose when concerns by hospital staff about patient safety after discharge, legal liability for “unsafe” plans, and continuity of care—and their resulting use of coercion to address these concerns—conflicted with clients’ rights to autonomy and self-determination. The use of coercion to override mentally competent clients’ rights violates the *NASW Code of Ethics* (NASW, 1994), which holds that the primary responsibility of social workers is to promote client self-determination.

Planners’ use of coercion raises ethical questions about the nature of the discharge planning protocol for high-risk patients used in this hospital, which precludes client participation in referral decisions. Planners often denied patients and caregivers the relevant information and options they needed, sufficient time to consider the risks and benefits of their options, and a chance to participate in the decision. Whether this coercion was by domination or enforcement or was more subtle and perhaps subconscious, it is questionable and unethical.

HEALTH CARE PROVIDERS HAVE AN ETHICAL AND LEGAL RESPONSIBILITY TO MAXIMIZE EQUALITY OF ACCESS TO CARE AND TO PROVIDE HELP THAT IS CULTURALLY SENSITIVE.

Making referral decisions about a discharge destination within 24 hours of admission was largely driven by DRGs, hospital administrators, and the quick decision-making style of some physicians. These decisions raise concerns about the role of discharge planners vis-à-vis physicians and hospital administrators as autonomous professionals with standards of practice guided by ethical codes. Elderly patients’ physical and mental status may fluctuate greatly from admission to discharge, and subjective factors related to patients and families may influence premature decisions by hospital staff. Coercion by other officials affects the ability of planners to accommodate to changing needs of patients and families over the course of hospitalization.

Cultural Stereotyping

Discharge planners cited a language barrier as one reason why patients were not involved in the planning process. Likewise, caregivers felt that planners did not fully engage patients in planning because of their ethnicity. White middle-class planners may have been uncomfortable with culturally different clients of varied ethnic backgrounds. Presupposing a language barrier may have provided social distance as a way to cope with the discomfort evoked by cultural differences. Moreover, it may have been seen as too time consuming for planners to assess fully the English-speaking ability of ethnic patients.

The implication of cultural stereotyping and assumption of language barriers by planners is that some patients may be excluded from participation in the discharge process. Health care providers have an ethical and legal responsibility to maximize equality of

access to care and to provide help that is culturally sensitive. The decision by planners not to use available hospital interpreters appears to constitute discrimination in that equal participation was denied to clients based on their ethnicity. Ethnic-sensitive practice that involves clients early in the discharge decision-making process and uses interpreters when necessary empowers clients and promotes self-determination.

IMPLICATIONS

Practice

The discharge protocol followed by this hospital, along with similar ones used in many other hospitals, raises ethical concerns. With these protocols in mind, I make several recommendations.

The hospital should change its policy of requiring nursing home application and placement of high-risk elderly patients. The hospital cannot legally and ethically force social work planners to require application and placement of mentally competent patients.

Discharge planning should be handled by one department staffed jointly by nurses and social workers. A team of social workers, nurses, and physicians could assess each patient, thereby removing structural barriers to information and permitting access by clients to their full range of options and also promoting greater collaboration between health care professionals and clients.

Planners should inform all patients and caregivers in writing of all discharge options and the risks and benefits of each, thereby releasing staff from perceived legal liability for risks that competent clients wish to take by returning home. Also, planners should inform patients and families that they have the right to refuse placement in a nursing home and to appeal a discharge plan with the hospital's ethics committee. This information could be included in the pamphlet of patients' rights that Medicare requires be given to all elderly patients on admission.

In-service training should be provided to planners that examines patterns of practice fostering mismatched perceptions of the process and that promotes cultural sensitivity to diverse help-seeking styles. Also, education should be provided to physicians, administrators, and hospital staff about ethical principles in discharge planning practice.

The hospital should work to develop other means of prompt and safe discharge, such as a step-down unit. Such a unit would facilitate discharge of high-risk patients and alleviate concerns about legal liability. The Medicare extended-care benefit would pay for care in such a setting and provide the hospital with additional revenue.

Because the sample size in this exploratory study is small, caution is needed in generalizing the findings. Given the important ethical concerns raised by this study, larger studies of participants' perceptions of the same discharge process should be done to develop ethical protocols for practice. Future research should investigate early decision-making processes in which patients are first referred for home care or nursing home planning, with attention to informed consent.

Policy

Although some have argued that it is doubtful that scarce health care resources will be allocated for community-based services (Dubler, 1988), to change the coercive discharge planning practice in this and other hospitals it is necessary to develop and support public policies that foster viable community-based alternatives to institutional care. Incentives in Medicare, Medicaid, and private insurance have favored care offered in institutions over care offered in the community. The discharge planners and other health care professionals in this study promoted institutional plans over home care plans, which they thought were less safe and more vulnerable to failure. "Unskilled" social services and help with activities of daily living (ADLs) are the most pressing postacute and long-term care needs of elderly people for continuity of care in the community (Dubler, 1988; Kane & Kane, 1987). However, clients have difficulty obtaining these services because they are not reimbursed by most health insurance plans.

In this study Medicare reimbursement appeared to dictate the nature of information and limited choice of plans the discharge planners gave to patients and caregivers. Because Medicare limits the length of hospital stays, constraints are often placed on the amount and adequacy of time to decide the plan and the nature of patient-caregiver influence in the decision. Expansion of noninstitutional services covered by public and private insurance to include social services and help with ADLs in the community seems to be a more ethical approach than the one currently in place.

Unless health care insurance reimbursement changes to cover adequate community-based care, public policies will continue to exert pressure on hospital staff to practice coercion in discharge planning. A mix of public and private insurance approaches to cover postacute and community-based long-term care, with expanded benefits and cost controls, is recommended.

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REFERENCES

- Abrahamson, J. (1988). Participation of elderly patients in discharge planning. *Gerontologist*, 28, 443-448.
- Asser, E. (1978). Social class and help-seeking behavior. *Journal of Community Psychology*, 6, 465-475.
- Blazyk, S., & Canavan, M. M. (1986). Managing the discharge crisis following catastrophic illness or injury. *Social Work and Health Care*, 11(4), 19-32.
- Coulton, C., Dunkle, R., Chow, J., Haug, M., & Vielhaber, D. (1988). Dimensions of post-hospital care decision making: A factor analytic study. *Gerontologist*, 28, 218-223.
- Coulton, C., Dunkle, R., Goode, R. A., & MacKintosh, J. (1982). Discharge planning as a decision making process. *Health & Social Work*, 7, 253-261.
- Dubler, N. L. (1988). Improving the discharge planning process: Distinguishing between coercion and choice. *Gerontologist*, 28(Suppl.), 76-81.
- Kane, R. A. (1988). Case management: Ethical pitfalls on the road to high-quality managed care. *Quality Review Bulletin*, 14, 161-166.
- Kane, R. A., & Kane, R. L. (1987). *Long-term care: Principles, programs and policies*. New York: Springer.
- Kleinman, A. (1973). Medicine's symbolic reality, on a central problem in the philosophy of medicine. *Inquiry*, 16, 206-213.
- Lefton, M., & Rosengren, W. (1971). Organizations and clients: Lateral and longitudinal dimensions. In J. G. Maurer (Ed.), *Readings in organization theory: Open systems approaches* (pp. 200-209). New York: Random House.
- National Association of Social Workers. (1994). *NASW code of ethics*. Washington, DC: Author.
- Pruitt, D. G. (1981). *Negotiation behavior*. New York: Academic Press.
- Wetle, T., Levkoff, S., Cwikel, J., & Rosen, A. (1988). Nursing home residents' participation in medical decisions: Perceptions and preferences. *Gerontologist*, 28(Suppl.), 32-38.

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