Part One

Perspectives on Teaching and Learning

Chapter 1

Overview of Education in Health Care

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CHAPTER HIGHLIGHTS

Historical Foundations for the Teaching Role of Health Professionals
Social, Economic, and Political Trends Affecting Health Care
Purposes, Goals, and Benefits of Client and Staff Education
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KEY TERMS

- ❏ education process
- ❏ teaching/instruction
- ❏ learning
- ❏ patient education
- ❏ staff education
- ❏ barriers to teaching
- ❏ obstacles to learning

OBJECTIVES

After completing this chapter, the reader will be able to

1. Discuss the evolution of the teaching role of health professionals.
2. Recognize trends affecting the healthcare system.
3. Identify the purposes, goals, and benefits of client and staff/student education.
4. Compare the education process to healthcare practice.

5. Define the terms *education process*, *teaching*, and *learning*.
6. Identify reasons why client and staff/student education is an important duty for health professionals.
7. Discuss the barriers to teaching and the obstacles to learning.
8. Formulate questions that health professionals in the role of educator should ask about the teaching–learning process.

Education in health care today—both patient education and staff/student education—is a topic of utmost interest to health professionals in every setting in which they practice. Teaching is an important aspect of the professional role for the majority of health professionals. The current trends in health care are making it essential that clients be prepared to assume responsibility for self-care management. Also, these trends make it imperative that health professionals in the workplace be accountable for the delivery of high-quality care. The focus is on outcomes that demonstrate the extent to which clients and their significant others have learned essential knowledge and skills for independent care, or that staff and students have acquired the up-to-date knowledge and skills needed to competently and confidently render care to the consumer in a variety of settings.

According to Carpenter and Bell (2002), the need for nurses to teach others and to help others learn will continue to increase in the healthcare environment. This is certainly true for all health professionals. Because there are so many changes occurring in the healthcare system, health professionals are increasingly finding themselves in challenging, constantly changing, and highly complex positions. Health professionals in the role of educators must understand the forces, both historical and present day, that have influenced and continue to influence their responsibilities in practice.

One purpose of this chapter is to shed light on the historical evolution of teaching as part of the health professional's role. Another purpose is to offer a perspective on the current trends in health care that make the teaching of clients a highly visible and required function of healthcare delivery. This chapter also addresses the continuing education efforts required to ensure ongoing practice competencies of health personnel.

In addition, this chapter clarifies the broad purposes, goals, and benefits of the teaching–learning process; focuses on the philosophy of the health professional–client partnership in teaching and learning; identifies barriers to teaching and obstacles to learning; and highlights the status of research in the field of patient education as well as staff and student education. The focus is on the overall role of the health professional in teaching and learning, no matter who the audience of learners may be. Health professionals must have a basic prerequisite understanding of the principles and processes of teaching and learning to carry out their professional practice responsibilities with efficiency and effectiveness.

Historical Foundations for the Teaching Role of Health Professionals

"Patient education has been a part of health care since the first healer gave the first patient advice about treating his (or her) ailments" (May, 1999 p. 3). Although the term patient education was not specifically used, considerable efforts by the earliest healers to inform, encourage, and caution patients to follow appropriate hygienic and therapeutic measures occurred even in prehistoric times

(Bartlett, 1986). Since the early healers—physicians, herbalists, midwives, and shamans—did not have a lot of effective diagnostic and treatment interventions, it is likely that education was, in fact, one of the most common interventions (Bartlett, 1986).

From the mid-1800s through the turn of the 20th century, described as the formative period by Bartlett (1986), several key factors influenced the growth of patient education. The emergence of the nursing profession, the surplus of physicians, technological developments, the patient–caregiver relationship, the spread of tuberculosis, and the growing interest in the welfare of mothers and children all had an impact on patient education (Bartlett, 1986). In nursing, Florence Nightingale was a resolute advocate of the educational responsibilities of district nurses and authored Health Teaching in Towns and Villages, which advocated for school teaching of health rules as well as health teaching in the home (Monterio, 1985).

The number of physicians swelled during this time, and the surplus was made worse by the urbanization of the population and technological changes such as the development of the automobile and telephone. The population shift and technological advances contributed to decreasing the amount of time physicians spent making house calls to rural patients (Starr, 1982). Because care was then less time consuming, fewer physicians were needed. The invention of the stethoscope, ophthalmoscope, and laryngoscope contributed to increasing the social distance between patients and physicians and thus changed the dynamics of the physician–patient relationship (Reiser, 1978). For example, instead of putting their head on patients' chests to hear the heart beating, physicians began using an instrument (a cold stethoscope) to hear the heartbeat. This lessened the amount of touching that occurred during a visit and encouraged a more detached relationship. Evidence suggests that during this time some physicians were uncomfortable with patients questioning them, and they also discouraged self-care activities by patients to keep patients coming to them for care (Bartlett, 1986).

The chronic illness of tuberculosis required patients to take medication over long periods of time. This was not consistent with the traditional medical approach of making a diagnosis and prescribing therapy, so education took on an important role (Bartlett, 1986). The first Society for the Prevention of Tuberculosis strongly emphasized education measures (Bartlett, 1986). In support of maternal and child health, the Division of Child Hygiene was established in New York City in 1908 (Bartlett, 1986). Here, public health nurses provided instruction to mothers of newborns in the lower East Side on how to keep their infants healthy.

The period from 1930 through 1960 is described as a time of relative quiet for patient education. Education continued to occur as a part of clinical encounters, but it was overshadowed by the rising technological orientation of medicine (Bartlett, 1986). The first references in the literature to patient education began to appear in the early 1950s (Falvo, 2004). In 1953, the Veterans Administration (VA) hospitals issued a technical bulletin titled *Patient Education and the Hospital Program*. This bulletin identified the nature and scope of patient education and provided guidance to all hospital services involved in patient education (Veterans Administration, 1953). At the same time, members of the National Tuberculosis Association started teaching patients and their families about the disease and its treatment (Breckon, 1982).

In the 1960s and 1970s, patient education began to be seen as a specific entity where emphasis was placed on educating individual patients rather than providing general public health education. Developments during this time, such as the civil rights movement, the women's movement, and the consumer and self-help movement, all affected patient education (Bartlett, 1986; Nyswander, 1980;

Rosen, 1977). In the early sixties, voluntary agencies and the Public Health Service funded several patient and family education projects dealing with congestive heart failure, stroke, cancer, and renal dialysis, and hospitals in a variety of states also became involved in various education programs and projects (Public Health Service, 1971). In 1964, the American Medical Association held the First National Conference on Health Education Goals where a noteworthy outcome was the development of an objective focusing on educating individuals to have better accountability for maintaining their own health (Falvo, 2004).

Concerned that patient education was being provided only occasionally and that patients were not routinely being given information that would allow them to participate in their own health care, the American Public Health Association formed a multidisciplinary Committee on Educational Tasks in Chronic Illness in 1968 that recommended a more formal approach to patient education (Public Health Service, 1971). One of the committee's seven basic premises was the suggested use of an educational prescription that would base teaching on individual patient needs and be included as part of the patient's record. This was one of the first times that the documentation of patient education was mentioned (Falvo, 2004). The committee developed a model that defined the educational processes necessary for patient and family education that could be used with any illness by any member of the healthcare team (Health Services and Mental Health Administration, 1972).

In 1971, two significant events occurred: A publication from the Department of Health, Education and Welfare titled *The Need for Patient Education* emphasized a concept of patient education that provided information about disease and treatment as well as teaching patients how to stay healthy, and President Nixon in a message to Congress used the term *health education* (Falvo, 2004). Nixon later appointed the President's Committee on Health Education that recommended hospitals offer health education to families of patients (Bartlett, 1986; Weingarten, 1974). Although the terms *health education* and *patient education* were used interchangeably, this recommendation had a great impact on the future of patient education because a health education focal point was established in what was then the Department of Education and Welfare (Falvo, 2004). As a result of this committee's recommendations, the American Hospital Association (AHA) appointed a special committee on Health Education (Falvo, 2004). The AHA committee believed that it was a responsibility of hospitals as well as other healthcare institutions to provide educational programs for patients and that all health professionals were to be included in patient education. Through these health education programs, hospitals could contribute to important healthcare goals such as improved quality of patient care, reduced healthcare costs, shorter lengths of stay, fewer admissions and readmissions to inpatient facilities, and better utilization of outpatient services (AHA, 1976). In 1978, the AHA established the Center for Health Promotion (Bartlett, 1986). The concept of patient education expanded during this era, affecting the healthcare delivery system as well as the patient (Falvo, 2004). Also, the healthcare system began to pay more attention to patient rights and protections involving informed consent (Roter, Stashefsky-Margalit, & Rudd, 2001).

Patient education was a significant part of the AHA's *A Patient's Bill of Rights*, affirmed in 1972 and first published in 1973 (AHA, 1973). This document outlines patients' rights to receive current information about diagnosis, treatment, and prognosis in understandable terms as well as information that enables them to make informed decisions about their health care. The *Patient's Bill of Rights* also guarantees a patient's right to respectful and considerate care. The adoption of this bill of rights promoted additional growth in the concept of patient education because it came to be seen as a "patient right" as well as an obligation and legal

responsibility of health professionals. In addition, patient education was recognized as a condition of quality care and as a factor that could affect the efficiency of the healthcare system (Falvo, 2004).

In the 1970s, insurance companies also dealt with issues surrounding patient education (Bartlett, 1986). They began to see the possible positive impact patient education could have on the costs of health care. Several papers, publications, and brochures, such as *White Paper. Patient Health Education*, approved by the Board of Governors of the Blue Cross Association in 1974, *Report from the Committee on Health Education to the Health Insurance Benefits Advisory Council of the Department of Health, Education, and Welfare*, and *Financing In-Hospital Patient Education: Proposed Criteria* by the Health Insurance Association of America, dealt with how patient education could be included as a part of medical care (Bartlett, 1986).

Further support and validation of patient education as a right and expectation of quality health care came as a result of the 1976 edition of the *Accreditation Manual for Hospitals* published by the Joint Commission on Accreditation of Healthcare Organizations, now known as Joint Commission (Falvo, 2004). This edition of the manual broadened the scope of patient education to include outpatient as well as inpatient services and specified that criteria for patient education should be established. Patients had to receive information about their medical problem, prognosis, and treatment. The manual further stated that evidence be provided that patients understood the information they were given and that final progress notes included the specific instructions the patient and family received (Joint Commission on Accreditation of Healthcare Organizations, 1976).

In the 1980s, national health education programs once again came into vogue as healthcare trends focused on disease prevention and health promotion. This was a logical response to the cost-containment efforts occurring in health care at that time. The U.S. Department of Health and Human Services' *Healthy People 2000: National Health Promotion and Disease Prevention Objectives*, issued in 1990 and building on the U.S. Surgeon General's *Healthy People* report of 1979, established important goals for national health promotion and disease prevention in 22 areas (U.S. Department of Health and Human Services [USDHHS] Office of Disease Prevention and Health Promotion, 2000). Establishing educational and community-based programs was one of the priority areas in this document. Following *Healthy People 2000, Healthy People 2010* built on the previous two initiatives and provided a framework for health prevention for the nation. Specific objectives in 28 focus areas support the two overarching goals of increasing the quality and years of healthy life and eliminating health disparities (USDHHS, 2010). These goals and objectives include the development of effective health education programs to assist individuals to recognize and change risk behaviors, to adopt or maintain healthy practices, and to make appropriate use of available services for health care. Patient education is a fundamental component of these far-reaching national initiatives.

In recognition of the importance of patient education by nurses, the Joint Commission (JC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), established nursing standards for patient education as early as 1993. These standards, known as mandates, describe the type and level of care, treatment, and services that agencies or organizations must provide to receive accreditation. Required accreditation standards have provided the impetus for nursing service managers to emphasize unit-based clinical staff education activities for the improvement of nursing care interventions to achieve expected client outcomes (JCAHO, 2001). Nurses are to achieve positive outcomes of patient care through teaching activities that must be patient centered and family oriented. More recently, the JC expanded its expectations to include an interdisciplinary team approach in the provision of

patient education as well as evidence that patients and their significant others participate in care and decision making and understand what they have been taught. This requirement means that providers must consider the literacy level, educational background, language skills, and culture of every client during the education process (Cipriano, 2007; Davidhizar & Brownson, 1999; JCAHO, 2001).

In the mid-1990s, the Pew Health Professions Commission (1995), influenced by the dramatic changes surrounding health care, published a broad set of competencies it believes would mark the success of the health professions in the 21st century. Shortly thereafter, the commission released a fourth report as a follow-up on health professional practice in the new millennium (Pew Health Professions Commission, 1998). The fourth report offers recommendations that affect the scope and training of all health professional groups, as well as a new set of competencies for the 21st century. Many of the competencies pertain to the teaching role of health professionals. These competencies for the practice of health care include the need for health professionals to do the following:

- Embrace a personal ethic of social responsibility and service
- Provide evidence-based, clinically competent care
- Incorporate the multiple determinants of health in clinical care
- Rigorously practice preventative health care
- Improve access to health care for those with unmet health needs
- Practice relationship-centered care with individuals and families
- Provide culturally sensitive care to a diverse society
- Use communication and information technology effectively and appropriately
- Continue to learn and help others learn

In 2006, the Institute for Healthcare Improvement announced the 5 Million Lives campaign. The campaign's objective is to reduce the 15 million incidents of medical harm that occur in U.S. hospitals each year. Such an ambitious campaign has major implications for teaching patients and their families as well as staff and students the ways they can improve care to reduce injuries, save lives, and decrease costs of health care (Berwick, 2006).

Another recent initiative is the formation of the Sullivan Alliance to recruit and educate health professionals to deliver culturally competent care to the public they serve. Effective health care and health education of patients and their families depend on a sound scientific base and cultural awareness in an increasingly diverse society. This organization's goal is to increase the racial and cultural mix of health professional faculty, students, and staff, who are sensitive to the needs of clients of diverse backgrounds (Sullivan & Bristow, 2007).

Accomplishing the goals and meeting the expectations of these various organizations call for a redirection of education efforts. Since the 1980s, the role of the health professional as educator has undergone a paradigm shift, evolving from what once was a disease-oriented approach to a more prevention-oriented approach. In other words, the focus is on teaching for the promotion and maintenance of health (Roter et al., 2001). Education, once done as part of discharge plans at the end of hospitalization, has expanded to become part of a comprehensive plan of care that occurs across the continuum of the healthcare delivery process (Davidhizar & Brownson, 1999).

As described by Grueninger (1995), this transition toward wellness entails a progression "from disease-oriented patient education (DOPE) to prevention-oriented patient education (POPE) to ultimately become health-oriented patient education (HOPE)" (p. 53). Instead of the traditional aim of simply imparting information, the emphasis is now on empowering patients to use their

potentials, abilities, and resources to the fullest (Glanville, 2000). Along with supporting patient empowerment, health professionals must be mindful to continue to ensure the protection of "patient voice" and the therapeutic relationship in patient education against the backdrop of ever-increasing productivity expectations and time constraints (Roter et al., 2001).

Today, the vast majority of health professionals consider the education of clients, families, colleagues, students, and others to be part of their professional responsibility. It was not until recently, however, that many of the professions formally identified the responsibility of teaching in their professional documents. According to Breslow (1985), every student of medicine learns that *doctor* means teacher, yet it was only in 1975 that the House of Delegates of the American Medical Association (AMA) adopted a formal statement that addressed patient education as an integral part of high-quality health care (AMA, 1976). This statement by the AMA emphasizes the responsibility of physicians in conducting patient education, but it also recognizes the responsibility of nurses, dietitians, and other health professionals in this area. It stresses the "team effort" aspect of patient education as well as the patient's responsibility for patient education outcomes (Falvo, 2004).

In the 1970s, the fields of pharmacy, dietetics, and physical therapy also published formal statements on their role in patient education. The *Statement on Pharmacist-Conducted Patient Counseling*, published in 1976 by the American Society of Hospital Pharmacists, delineates the role of pharmacists in educating patients about their medications (American Society of Hospital Pharmacists, 1976). A position paper by the American Dietetic Association in 1976 recommends that dietitians counsel individuals and families in nutritional principles, dietary plans, and food selections, adapting plans to the individual's lifestyle. It also recommends that dieticians record dietary history in medical records and compile or develop educational materials to use as aids in nutrition counseling (American Dietetic Association, 1976). In 1958, an early article recognizing the importance of teaching as a fundamental part of treatment appeared in the physical therapy literature, but the first accreditation criteria related to the teaching role of physical therapists were developed by the American Physical Therapy Association in 1978 (May, 1999). This document states that the physical therapy graduate should be able to "apply basic educational concepts of learning theories in designing, implementing and evaluating learning experiences in order to teach patients and families and to design and implement community education in-service programs" (American Physical Therapy Association, 1978, p. B-7).

Nursing is unique among the health professions in that patient education has long been considered a major component of standard care given by nurses. Since the mid-1800s, when nursing was first acknowledged as a unique discipline, the responsibility for teaching has been recognized as an important role of nurses as caregivers. The focus of nurses' teaching efforts is on the care of the sick and promotion of the health of the well public, as well as educating other nurses for professional practice.

As early as 1918, the National League of Nursing Education (NLNE) in the United States (now the National League for Nursing [NLN]) observed the importance of health teaching as a function within the scope of nursing practice. Two decades later, this organization recognized nurses as agents for the promotion of health and the prevention of illness in all settings in which they practiced (NLNE, 1937). By 1950, the NLNE had identified course content in nursing school curricula to prepare nurses to assume the role of teachers of others. So, too, the American Nurses Association (ANA) has for years put forth statements on the functions, standards, and qualifications for nursing practice, of which patient teaching is a key element. In addition, the International Council

of Nurses (ICN) has long endorsed the nurse's role as educator to be an essential component of nursing care delivery. Today, all state nurse practice acts (NPAs) include teaching within the scope of nursing practice responsibilities. Nurses, by legal mandate of the NPAs, are expected to provide instruction to consumers to assist them to maintain optimal levels of wellness and manage illness.

A variety of other health professions also identify their commitment to patient education in their professional documents (Falvo, 2004). Standards of practice, practice frameworks, accreditation standards, guides to practice, and practice acts of many health professions delineate the educational responsibilities of their members. In addition, professional workshops and continuing education programs routinely address the skills needed for quality patient and staff education. Although specific roles vary according to profession, contemporary patient education clearly echoes Bartlett's (1986) assertion that it "must be viewed as a fundamentally multidisciplinary enterprise" (p. 146).

In addition to providing patient education, health professionals are also responsible for educating their colleagues. Another role of today's health professional educator is one of training the trainer—that is, preparing staff through continuing education, in-service programs, and staff development to maintain and improve their clinical skills and teaching abilities. Health professionals must be prepared to effectively perform teaching services that meet the needs of many individuals and groups in different circumstances across a variety of practice settings.

Health professional educators also serve as clinical instructors for students in the practice setting. Many health professionals function as clinical instructors, preceptors, and mentors to ensure that students meet their expected learning outcomes. However, evidence indicates that some health professionals in the clinical and academic settings feel inadequate as mentors and preceptors as a result of poor preparation for their role as teachers. This challenge of relating theory learned in the classroom setting to the practice environment requires health professionals not only to be up-to-date with clinical skills and innovations in practice, but also to possess the knowledge and skills of the principles of teaching and learning. Knowing the practice field is not the same thing as knowing how to teach the field. The role of the clinical educator is a dynamic one that requires the teacher to actively engage students to become competent and caring professionals (Gillespie & McFetridge, 2006).

Social, Economic, and Political Trends Affecting Health Care

In addition to the professional and legal standards various organizations and agencies have put forth, many social, economic, and political trends nationwide that affect the public's health have focused attention on the role of the health professional as teacher and the importance of client and staff education. The following are some of the significant forces influencing nursing practice in particular and healthcare practice in general (Birchenall, 2000; Bodenheimer, Lorig, Holman, & Grumbach, 2002; Cipriano, 2007; DeSilets, 1995; Glanville, 2000; USDHHS, 2000; Zikmund-Fisher, Sarr, Fagerlin, & Ubel, 2006):

- As discussed earlier, the federal government published *Healthy People 2010: Understanding and Improving Health* and will soon publish *Healthy People 2020*, setting forth national health goals and objectives for the next decade. Achieving these national priorities would dramatically cut the costs of health care, prevent the premature onset of disease and disability, and help all Americans lead healthier and more productive lives. Health professionals play an important role in making a real difference by

teaching clients to attain and maintain healthy lifestyles.

- The growth of managed care has resulted in shifts in reimbursement for healthcare services. Greater emphasis is placed on outcome measures, many of which can be achieved primarily through the health education of clients.
- Health providers are recognizing the economic and social values of reaching out to communities, schools, and workplaces to provide education for disease prevention and health promotion.
- Politicians and healthcare administrators alike recognize the importance of health education to accomplish the economic goal of reducing the high costs of health services. Political emphasis is on productivity, competitiveness in the marketplace, and cost-containment measures to restrain health service expenses.
- Health professionals are increasingly concerned about malpractice claims and disciplinary action for incompetence. Continuing education, either by legislative mandate or as a requirement of the employing institution, has come to the forefront in response to the challenge of ensuring the competency of practitioners. It is a means to transmit new knowledge and skills as well as to reinforce or refresh previously acquired knowledge and abilities for the continuing growth of staff.
- Consumers are demanding increased knowledge and skills about how to care for themselves and how to prevent disease. As people are becoming more aware of their needs and desire a greater understanding of treatments and goals, the demand for health information is expected to intensify. The quest for consumer rights and responsibilities, which began in the 1990s, continues into the 21st century.
- Demographic trends, particularly the aging of the population, require the health professions to emphasize self-reliance and maintenance of a healthy status over an extended life span. As the percentage of the U.S. population older than age 65 years climbs dramatically in the next 20 to 30 years, the healthcare needs of the baby-boom generation of the post–World War II era will increase as people deal with degenerative illnesses and other effects of the aging process.
- Among the major causes of morbidity and mortality are those diseases now recognized as being lifestyle related and preventable through educational intervention. In addition, millions of incidents of medical harm occur every year in U.S. hospitals so that it is imperative that clients, staff, and students be educated about preventive measures to reduce these incidents (Berwick, 2006).
- The increase in chronic and incurable conditions requires that individuals and families become informed participants to manage their own illnesses. Client teaching can facilitate an individual's adaptive responses to illness and disability.
- Advanced technology increases the complexity of care and treatment in home and community-based settings. More rapid hospital discharge and more procedures done on an outpatient basis force clients to be more self-reliant in managing their own health. Patient education assists them to follow through with self-management activities independently.
- To improve health outcomes nationwide, healthcare providers increasingly recognize client health literacy as an essential skill. Health professionals must attend to the education needs of their clients to be sure that clients adequately understand the information required for independence in self-care activities that promote, maintain, and restore their health.
- Many healthcare providers believe, and this belief is supported by research, that client education improves compliance and, hence, health and well-being. Better understanding by clients and their families of the recommended

treatment plans can lead to increased cooperation, decision making, satisfaction, and independence with therapeutic regimens. Health education enables patients to solve problems they encounter outside the protected care environments of hospitals, thereby increasing their independence.
- An increasing number of self-help groups exist to support clients in meeting their physical and psychosocial needs. The success of these support groups and behavioral change programs depends on the health professional's role as teacher and advocate.

Health professionals recognize the need to develop their expertise in teaching to keep pace with the demands of patient and staff education. As they continue to define their role, body of knowledge, scope of practice, and professional expertise, they realize, more than ever before, the significance of their role as educators. Health professionals have many opportunities to carry out health education. Interestingly, the health professions included in the Gallup honesty and ethics poll (nurses, pharmacists, and physicians) comprised three of the four top-rated professions in the poll. Close to two thirds of Americans rated these professions very high or high in this area (Saad, 2008). The trusting relationship generated between the health professional and client facilitates the exchange of health education information.

Purposes, Goals, and Benefits of Client and Staff Education

The purpose of patient education is to increase the competence and confidence of clients for self-management. The goal is to increase the responsibility and independence of clients for self-care. This can be achieved by supporting clients through the transition from being dependent on others to being self-sustaining in managing their own care and from being passive listeners to active learners. An interactive, partnership education approach provides clients the opportunity to explore and expand their self-care abilities (Cipriano, 2007).

The single most important action of health professionals as educators is to prepare clients for self-care. If clients cannot independently maintain or improve their health status when on their own, health professionals have failed to help them reach their potential (Glanville, 2000). The benefits of client education are many. For example, effective teaching by a health professional can do the following:

- Increase consumer satisfaction
- Improve quality of life
- Ensure continuity of care
- Decrease client anxiety
- Effectively reduce the complications of illness and the incidence of disease
- Promote adherence to treatment plans
- Maximize independence in the performance of activities of daily living
- Energize and empower consumers to become actively involved in the planning of their care

Because clients must handle many health needs and problems at home, a need to educate people on how to care for themselves—both to get well and to stay well—truly exists. Illness is a natural life process, but so is humankind's ability to learn. Along with the ability to learn comes a natural curiosity that allows people to view new and difficult situations as challenges rather than as defeats. As Orr (1990) observes, "Illness can become an educational opportunity … a 'teachable moment' when ill health suddenly encourages [patients] to take a more active role in their care" (p. 47). This observation remains relevant today.

Numerous studies document the fact that informed clients are more likely to comply with medical treatment plans, find innovative ways to cope with illness, and be less likely to experience

complications. Overall, clients are more satisfied with care when they receive adequate information about how to manage for themselves. One of the most frequently cited complaints by patients in litigation cases is that they were not adequately informed (Reising, 2007).

Just as the need exists to teach clients to become participants and informed consumers to achieve independence in self-care, the need also exists for staff to be exposed to up-to-date information with the ultimate goal of enhancing their practice. The purpose of staff and student education is to increase the competence and confidence of health professionals to function independently in providing care to the consumer. The goal of education efforts is to improve the quality of care delivered by health professionals. In turn, the benefits to health professionals in their role as educators include increased job satisfaction when they recognize that their teaching actions have the potential to forge therapeutic relationships with clients, enhanced patient–health professional autonomy, increased accountability in practice, and the opportunity to create change that really makes a difference in the lives of others.

Health educators' primary aims, then, should be to nourish clients, mentor staff, and serve as teachers and clinical instructors for health professional students. They must value their role in educating others and make it a priority for their clients, fellow colleagues, and the future members of the profession.

The Education Process Defined

The **education process** is a systematic, sequential, logical, scientifically based, planned course of action consisting of two major interdependent operations, teaching and learning. This process forms a continuous cycle that also involves two interdependent players, the teacher and the learner. Together, they jointly perform teaching and learning activities, the outcome of which leads to mutually desired behavior changes. These changes foster growth in the learner and, it should be acknowledged, growth in the teacher as well. Thus, the education process is a framework for a participatory, shared approach to teaching and learning (Carpenter & Bell, 2002).

The education process is similar across the practice of many of the health professions. In fact, the educational process is often compared to the nursing process because the steps of each run parallel to one another. (See **Figure 1–1**.) The education process, like professional practice in nursing and most healthcare disciplines, consists of the basic elements of assessment, planning, implementation, and evaluation. Whereas the general practice of many of the health professions focuses on the planning and implementation of care based on the assessment and diagnosis of the physical and psychosocial needs of the patient, the education process, on the other hand, focuses on the planning and implementation of teaching based on an assessment and prioritization of the client's learning needs, readiness to learn, and learning styles (Carpenter & Bell, 2002). The outcomes of health professional practice are achieved when the physical and psychosocial needs of the client are met. The outcomes of the education process are achieved when changes in knowledge, attitudes, and skills occur. Both processes are ongoing, with assessment and evaluation perpetually redirecting the planning and implementation phases. If mutually agreed-on outcomes in either process are not achieved, as determined by evaluation, then the process can and should begin again through reassessment, replanning, and reimplementation.

Note that the actual act of **teaching** or **instruction** is merely one component of the education process. Teaching and instruction, terms often used interchangeably, are deliberate interventions that involve sharing information and experiences to meet intended learner outcomes in the cognitive,

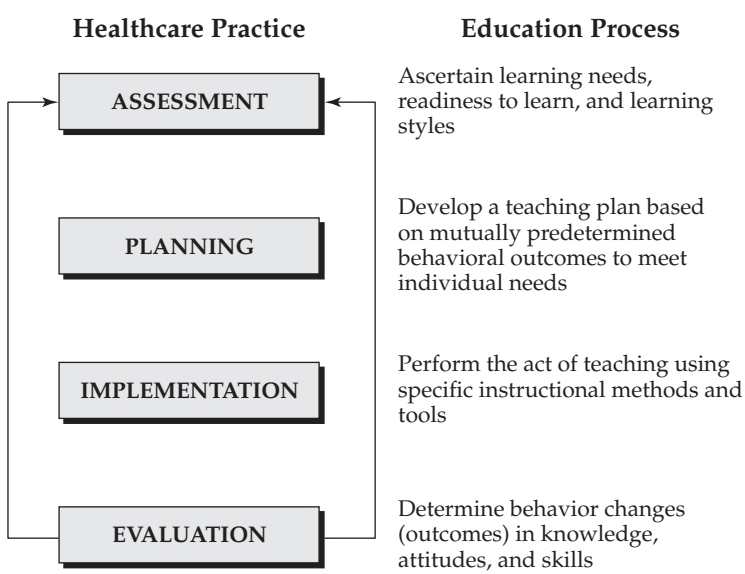
affective, and psychomotor domains according to an education plan. Teaching and instruction, both one and the same, are often formal, structured, organized activities prepared days in advance, but they can be performed informally on the spur of the moment during conversations or incidental encounters with the learner. Whether formal or informal, planned well in advance or spontaneous, teaching and instruction are nevertheless deliberate and conscious acts with the objective of producing learning (Carpenter & Bell, 2002).

The fact that teaching and instruction are intentional does not necessarily mean that they have to be lengthy and complex tasks, but it does mean that they comprise conscious actions on the part of the teacher in responding to an individual's need to learn. The cues that someone has a need to learn can be communicated in the form of a verbal request, a question, a puzzled or confused look, a blank stare, or a gesture of defeat or frustration. In the broadest sense, then, teaching is a highly versatile strategy that can be applied in preventing, promoting, maintaining, or modifying a wide variety of behaviors in a learner who is receptive, motivated, and adequately informed (Duffy, 1998).

Learning is defined as a change in behavior (knowledge, attitudes, and/or skills) that can be observed or measured and that occurs at any time or in any place as a result of exposure to environmental stimuli. Learning is an action by which knowledge, skills, and attitudes are consciously or unconsciously acquired such that behavior is altered in some way (see Chapter 3). The success of the health professional educator's endeavors at teaching is measured not by how much content he or she imparts, but rather by how much the person learns (Musinski, 1999).

Specifically, **patient education** is a process of assisting people to learn health-related behaviors

Figure 1–1 Education Process Parallels Healthcare Practice



that they can incorporate into everyday life with the goal of optimal health and independence in self-care. **Staff education**, by contrast, is the process of influencing the behavior of colleagues by producing changes in their knowledge, attitudes, and skills to help them maintain and improve their competencies for the delivery of quality care to the consumer. Both patient and staff education involve forging a relationship between the learner and the educator so that the learner's information needs (cognitive, affective, and psychomotor) can be met through the process of education (see Chapter 10).

The ASSURE model is a useful paradigm originally developed to assist nurses to organize and carry out the education process (Rega, 1993). This model is appropriate for all health professional educators. The acronym stands for

- **A**nalyze the learner
- **S**tate the objectives
- **S**elect the instructional methods and materials
- **U**se the instructional methods and materials
- **R**equire learner performance
- **E**valuate the teaching plan and revise as necessary

Role of the Health Professional as Educator

Over the years, organizations governing and influencing the practice of various health professionals have identified teaching as an important responsibility. For health professionals to fulfill the role of educator, no matter whether their audience consists of patients, family members, students, staff, or other agency personnel, they must have a solid foundation in the principles of teaching and learning.

The role of educator is not primarily to teach, but to promote learning and provide for an environment conducive to learning—to create the teachable moment rather than just waiting for it to happen (Lawson & Flocke, 2009; Wagner & Ash, 1998). Also, the role of the health professional as teacher of clients, families, staff, and students certainly should stem from a partnership philosophy. A learner cannot be made to learn, but an effective approach in educating others is to actively involve learners in the education process (Bodenheimer et al., 2002).

Although health professionals are expected to teach, many lack formal preparation in the principles of teaching and learning. As you see in this textbook, a health professional needs a great deal of knowledge and skill to carry out the role as educator with efficiency and effectiveness. Although all health professionals are able to function as givers of information, they need to acquire the skills of being a facilitator of the learning process (Musinski, 1999). Consider the following questions:

- Is every health professional adequately prepared to assess for learning needs, readiness to learn, and learning styles?
- Can every health professional determine whether information given is received and understood?
- Are all health professionals capable of taking appropriate action to revise the approach to educating the client if the client does not comprehend the information provided?
- Do health professional educators realize they need to transition their role from being a content transmitter to being a process manager, from controlling the learner to releasing the learner, and from being a teacher to becoming a facilitator (Musinski, 1999)?

A growing body of evidence suggests that effective education and learner participation go hand in hand. The health professional should act as a facilitator, creating an environment conducive to learning that motivates individuals to want to learn and makes it possible for them to learn (Musinski,

1999). Both the educator and the learner should participate in the assessment of learning needs, the design of a teaching plan, the implementation of instructional methods and materials, and the evaluation of teaching and learning. Thus, the emphasis should be on the facilitation of learning from a nondirective rather than a didactic teaching approach (Donner, Levonian, & Slutsky, 2005; Knowles, Holton, & Swanson, 1998; Mangena & Chabeli, 2005; Musinski, 1999).

No longer should teachers see themselves as simply transmitters of content. Indeed, the role of the educator has shifted from the traditional position of being the giver of information to that of a process designer and coordinator. This role alteration from the traditional teacher-centered to the learner-centered approach is a paradigm shift that requires educators to possess skill in needs assessment as well as the ability to involve learners in planning, link learners to learning resources, and encourage learner initiative (Knowles et al., 1998; Mangena & Chabeli, 2005).

Instead of the teacher teaching, the new educational paradigm focuses on the learner learning. That is, the teacher becomes the guide on the side, assisting the learner in his or her effort to determine objectives and goals for learning, with both parties being active partners in decision making throughout the learning process. To increase comprehension, recall, and application of information, clients must be actively involved in the learning experience (Kessels, 2003; London, 1995). Glanville (2000) describes this move toward assisting learners to use their own abilities and resources as "a pivotal transfer of power" (p. 58).

Barriers to Teaching and Obstacles to Learning

It has been said by many educators that adult learning takes place not by the teacher's initiating and motivating the learning process, but rather by the teacher's removing or reducing obstacles to learning and enhancing the process after it has begun. The educator should not limit learning to the information that is intended but should clearly make possible the potential for informal, unintended learning that can occur each and every day with each and every teacher–learner encounter (Carpenter & Bell, 2002).

Unfortunately, health professionals must confront many barriers in carrying out their responsibilities for educating others. Also, learners face a variety of potential obstacles that can interfere with their learning. For the purposes of this textbook, **barriers to teaching** are defined as those factors that impede the health professional's ability to deliver educational services. **Obstacles to learning** are defined as those factors that negatively affect the ability of the learner to pay attention to and process information.

Factors Affecting the Ability to Teach

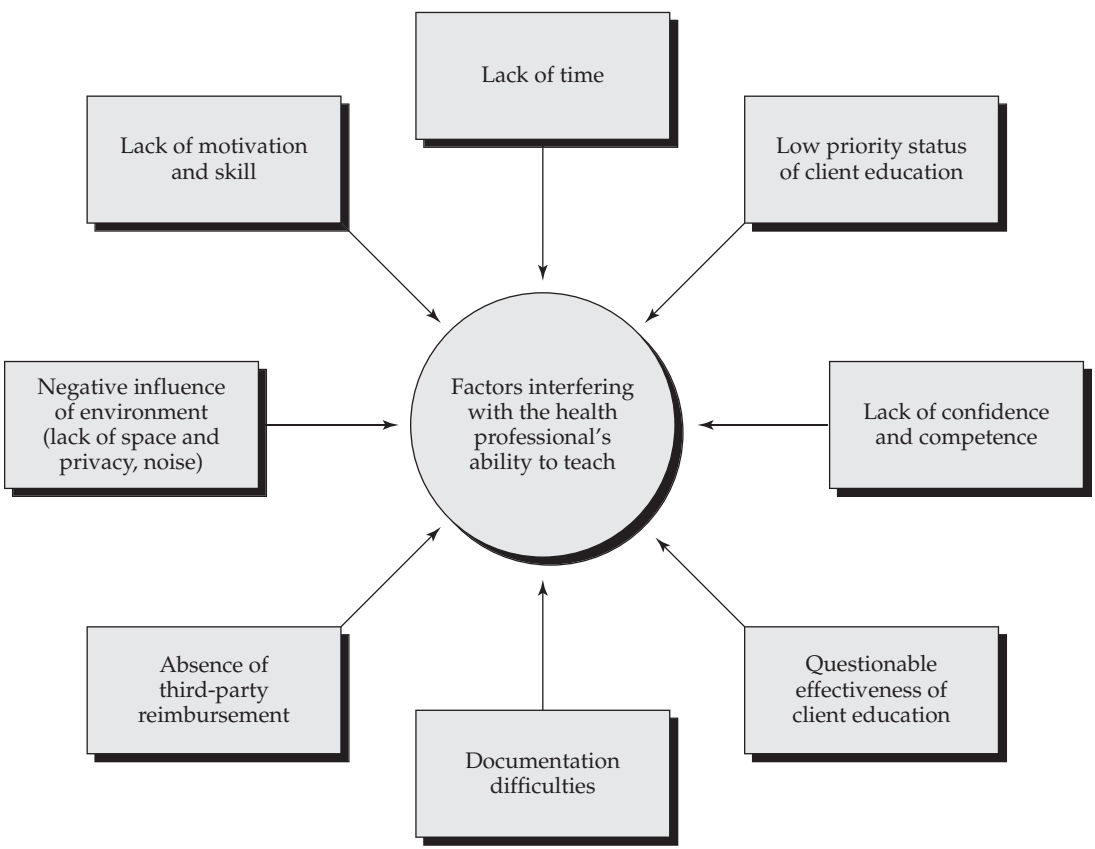
The following include the major barriers that interfere with the ability of health professionals to carry out their roles as educators (Carpenter & Bell, 2002; Casey, 1995; Chachkes & Christ, 1996; Duffy, 1998; Glanville, 2000; Honan, Krsnak, Petersen, & Torkelson, 1988) (see also **Figure 1–2**):

1. Lack of time to teach is a common barrier that prevents health professionals from being able to carry out their educator role effectively. Early discharge from inpatient and outpatient settings often results in health professionals and clients having fleeting contact with one another. In addition, the schedules and responsibilities of health professionals are very demanding. Finding time to allocate to teaching is very challenging in light of other work demands and expectations. In one survey by the Joint Commission, 28% of the nurses claimed that they were not able to provide patients and their

families with the necessary instruction because of lack of time during their shifts at work (Stolberg, 2002). Health professionals must know how to adopt an abbreviated, efficient, and effective approach to client and staff education by first adequately assessing the learner and then by using appropriate instructional methods and instructional tools at their disposal. Discharge planning plays an ever more important role in ensuring continuity of care across settings.

2. Many health professionals admit that they do not feel competent or confident with their teaching skills. As stated previously, although health professionals are expected to teach, few have ever taken a specific course on the principles of teaching and learning. The concepts of patient education are often integrated throughout health professional curricula rather than being offered as a specific course of study. Pohl (1965) compiled some interesting statistics re-

Figure 1–2 Barriers to Teaching



garding nursing, long considered one of the first health professions to have a strong teaching role. As early as the mid-1960s, Pohl found that one third of 1,500 nurses, when questioned, reported that they had no preparation for the teaching they were doing, while only one fifth felt they had adequate preparation. Almost 30 years later, Kruger (1991) surveyed 1,230 nurses in staff, administrative, and education positions regarding their perceptions of the extent of nurses' responsibility for and level of achievement of patient education. Although all three groups strongly believed that client and staff education is a primary responsibility of nurses, the vast majority of them rated their ability to perform educator role activities as unsatisfactory. Many of the other health professions share similar views. Few additional studies have been forthcoming on nurses' perceptions of their educator role (Trocino, Byers, & Peach, 1997).

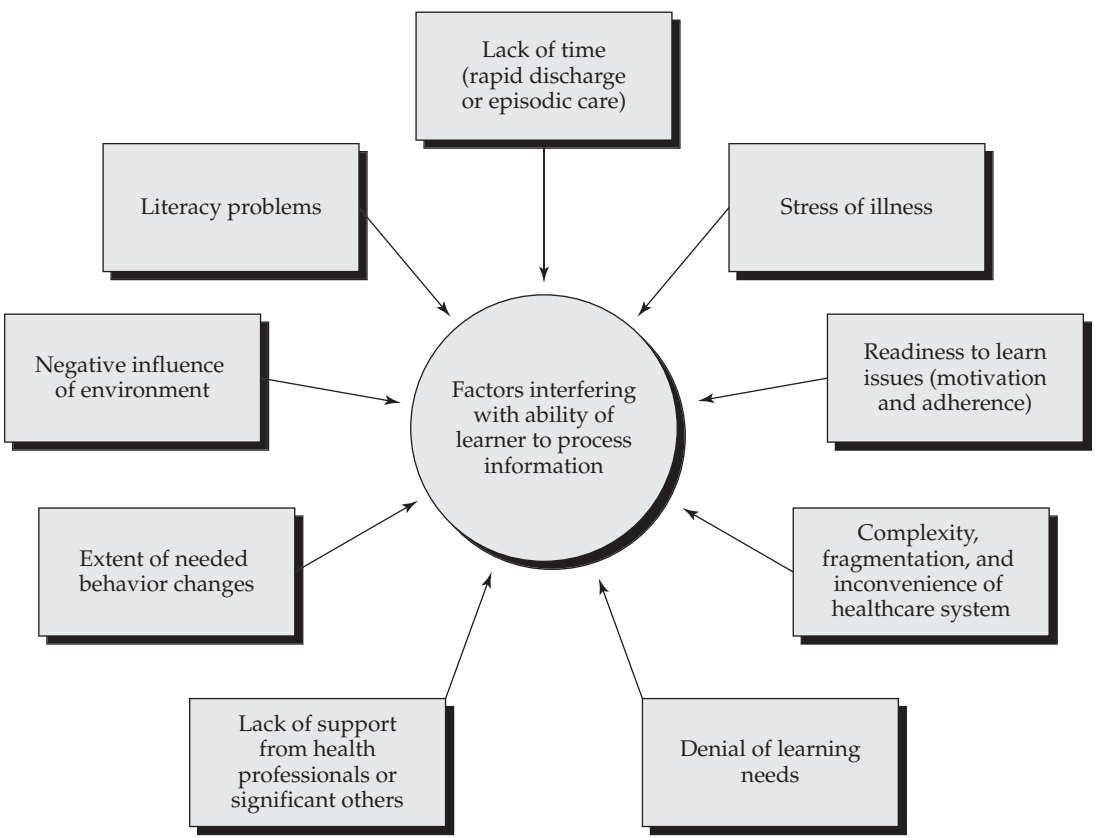
3. Personal characteristics of the health professional educator play an important role in determining the outcome of a teaching–learning interaction. Motivation to teach and skill in teaching are prime factors in determining the success of any educational endeavor (see Chapter 11).
4. Until recently, administration and supervisory personnel assigned low priority to patient and staff education. With the strong emphasis on Joint Commission mandates, the level of attention paid to the educational needs of consumers as well as healthcare personnel has changed significantly. However, budget allocations for educational programs remain tight and can interfere with the adoption of innovative and time-saving teaching strategies and techniques.
5. The environment in the various settings where health professionals are expected to teach is not always conducive to carrying out the teaching–learning process. Lack of space, lack of privacy, noise, and frequent interferences caused by client treatment schedules and staff work demands are just some of the factors that negatively affect the health professional's ability to concentrate and effectively interact with learners.
6. An absence of third-party reimbursement to support patient education relegates teaching and learning to less than high-priority status. Services of health professionals within healthcare facilities are subsumed under hospital room costs and, therefore, are not often specifically reimbursed by insurance payers. In fact, patient education in some settings, such as home care, often cannot be incorporated as a legitimate aspect of routine care delivery unless specifically ordered by a physician. Because there are no separate billing codes for patient education in the American Medical Association's Common Procedural Terminology (CPT) codes, it is difficult to make it an area of focus and it must be integrated into a therapeutic intervention for many health professionals (Hack, 1999).
7. Some health professionals question whether patient education is effective as a means to improve health outcomes. They view patients as impediments to teaching when patients do not display an interest in changing behavior, when they demonstrate an unwillingness to learn, or when their ability to learn is in question. Concerns about coercion and violation of free choice, based on the belief that patients have a right to choose and that they cannot be forced to comply, explain why some professionals feel frustrated in their efforts to teach. Unless all healthcare members buy into the utility of patient education (that is, they believe it can lead to significant behavioral changes and increased compliance to therapeutic regimens), then some professionals may continue to feel absolved of their responsibility to provide adequate and appropriate patient education.
8. The type of documentation system used by healthcare agencies has an effect on the quality

and quantity of patient teaching. Both formal and informal teaching are often done (Carpenter & Bell, 2002) but not written down because of insufficient time, inattention to detail, and inadequate forms on which to record the extent of teaching activities. Many of the forms used for documentation of teaching are designed to simply check off the areas addressed rather than allow for elaboration of what was actually accomplished. In addition, many health professionals do not recognize the scope and depth of teaching that they perform on a daily basis. Communication among healthcare providers regarding what has been taught needs to be coordinated and appropriately delegated so that teaching can proceed in a timely, smooth, organized, and thorough fashion.

Factors Affecting the Ability to Learn

The following are some of the major obstacles interfering with a learner's ability to attend to and process information (Glanville, 2000; Weiss, 2003) (see also **Figure 1–3**):

Figure 1–3 Obstacles to Learning



1. Lack of time to learn resulting from rapid patient discharge from care and the amount of information a client is expected to learn can discourage and frustrate the learner, impeding his or her ability and willingness to learn.
2. The stress of acute and chronic illness, anxiety, and sensory deficits in patients are just a few problems that can diminish learner motivation and interfere with the process of learning. However, illness alone seldom acts as an impediment to learning. Rather, illness is often the impetus for patients to attend to learning, make contact with the healthcare professional, and take positive action to improve their health status.
3. Low literacy and functional health illiteracy have been found to be significant factors in the ability of clients to make use of the written and verbal instructions given to them by providers. Almost half of the American people read and comprehend at or below the eighth-grade level and an even higher percentage suffer from health illiteracy (see Chapter 7).
4. The negative influence of the hospital environment itself, resulting in loss of control, lack of privacy, and social isolation, can interfere with a patient's active role in health decision making and involvement in the teaching–learning process.
5. Personal characteristics of the learner have major effects on the degree to which behavioral outcomes are achieved. Readiness to learn, motivation and compliance, developmental-stage characteristics, and learning styles are some of the prime factors influencing the success of educational endeavors.
6. The extent of behavioral changes needed, both in number and in complexity, can overwhelm learners and dissuade them from attending to and accomplishing learning objectives and goals.
7. Lack of support and lack of ongoing positive reinforcement from health professionals and significant others serve to block the potential for learning.
8. Denial of learning needs, resentment of authority, and lack of willingness to take responsibility (locus of control) are some psychological obstacles to accomplishing behavioral change.
9. The inconvenience, complexity, inaccessibility, fragmentation, and dehumanization of the healthcare system often result in frustration and abandonment of efforts by the learner to participate in and comply with the goals and objectives for learning.

Questions to Be Asked About Teaching and Learning

To maximize the effectiveness of client, staff, and student education, the health professional must examine the elements of the education process and the role of the health professional as educator. Many questions arise related to the principles of teaching and learning. The following are some of the important questions that the chapters in this textbook address:

- How can members of the healthcare team work together more effectively to coordinate educational efforts?
- What are the ethical, legal, and economic issues involved in patient and staff education?
- Which theories and principles support the education process, and how can they be applied to change the behaviors of learners?
- What assessment methods and tools can health professionals as educators use to determine learning needs, readiness to learn, and learning styles?
- Which learner attributes negatively and positively affect an individual's ability and willingness to learn?

- What can be done about the inequities (in quantity and quality) in the delivery of education services?
- Which elements must the health professional as educator take into account when developing and implementing teaching plans?
- Which instructional methods and materials are available to support teaching efforts?
- Under which conditions should health professionals use certain teaching methods and materials?
- How can teaching be tailored to meet the needs of specific populations of learners?
- What common mistakes do health professionals make when teaching others?
- How can teaching and learning be best evaluated?

State of the Evidence

The literature on patient and staff education, from both a research- and non-research-based perspective, is particularly extensive in nursing. Much of it can be broadly applied to all the health professions. The nonresearch literature on patient education is prescriptive in nature and tends to give anecdotal tips on how to take individualized approaches to teaching and learning. A computer literature search, for example, reveals literally thousands of nursing and allied health articles and books on teaching and learning that are available from the general to the specific.

However, many research-based studies are being conducted on teaching specific population groups about a variety of topics, but only recently has the field focused attention on how to most effectively teach those with long-term chronic illnesses. Health professionals as educators must conduct much more research on the benefits of patient education as it relates to the potential for increasing quality of life, enabling patients to lead a disability-free life and manage themselves independently at home, and decreasing the costs of health care through anticipatory teaching approaches. Studies from acute-care settings tend to focus on preparing a patient for a procedure, with emphasis on the benefits of information to alleviate anxiety and promote psychological coping. Evidence does suggest that patients cope much more effectively when taught exactly what to expect (Donovan & Ward, 2001; Duffy, 1998; Mason, 2001).

More research is definitely needed on the benefits of teaching methods and instructional tools that use the technologies of computer-assisted instruction, online and other distance learning modalities, cable television, podcasts, and Internet access to health information for both patient and staff education. These new approaches to information dissemination require a role change of the educator from one of teacher to resource facilitator as well as a shift in the role of the learner from being a passive to an active recipient. The rapid advances in technology for teaching and learning also require educators to have a better understanding of generational orientations and experiences of the learner (Billings & Kowalski, 2004). Also, the effectiveness of videotapes and audiotapes with different learners and in different situations must be further explored (Kessels, 2003). Given the significant incidence of low literacy rates among patients and their family members, much more investigation needs to be done on the impact of printed versus audiovisual materials as well as written versus verbal instruction on learner comprehension (Weiss, 2003).

Gender issues, the influence of socioeconomics on learning, and the strategies of teaching cultural groups and populations with disabilities need further exploration as well. Unfortunately, the findings from interdisciplinary research on the influence of gender on learning remain inconclusive.

Nevertheless, health professionals are expected to teach diverse populations with complex needs

and a range of abilities in both traditional settings and nontraditional, unstructured settings. For more than 30 years, researchers have been studying how best to teach patients, but much more research is required (Mason, 2001). The health professions need to establish a stronger theoretical basis for intervening with clients throughout "all phases of the learning continuum, from information acquisition to behavioral change" (Donovan & Ward, 2001, p. 211).

In addition, health professionals as educators should further investigate the cost effectiveness of educational efforts in reducing hospital stays, decreasing readmissions, improving the personal quality of life, and minimizing complications of illness and therapies. Furthermore, given the number of variables that can potentially interfere with the teaching–learning process, additional studies must be conducted to examine the effects of environmental stimuli, the factors involved in readiness to learn, and the influences of learning styles on learner motivation, compliance, comprehension, and the ability to apply knowledge and skills once they are acquired. One particular void is the lack of information in the research database on how to assess motivation. The author of Chapter 6 proposes parameters to assess motivation but notes the paucity of information specifically addressing this issue.

More than 20 years ago, Oberst (1989) delineated the major issues in patient education studies related to the evaluation of the existing research base and the design of future studies. The following four broad problem categories that she identified remain pertinent today:

1. Selection and measurement of appropriate dependent variables (educational outcomes)
2. Design and control of independent variables (educational interventions)
3. Control of mediating and intervening variables
4. Development and refinement of the theoretical basis for education

Summary

Health professionals can be considered information brokers—educators who can make a significant difference in how patients and families cope with their illnesses and disabilities, how the public benefits from education directed at prevention of disease and promotion of health, and how colleagues and students gain competency and confidence in practice through education activities that are directed at continuous, lifelong learning. As this nation moves forward in the 21st century, many challenges and opportunities are ahead for health professional educators in the delivery of health care.

The teaching role is becoming even more important and more visible as health professionals respond to the social, economic, and political trends affecting health care today. The foremost challenge for health professionals is to be able to demonstrate, through research and action, that definite links exist between education and positive behavioral outcomes of the learner. In this era of cost containment, government regulations, and healthcare reform, the benefits of client, staff, and student education must be made clear to the public, to healthcare employers, to healthcare providers, and to payers of healthcare benefits. To be effective and efficient, health professionals must be willing and able to work collaboratively with each other to provide consistently high quality education to the audiences they serve.

Health professionals can demonstrate responsibility and accountability for the delivery of care to the consumer, in part, through education based on solid principles of teaching and learning. The key to effective education of the varied audiences of learners the health professional encounters is his or her understanding of and ongoing commitment to the role of educator.

REVIEW QUESTIONS

1. Which health profession historically has had the most significant impact on patient education?
2. What key factors influenced the growth of patient education during its formative period?
3. How did the concept of patient education change in the 1960s and 1970s?
4. What is the current focus and orientation of patient education?
5. What social, economic, and political trends today make it imperative that clients and health professional staff be adequately educated?
6. What are the similarities and differences between the education process and the general practice of health care?
7. What are three major barriers to teaching and three major obstacles to learning?
8. What common factor serves as both a barrier to education and as an obstacle to learning?
9. What is the current status of research- and non-research-based evidence pertaining to education?

CASE STUDY

As part of Lackney General Hospital's continuous quality improvement plan, and in preparation for the next Joint Commission accreditation visit, all departments in the hospital are in the process of assessing the quality and effectiveness of their patient and staff education efforts. When you solicit feedback from your staff regarding their feelings on this topic, you are surprised at the frustration they express. Liz states, "Although I am incredibly frustrated by the lack of administrative support for patient education, I do believe that patient education makes a difference." Jerimiah jumps in and says, "I am sick of all the boring, mandated continuing education programs we are required to complete." Finally, Jaipaul comments, "I have no idea how I am supposed to fit education in with all the other tasks I am supposed to complete." Because the staff obviously has some strong feelings about the department's education efforts, you feel a SWOT (strengths, weaknesses, opportunities, threats) analysis is a good place to begin to gather information from your colleagues.

1. As a prelude to the SWOT analysis, identify the goals of patient and staff education.
2. Use the section titled "Barriers to Teaching and Obstacles to Learning" as a beginning framework for the weaknesses and threats section of the SWOT analysis, and then describe five potential barriers to teaching and five potential obstacles to learning that your staff might identify.
3. Provide possible solutions to the issues you identified as barriers and obstacles that would serve to enhance patient and staff education.

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