



PART 1

Perspectives on Teaching and Learning

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CHAPTER 1

Overview of Education in Health Care

Susan B. Bastable

Pamela R. Gramet

CHAPTER HIGHLIGHTS

- Historical Foundations for Patient Education in Health Care
- The Evolution of the Teaching Role of Health Professionals
- Social, Economic, and Political Trends Affecting Health Care
- Purposes, Goals, and Benefits of Patient, Staff, and Student Education
- The Education Process Defined
- The Contemporary Role of the Health Professional as Educator
 - *Interprofessional Education*
 - *Patient-Centered Care*
- Barriers to Teaching and Obstacles to Learning
 - *Factors Affecting the Ability to Teach*
 - *Factors Affecting the Ability to Learn*
- Questions to Be Asked About Teaching and Learning
- State of the Evidence

KEY TERMS

education process
teaching/instruction
learning

patient education
staff education
interprofessional education

patient-centered care (PCC)
barriers to teaching
obstacles to learning

OBJECTIVES

After completing this chapter, the reader will be able to

1. Discuss the evolution of patient education in health care as it pertains to the teaching role of health professionals.
2. Recognize trends affecting the healthcare system.
3. Identify the purposes, goals, and benefits of patient, staff, and student education.
4. Compare the education process to the process of healthcare practice.
5. Define the terms *education process*, *teaching*, and *learning*.
6. Identify why patient, staff, and student education is an important duty for health professionals.
7. Analyze the significance of interprofessional collaboration.
8. Explain why the patient-centered care movement is a trend in health care.
9. Discuss the barriers to teaching and the obstacles to learning.
10. Formulate questions that health professionals in the role of educator should ask about the teaching–learning process.

Education in health care today—including patient, staff, and 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 health professional's role (Andersson, Svanström, Ek, Rosén, & Berglund, 2015; Friberg, Granum, & Bergh, 2012; Jensen & Mostrom, 2013; Steketee & Bate, 2013), whether it involves educating patients and their family members, colleagues, or students. The current trends in health care are making it essential that patients be prepared to assume responsibility for self-care management and that health professionals in the workplace be accountable for the delivery of safe, high-quality care (Jacobs, 2017; Lockhart, 2016; Shi & Singh, 2015; U.S. Department of Health and Human Services [USDHHS], 2015). The focus of modern health care is on outcomes that demonstrate the extent to which patients and their significant others have learned essential knowledge and skills for independent care or to which staff and health professional 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 (Adams, 2010; Doyle, Lennox, & Bell, 2013; Institute of Medicine [IOM], 2001).

According to Friberg and colleagues (2012), patient education is an issue in nursing practice and will continue to be a significant focus in the healthcare environment. This is certainly true for all health professions. Because so many changes are occurring in the healthcare system, health professionals are increasingly finding themselves in challenging, constantly changing, and highly complex positions (Gillespie & McPetridge, 2006; Pollack, 2017; Vennum, 2017). 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 patient education in health care and the health professional's role as teacher. 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 in the delivery of health services. Also, this chapter addresses the continuing education efforts necessary to ensure ongoing practice competencies of health professionals.

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; compares the education process to the process of healthcare practice; stresses the importance of interprofessional collaboration and patient-centered care; identifies barriers to teaching and obstacles to learning; and highlights the status of research in the field of patient education as well as in the education of staff and students. The focus is on the overall role of the health professional in teaching and learning, regardless of who the audience of learners might 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 Patient Education in Health Care

“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). Because these 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) and as the first phase in the development of organized health care by Dreeben (2010), several key factors influenced the growth of patient education. The emergence of nursing and other health professions,

technological developments, the emphasis on the patient–caregiver relationship, the spread of tuberculosis and other communicable diseases, and the growing interest in the welfare of mothers and children all had an impact on patient education (Bartlett, 1986; Dreeben, 2010). In nursing, Florence Nightingale emerged as a resolute advocate of the educational responsibilities of district public health nurses and authored *Health Teaching in Towns and Villages*, which advocated for school teaching of health rules and health teaching in the home (Monterio, 1985).

Dreeben (2010) described the first four decades of the 20th century as the second phase in the development of organized health care. In support of maternal and child health in the United States, the Division of Child Hygiene was established in New York City in 1908 (Bartlett, 1986). Under the auspices of this organization, public health nurses provided instruction to mothers of newborns in the Lower East Side on how to keep their infants healthy. Diagnostic tools, scientific discoveries, new vaccines and antibiotic medications, and effective surgery and treatment practices led to education programs in sanitation, immunization, prevention and treatment of infectious diseases, and a growth in the U.S. public health system. The National League of Nursing Education recognized that public health nurses were essential to the well-being of communities, and the teaching they provided to individuals, families, and groups was considered “a precursor to modern patient and health education” (Dreeben, 2010, p. 11).

The third phase in the development of organized health care began after World War II. It was a time of significant scientific accomplishments and a profound change in the delivery system of health care (Dreeben, 2010). The late 1940s through the 1950s is described as a time when patient education continued to occur as part of clinical encounters, but often it was overshadowed by the increasingly technological orientation of health care (Bartlett, 1986). The first references in the literature to

patient education began to appear in the early 1950s (Falvo, 2004). In 1953, Veterans Administration 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).

In the 1960s and 1970s, patient education began to be seen as a specific task in which 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 1960s, voluntary agencies and the U.S. 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 became involved in various education programs and projects (Rosen, 1971). By the mid-1960s, patients were recognized as healthcare consumers, and society adopted the new perspective that health care was a right and not a privilege for all Americans. In 1965, the U.S. Congress passed Titles XVIII and XIX of the Social Security Act, which created, respectively, the Medicare and Medicaid plans to provide health care to indigent persons, older adults, and people with medical disabilities (Dreeben, 2010).

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 (Rosen, 1971). One of the committee's seven basic premises was an educational prescription that would base teaching on individual patient needs and be included as part of the patient's

record. This recommendation represented one of the earliest mentions of the documentation of patient education (Falvo, 2004). The committee ultimately 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: (1) A publication from the U.S. 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 (2) President Richard Nixon issued a message to Congress using the term *health education* (Falvo, 2004). Nixon later appointed the President's Committee on Health Education, which recommended that 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 U.S. Department of Health, Education, and Welfare (Falvo, 2004).

Resulting from this committee's recommendations, the American Hospital Association (AHA) appointed a special committee on health education (Falvo, 2004). The AHA committee suggested that it was a responsibility of hospitals and other healthcare institutions to provide educational programs for patients and that all health professionals were to be included in patient education (American Hospital Association [AHA], 1976). Also, the healthcare system began to pay more attention to patient rights and protections involving informed consent (Roter, Stashefsky-Margalit, & Rudd, 2001).

Also in the early 1970s, patient education was a significant part of the AHA's *Statement on a Patient's Bill of Rights*, affirmed in 1972 and then formally published in 1973 (AHA,

1973). This document outlines patients' rights to receive current information about their diagnosis, treatment, and prognosis in understandable terms, and 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, which reinforced the concept as a "patient right" and its being seen as an obligation and legal responsibility of health professionals. In addition, patient education was recognized as a condition of high-quality care and as a factor that could affect the efficiency of the healthcare system (Falvo, 2004). Furthermore, during the 1970s, insurance companies began to deal with issues surrounding patient education because they saw how it could positively influence the costs of health care (Bartlett, 1986).

Further support for and validation of patient education as a right and the expectation of high-quality health care came in the 1976 edition of the *Accreditation Manual for Hospitals* published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), now known as The Joint Commission (Falvo, 2004). This manual broadened the scope of patient education to include both outpatient and inpatient services and specified that criteria for patient education should be established. Patients had to receive information about their medical problem, prognosis, and treatment, and evidence had to be provided indicating that patients understood the information they were given (Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 1976).

In the 1980s and 1990s, national health education programs once again became popular as healthcare trends focused on disease prevention and health promotion. This evolution represented a logical response to the cost-containment efforts occurring in health care at that time (Dreeben, 2010). 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 (USDHHS, 1990). Establishing educational and community-based programs was one of the priority areas identified in this document.

In addition, in recognition of the importance of patient education by nurses, The Joint Commission (TJC) 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 in order to achieve expected client outcomes (JCAHO, 2001). These standards required nurses to achieve positive outcomes of patient care through teaching activities that must be patient centered and family oriented. More recently, TJC expanded its expectations to include an interdisciplinary team approach in the provision of patient education, and evidence that patients and their significant others participate in care and decision making and understand what they have been taught. This requirement means that all healthcare 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 believed 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). This report offered recommendations pertinent to 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 deal with the teaching role of health professionals. These competencies for the practice of health care include the need for all 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 preventive 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

For the 21st century, the Institute for Healthcare Improvement announced the 5 Million Lives campaign in 2006. This campaign's objective was 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 teaching staff and students the ways they can improve care to reduce injuries, save lives, and decrease costs of health care (Proctor, 2007).

Another initiative was 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).

In addition, following on the heels of *Healthy People 2000*, *Healthy People 2010* built on the previous two initiatives and provided an expanded framework for health prevention for the nation (USDHHS, 2000). Specific goals and objectives included 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 (USDHHS, 2000). As the latest iteration of the Healthy People initiative, *Healthy People 2020* is the product of an extensive evaluation process by stakeholders. Its 40 topic areas support four overarching goals: attaining high-quality and longer lives; achieving health equity and eliminating disparities; creating social and physical environments that promote good health for all; and promoting quality of life, healthy development, and behaviors across the entire life span (USDHHS, 2010). Patient education is a fundamental component of these far-reaching national initiatives. Presently, the Secretary of Health and Human Services is in the process of establishing an advisory committee and proposed framework, informed by the latest scientific evidence, for the development and implementation of recommendations on national health promotion and disease prevention objectives for *Health People 2030* (USDHHS, 2017).

Thus, since the 1980s, the role of the health professional as educator has undergone a paradigm shift, evolving from 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, which was once performed as part of discharge planning 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; Kelliher, 2013). 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 (Liu, Yu, & Yuan, 2016; Roter et al., 2001).

► The Evolution of the Teaching Role of Health Professionals

Today, most health professionals consider educating clients, families, colleagues, students, and the public to be part of their professional responsibility. However, it was not until relatively recently that many of the professions formally identified the responsibility of teaching in their professional practice standards and codes of ethics. 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 (American Medical Association, 1976). This statement by the AMA emphasized the responsibility of physicians in conducting patient education, but it also recognized the teaching responsibility of nurses, nutritionists, and other health professionals. It stressed the “team effort” aspect of patient education and

the patient’s responsibility for patient education outcomes (Falvo, 2004).

Pharmacy, dietetics, and physical therapy organizations also published formal statements on their role in patient education in the 1970s. The *Statement on Pharmacist-Conducted Patient Counseling* by the American Society of Hospital Pharmacists (1976) delineated the role of pharmacists in educating patients about their medications. A position paper by the American Dietetic Association (1976) recommended that dietitians counsel individuals and families in nutritional principles, dietary plans and food selections, and menu plans adapted to the individual’s lifestyle. It also recommended that dietitians record dietary history in medical records and compile or develop educational materials to use as aids in nutrition counseling. An early article recognizing the importance of teaching as a fundamental part of treatment appeared in the physical therapy literature in 1958, but the first accreditation criteria related to the teaching role of physical therapists was developed by the American Physical Therapy Association (APTA) in 1978 (May, 1999). It stated 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 [APTA], 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 promoting the health of the well public.

Florence Nightingale, the founder of modern nursing, was the ultimate educator. Not only did she develop the first school of

nursing, but she also devoted a large portion of her career to teaching nurses, physicians, and health officials about the importance of proper conditions in hospitals and homes to improve the health of people. Nightingale also emphasized the importance of teaching patients the need for adequate nutrition, fresh air, exercise, and personal hygiene to improve their well-being. By the early 1900s, public health nurses in the United States clearly understood the significance of the role of the nurse as teacher in preventing disease and in maintaining the health of society (Chachkes & Christ, 1996; Dreeben, 2010).

For decades, then, patient teaching has been recognized as an independent nursing function. Nurses have always educated others—patients, families, colleagues, and nursing students. It is from these roots that nurses have expanded their practice to include the broader concepts of health and illness (Glanville, 2000). Today, all state nurse practice acts (NPAs) include teaching within the scope of nursing practice responsibilities. Nurses, by legal mandate of their NPAs, are expected to provide instruction to consumers to assist them in maintaining optimal levels of wellness and manage illness. Nursing career ladders often incorporate teaching effectiveness as a measure of excellence in practice (Rifas, Morris, & Grady, 1994). By teaching patients and families, nurses can achieve the professional goal of providing cost-effective, safe, and high-quality care (Santo, Tanguay, & Purden, 2007; Shi & Singh, 2015).

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 high-quality patient and staff education. Although specific roles vary according to profession, directives

related to contemporary patient education clearly echo 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 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.

Other very important roles of health professionals as educators are serving as clinical instructors, preceptors, and mentors for students in the practice setting 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 clinical instructors, preceptors, and mentors 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 keep up to date with clinical skills and innovations in practice but also to possess knowledge and skills related to the principles of teaching and learning (Levy et al., 2009; Licata, 2014). Knowing the practice field is not the same 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 (Billings & Hallstead, 2016; Cangelosi, Crocker, & Sorrell, 2009; Gillespie & McFetridge, 2006; Salminen, Stolt, Koskinen, Katajisto, & Leino-Kilpi, 2013). The Credentialed Clinical Instructor Program is designed by APTA, but courses offered in the program are open to clinicians from other healthcare professions. These courses are taught throughout the year in both the United States

and Canada to help those who work in the clinical setting to improve their teaching skills (APTA, 2018).

► Social, Economic, and Political Trends Affecting Health Care

In addition to the professional and legal standards put forth by various organizations and agencies representing or regulating the health professions, 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, staff, and student education. The following are some of the significant forces influencing healthcare practice (Ainsley & Brown, 2009; Berwick, 2006, 2014; Birchenall, 2000; Bodenheimer, Lorig, Holman, & Grumbach, 2002; Cipriano, 2007; IOM, 2001, 2011; Gantz et al., 2012; Glanville, 2000; Jacobs, 2017; Lea, Skirton, Read, & Williams, 2011; Lockhart, 2016; Shi & Singh, 2015; USDHHS, 2010; Zikmund-Fisher, Sarr, Fagerlin, & Ubel, 2006):

- The federal government, as discussed earlier, published *Healthy People 2020*, a document that set 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. Among the major causes of morbidity and mortality are those diseases now recognized as being lifestyle related and preventable through educational intervention. Health professionals play an important role in making a real difference by teaching clients to attain and maintain healthy lifestyles.
- The Institute of Medicine (2011) established recommendations designed to enhance the role of nurses in the delivery of health care. This includes nurses functioning to the full extent of their education and scope of practice. Patient and family education is a key component of the nurse's role.
- The U.S. Congress passed into law in 2010 the Affordable Care Act (ACA), a comprehensive healthcare reform legislation. The ACA is designed to provide cost-effective, accessible, equitable, high-quality health care to all Americans with the intent of improving their health outcomes. If the ACA survives the political pressures to alter or dismantle it, universal accessibility to health care has the potential to transform the healthcare system, and health professionals will play a major role in meeting the demands and complexities of this increasing population of patients.
- 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 value of reaching out to communities, schools, and workplaces—all settings where health professionals practice—to provide public 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 becoming 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 and to reinforce or refresh previously acquired knowledge and abilities for the continuing growth of staff.

- Consumers are demanding increased knowledge and skills to care for themselves and 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 1960s, continues into the 21st century.
- 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.
- Demographic trends, particularly the aging of the population, require health professionals to emphasize self-reliance and maintenance of a healthy status over an extended life span. The percentage of the U.S. population older than age 65 years will climb dramatically in the next 20–30 years, and the healthcare needs of the baby boom generation of the post–World War II era will increase as this vast cohort deals with degenerative illnesses and other effects of the aging process.
- In addition, millions of incidents of medical harm occur every year in U.S. hospitals. Clearly, it is imperative that clients, staff, and students be educated about preventive measures to reduce these incidents.
- The increased prevalence of chronic and incurable conditions requires that individuals and families become informed participants to manage their own illnesses. Patient 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 outpatient procedures being done force patients to be more self-reliant in managing their own health. Patient education assists them in following through with self-management activities independently.
- Healthcare providers increasingly recognize client health literacy as an essential skill to improve health outcomes nationwide. Health professionals must attend to the education needs of their patients and families to be sure that they 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 patients 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.
- Online technologies used in health professional education programs are increasing. Health professionals are expected to have the critical thinking skills needed to identify problems, conduct research on problems encountered, and apply new knowledge to address these problems. In addition, health professionals are expected to have familiarity with computerized charting and electronic health information records. Informatics is becoming highly important in the paperless world of patient care, and health professional educators are preparing health professional students and staff in the practice setting with the skills needed for proper electronic data collection, documentation, and analysis.
- The fields of genetics and genomics, as included in the holistic approach of

healthcare practice, are providing patients with more options to consider for screenings, procedures, and therapies to obtain optimal health. The United States and Europe have established core competencies in genetics and genomics relevant to certain health professionals to support the development of skills, knowledge, and attitudes in the delivery of safe comprehensive care.

Health professionals recognize the need to acquire expertise in teaching to keep pace with the demands of patient, staff, and student education. As they continue to define their role, body of knowledge, scope of practice, and professional expertise, they are realizing, more than ever before, the significance of their role as educators. Health professionals have many opportunities to carry out health education. Many health professionals have continuous contact with clients, are usually a very accessible source of information for the consumer, and are highly trusted. In fact, three members of the health professions included in the Gallup honesty and ethics poll (nurses, pharmacists, and physicians) were ranked as 3 of the 4 top-rated professions by nearly two-thirds of Americans who were randomly surveyed (Saad, 2008), and nurses have continued to be ranked number 1 for 15 consecutive years in honesty and ethical standards (McCafferty, 2002; Olshansky, 2011; Riffkin, 2014; Williamson, 2016). This is pertinent because a trusting relationship between health professionals and clients facilitates the exchange of health education information.

► Purposes, Goals, and Benefits of Patient, Staff, and Student Education

The purpose of patient education is to increase the competence and confidence of clients for self-management. The primary goal is to

increase the responsibility and independence of clients for self-care. This can be achieved by supporting patients 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 with opportunities to explore and expand their self-care abilities (Cipriano, 2007).

The single most important action of health professionals as educators is to prepare patients for self-care. If patients 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 (Adams, 2010; Dreeben, 2010; Ferrer, 2015; LiberateHealth, 2014; Sarasohn-Kahn, 2013). For example, effective teaching by the health professional can do the following:

- Increase consumer satisfaction
- Improve quality of life
- Ensure continuity of care
- Decrease patient 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 patients must handle many health needs and problems at home, people must be educated on how to care for themselves—that is, both to get well and to stay well. 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) observed, "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 have documented that informed clients are more likely to comply with medical treatment plans, more likely to find innovative ways to cope with illness, and less likely to experience complications. Overall, clients are more satisfied with care when they receive adequate information about how to manage for themselves (Ferrer, 2015; Sarasohn-Kahn, 2013). One of the most frequently cited complaints by patients in litigation cases is that they were not adequately informed (Reising, 2007).

Just as there is a need for teaching patients to become participants and informed consumers in order to achieve independence in self-care, so too is there a need 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 and to function interprofessionally with colleagues in a collaborative, team-based approach to health-care delivery (IOM, 2003b). 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 (Witt, 2011).

The primary aims of health professional educators, then, should be to nourish clients, mentor staff, and serve as teachers, clinical instructors, and preceptors for students. They must value their role in educating others and make it a priority for their patients, fellow colleagues, and the future members of the profession. As the ancient Chinese (author unknown) proverb says, “Provide a man a fish and he may eat for a day. Teach a man to fish and he may eat for a lifetime.” As Johaun Jackson (2015),

a student in a nurse educator course, recently stated, this mantra speaks to the sacred and honorable act of teaching—imparting knowledge to others and empowering them to no end—and there can be no higher calling than that of an educator.

► 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; Kelo, Eriksson, & Eriksson, 2013).

The education process is similar across the practice of many of the health professions. In fact, it can be compared to the healthcare practice process because the steps of each process run parallel to the steps of the other (**FIGURE 1.1**). The education process, like the process of healthcare practice, consists of the basic elements of assessment, planning, implementation, and evaluation (Dreeben, 2010; Wingard, 2005). 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 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).

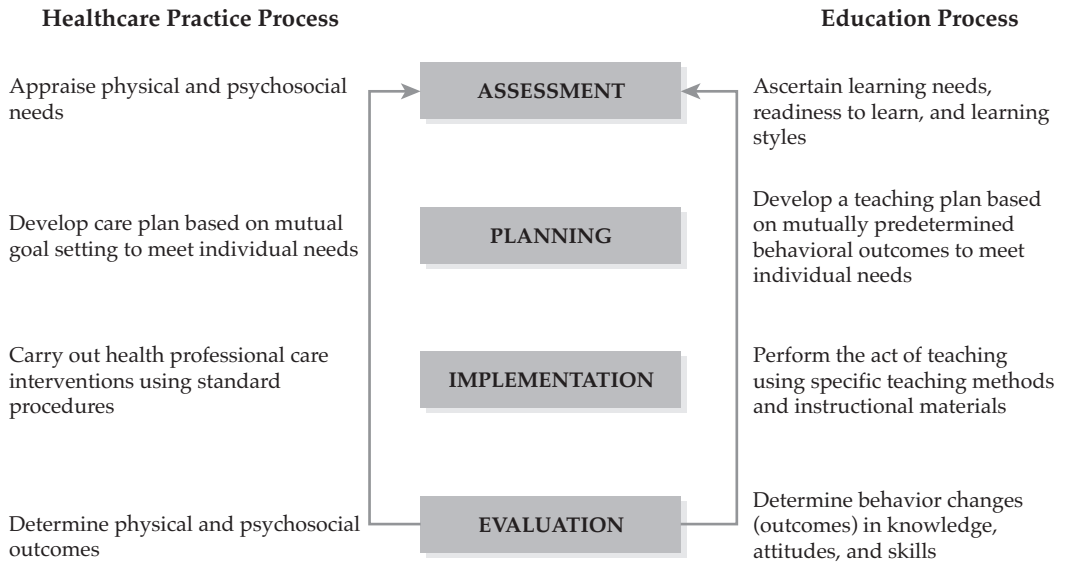


FIGURE 1.1 Education process parallels healthcare practice process.

The outcomes of the healthcare practice process 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, the process can and should begin again through reassessment, replanning, and reimplementation (Dreeben, 2010).

Note that the actual act of teaching or instruction is merely one component of the education process. **Teaching and instruction**—terms that are 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 thought of as formal, structured, organized activities, but they also can be informal, spur-of-the-moment education sessions that occur during conversations and 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; Gregor, 2001).

Just because teaching and instruction are intentional does not necessarily mean that they must be lengthy and complex tasks; however, 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 (Gregor, 2001).

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 and in any place resulting from 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. The success of the educator's endeavors in teaching is measured not by how much content he or she imparts, but rather by how much the person learns (Ackoff & Greenberg, 2008; Musinski, 1999; Seelig, 2016).

Patient education is a process of assisting people in learning health-related behaviors that they can incorporate into everyday life, with the goal of achieving optimal health and independence in self-care. Friedman, Cosby, Boyko, Hatton-Bauer, and Turnbull (2011) specifically defined it as “any set of planned educational activities, using a combination of methods (teaching, counseling, and behavior modification), that is designed to improve patients’ knowledge and health behaviors” (p. 12). **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 high-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.

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

- Analyze the learner
- State the objectives
- Select the teaching methods and instructional materials
- Use the teaching methods and instructional materials
- Require learner performance
- Evaluate the teaching plan and revise as necessary

► The Contemporary 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 (Dreeben, 2010; Lewenson, McAllister, & Smith, 2016; Mohanna, 2007). For health professionals to fulfill the role of educator—regardless of 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.

With significantly more attention being paid to the teaching role of health professionals, it is imperative that educators recognize the theories in health care and educational psychology that provide the frameworks for understanding how and why people change their health-related behaviors and how health professionals can best teach and how learners can best learn. Foundational to teaching and learning are cognitive and social learning theories described in Chapter 3 as they apply to healthcare practice.

The role of educator is not primarily to teach, but rather to promote learning and provide for an environment conducive to learning. In addition, the role of the health professional as teacher of patients and families as well as professional 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 create the teachable moment, rather than just waiting for it to happen, and to actively involve learners in the education process (Bodenheimer et al., 2002; Lawson & Flocke, 2009; Tobiano, Bucknell, Marshall, Guinane, & Chaboyer, 2015; Wagner & Ash, 1998).

Although health professionals are expected to teach, many lack formal preparation in the

principles of teaching and learning (Donner, Levonian, & Slutsky, 2005; Steketee & Bate, 2013). Of course, a health professional needs a great deal of knowledge and skill to carry out the role of educator with efficiency and effectiveness. Although all health professionals have always functioned as givers of information, they must now assume a new role by acquiring the skills as a facilitator of the learning process (Dreeben, 2010; Kelliher, 2013; 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 the information given is actually received and understood? Are all health professionals capable of taking appropriate action to revise the approach to educating the patient if the patient does not comprehend the information provided through the initial approach?
- Do health professionals realize that they need to transition their role as educator 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?

A growing body of evidence suggests that effective education and learner participation go hand in hand (Dreeben, 2010; Kelliher, 2013). As a facilitator, the health professional should create an environment conducive to learning that motivates individuals to want to learn and makes it possible for them to learn (Musinski, 1999; Seelig, 2016; Sykes, Durham, & Kingston, 2013). Both the educator and the learner should participate in the assessment of learning needs, the design of a teaching plan, the implementation of teaching methods and instructional 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 (Ackoff & Greenberg, 2008; Donner et al.,

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 giver of information to that of a process designer and coordinator. This role alteration from the traditional teacher-centered perspective to a 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 (Kelliher, 2013; Knowles et al., 1998; Mangena & Chabeli, 2005).

Instead of the teacher teaching, the new educational paradigm focuses on the learner learning (Ackoff & Greenberg, 2008). 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 (Adams, 2010; Kessels, 2003; M. Smith, Saunders, Stuckhardt, & McGinnis, 2013). Glanville (2000) describes this move toward assisting learners to use their own abilities and resources as “a pivotal transfer of power” (p. 58).

Interprofessional Education

A relatively recent transformative movement in the delivery of patient care and, by extension, patient teaching is the emphasis on **interprofessional education (IPE)**. IPE best serves consumers of health care when professionals work more closely together in a collaborative, interdependent manner and in partnership with patients to deliver appropriate, cost-effective, and efficient care within the complex environment of the healthcare system (Nester, 2016). Team-based care has been associated with improved healthcare outcomes (Reeves, Perrier, Goldman, Freeth, & Zwarenstein,

2013; Zwarenstein, Goldman, & Reeves, 2009) and patient satisfaction (Wen & Shulman, 2014). IPE is now included in many accreditation standards as an educational requirement (Zorek & Raehl, 2013) to prepare students for future interprofessional practice and collaboration (Gilbert, Orchard, & Bainbridge, 2010; Lutfiyya, Brandt, & Cerra, 2016; World Health Organization [WHO], 2010). Major barriers to the implementation and sustainability of IPE include such issues as time constraints, rigid curriculum structures, desire to maintain professional identity, and limited faculty support.

Many international and federal reports over the past four decades have advocated for more interprofessional education and practice (Frank et al., 2010; IOM, 1972, 2001, 2003a, 2003b; Interprofessional Education Collaborative Expert Panel, 2011; O'Neil, 1988; WHO, 1988, 2010). As a result, several countries (the United Kingdom, Canada, Australia, and the United States) developed IPE frameworks to guide the education of their health professionals. In the United States, core competencies (Interprofessional Education Collaborative Expert Panel, 2011) were identified by experts representing the various health professions, higher education institutions, and professional associations. These competencies are used by many institutions in this country as a guiding document for developing interprofessional initiatives. Five years later, an update was released that (1) reaffirmed the importance and impact of the core competencies; (2) organized the competencies within a singular domain that addresses the values and ethics of collaboration as well as the roles and responsibilities for communication and teamwork between professionals; and (3) broadened the interprofessional competencies to better achieve the triple aim of improving the patient experience, improving the health of populations, and reducing the per capita cost of health care (Interprofessional Education Collaborative, 2016).

Direct assessment of these competencies is challenging because of the varying definitions of IPE frameworks and constructs and

the lack of clarity about interprofessional outcomes (Reeves et al., 2013; Thistlethwaite et al., 2014). It is important, however, that validated tools be designed to effectively translate IPE teaching to practice (Havyer et al., 2016). Currently, researchers are focusing on developing and testing assessment and evaluation tools to measure interprofessional education outcomes (Lie, Richter-Lagha, Forest, Walsh, & Lohenry, 2017; Lockeman et al., 2016; Nisbet, Jorm, Roberts, Gordon, & Chen, 2017; Thistlethwaite et al., 2016; West et al., 2015).

Creating a linkage between interprofessional education and collaborative practice will result in a climate whereby “all participants learn, all teach, all care, and all collaborate” (Josiah Macy Jr. Foundation, 2013, p. 1). According to Deusinger, Crouner, Burlis, and Stith (2014), “we owe it to our patients to unify IPE and interdisciplinary practice” (p. 57). To achieve the goal of safe, high-quality care, a collaborative process is required whereby all team members have equal power. The silos that exist in the education and practice settings are difficult barriers to overcome because of the entrenched professional identities and power differentials. However, interdisciplinary cooperation and teamwork are essential to improve the health outcomes of patients and to achieve a more highly functional health-care system (Meleis, 2016). The Robert Wood Johnson Foundation has recently shifted its focus to build a culture of health by engaging people from diverse fields of expertise who can bring creative and innovative perspectives to solve the many challenges facing the nation's healthcare system (Hassmiller, 2014).

Patient-Centered Care

A trend that often goes hand in hand with the interprofessional collaboration movement is the focus on **patient-centered care (PCC)**. Over the past 25 years, approaches to patient care have been transitioning from paternalistic care to more patient partnership-based care (Pomey, Ghadiri, Karazivan, Fernandez, & Clavel, 2015).

This is a logical transition given the prevalence of chronic diseases and the emphasis on containing healthcare costs (Schlesinger & Fox, 2016). The rising incidence of chronic illness is challenging the traditional healthcare delivery models that were developed after World War II to primarily provide acute care and manage infectious diseases (Pomey et al., 2015). The health professional's role in chronic disease includes supporting and guiding patients as they carry out self-care activities, as opposed to the strictly healing practices approach that occurred previously (Karazivan et al., 2015).

In PCC, healthcare professionals work to reach a shared understanding with patients and to more fully respond to their needs (Stewart et al., 1995, 2000). PCC is defined as "health care that is respectful of, and responsive to, the preferences, needs and values of patients and consumers" (Australian Commission on Safety and Quality in Health Care [ACSQHC], 2011, p.1). Patient-centric care, person-centered care, patient engagement, and the patient-as-partner approach are all forms of PCC. These approaches support the development of patient competency in care and require some surrendering of control by the health professional. They recognize that the patient as well as the healthcare provider possesses special expertise (Karazivan et al., 2015).

Patients who actively participate in healthcare decision making have better health outcomes (Arnetz, Almin, Bergstrom, Franzen, & Nilsson, 2004; Arnetz et al., 2010; Coleman et al., 2004; Coleman, Parry, Chalmers, & Min, 2006; Hibbard & Greene, 2013; Rachmani, Levi, Slavachevski, Avin, & Ravid, 2002; Weingart et al., 2011) and more positive experiences of care (Weingart et al., 2011). According to Coulter (2012) and Domecq et al. (2014), patient participation can be a useful approach to ensure that appropriate care is provided in the current environment of strained resources. Hassmiller and Bilazarian (2018) found that consumer engagement focusing on compassionate interactions was associated with increases in treatment

savings and patient safety in terms of length of stay and reduced medication errors. Systematic reviews demonstrate a positive relationship between PCC and reduced morbidity, improved quality of life, and increased adherence to management protocols (Bauman, Fardy, & Harris, 2003) as well as a possible relationship between PCC and positive health behavior and health status (Dwamena et al., 2012). Shared decision making, expert patients, therapeutic education, and self-management are all examples of ways to involve patients in their own care (Karazivan et al., 2015).

A number of national and international health agencies emphasize PCC in healthcare delivery (ACSQHC, 2011; Center for Advancing Health, 2010; JCAHO, 2003; National Health Service Commissioning Board, 2012; WHO, 2016). In addition, the Institute of Medicine published a signal report titled *Crossing the Quality Chasm: A New Health System for the 21st Century* (IOM, 2001). This report called for urgent and fundamental change to close the quality gap by redesigning the healthcare system in the United States. In this report, PCC was identified as an essential dimension of high-quality care and as a clear focus of new models of delivering care, such as primary care patient-centered medical homes and accountable care organizations.

In 2012, the Nursing Alliance for Quality Care (NAQC) announced an initiative to address care coordination and to promote patient engagement during care. Nine core principles were issued to encourage nurses and other healthcare providers to improve the quality and safety of the care they deliver. The focus is on developing policies that integrate decision making by patients and their families into the health professionals' plan of care. According to the NAQC (2012), the following principles should be at the core of professional health provider practice:

1. High-quality care is based on a dynamic partnership between healthcare providers, patients, and their families. There

- must be a mutual respect of privacy, decision making, and ethical behaviors.
2. The relationship must be established on confidentiality, and the patient has the right to make his or her own decisions.
 3. There are mutual responsibilities and accountabilities that must be observed by all parties to be effective.
 4. Healthcare providers must understand to what extent the patient can engage in his or her own care and advocate for those patients who are not able to fully participate.
 5. All interactions with the patient and family must respect the boundaries that protect the patient as well as healthcare providers.
 6. Patient advocacy is a representation of a functioning dynamic partnership.
 7. The patient-provider relationship is centered on respect for the patient's rights, which includes mutuality.
 8. Mutual decision making is based on the sharing of information.
 9. Healthcare providers must be aware of the health literacy level and appreciate the diversity of cultural backgrounds of their patients and families to allow for full patient engagement.

With the national concern about lack of good information on the quality of care, the Consumer Assessment of Healthcare Providers and Systems (CAHPS) program was established as a multiyear initiative in 1995 by the Centers for Medicare and Medicaid Services (CMS). The CAHPS national survey mandates that healthcare organizations regularly collect data on consumer involvement in healthcare decision making. In 2005, the Hospital CAHPS (HCAHPS) was developed, which is specifically designed for use by hospitals (Agency for Healthcare Research and Quality, 2016). The purpose of the CAHPS and HCAHPS is to increase consumer engagement in healthcare decision making and to measure health outcomes. In addition, many studies have

focused on how effectively outcomes have been achieved in healthcare organizations by exploring the links between patient experiences and health outcomes, as well as the extent to which actionable information has facilitated organizational change (Doyle et al., 2013; Manary, Boulding, Staelin, & Glickman, 2013).

Even though the focus has moved from paternalistic practice to patient-centered practices, much work still needs to be done to shift healthcare delivery and education culture. The vision statement from the Josiah Macy Jr. Foundation (2014) conference “Partnering with Patients, Families and Communities to Link Interprofessional Practice and Education” sums up the direction of the PCC movement:

We envision a future in which individuals, families, and communities are understood to be the very reason our healthcare system exists, and that those who are caring, teaching, learning, or otherwise working within the system must partner fully and effectively with them to foster optimal health and wellness for all. (p. 27)

Initiatives in the PCC movement around the globe include such examples as the Patient Expert Programs in the United Kingdom (National Health Service, 2001); Patient Universities in Spain, Germany, and France (Karazivan et al., 2015); the University of Gothenburg Centre for Person-Centered Care in Sweden (Moore et al., 2017); the Patient-Centered Outcomes Research Institute (Washington & Lipstein, 2011), the Relationship Centered Care Initiative at the Indiana School of Medicine (Cottingham et al., 2008), the Task Force on Patient and Family Engagement at the North Carolina Institute of Medicine (North Carolina Institute of Medicine Task Force, 2015), the Center for Patient Partnership in Health Care by the American College of Physicians (American College of Physicians, 2013) in the United States; and the Patients as Partners approach introduced in 2007 by the province of British Columbia in

Canada (Bar, Grant, Asuri, & Holms, 2018). In 2010, the University of Montreal, a leader in the Patients as Partners movement, embraced and expanded the concept of patient engagement even further by involving patients as full-fledged members of the healthcare team in the organization structure, health professions training, collaborative practice optimization initiatives, and research (Dumez & Vanier, 2014). In addition, current literature calling for increasing patient involvement in drug development (Getz, 2015; Lowe et al., 2016), medical device development (Hurst et al., 2017), and research (Hamilton et al., 2017) reflects progression of the PCC healthcare initiative.

In a qualitative study by Pomey et al. (2015) about patients' engagement in their health care, patients who were familiar with the Patients as Partners concept described themselves as proactively engaging in three types of practice. The first is a process of continuous learning, the second is an assessment of the quality of the health care they receive, and the third is an adaptation process where the patients build on their learning and assessments to compensate for what they perceive to be optimal or nonoptimal health care. This occurred regardless of whether the health professionals they were working with were open to their role as a partner in their health care. That the patients in this study appeared to play a more active role in their own health care than previous literature suggests is encouraging and indicates that consumers, as well as policy mandates, are helping to change the healthcare culture.

► Barriers to Teaching and Obstacles to Learning

It has been said by many educators that adult learning takes place not by the teacher initiating and motivating the learning process, but rather by the teacher 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 day with every teacher–learner encounter (Carpenter & Bell, 2002; Gregor, 2001). The evidence supports that these teachable moments are not necessarily unplanned or that a coordinated set of circumstances will always lead to positive health change. Instead, it is the interaction between learner and teacher that is central to the development of a teachable moment, regardless of the obstacles or barriers that may be encountered (Konradsen, Nielsen, Larsen, & Hansen, 2012; Lawson & Flocke, 2009).

Unfortunately, health professionals must confront many barriers in carrying out their responsibilities for educating others. In addition, learners face a variety of potential obstacles that can interfere with their learning. Conditional factors, such as the environment, the organization's culture, the level of cooperation between the disciplines, beliefs and knowledge of the team members, types of patient education activities, and the patient population, can either enable or hinder the teaching–learning process (Farahani, Mohammadi, Ahmadi, & Mohammadi, 2013; Friberg et al., 2012).

For the purposes of this text, **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 barriers (**FIGURE 1.2**) may interfere with the ability of health professionals to carry out their roles as educators (Carpenter & Bell, 2002; Chachkes & Christ, 1996; Donovan & Ward, 2001; Farahani

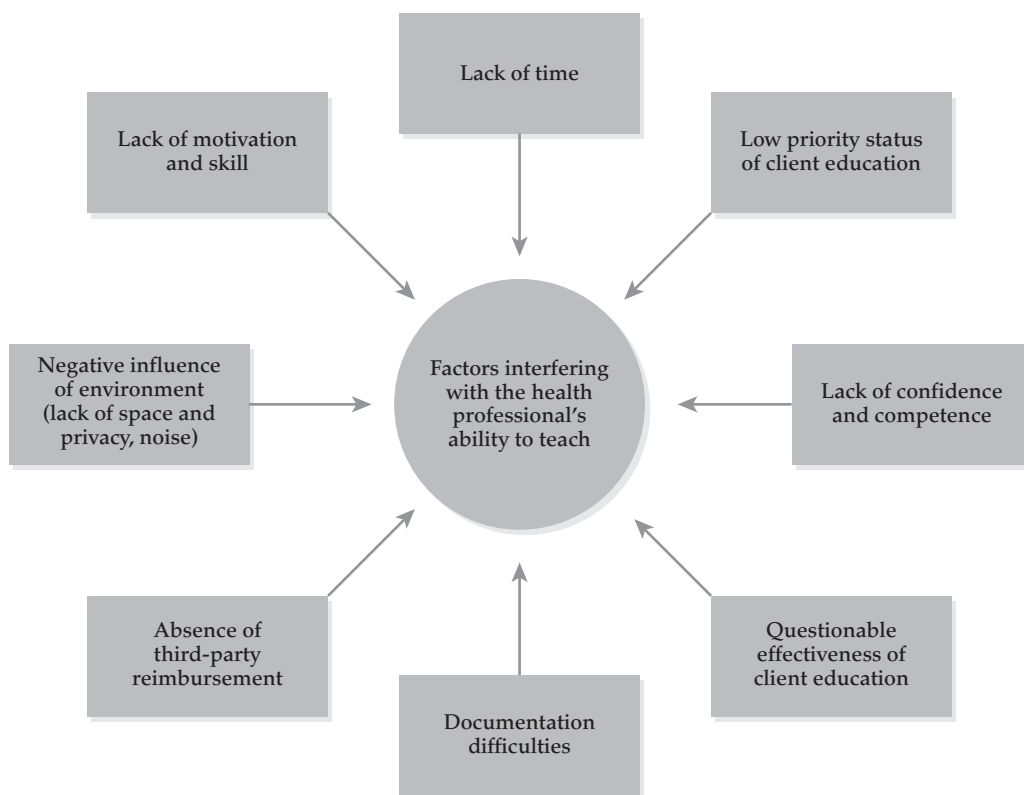


FIGURE 1.2 Barriers to teaching.

et al., 2013; Friberg et al., 2012; Glanville, 2000; Honan, Krsnak, Petersen, & Torkelson, 1988; Livne, Peterfreund, & Sheps, 2017; J. A. Smith & Zsohar, 2013; Tobiano et al., 2015):

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 each other. 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 TJC, 28% of 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 first by adequately assessing the learner and then by using appropriate teaching methods and instructional tools at their disposal. Discharge planning is playing an ever more important role in ensuring continuity of care across settings.

2. Many healthcare personnel 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 regarding nursing, long considered one of the first health professions to have a strong teaching role. As early as the mid-1960s, Pohl (1965) found that one-third of 1,500 nurses, when questioned, reported that they had no preparation for the teaching they were doing, whereas 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, a large majority of respondents rated their ability to perform educator role activities as unsatisfactory. Members of many of the other health professions share similar views. Few new additional studies have been forthcoming on nurses' perceptions of their patient education and nursing staff/student clinical teaching roles (Kelo, Martikainen, & Eriksson, 2013; Lahl, Modic, & Siedlecki, 2013; Nyoni & Barnard, 2016). Today, the role of the health professional as educator still must be strengthened in health professional education programs.
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.
 4. Until recently, administrators and supervisory personnel assigned a low priority to patient and staff education. With the strong emphasis of TJC mandates, the level of attention paid to the educational needs of both consumers and 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 interruptions caused by patient treatment schedules and staff work demands are just some of the factors that may 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 inpatient healthcare facilities are often subsumed under hospital room costs and therefore are not specifically or separately 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. Insurance coverage for healthcare services historically has been structured on a model of care with the physician as the primary provider being reimbursed on a fee-for-service basis. However, as of January 1, 2013, a Medicare rule allows for payment of advanced practice registered nurses (APRNs) for the delivery of primary care services in outpatient settings. "With up to 20% of Medicare patients readmitted to hospitals within 30 days of discharge, more value has been placed

on effective transitional care and care coordination” by APRNs (Nurse.com, 2012, para. 3). Now a separate billing code for patient education and counseling by RNs is included in the American Medical Association’s Common Procedural Terminology (CPT) codes, but many restrictions exist on the ability to use this code for reimbursement of staff nurse services. As for health education and wellness programs, Medicare generally does not cover these costs except in specific cases, such as diabetes and kidney disease education, nutritional therapy for diabetes or kidney disease, obesity counseling, depression screenings, and counseling to stop smoking or for alcohol misuse (U.S. Centers for Medicare & Medicaid Services, n.d.). Thus, under most circumstances, when health professionals deliver patient education, this therapeutic intervention is not reimbursable by third-party payers. Recently, a new role has been created in primary care practices, known as the health education specialist (HES). HESs are trained to teach individuals and populations to practice healthier behaviors and seek preventive care (Chambliss, Lineberry, Evans, & Bibeau, 2014).

7. Some health professionals question whether patient education is effective in improving 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 with therapeutic regimens), 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 impact on the quality and quantity of patient teaching. Both formal and informal teaching are often done 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 hard-copy forms or computer software used for documentation of teaching are designed to simply check off the areas addressed rather than to allow for elaboration of what has been accomplished. In addition, most health professionals do not recognize the scope and depth of teaching that they perform daily. 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 obstacles (**FIGURE 1.3**) may interfere with a learner’s ability to attend to and process information (Beagley, 2011; Billings & Kowalski, 2004; Farahani et al., 2013; Glanville, 2000; Graves, Doucet, Dubé, & Johnson, 2018; Kessels, 2003; McDonald, Wiczorek, & Walker, 2004; O’Connor et al., 2016; Weiss, 2003):

1. Lack of time to learn as a result of 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.

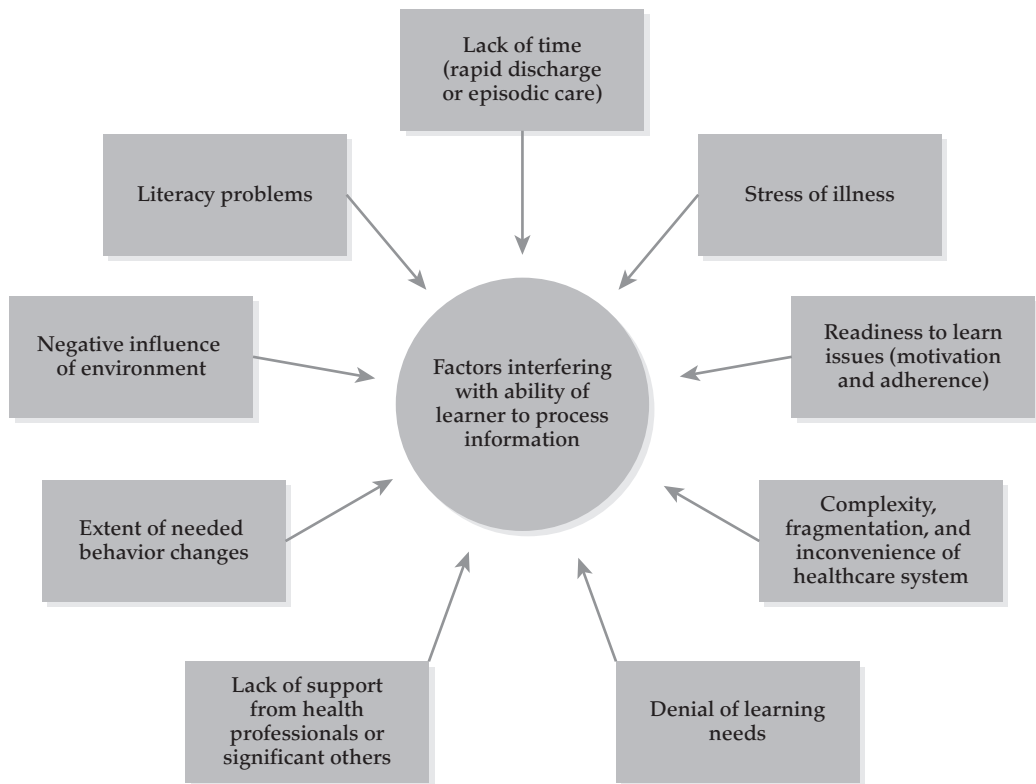


FIGURE 1.3 Obstacles to learning.

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, contact healthcare professionals, 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 population reads and comprehends at or below the eighth-grade level, and an even higher percentage suffers from health illiteracy.
4. The negative influence of the hospital environment itself, which results 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 the health professional 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.
 10. Complex technology, such as digital health intervention in the form of telehealth, patient portals, and personal health records to manage chronic illness independently and at a distance while remaining connected to health information and engaged with care providers, can be costly, inaccessible, and difficult to navigate, especially if computer and information literacy is a problem.
- 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?
 - Which assessment methods and tools can health professional 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?
 - How can teaching be tailored to meet the needs of specific populations of learners, such as those with diverse cultural backgrounds, low literacy skills, physical and mental disabilities, and different socioeconomic and educational levels?
 - To what extent does teaching improve health status and reduce the costs of health care?
 - Which methods and materials are available to support teaching efforts?
 - Which elements must the health professional as educator account for when developing and implementing teaching plans?
 - Under which conditions should health professionals use certain teaching methods and instructional materials?
 - Which common mistakes do health professionals make when teaching others?
 - How can teaching and learning be best evaluated?

► Questions to Be Asked About Teaching and Learning

To maximize the effectiveness of patient, 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, especially given the pressures to contain costs and to improve learner outcomes. The following are some of the important questions that this text addresses:

- How can members of the healthcare team work together more effectively to coordinate educational efforts?

► 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 non-research-based literature on patient education is prescriptive in nature and tends to offer anecdotal tips on how to take individualized approaches to teaching and learning. A computer literature search, for example, reveals literally thousands of nursing and other health professional articles and books on teaching and learning that are available, ranging from the general to the specific.

Although many research-based studies are being conducted on teaching specific population groups about a variety of topics, only recently has the field focused its attention on how to most effectively teach persons with long-term chronic illnesses. Health professionals must conduct much more research on the benefits of patient education as they relate 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 in alleviating anxiety and promoting psychological coping. The evidence does suggest that patients cope much more effectively when taught exactly what to expect (Adams, 2010; Donovan & Ward, 2001; Dreeben, 2010; Mason, 2001; Wong, Chan, & Chair, 2010).

More research is needed on the benefits of teaching methods and instructional tools that use Information (Digital) Age technologies such as the World Wide Web, the Internet, social media, podcasts, Webcasts, and webinars as methods to access health information for both patient and staff education. The use of Information Age technology has had such a dramatic effect on health education that a new field has emerged: consumer informatics (American Medical Informatics Association, 2017). Researchers in the field of consumer informatics are working to find ways to use technology to strengthen the relationships between patient and healthcare provider and

to teach and empower patients dealing with healthcare issues.

These new approaches to information dissemination require a role change for the educator, from being a giver of information to becoming a resource facilitator, as well as a shift in the role of the learner, from being a passive recipient to becoming an active partner. 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). Because 15% of American adults do not use the Internet (Zickuhr, 2013), more investigation needs to be done regarding how to help clients bridge the digital divide and the information literacy gap.

Gender issues, the influence of socioeconomics on learning, and the strategies of teaching cultural groups and populations with disabilities need further exploration as well. For example, the findings from interdisciplinary research on the influence of gender on learning remain inconclusive, although neuroscience is uncovering increasing evidence on the functions of the different parts of the male and female brain and how they interact. Research on the influence that socioeconomics has on learning reveals it plays a significant factor, but the underlying mechanisms of its effects are still unclear. More research needs to be done on the extent to which teaching can improve the health status of individuals and communities, decrease the incidence of disease, and enhance the quality and safety of healthcare delivery.

Despite the questions that remain unanswered, 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 (Adams, 2010; Mason, 2001). In addition, relatively few studies have examined health professionals'

perceptions about their role as educators in the practice setting (Friberg et al., 2012). We 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). Also, emphasis needs to be placed on research in health professional education to ensure that the workforce is prepared for a challenging, complex, and uncertain future in health care (Benner, Sutphen, Leonard, & Day 2010; IOM, 2001, 2011; Meleis, 2016).

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 notable void is the lack of information in the research database on how to assess motivation.

Approximately 30 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 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 staff and students gain competency and confidence in practice through education activities that are directed at continuous, lifelong learning. As the United States moves forward in the 21st century, many challenges and opportunities lie 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, healthcare employers, healthcare providers, and payers of healthcare benefits. To be effective and efficient, health professionals must be willing and able to work collaboratively with one another to provide consistently high-quality education to the audiences they serve. They also must embrace PCC and recognize the expertise that patients bring to the provider–patient relationship.

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 is the health professional’s 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. Which key factors influenced the growth of patient education during its formative years?
3. How did the concept of patient education change in the 1960s and 1970s?
4. What is the evolution of the teaching role of the health professional?
5. What is the current focus and orientation of patient education?
6. Which social, economic, and political trends today make it imperative that patients be adequately educated?
7. What are the similarities and differences between the education process and the healthcare practice process?
8. What are three major barriers to teaching and three major obstacles to learning?
9. Which factor serves as both a barrier to teaching and an obstacle to learning?
10. What is the present status of research- and non-research-based evidence pertaining to patient education?

CASE STUDY

Gianna Suarez, MD, PhD, the agency administrator at your facility, Vicar Health Care, recently attended a Josiah Macy Jr. Foundation conference on patient-centered care. She was very impressed with the content of the conference and how well it aligned with Vicar's new "Patients First" initiative. She appointed you to be chairperson of an interprofessional committee charged with the task of developing new guidelines for patient education that reflect the Patients First philosophy. At the first committee meeting, you solicit feedback from the committee members about their experiences with patient education and their feelings about patient-centered care. Miranda from physical therapy states, "If patient-centered care means everything we do has to revolve around what the patients want, that isn't going to work in our department. With our hectic schedules, we can barely even fit in patient education." Joseph from speech language pathology is very excited about patient-centered care: "I want to do anything that will help us have a better image with our patients." Lavinia, the nursing supervisor, is concerned about the bottom line: "Will this approach help us be more efficient and have better outcomes?" Because the committee members expressed such varied opinions and beliefs about patient-centered care and patient education, you feel it is important to begin by having the group reflect on the purpose and goal of patient education, then present the essential components of patient-centered care, and finally develop new patient care guidelines that embrace the Patients First philosophy.

1. Identify the purpose and goal of patient education and discuss whether they are in alignment with the philosophy of patient-centered care.
2. What is the definition of patient-centered care, and why is the healthcare system transitioning to this model of care? Describe how well the comments of Miranda, Joseph, and Lavinia accurately reflect this model of health care.
3. Give two examples of how patient-centered care can be integrated into new patient education guidelines.

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