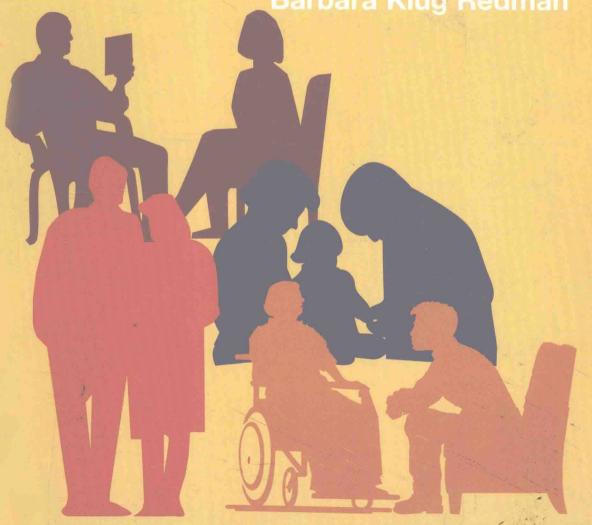# The Practice of PATIENT EDUCATION

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PATIENT EDUCATION

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The Practice of
PATIENT EDUCATION

To
Darlien and Harlan Klug

In grateful appreciation
for years of sustenance of various kinds

Preface

This book is written for all health care providers who want to know more about how to teach patients and families. Because the book began as a text in nursing and because nursing has such a rich philosophic and conceptual heritage in patient education, much of the background is still drawn from that field. Students should be ready to use the book when they recognize in their patients the need for learning, when they have enough knowledge to be able to teach the subject matter, and when they are competent in their interactions with patients.

The book was inspired by students who were interested in and excited about teaching patients. It has been nourished over the years by extensive contact with providers who develop and manage programs of patient education.

To reflect the development of the field, the book is entirely reorganized into two basic sections—the first describing the process of learning and teaching and the second reflecting the development of the major fields of patient education practice in place today. Examples given are not meant to be exhaustive; they are only illustrative of the teaching-learning process. It will be advantageous if the student already has a basic understanding of the psychology of learning because this complex subject must be abbreviated in a book of this size.

Barbara Klug Redman

Contents

I THE PRACTICE OF PATIENT EDUCATION

1 The Practice of Patient Education: Overview

Patient education is now well accepted as an essential part of the practice of all health professionals. It seems odd to remember that it was not always so and that the modern movement of patient education into health care is only about 30 years old. Standards of expected practice in this field are still developing, and a procedure-oriented reimbursement system has not provided incentives for incorporating patient education into one's professional practice.

Because learning is at the center of humans' ability to adapt, all social institutions, including health care, make provision for teaching and learning. Much learning (a persistent change in human performance or performance potential) is incidental to experience. Instruction is the deliberate arrangement of conditions to promote attainment of some intentional goal.[1] Patient and public education programs are among the fastest growing components of the health care system, expanding from 50 hospitals with a patient education program in 1970 to the present, when virtually every health care center has some type of patient education activity.[2]

This chapter provides an introductory overview of patient education practice, which will be expanded and developed in subsequent chapters. Patient education is both a practice and a movement. Its *practice* is based on a set of theories, on research findings, and on skills that must be learned and practiced. In addition to general theories of learning and instruction, each area of practice (e.g., diabetes, cardiac, parenting) has evolved with a tradition and a set of goals particular to that area. Patient education is also a *movement* because its acceptance as an essential aspect

of professional practice is relatively recent and still evolving. It is replacing a paternalistic view that held that professionals knew what was best for patients, made decisions for them, and did not share information with them.

Three other aspects of patient education are an organizational form, an evolving set of standards, and an ethical and legal base.

Through its *organizational form,* services are delivered, frequently integrated with other care and across settings (e.g., home, hospital, nursing home) but also in separate programs such as a diabetes self-management program. One of the weaknesses of the field is lack of practitioner responsibility for assessing the need for education and delivering it, as well as its vague organizational accountability for providing the materials and time necessary to teach. Very little economic analysis is available to guide practitioners in decisions about when and how resources are best invested in patient education.

An *evolving set of standards* has emerged, which has been accepted formally in some fields such as diabetes education. Frequently the focus is on ensuring that processes of teaching have been carried out, even though the desired outcomes may not always be achieved.

The *legal* base has been developed through case law and regulations governing professional practice and most especially through the doctrine of informed consent. The *ethical* base is virtually undeveloped. Ideally it requires the competent practice of patient education by professionals, avoidance of the harms that this intervention can induce (such as debilitating confusion), and serious examination of the reasons one is asking the

patient or family members to change beliefs and practices, frequently at great cost to themselves. In general, patient education has not been a patient-centered field but rather a practice developed for the convenience of "the system."

Perhaps the field to which patient education is most closely related conceptually is health education. Table 1-1 describes my views of the differences between these two fields.

THE PROCESS OF PATIENT EDUCATION

Patient education is practiced by use of a process of diagnosis and intervention. The needs-assessment phase determines the nature of a need and motivation to learn, and goals are mutually set with the patient. The intervention is constructed to provide instructional stimulation for the exact learning needs the patients have. Evaluation occurs throughout instruction, summarized at periodic intervals to determine whether the outcome goals are being met. Reteaching is frequently necessary because it is not possible to ac-

curately predict what instructional intervention will yield the desired learning by a particular patient.

The process of teaching can be summarized as follows:

Little is known about how process is actually used by practitioners, but what seems clearest is that it does not flow in an orderly, sequential fashion, as shown in the preceding diagram.

Table 1-1   Comparison of patient education and health education

FOCUS	PATIENT EDUCATION	HEALTH EDUCATION
Philosophy	Patient use of information and skills for whatever purpose is desired	Behavior change for health promotion and compliance with medical regimen
Unit of service	Individuals, families, and other groups	Specific populations
Delivery system	Part of clinical care by all direct-care providers in any setting	Campaigns that include mass media and work through community institutions
Content	Patient experiences, coping, helping patient develop self-management skills, decisional support	Risk factors, health behaviors
Theory base	Direction from field's theory of practice, learning, and instructional theory	Behavioral science, epidemiology
Ethical concerns	Scientific stability and cultural bias of what patients are asked to learn; subtle manipulation possible in provider-patient relationship; inadvertent side effects (e.g., loss of self-confidence)	Scientific stability and cultural bias of what patients are asked to learn; manipulation by government, under which many programs are carried out; inadvertent side effects such as "blaming the victim"
Literature	Integration of literature of disease entity or health problem	Public health literature and certain specialized health education journals
Challenges	Reliable delivery system, including outcome measurement	Accessing very powerful provider-patient relationship

One starts at the beginning of the process but subsequently skips from step to step; however, the elements do serve as checkpoints to ensure that the relevant variables that affect the teaching-learning activity have been considered. Although teaching does not have a complete set of commonly used diagnostic categories, the objectives can serve such a purpose. In addition, as nursing diagnostic categories have been refined and expanded, they are useful but incomplete in categorizing patient learning needs.

The teaching process can be seen as parallel to the nursing process in that each has an assessment, diagnosis, goals, intervention, and evaluation phase (Table 1-2). Because learning about health is pertinent to nursing practice, some general screening questions should be part of the general nursing assessment; for example, what do patients know and how do they see their present problems? If at any time during care the ongoing assessment indicates a patient learning problem that teaching can alleviate, a more refined assessment of need and readiness is made and that problem is dealt with through the teaching process.

Of course, the most cogent question concerns the quality of use of either the nursing process or the teaching process and whether (at least in the psychosocial realm) fine points used in the process make any difference in patient outcome. I believe that there are gross errors in the practice of patient education that make a difference. Errors in practice are probably made in this order: (1) omission of assessment of the patient's need to learn, so that no activity in patient education is initiated; and (2) omission of any given step: for example, omitting the assessment of readiness, the setting of goals, or the systematic evaluation, but not omitting the actual intervention. Of course, it is impossible not to have at least implicit goals when one teaches, but the goals may not be related to a particular patient's readiness and the instruction may not be constructed to meet those goals.

With adequate practice, providers can become proficient in thinking through the required steps of the teaching process. They can become sensitive to expressions of readiness that may be part of an ordinary conversation with the patient and can learn to organize care to elicit measurements of readiness. The teaching that many patients require can be accomplished in the same amount of time that the nursing process takes if it is done at the proper level of proficiency.

Table 1-2   Relationship of teaching process to nursing process

ASSESSMENT	DIAGNOSIS	GOALS	INTERVENTION	EVALUATION
Nursing process				
General screening questions to detect patient's need to learn	One of problem statements may be a need to learn or a nursing diagnosis	Learning goals are a subset of goals	Teaching intervention may be delivered with other intervention	Evaluating whether nursing care outcome was met
Teaching process				
Refined assessment of need and readiness to learn	Learning diagnosis	Setting of learning goals	Teaching	Evaluating learning

SUMMARY

Patient education is an expanding and evolving field, now seen as central to achieving adequate outcomes of care. It is integrated throughout care to individuals and groups in all settings. A diagnostic-intervention-evaluation process model is used to practice patient education.

? STUDY QUESTIONS/ACTIVITIES

1. During a few days of clinical practice, keep a log of instances of paternalism on the part of staff members toward patients. Did these instances occur because the patients involved could not understand the decisions about their care, or did they occur for other reasons? Are these reasons justifiable?

2. T. Berry Brazelton has written: "Demonstrating the behavior of a newborn baby to an inexperienced mother can be both exciting and revealing. The mother's comments as the baby performs are likely to be meaningful in terms of her past experience and present expectations. As her baby goes from sleep to crying in an all-too-short period, the examiner might describe the speed of the state change without labeling it with a value judgment. The mother may then feel it safe to say: 'I just get frantic when he cries and I don't know how to stop him.' The pediatrician or nurse practitioner can then join her, recognizing her anguish and offering to participate with her by saying, 'Well, I don't know how either yet but we can work on it together.' A tacit but powerful alliance between the two is struck, with the baby's behavior a common ground for open communication."*

Label the parts of the teaching-learning process, as discussed in this chapter: assessment of need and readiness to learn, diagnoses and goal setting, intervention, and evaluation.

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2 Motivation and Learning

MOTIVATION

Motivation is a term that describes forces acting on or within an organism that initiate, direct, and maintain behavior. Motivation also explains differences in the intensity and direction of behavior. In the teaching-learning situation, motivation addresses the willingness of the learner to embrace learning. The term *readiness* describes evidence of motivation at a particular time. This chapter discusses theories of motivation in general, with specific application to health. It also describes assessment of motivation as part of the teaching-learning process and presents teaching practices that stimulate and develop motivation.

Six general theories of motivation can be used to direct learning in a variety of situations.[30]

Reinforcers. In behavioral learning theory the concept of motivation is tied closely to reinforcement of repeated behaviors. For example, behaviors that have been reinforced in the past are more likely to be repeated than are behaviors that have not been reinforced or that have been punished. Reinforcement histories and schedules of reinforcement help explain why some individuals learn better than others.

Needs. Satisfaction of needs for food, shelter, love, and maintenance of positive self-esteem explains the concept of motivation for other theorists. Persons differ in the degree of importance they attach to each of these needs.

Cognitive dissonance. Cognitive dissonance theory holds that individuals experience tension or discomfort when a deeply held value or belief is challenged by a psychologically inconsistent belief or behavior. To resolve the discomfort, patients may change a behavior or a belief or they may develop justifications or excuses that resolve the inconsistency.

Attribution. To make sense of the world, individuals will often try to identify causes to explain why something has happened to them. Persons are particularly motivated to conduct attributional searches in ambiguous, extraordinary, unpredictable, or uncontrollable situations. Attributions may occur after a diagnosis, an exacerbation of chronic illness, an accidental injury, or the relief or cure of a symptom or illness. We know that attributions can have powerful effects on psychological adjustment, behavior, and morbidity. In a study of patients with myocardial infarctions, attributions of patients and their spouses (Why did this happen to me?) significantly predicted whether the family considered itself rehabilitated. Individuals make attributions about disease severity and treatment efficacy. They use these ideas to regulate self-management of their diseases.[17] Thus it is always important to know patients' beliefs about the cause of their present situation because their actions are guided by these attributions.

A concept central to attribution theory is locus of control. Those with an internal locus of control in a situation attribute success or failure to their own efforts or abilities. Those with an external locus of control believe that success or failure depends on luck, task difficulty, or other persons' actions.

Personality. Motivation in personality theory describes a general tendency to strive toward certain types of goals such as affiliation or achievement. An extreme motivation to avoid failure is

learned helplessness, which causes persons to believe that they are doomed to failure no matter what. This behavior can arise from an inconsistent and unpredictable use of rewards and punishments by teachers. The problem can be avoided or alleviated by giving learners opportunities to realize success in small steps and by giving them immediate, positive feedback with consistent expectations and follow-through. Coping styles may also be part of personality. Some individuals are vigilant and seek information from all available sources. If these persons find discrepancies in the information they receive, they will feel anxious. Others use a coping style of avoidance. They want little information because it constitutes a source of stress.

Expectancy. Expectancy theories of motivation hold that a person's motivation to realize a goal depends on the perceived chance of success, as well as how much value that person places on success. The theory of reasoned action posits that volitional behavior is predicted by the person's intention to perform the behavior. Intention is, in turn, a function of beliefs about the consequences of the behavior and norms about the behavior that are held by significant others.[22]

Summaries of research have shown a powerful relationship between perceived self-efficacy and adequate performance. How individuals judge their capabilities to produce and regulate events in their lives affects their motivation, their thought patterns, their behavior, and their emotions. Those who believe that they will not be able to cope well dwell on their personal deficiencies and imagine that potential difficulties will be more formidable than they really are. Self-efficacy increases notably when persons' experiences contradict their fears and when they gain new skills in managing threatening activities. Repeated failures lower self-efficacy, especially if failure occurs early in the course of events and does not reflect lack of effort or adverse external circumstances.[2]

Judgments about self-efficacy are based on the following sources of information: performance attainments (the most influential), vicarious experiences of observing performance of others, verbal persuasion and other social influences, and physiological states. Self-efficacy probes during the course of treatment can provide helpful guides for implementing a program of personal change. Adopting attainable subgoals that lead to more impressive future goals can provide the patient with clear markers of progress to verify a growing sense of self-efficacy.[2]

Finally, humanistic interpretations of motivation emphasize personal freedom, choice, self-determination, and a striving for personal growth. Although generally not expressed as a theory in the scientific sense, important assumptions made by humanists cause us to reflect on learners' resolutions to become motivated and to make their own decisions about whether to pursue a course of action.

Two theoretical models used to assess and stimulate motivation in patients follow. Seeking care and adapting to illness are examples of tasks that require motivation on the part of patients and may well be the focus of educational programs.

Health Belief Model

The health belief model[28] affirms that individuals are not likely to take a health action unless (1) they believe that they are susceptible to the ill-health condition in question; (2) they believe that it would have serious effects on their lives if they should contract it; (3) they believe that the benefits of action outweigh the barriers to action; and (4) they are confident that they can perform the action (self-efficacy). Cues, such as an interpersonal crisis or the nature and severity of symptoms, trigger action. This model, which is depicted in Figure 2-1, is an example of the value-expectancy approach, developed to explain an individual's health actions under conditions of uncertainty.

In patient education practice, the health belief model has been used to assess whether an individual holds these beliefs and if not, to direct teaching at missing skills or information. The breast self-examination (BSE) questionnaire