Helping Patients Prevent & Manage Chronic Conditions: Patient Education and Teachable Moments

CHRONIC CONDITIONS

Because so many chronic conditions can be affected by an individual's lifestyle – smoking, diet, and exercise, or the lack thereof – a frequent focus of patient education is to help individuals make lifestyle changes. As many practitioners know, however, this is a daunting task. It's difficult enough for patients, whose motivation for change comes from within, to actually make those changes. It's even more difficult when the motivation for change comes from without – from their health practitioners.

Much has been written, then, about how practitioners might approach the task of educating their patients and helping them to make those lifestyle changes that can help in the prevention and management of serious chronic conditions. One such approach is to take advantage of what has been called "teachable moments," which can be defined as those times when patients are open to the broaching of particular subjects – subjects they may normally resist addressing. Even better, teachable moments may signal an openness to respond to new information by taking action.

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Change: In Theory

Teachable moments are moments of opportunity for practitioners. Encouraging as they may be, however, there are no guarantees that patients will take the desired actions. How those moments are approached, therefore, may have an effect on the success of these timely educational interventions. The 'how' of teachable moments may be helped by the consideration of two theories of change – the first offered by Kurt Lewin and the second, by Martin Ford.[1]

According to Lewin's influential *Force Field Analysis*, efforts to affect change can more easily be facilitated when the forces that both drive people to, and restrain them from, making those changes are at equilibrium. However, increasing the driving forces for change, Lewin asserts, will be less successful in bringing about longstanding change because it will eventually result in the increase of the restraining forces to the point where they once again outweigh the driving forces. Instead, he claims, efforts to affect change are better served by reducing the restraining forces. In other words, practitioners can best help patients affect lifestyle changes by first determining the particular factors that constrain each individual patient from making the needed changes and, having done so, then helping them find ways to reduce or eliminate those constraints.

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Ford, in outlining his *Motivational Systems Theory*, identifies three psychological factors that influence people's motivation to change and, in doing so, provides insights for identifying and reducing constraints to action. These factors are: *personal goals, emotional arousal process*, and *personal agency beliefs*. As might be expected, the motivation to change is sparked by personal goals – what people want to achieve and/or avoid. Once a particular goal becomes important enough to pursue, Ford states, their emotional states will either energize or inhibit any goal-directed actions as will their personal agency beliefs – namely, whether they are capable of the actions they contemplate and whether there will be support or resistance from their circle of family, friends, colleagues, and the like.

In other words, having taken advantage of teachable moments (bringing patients to the point of expressing an interest in affecting change) the success of practitioners' interventions might call for following up by providing additional information and support. For example, practitioners who learn that particular patients don't exercise because they feel they can't walk long and hard, or find the time, might facilitate the success of change efforts by helping them set realistic, incremental goals – thus reducing a constraining fear of failure.

Where family support is questionable, practitioners might also try to assist patients in garnering their support for the desired changes by inviting patients to bring family with them, during office visits, to discuss change goals and enlist their support. Practitioners might also refer their patients to local and online support groups.

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Teaching: In Theory

From time immemorial, a variety of philosophies, or views of life, have influenced many in the way they practice their vocations and in the relationships they form in the pursuit of those vocations. Such is the case with educators and healthcare practitioners. Two competing views currently dominate: positivism and constructivism. With respect to education, positivism, sees teachers as experts who convey knowledge to their students. Students, as passive recipients, are then expected to learn through repetition, practice, and the reinforcement of correct answers. Critics of this approach assert that knowledge gained in this manner not only has a short 'shelf life,' but also ill prepares students to apply this new knowledge when necessary.[2]

Constructivism advocates a 'student-centered' approach in which teacher-experts function as facilitators. The theory is that individuals bring their own sense of the world to learning experiences; that teachers facilitate the process through which individuals reconcile new information with their own perceptions – sometimes validating, sometimes reconstructing those perceptions; and that this process serves to build understandings that enable students to apply newly gained knowledge as needed.[3] Critics of this approach decry the underemphasizing of proven knowledge; the abandonment of teaching techniques proven to be effective, and the accompanying loss of discipline (both academic and otherwise).[4]

Teaching: In Healthcare Practice

One doesn't need to look far to see the similarities between these two views and the nature of the doctor-patient relationship – what is was and what it is becoming – as well as their implication for healthcare practitioners seeking to take advantage of teachable moments. Regarding which approach to take, common sense would suggest that each view has its merits and that, regardless of discipline, educational efforts might do well to incorporate both. Although well-established facts should be shared with patients, given both the influence of their experiences, perceptions and values on their actions and the uncertainty inherent to medicine, the need for practitioners to incorporate some constructivist 'teaching' strategies, would seem apparent. Simply "educating" patients by giving them the relevant information, one can argue, is not sufficient.

Consider the example of a women going in for her annual mammography. Before the procedure, a nurse asks her some preliminary questions, including whether she does her own monthly breast self-examination. When the patient replies that she does not, the nurse takes the opportunity to educate the women by telling her why it is important, briefly demonstrating how to do it, and reassuring her that after doing it a while, she will come to detect when something is different. The woman smiles and says 'thank you' as she is led to the exam room.

Was this educational intervention successful? Certainly the information conveyed seemed to cover all that was necessary. However, it turns out that the woman had long known all that the nurse had told her and it had not, prior to this, spurred her to action. What else, then, might the nurse have done? According to health education specialists, practitioners need to learn about their patients in order to effectively teach those patients.[5] It is important, they say, for practitioners to assess any physical attributes that might constrain the learning process – difficulty seeing or hearing, for instance. But it is also, we suggest, important for practitioners to try to find out the whys of what their particular patients do or don't do.

What the nurse might have tried, in this case, was to learn what was keeping this woman from doing breast self-examinations. Was it because she did not know how? Or was there some other reason? If she could find the reason, the nurse might then be able to figure out, with the woman, how to eliminate or decrease the forces that keep her from doing those examinations. Let's imagine the following dialogue after the woman says she does not examine herself.

Nurse: *What keeps you from doing breast self-examination?*
Woman: *I know how to do it and want to do it, but I just can't get into the routine.*
Nurse: *Is there any particular reason?*
Woman: *Well, I have to do it lying down. But it's inconvenient during the day. In the morning I'm anxious to get up and going and at night, when I go to sleep, I'm way too tired.*
Nurse: *There are other places you can do it. You don't have to be lying down. You can do it when you're showering, for instance. Is that something that might work for you?*
Woman: *Yes, it is. I will give that a try. Thank you.*

By engaging in conversations such as this, practitioners can learn which directions to take in educating particular patients. Perhaps, therefore, it might be more appropriate to consider these moments as 'learning' moments. Whatever they are called, however, one might think of this process, as a two-way dynamic of teaching *and* learning – a dynamic in which patients and practitioners learn from and teach the other. One might, in fact, think of this as yet another form of collaboration between practitioner and patient.□

[1] Kurt Lewin, *Field Theory in Social Science: Selected Theoretical Papers,* (New York: Harper & Brothers Publishers, 1951) and Martin E. Ford, *Motivating Humans: Goals, Emotions and Personal Agency Beliefs*, (Newbury Park., CA: Sage Publications, 1992).
[2] Paige L. Schulte, "A Definition of Constructivism," *Science Scope* 20(6): 25-27 (1996).
3 See Note 2.
[4] See "What's Wrong With Our Schools" at **www.illinoisloop.org/whatswwrong.html** and "What's Wrong With Constructivism" at **www.reformk-12.com/archives/000071.nelk**.
[5] "Teaching moments create learning opportunities; watch and listen to clues," *Rehab Continuum Report* 11(8) (August 2002

How to Make a Difference When Nothing More Can Be Done

Practitioners may not be able to cure a disease, but they can take steps to help their patients become whole again – to heal. How? By listening, by validating feelings, and by taking advantage of teachable moments to help patients regain a sense of self.