A Qualitative Examination of Health Care Professionals’ Experience as Patient Educators: Cases from Canadian Chiropractors

by

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ABSTRACT

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This qualitative research study examined the patient education experience from the point of view of health care professionals, namely doctors of chiropractic in the Greater Toronto Area practicing for up to ten years. Health care professionals’ views and beliefs of this important aspect of health care have not been well studied. Patient education is defined as, “the process by which patients learn or acquire knowledge about his/her health status or condition and may involve learning in the cognitive, affective, and/or psychomotor domains.” Most often, the health care professional is a part of this process serving as a key source of information for patients.

The study explored eight participants’ views on the nature of patient education in their early and current practices by examining their feelings, beliefs, and use of patient education, its role in their practices, as well as the perceptions of their roles as patient educators. Two semi-structured interviews were conducted with each of the participants. The transcribed interviews underwent detailed qualitative analysis to determine response trends and consensus.

The key findings revealed that the participants felt that, while they were well prepared in their undergraduate curricula to diagnose and treat patients, they were not as well prepared to be effective patient educators when they entered practice. Early in their
careers, they did not understand or appreciate patient education’s importance and value as a component of their practice. Over time, their beliefs and understanding of patient education changed and participants reported that with experience, they began to value patient education to a greater extent. Changing values reflected changing behaviours. For example, participants increased their time and efforts related to patient education with increased clinical experience.

A variety of teaching aids were used with wall charts/posters, three dimensional anatomical models, printed materials and images from textbooks being among the most common. Most of the teaching described by the participants can be characterized as transmission with a one-way flow of information from the doctor to the patient. To a great extent, patient education involved speaking with individual patients.

Participants reported encountering, throughout their careers, intrinsic and extrinsic barriers that interfered with the effectiveness of their patient education.

The findings suggest that curricular planners for health care professional programs, and specifically for chiropractors, might consider developing content aimed at improving students’ patient education knowledge and skills.
Acknowledgments

This study has taken a great deal of time and effort, much more than I initially thought would be necessary, and it would not have been possible without the support and advice of my thesis committee who not only taught me in their classes, but also were both patient and supportive all through this study.

I also want to make special mention of the assistance and support from my thesis advisor, Dr. Brent Kilbourn, who devoted a great deal of time and effort in helping me deal with all the issues related to conceiving and conducting this study. I think it is difficult for many people to appreciate the value and importance of effective patient education since they have, for the most part, little experience with it. However, I appreciate the efforts made by Dr. Kilbourn both to understand and appreciate the importance of patient education and the value of this study.

My gratitude is extended to all the participants who willingly gave of their valuable time to contribute their information to this project. Without their recollections, information, thoughts, and examples, this study could not have been undertaken.

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# TABLE OF CONTENTS

Abstract .............................................................................................................. ii

Acknowledgements .......................................................................................................................... iv

CHAPTER 1 ....................................................................................................................... 1

Introduction to the Research Topic .............................................................................................. 1

Overview ................................................................................................................................. 1

General Context ......................................................................................................................... 1

The Problem, Research Questions, and Significance ................................................................. 3

Rationale and Significance of the Study ...................................................................................... 4

Personal Background in Patient Education and Assumptions ................................................. 5

Outline of Subsequent Chapters ................................................................................................. 6

Summary ................................................................................................................................. 8

CHAPTER 2 ....................................................................................................................... 9

Literature Review ..................................................................................................................... 9

The HCP-Patient Relationship ................................................................................................. 9

Patient Education ................................................................................................................... 11

Definition and Purpose of Patient Education ......................................................................... 14

Professional Responsibility ................................................................................................. 14

Objectives of Patient Education ............................................................................................... 15

Patient Empowerment ......................................................................................................... 16

Informed Consent .................................................................................................................. 17

Risk Management ................................................................................................................ 17

Societal Implications ............................................................................................................. 17

Models of Patient Education ................................................................................................. 18
Influences on Perception, Attitudes, and Feelings ........................................22
Pre-service Curricular Content .................................................................22
Available Time in Practice .................................................................23
Communicating with Patients .................................................................23
Sharing Authority .................................................................24
Paradigm Challenges .................................................................25
Summary .................................................................25
CHAPTER 3 .................................................................23
Methods .................................................................23
  Participant Selection .................................................................30
  Analytical Framework .................................................................30
  Ethical Considerations .................................................................35
  Informed Consent .................................................................35
  Confidentiality and Anonymity .................................................................36
  Institutional Review and Regulations .................................................................36
CHAPTER 4 .................................................................37
Interview Analyses .................................................................37
  Amy .................................................................37
    Practice Experience and Patient Groups .................................................................37
    Functions of Patient Education: Early and Current Years .................................................................38
    The HCP’s Role in Patient Education: Early and Current Years .................................................................42
    Nature of Patient Education Interventions: Early and Current Years .................................................................44
    Key Beliefs and Feelings: Early and Current Years .................................................................50
    Perceived Barriers to Effective Patient Education: Early and Current Years .................................................................53
    Changes Related to Patient Education: Early and Current Years .................................................................55
  Don .................................................................57
<table>
<thead>
<tr>
<th>Topic</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>57</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>57</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>60</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>65</td>
</tr>
<tr>
<td>Key Beliefs and Feelings: Early and Current Years</td>
<td>61</td>
</tr>
<tr>
<td>Perceived Barriers to Effective Patient Education: Early and Current Years</td>
<td>69</td>
</tr>
<tr>
<td>Changes Related to Patient Education: Early and Current Years</td>
<td>71</td>
</tr>
<tr>
<td>Ed</td>
<td>74</td>
</tr>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>74</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>75</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>80</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>82</td>
</tr>
<tr>
<td>Key Beliefs and Feelings: Early and Current Years</td>
<td>86</td>
</tr>
<tr>
<td>Perceived Barriers to Effective Patient Education: Early and Current Years</td>
<td>91</td>
</tr>
<tr>
<td>Changes Related to Patient Education: Early and Current Years</td>
<td>96</td>
</tr>
<tr>
<td>Erica</td>
<td>97</td>
</tr>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>97</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>98</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>102</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>106</td>
</tr>
<tr>
<td>Key Beliefs and Feelings: Early and Current Years</td>
<td>108</td>
</tr>
<tr>
<td>Perceived Barriers to Effective Patient Education: Early and Current Years</td>
<td>113</td>
</tr>
<tr>
<td>Changes Related to Patient Education: Early and Current Years</td>
<td>116</td>
</tr>
<tr>
<td>Josie</td>
<td>118</td>
</tr>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>118</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>119</td>
</tr>
<tr>
<td>Topic</td>
<td>Page</td>
</tr>
<tr>
<td>----------------------------------------------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>123</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>125</td>
</tr>
<tr>
<td>Key Beliefs and Feelings: Early and Current Years</td>
<td>127</td>
</tr>
<tr>
<td>Perceived Barriers to Effective Patient Education: Early and Current Years</td>
<td>132</td>
</tr>
<tr>
<td>Changes Related to Patient Education: Early and Current Years</td>
<td>135</td>
</tr>
<tr>
<td>Kelly</td>
<td>137</td>
</tr>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>137</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>138</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>139</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>140</td>
</tr>
<tr>
<td>Key Beliefs and Feelings: Early and Current Years</td>
<td>141</td>
</tr>
<tr>
<td>Perceived Barriers to Effective Patient Education: Early and Current Years</td>
<td>144</td>
</tr>
<tr>
<td>Changes Related to Patient Education: Early and Current Years</td>
<td>145</td>
</tr>
<tr>
<td>Norm</td>
<td>146</td>
</tr>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>146</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>147</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>151</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>151</td>
</tr>
<tr>
<td>Key Beliefs and Feelings: Early and Current Years</td>
<td>154</td>
</tr>
<tr>
<td>Perceived Barriers to Effective Patient Education: Early and Current Years</td>
<td>158</td>
</tr>
<tr>
<td>Changes Related to Patient Education: Early and Current Years</td>
<td>161</td>
</tr>
<tr>
<td>Sam</td>
<td>162</td>
</tr>
<tr>
<td>Practice Experience and Patient Groups</td>
<td>162</td>
</tr>
<tr>
<td>Functions of Patient Education: Early and Current Years</td>
<td>163</td>
</tr>
<tr>
<td>The HCP’s Role in Patient Education: Early and Current Years</td>
<td>165</td>
</tr>
<tr>
<td>Nature of Patient Education Interventions: Early and Current Years</td>
<td>166</td>
</tr>
</tbody>
</table>
Chapter 1

Introduction to the Research Topic

Overview

This study is about teachers and their experiences throughout the first years of their professional practice. The study, however, does not deal with classroom teachers. Rather it is concerned with health care professionals (HCP) and specifically Canadian doctors of chiropractic and their perceptions of their roles as teachers and educators for their patients. The problem that the study addresses is the lack of both research into and knowledge about how health care professionals, in this case chiropractors, deal with patient education in their interactions with their patients. Patient education is an important element of health care and this study seeks to understand better how HCPs feel about their experiences while teaching their patients. The study is based on a qualitative approach and data has been collected from the HCPs themselves through structured interviews with each of the eight chiropractor-participants.

General Context

Patient education is not only a key element of the relationship between the health care professional (HCP) and the patient, but also is often a determinant of case outcome (Yoon, Conway & McMillan 2005). Further, patient education carries with it legal, ethical, humanistic, and social obligations and implications for the health care professional (see Chapter 2). However, patients and health care professionals often have different perceptions of patient education as it pertains to the quality of care (Miranda 2004).

In their pre-service curricular experiences, health care professional students receive very little formal education that is designed to improve their knowledge and skills related to their serving as educators for their patients as I will show through the literature presented in Chapter 2. While they are instructed that patient education is important in their practices, the expectation is that newly graduated health care professionals will automatically become good patient educators (Burkhead, Jones, VonCannon & Hu 2003). Even though there is consensus on the importance of patient education, little is known or understood about the experience of health care professionals with respect to patient education, their own perceptions of their roles as patient educators, and how they use the intervention of patient education in their practices. In this study, I qualitatively examine the nature of the patient education experience and the perceptions, feelings, and attitudes of HCPs as aspects of their patient educator role. This work is potentially important because of its
implications for the HCP/patient relationship, case outcomes, and the design and improvement of the patient education aspect of HCP education and training.

In professional practice, HCPs perform duties spanning a broad spectrum. Some of these duties include patient examination and assessment, diagnosis, treatment, and patient education. Patient education is quite different from the others and this difference presents a potential difficulty for HCPs. Patient examination and assessment, diagnosis, and treatment are all relatively mechanistic processes which are based on cause and effect. This does not mean that these processes are simple and routine. Rather, I mean that both diagnosis and treatment are processes that rely on the HCP being able to use the cause and effect paradigm to work through these complex processes. This point is further discussed and explained in Chapter 2. Patient education, on the other hand, is not based on this same cause and effect relation in the sense that the same words spoken in the same order to different patients will not produce the same learning effect. While HCPs are very well trained in their pre-service curricula in the former three, they may not be as well trained in patient education. The dichotomy of these two relations may be problematic or challenging for HCPs, especially in their early years of practice. Like many professionals, HCPs will have aspects of their practice that they enjoy performing and others that may be less enjoyable, even though these may be equally important. As humans, inevitably, we all change in some ways; however, in others we may remain virtually unchanged. Over time, the clinicians’ feelings and attitudes about their role and responsibility to educate their patients may evolve, or it may remain static. Some HCPs may have very positive attitudes and feel a high degree of comfort during their work as patient educators while others may feel very differently. Some HCPs may be confident in their patient education efforts, while others may feel much less so. These feelings or beliefs may change for some HCPs during their years of practice. An examination of the nature of the patient educator experience can add valuable information to the field of professional health care practice as it relates to patient education.

Patient education is an important part of almost every HCP’s practice. In practices in which there is direct contact between the HCPs and patients, the HCPs have the responsibility to serve as teachers for their patients. For the purposes of this study, I rely upon a previously determined and accepted definition of patient education as “the process by which patients learn or acquire knowledge about his/her health status or condition and may involve learning in the cognitive, affective, and/or psychomotor domains” (Piccininni & Drover 2000). HCP’s are often directly involved in this process as sources of information for their patients.
The Problem, Research Questions, and Significance

The basis of the problem addressed by this study is that while patient education is indeed an important area of health care with wide-ranging influences and effects, we do not know enough about the feelings, beliefs, and attitudes of health care professionals as they take on the responsibility for serving as teachers for their patients. If we recognize and agree on the importance of patient education, then it is also important to learn as much as we can about the feelings and attitudes of those responsible for its delivery. One effective way to learn about these feelings and attitudes is through a qualitative research approach based on in-depth interviews. This approach will allow us to discover at least some of the valuable and needed information.

The following four points summarize the issue and problem at hand and formulate the core of the problem investigated in this study. First of all, patient education, for a number of reasons as explained above, is a very important component in health care practice. Second, from the literature, and from practice, we know that patient education has ethical, legal, societal implications. Third, patient education can be a key determinant of case outcome and as such, we need to understand it well. Finally, to date, there has been insufficient research into this area.

Patients and HCPs have different expectations of health care services and perceptions of patient education. While both patients and health care professionals often agree that patient education is important in the relationship between the HCP and the patient, they differ on their views of patient education as a measure of quality of care. We should have a good understanding of how HCPs perceive the value of patient education and how important it may be in their own view.

In general, the literature reveals that HCPs receive very little pre-service education specifically aimed at making them effective or better educators for their patients. Given the importance of patient education, we need to know more about this aspect of health care so we can determine how best to teach our pre-service HCPs to become effective teachers for their parents.

While there is a body of literature on the doctor-patient relationship, the topic of patient education from the point of view of the HCP has received little attention, particularly in the case of the chiropractic profession. With a more complete knowledge of this important aspect of health care, we may be better able to address improvements in patient education interventions and therefore enhance this one key element of our health care system.

In the next chapter, I discuss the relevant literature in the field in order to establish and explain my rationale for the study, its value, and also to show the areas of patient education that have been studied. I show that while the literature does reflect quite a bit of information and study about some aspects of patient education, there is little written that represents a qualitative
approach to the matter and also very little that addresses patient education from the standpoint of those who have the responsibility to deliver this intervention, the health care professionals themselves.

The four research questions that guide this study originate not from what is included in the literature, but rather what has been neither studied nor published to a sufficient extent. The first question serves as the overlying guiding question and the subsequent three focus on various specific aspects of patient education.

1. What is the nature of the patient education experience from the point of view of the health care professional serving as a teacher for patients?

2. How do HCPs feel about serving as patient educators in their practices?

3. What attitudes and beliefs become evident when HCPs speak about their roles as patient educators and patient education in their practices?

4. Over the years of their practice, what changes related to patient education have occurred in their practices and how have the HCPs’ feelings and attitudes towards being patient educators changed?

Rationale and Significance of the Study

We do know from what has been written that patients and HCPs have different expectations and perceptions when it comes to their feelings about patient education and health care. Yet, this important area of health care, when viewed from the standpoint of those who have the responsibility for ensuring that this intervention is introduced and carried out in the doctor/patient relationship, is insufficiently studied and consequently not very well understood. Now we need more research into this aspect of the field of patient education because if we are to be seriously concerned about improving patient education and constructing a curriculum based on improving HCPs’ patient education knowledge and skills, then we need to understand patient education from a variety of viewpoints, including that of the health care professional. Therefore, it is inherently valuable to study this important aspect of professional health care practice. I can find no literature that systematically addresses this key aspect of clinical practice in the way I have done in this study. In some small, but potentially valuable way, I anticipate that this study may be significant as it can add important information to the understanding of this component of professional health care practice in the following ways:
1) The study begins to lay a foundation of understanding about what HCPs have to say about their practices, especially in the area of patient education, to which the literature has not attended.

2) This study begins to establish information and understanding that will help enable curriculum developers to design or modify content that is aimed at preparing pre-service HCPs to become effective patient educators.

3) Further, the information gained through this study may be of assistance to both new and experienced HCPs in their own understanding and expectations related to patient education.

4) The study may also be of help to the research participants as they reflect on their own practices and the care they provide to their patients.

5) This work may lead to the development of useful research instruments such as the development of reliable questionnaires related to patient education in a health care setting which may facilitate data collection and analysis.

**Personal Background in Patient Education and Assumptions**

Inherent within the nature of interpretive qualitative research is the assumption of a certain level of subjectivity on the part of the participants as well as the researcher. Personal background and interest in the specific area of the research no doubt influence the researcher, at least to some extent. Researchers, and those reading the research, need to acknowledge and accept that the research report has been influenced by this subjectivity. In this section, I summarize the genesis of the study by explaining some of my personal background in the field of patient education and then connecting my personal experience to the ideas that gave birth to this research study. During my professional life, I have served as a HCP, teacher, and researcher; all of these relate to my interest in patient education.

Virtually all adults have some background in patient education from their experiences as patients. In Canada, we have all visited a doctor, dentist, and/or chiropractor at some time. Some of us have been treated by nurses, therapists, or other health care professionals and have had the HCP act as a teacher, delivering information and perhaps answering questions about our conditions and treatment. My primary interest in this area derives from my experience as a health
care professional, having been certified as an athletic therapist more than three decades ago. However, I am also a teacher with experience instructing in the university, community college, private college, and secondary school environments. Many of my years as an instructor were spent in health care education programs, and so I am familiar with the patient education content in health care curricula. Related to this is my research experience that has included the study of patient education from the standpoint of the patient and the pre-service HCP student.

During my years as an athletic therapist, I have often seen different patients with identical conditions who progressed at vastly different rates. While there may be several reasons to account for this, it appears to me that the influence of patient education is almost always a contributing factor. Patients who have an accurate and comprehensive understanding of their own conditions and who have learned how to manage them almost always achieve better and faster results compared to those patients who have not learned well about their own conditions. The literature supports the concept that health care professionals are the principal source of information for those under their care, and so, it is in the best interest of the patient if the HCP is an effective educator.

I have also learned through my experience that patients need individualized approaches to their patient education needs. The same ‘script’ will not be effective with all patients. Consequently, the HCPs must be, at least, somewhat adaptable in approaching their roles as patient educators. Several explanations justifying the need for an individualized approach are discussed in the following literature review section. These include patient literacy and language level, patient age, patient attitude, expectations and goals, and patient motivation. It is my belief that the HCP has a responsibility to identify the factors that can influence or serve as barriers to patient learning and then must address these in formulating a plan for patient education as a part of the overall treatment plan.

My experience has shown me that, as mentioned earlier, little formal curricular content is devoted directly to teaching the health care professional students how to become effective patient educators, a point which is supported by the literature as shown in Chapter 2. There does seem to be a consensus among instructional faculty that patient education is indeed an important part of practice. This message is delivered in the undergraduate curriculum, even though there is little or no specific instruction that is designed with the goal of making the graduates effective patient educators. Further discussion on this point is included in the literature review (see Chapter 2). The general expectation is that HCPs will just become effective teachers for their patients. Having worked closely with many HCPs both in my discipline and in others, I have seen that
some have become good, effective patient educators while others include only minimal educational intervention in their clinical assessment and treatment protocols.

My personal professional beliefs about patient education have led me to some assumptions that must be recognized as they most likely had an influence on my research. Needless to say, in this study, I assume that patient education is a key contributing factor to case outcome and that generally, patients who are better educated about their conditions will have better case outcomes.

Outline of Subsequent Chapters

In Chapter 2, the literature review, I explain, how and why patient education is a very important part of health care delivery and practice by examining what has been written about several different aspects of patient education. The literature review begins with an examination of some of the literature on doctor-patient relationships and then moves to a discussion of various areas including how patient education may be related to case outcomes and the legal, ethical, social, and humanistic aspects of patient education (Freidrich, Gittler & Halberstadt 1998; Piccininni & Drover 2000).

Chapter 3 presents a discussion of the methods used in this study explaining the research approach, how the interview questions were developed, and the participants selected. The interview process, collection, and analysis of the data are also discussed.

Chapter 4 includes a presentation of the important data collected during the sixteen interviews with the eight participants. A detailed portrait of each of the participants is presented with their interview content arranged in a parallel manner with their comments organized using the same categories for each of the participants. This chapter provides a descriptive approach to the data along with some interpretation when needed.

Chapter 5 provides an overview of the interviews of all of the participants and takes an inferential approach to the data. In this chapter, the trends and themes that emerged from the sixteen interviews are presented and discussed.

Chapter 6 deals with the findings of the study and discusses these in relation to the literature review. A summative discussion of the data is presented to provide a response to each of the four research questions. In addition, the limitations and significance of the study are also discussed in this chapter as well as my final reflections on the study along with my recommendations for using the information learned and for future research in the field.
Summary

This study inquires into the nature of the patient education experience from the standpoint of the health care practitioners who must serve as educators for their patients. In this study, I have collected information from eight participating health care practitioners, specifically doctors of chiropractic, through a series of interviews and then qualitatively analyzed, interpreted, and reported on the data. The analysis of the interview data allows me to report, with confidence, on the feelings, attitudes, beliefs, and related behaviours of these HCPs as they talked about their experiences as educators for their patients as well as the nature of the educational interventions they use in their practices.
Chapter 2

Literature Review

Serving as a teacher for patients during the ongoing process of patient education may be seen as a part of the overall HCP-patient relationship and while the literature related directly to my study is sparse, there is a reasonable body of published material on the broader topic of the HCP-patient relationship. This chapter includes an examination of a sample of the literature related to the wider area of the HCP-patient relationship as well as a discussion of the literature that is more specific to my research. This approach will assist the reader in positioning my study within the broader contexts of HCP professional practice and how HCPs relate to their patients. The literature review will also be used to establish and explain the rationale for and value of this study. Briefly, my rationale for undertaking this study stems from the following beliefs:

a) Patient education is an important element of health care practice.

b) The HCP, as a patient educator, is a key player in the patient education process.

c) The nature of patient education from the HCPs’ viewpoint has not been sufficiently studied.

Most of the papers and references for this literature review were found using two principal medical research on-line databases – Medline and Cinahl. Some additional papers were found searching authors’ names or article titles by using non-medical on-line search engines. These searches were supplemented by a manual search of the library at the Canadian Memorial Chiropractic College which is the largest and most comprehensive collection of chiropractic-related material in Canada. Finally, to this was added a selection of published material from my personal collection and library which had been collected over the period of time that I had been learning about and studying patient education and related areas.

The HCP-Patient Relationship

As will be seen in subsequent sections of this thesis, HCPs seem to change their beliefs, attitudes, and practices with increased clinical experience. After graduation from their pre-service schools, the new HCPs appear to have some challenges with confidence and comfort in fulfilling all their perceived roles. With experience, these challenges certainly change and may also diminish. Martin (2008) writes about new family practice residents that as they gained experience, “…they gained confidence in their ability to use their knowledge effectively.” Similarly, Marel, Lyon, Field, et al. (2000) studied the relationship between experience and levels
of confidence of young doctors and found that the participants in their study tended to report some confidence difficulties early in their professional careers. They note that young doctors tended to, “…acquire high levels of confidence…in most skill areas…” after a few years of practice. Brown, Chapman, and Graham (2007) concur with these idea and report that the transition from health care student to practicing professional, “…often raises feelings of anxiety and insecurity from the fear of not fully knowing how to interpret or adapt to a new professional role and working environment.”

Establishing an effective relationship with one’s patients can also present a challenge for newly graduated HCPs. Nogueira-Martins, Nogueira-Martins, and Turato (2006) wrote about the difficulties and challenges of building relationships with patients for new HCPs. Even though their participants were taught about the importance of the HCP-patient relationship in their undergraduate training, they still had difficulties and reported that their pre-service education in this area was too far removed from the reality of professional practice suggesting that their pre-service curricula may not have been as helpful as desired for the transition to real-life professional practice. The need for the curricula to become more effective at preparing health care students for real-world practice is also supported by Brown, Chapman, and Smith (2007). Further to this, other authors wrote that new HCPs also reported that they encountered various barriers to their efforts to establish workable relationships with their patients. Some of these barriers seemed to arise from the patients themselves, while others seem to be related to the HCPs (Nogueira-Martins, Nogueira-Martins, Turato 2006).

Other aspects of practice also presented barriers for new HCPs in establishing relationships with their patients. Williams, Cantillon, and Cochrane (2001) describe some of these barriers and how they might influence new doctors working under supervision. If new doctors experience what they perceive as a shortage of time to spend with each patient, they may experience a trend towards “emotional blunting” whereby new HCPs distance themselves from their patients. In addition, the attitudes of the supervisory doctors also influenced the new HCPs. For example, if new HCPs tried to take a more patient-centered approach to their care, their supervisors might identify these doctors as working too slowly. Consequently, at least in some situations, it may be that the establishment of the HCP-patient relationship was influenced by these factors.

One of the barriers to establishing relationships with patients is the lack of effective communication skills in newly graduated HCPs. Kramer, Dusman, Tan, et al. (2004) argue that effective communication skills are very important for new doctors, yet their study revealed that even after specific education in this area, the new doctors they studied still had “an unsatisfactory level” of skill related to patient communication. It would seem logical that the communication
skills of the HP could very well be a determinant of the effectiveness of patient education interventions. Kramer and colleagues indicate that the communication skill of the HCP will influence the “understanding of the health problem, the patient’s satisfaction, compliance and health, and the physician’s job satisfaction.”

Stern and Papadakis (2006) argue that both formal and informal experiences in school help to establish professional behaviours and beliefs and also teach health care students about professional values and what is seen as important in their future careers. In this regard, the importance of the pre-service curricula should not be underestimated in its role of preparing HCPs for practice and developing relationships with their patients. This role goes beyond teaching health care students to assess, diagnose, and treat their patients. Learning how to become a health care professional, and not just a technician, is a function of the pre-service curricula. Besides teaching knowledge and skills, these curricula also have a role in establishing affective domain learning.

One important aspect of the HCP-patient relationship has to do with sharing the responsibility for decision making and outcomes. Tied to this responsibility is the concept of patient-centeredness. There is increasing attention paid to health care being patient-centered and patient-centeredness can be seen as a sliding scale or continuum. In her recent study of medical family practice residents, Martin (2008) wrote that for the most part, the new residents felt that they should take full responsibility for the case outcome as opposed to sharing the responsibility with their patients.

On the other hand, some authors like Bensing (2000) and Epstein (2000) have written about the importance of sharing responsibility for various areas of care with patients and this sharing also involves decision making. Bensing (2000) discusses the two paradigms of evidence-based care and patient-centered care and suggests that these two concepts present a gap that needs to be bridged. Both of these paradigms have gained popularity recently and both can influence how health care decisions are made. While evidence-based medicine can be perceived as a scientific, positivist approach to decision-making, patient-centered care includes care that involves a “…humanistic, biopsychosocial perspective combining ethical values on facilitating patients’ disclosure of real worries, and negotiation theories on decision making” (Bensing 2000). This author also suggests that while both paradigms are “highly relevant” they seem to belong to “different worlds” and in the future, HCPs will have to find a way to bring these separate worlds together. Epstein (2000) writes about patient-centered care as a part of the doctor-patient relationship and also about the role of patient education in effective patient-centered care. He states that patient education can help in, “…reaching common ground about the illness, its
treatment, and the roles that the physician and the patient will assume.” Further to this, Epstein (2000) argues that while patient-centered treatment is becoming increasingly popular, not all patients want this type of approach to their care and that some patients will, “…gravitate to physicians who are more patient-centered; thus, patient-centeredness is also a quality of their relationship.”

New HCPs are influenced in their approach to being either doctor-centered or patient-centered by their pre-service education programs. Tsimtsiou et al. (2007) report that “…students develop more doctor-centered and disease centered attitudes as they progress through the clinical curriculum…” Yet, as will be seen later in this thesis, HCPs, even if they enter practice with this attitude or value, may very well change their approach as they gain professional experience. If what Epstein (2000) says about patients selecting HCPs based on their degree of patient-centeredness is correct, some of this change may be related to the HCP’s patient population and the way that their patients want to relate to their health care providers, at least in terms of their level of patient-centeredness.

One other aspect of the HCP-patient relationship is the degree to which making decisions is shared between the patient and the HCP. This is closely related to the degree of patient-centeredness in the relationship. Thistlethwaite (2002) reports that new HCPs (doctors) are somewhat reluctant to enter into a relationship with their patients in which there is a great deal of shared decision-making. He explains that one reason for this reluctance is related to the pre-service educational curricula which do not prepare health care students to share decisions with their patients or to be patient educators. Thistlethwaite (2002) says that new grads, “…lack training and opportunities to decide on management and discuss this with patients and yet, particularly in general practice, they have to practice these skills.” He goes on to explain that as they grow in practice, the new HCPs “…begin to develop strategies to decide how much information to give to patients and to what extent to involve patients in (case) management decisions.” That new HCPs are somewhat doctored-centered is also discussed by Martin (2008) who found that doctors in the beginning months of a family practice residency program felt that they had to assume full responsibility for the care of the patient as well as the eventual outcome of the case.

**Patient Education**

In reviewing the patient education literature, I discuss the research and published material as they relate to patient education, specifically what it is and how it is important in health care, in an effort to support the rationale for my study. The HCP is the principal supplier or source of patient
education, but to understand this important area more completely, we need to understand how the HCPs perceive and feel about patient education in their practices and specifically about how they perceive their roles as teachers for their patients. Consequently, included in this discussion is an examination of the role of the health care professional as a patient educator. I also examine the two principal models of patient education as found in the literature. These include the traditional HCP-centered model and the patient-centered model. Finally, I discuss the literature as it relates to the aspects and elements of patient education that may have an effect on the attitudes and feelings of the HCP as a patient educator. These various aspects and elements may serve as barriers to effective patient education or, conversely, may be perceived as assisting the HCP in the patient education process. Because some of the readers of this study will likely not be health care professionals, I also include a discussion of basic patient education concepts that would be known to HCPs, but not necessarily to the lay population.

The literature discussing patient education from the point of view of the health care professional is sparse, although on the general topic of patient education, one can find a plethora of published articles. These studies are generally quantitative in nature and report on various educational interventions, materials, and programs, often related to specific health care conditions. For example, one can read about whether one type of patient education is more effective than another. As an instance of this issue, the question as to whether small group sessions or pamphlets are more effective at reducing unnecessary patient visits has been studied by Newell, Girgis and Sanson Fisher (1995); Stankovic and Johnell (1990); Terry (2000); and Yetzer (2005). Other authors have written about various types of materials provided to patients (Malpani 1999; White 1999). There is a small selection of papers reporting on patient access to information outside the HCP’s control, such as the Internet, and which point to these sources as either beneficial or detrimental to the patient education process (Fogel 2002; Jadad 1999; Shepperd, Charnock & Gann 1999).

Because of the paucity of research examining the nature of the patient education experience from the HCP’s viewpoint, I have drawn on literature from several different health care disciplines including chiropractic, nursing, medicine and surgery, and sports medicine. While practitioners in each of these disciplines may be concerned with different content information in their patient education, the basic principles of patient education, its importance, and ethical and professional requirements remain consistent across the field of mainstream regulated health care disciplines.

Related to my research topic, the available literature can be separated into four general areas. The first of these is the role of the HCP in patient education. The second area deals with the main
objectives of patient education and its implications. The third area focuses on the two principal models of patient education, namely the traditional HCP-centered model and the more recent patient-centered model. Finally, the fourth area revolves around the various influences on the perceptions, attitudes, and feelings that have been reported to affect HCPs in their efforts to educate their patients. Some of these involve barriers to effective patient education involving the HCP, while others relate more to patients; both can interfere with the HCPs’ role in patient education.

I - Definition and Purpose of Patient Education; Role of Health Care Professionals

In the following discussion, I refer to articles written by Drover and myself since, other than this work, very few authors have written on the aspects of this specific topic that would allow us to hear and understand the experiences of the HCPs in their own voice. The working definition of patient education in the present study is “the process by which a patient learns or acquires knowledge about his/her health status or condition and may involve learning in the cognitive, affective, and/or psychomotor domains” (Piccininni & Drover 2000). As mentioned earlier, usually, the HCP is involved in this process as an important source of information for patients.

In the cognitive domain, patient education can include learning about, for example, various food groups and food choices, a medication schedule, treatment options, and the natural history of a disease or condition (Cooper 2002). Affective domain education may be of assistance to patients in recognizing and coping with their feelings about a diagnosis or prognosis. This can also help patients learn to prioritize treatment protocols and accept responsibility for carrying out self-care procedures. Learning in the psychomotor domain may involve skills such as blood sugar measurements, rehabilitation exercises, blood pressure self-monitoring, and home dialysis (Freidrich, Gittler & Halberstadt 1998; Piccininni & Drover 2000). Besides the content and type of patient education initiatives, health care professionals also deal with other related issues.

Professional Responsibility

Health care providers have a major responsibility to serve as educators for their patients. In many, if not most cases, HCPs are the principal source of health care information for their patients. It is well understood by many authors that “it is extraordinarily important that physicians and other providers educate their patients” (Lauerman 1993). Further to this, and related to the concept of informed consent, patients “require access to good quality, evidence-based information so they can take an active part in decisions about their health care” (Sheppard &
It is, therefore, incumbent on health care professionals that they become effective teachers for their patients.

While all HCPs have important responsibilities for patient education, some professionals, by the nature of their discipline, have increased opportunities in this role. Clinicians whose practice demands that they spend more time with patients and who also have patients make return visits are likely better suited to deliver, explain, and reinforce educational information. For example, about doctors of chiropractic, Carroll (1997) has written that the “chiropractor is in an excellent position to provide explanations to patients about their pain problem. A good deal of time is spent with each patient, and return visits allow for incremental education.” Other practitioners in similar clinical situations include, but are not limited to, athletic therapists, physical therapists, massage therapists, dentists, and some nurses. These professionals may spend longer periods of time with their patients and may see them repeatedly thereby allowing these HCPs to have more ‘teaching time’ with their patients.

HCPs can include effective patient education as an intervention, or as an adjunct to treatment to optimize case outcomes. Lorig and Lubeck (1985) support this concept by writing, “An informed patient can, in theory, play an important role in reducing predisposing factors and in managing established illness.” During their pre-service training, HCPs are commonly taught that patient education is an important element of their practices, and as Liebenson and Oslance (1996) have argued, on occasion, effective patient education is the sole requirement for a successful outcome. In other cases, effective education, along with judicious treatment, is an absolute necessity to a successful outcome (Piccininni & Drover 2002). Consequently, HCPs should not only recognize the importance of patient education, they also should understand and accept their own roles as patient educators. The roles of HCPs related to patient education include teaching patients in order to achieve various objectives that involve good health care. These objectives will be discussed in the next section.

II - Objectives of Patient Education

Patient education serves a number of functions and can fulfill several important objectives in a health care environment. This section identifies and explains some of the important objectives of effective patient education. For example, in successful case management, patient compliance is very important whether the patient is complying with decisions that have been made solely by the HCP or whether the decisions are the result of a partnership between the patient and the HCP. Patient education then, is often crucial to a good outcome (Freidrich, Gittler & Halberstadt 1998). Patients should know, and accept, that they have important roles to fulfill in managing their own
health matters (Yoon, Conway & McMillan 2005). Patient education has six main objectives about which there is general consensus and the first four of these are discussed below. The fifth point has been already discussed and the final point needs no additional discussion within this thesis.

a) **Patient Empowerment:** Patient education can empower patients by teaching them about their conditions, treatment choices, and expected outcomes.

b) **Informed Consent:** Patient education is required in order to obtain informed consent for assessment and treatment.

c) **Risk Management:** HCPs can use effective patient education as a strategy for risk management in their practices. (American Academy of Opthamology 2004; Piccininni & Drover 2000).

d) **Societal Implications:** Patient education can have a societal effect by reducing or minimizing health care costs (Sculpher, Watt & Gafni 1999).

e) **Patient Compliance:** Patient education can lead to improved patient compliance.

f) **Health Promotion:** Patient education is used to encourage health promotion.

**Patient Empowerment**

Effective patient education can lead to a number of results, some of which are identified and discussed here. Considered from the humanistic approach, patient education can be an important means of reducing or eliminating the power differential that often exists between the HCP and the patient (Grundstein-Amado 2008; Piccininni & Drover 2000; Yoon, Conway & McMillan 2005). Effective patient education can empower patients by teaching them how to participate in the decisions regarding their own health care (McGuire, McCullough & Weller 2005; Piccininni & Drover 2000). In addition, increasing a patient’s knowledge can have a positive effect on improving his/her conditions (Jamison 1997). Patients who learn that they can control, rather than be controlled by their conditions, may be able to reduce dependency on health care professionals, on medication, and so forth (Friedrich, Gittler & Halberstadt 1998; Ohnmeiss 1993). It should also be mentioned that failure to provide adequate patient education can lead to worsening of health conditions (Raine & Griffiths 1996). Further to this, patients report that they have a higher level of satisfaction with their treatment and practitioners when they are well educated about their cases (Jamison 1997; Schattner 1993; Terry 2000). Researchers have found that patients and HCPs may have different perceptions of patient education. While both agree on its importance, patients feel that patient education is a measure of quality of care. On the other hand, HCPs do not perceive patient education as an indicator of health care quality (Miranda et al. 2004).
Informed Consent

Patient education also involves legal and ethical aspects. When a relationship begins between a patient and a HCP, the practitioner is required to obtain informed consent from the patient. This requirement, now an integral part of the HCP-patient relationship (Wadey & Frank 1997), stems from the principle that patients, as individuals, have the right to control what will be done to them. This means that the right to accept or reject treatment, or a certain type of treatment, rests with the patient and not with the HCP. The clinical guidelines for chiropractic practice in Canada, for example, state that, “Consent for treatment is often implied rather than expressed. However, where there is risk of significant harm from the treatment proposed, this risk must be disclosed” (Henderson & Chapman-Smith 1993). Treatments that may have associated risks include surgery, oral and injected medication, and joint manipulation, to name a few. Patients need to learn about these so they can give a consent that is truly informed.

Risk Management

While the patient may consent to care, this consent can be insufficient if the patient is not adequately informed. At a minimal level, the process of obtaining informed consent requires the HCP to educate the patient as to the risks, benefits, and alternatives that are associated with any treatment or procedure. Without effective patient education, the patient cannot be adequately and truly informed. The HCP must ensure that the patient has “received information regarding the effects, risks, side effects, and alternatives to any treatment; the patient must be informed as to the consequences of not having the treatment performed; and the clinician must respond to the patient’s request for other information about the treatment and answer the patient’s questions” (Piccininni & Drover 2000).

These requirements place considerable responsibility on the HCP and may be a factor, for some, in both their comfort and confidence in serving as a patient educator. Failure to complete the informed consent process before initiating assessment or treatment can expose the HCP to ethical and legal disciplinary actions. This may also lead to civil litigation initiated by patients. Hence, effective patient education can be a strategy used by clinicians to reduce risk of litigation.

Societal Implications

Effective and efficient patient education also has implications for society as a whole. In Canada, one of the largest expenditures by our provincial governments is for health care. As health services and resources become more expensive and harder to access, patients who have been well-educated by their HCPs tend to diminish health care costs by reducing unnecessary
visits to health care facilities or practitioners, and by reducing hospital admissions. Several studies have shown that patient education can be effective in this regard (Allegrante 1984; Lahdensuo 1999; Osman & Abdalla 1994; Raine & Griffiths 1996; Rutten & Van Eijk 1991; van de Kar & Knottnerus 1992; Wilson 1999). By complying with their treatment plans, and learning when they should seek consultation and/or treatment, patients not only help themselves by improving their conditions and reducing recurrence, but also can have a positive influence on the expenditure of both government and insurer health care dollars (Sculpher, Watt & Gafni 1999).

III - Models of Patient Education

One cannot discuss patient education or the HCP as a patient educator without consideration of the various models of patient education that are in common use today. I suggest that HCPs’ views about patient education will be better understood if we also understand prominent models of patient education. In this section, I discuss the two principal models of patient education as they exist today and are described by the professional health care literature. This discussion includes an explanation of each of the models and an examination of pros and cons of each. This discussion demonstrates how the various models can affect the attitudes and feelings of health care professionals related to patient education.

For HCPs trying to educate their patients effectively, one of the complexities in teaching patients derives from the fact that there are different models of patient education. This variety of models may be a factor in how HCPs feel while undertaking patient education initiatives. Challenges for the HCP may result from the need to understand, select, and effectively apply various educational models. One model may not be appropriate in all patient education situations or environments. Yet, having to become competent at more than one model can present a difficulty in professional practice. While some patient education goes on in small group sessions, most patient education encounters occur on a one-on-one basis during a clinical encounter, so HCPs need to become adept educators in this teaching environment.

Traditionally, patients have looked up to their health care professionals as experts who would make key diagnostic and treatment decisions and deliver the treatment required to improve their conditions. This has been referred to as the HCP-centered or paternalistic model (Charles & Whelan 1999; Coulter 1999; Piccininni & Drover 2000; Simon 2000). In the last few decades, however, there has been a developing trend towards increased patient rights and greater accountability of health care professionals (Allegrante 1984; Grundstein-Amado 2008; Simon 2000). Some patients want to have a decision-making role in their own health care and so a patient-centered model, also known as the partnership educational model, would be more suitable
for them (Charles & Whelan 1999; Coulter 2000; Elwyn & Edwards 1999; Jadad 1999). Not all
patients, though, feel comfortable in the more modern model and so, the HCP must become
competent in at least both of these models. Both models seem to have a place in modern health
care and the appropriate approach depends on the patient (Lakshmi 1999).

While there are two principal patient education models, it should be mentioned for
completeness that several authors have delineated three models. Charles, Whelan, and Gafni
(1999) write about models of decision-making in health care. Key differences in these models
involve various approaches to patient education. Embedded within the distinct decision making
models are what can be considered models of patient education. Within their delineation, Charles
and her colleagues have essentially sub-divided the patient-centered model and believe that the
differences were significant enough that three separate models should be identified. They name
the three decision-making-education models as follows: the paternalistic model, the informed
model, and the shared model. In the first, the patient “passively acquiesces” to the HCP’s
decisions on treatment. In the second, the HCP communicates the relevant information to the
patient so that the patient can make an informed decision on the treatment approach. In the third,
the decision making process is shared between the HCP and the patient. This model is
characterized by a two-way exchange of information in which both the patient and the HCP
discuss their treatment preferences (Charles, Whelan & Gafni 1999).

In the early years of modern medicine, doctors were experts with a specialized set of skills
and knowledge. Patients sought medical advice and care because of these. It was expected by
both the doctor and the patient that the doctor would make the key decisions. The relationship
between the doctor and patient, in terms of decision-making authority, was decidedly one-sided
and rested with the health care professional who provided all the treatment necessary. Grundstein-
Amado (2008) has described this relationship saying “Historically, the dominant interaction
between the physician and the patient has been paternalistic. Physicians were obligated to use
their best discretion in seeking to benefit the patient.” Essentially, patients turned over the
responsibility for their own health care to the doctors and nurses who were prepared to accept it
(Grundstein-Amado 2008).

When medical research and knowledge developed to the point that it was no longer feasible
for HCPs to provide all treatments, patients needed to learn how to administer care themselves.
One historical event that led to this breakthrough was the discovery of insulin by Banting and
Best at the University of Toronto in 1922. Diabetic patients needed frequent injections. This
necessity made it too expensive and impractical for health care practitioners to administer all the
required injections. Patients now had to become involved in their own health care by having to
learn how and when to self-medicate. They also needed to learn about regulating their food intake and energy output. Because of Banting and Best’s discovery, suddenly, HCPs had to become educators for their patients and patients had to learn to accept some important responsibility for the management of their conditions (King 2004; Piccininni & Drover 2000).

A HCP-centered approach to patient education can be a part of a successful HCP-patient relationship and lead to a successful case outcome. Some patients expect the health care provider to be the expert and take the lead in making the key decisions in managing the patient’s case. Some patients just want the HCP to tell them what is wrong and the best way to cure it (Duffy & Schnirring 2000). After all, the HCP has graduated from a rigorous academic program and is expert in a specific health care discipline. As mentioned earlier, patients of this type are willing to give the responsibility for their health care decisions to their HCPs. Some health care professionals too, may be somewhat unwilling to give up some of their traditional authority, based in their specialized knowledge and skills, to the lay patients (Saint Lamont 1999). The HCP-centered approach can be efficient in terms of both time and cost (Mariotto 1999). It may very well lead to successful outcomes in both case management and patient satisfaction. Whether or not the HCP is willing to accept all this responsibility is another matter.

While there is some support and rationale for the HCP-centered model of patient education, most of the literature unequivocally supports the use of the patient-centered educational model (Charles & Whelan 1999; Elwyn & Edwards 1999; Jadad 1999; Jones & Hampshire 2001; Simon 2000; Towle & Godolphin 1999; Wilson, 1999). This model, introduced above, is the more contemporary of the two and the momentum “to equalize relationships between health professionals and patients” is growing (Coulter 1999). Some authors have described this as a partnership model of patient education in which the HCP seeks to create a relationship in which both the clinician and the patient are equal partners and share in the responsibility for decision making related to case management and treatment options. The patient, in this situation, must be willing to accept or retain responsibility for health management and outcomes and the HCP must be willing to educate the patient so that the patient learns enough to become a true partner in the relationship. The partnership model seeks to avoid unhealthy dependency of patients on HCPs. Proponents of this model eschew the HCP-centered model claiming that it is outdated and “has no place in modern health care” (Coulter 1999).

For this partnership model to be used successfully in a HCP-patient relationship, both partners need to recognize the intent. Patients should learn that they will be playing a major part in making the key decisions about their cases. HCPs should be willing to spend the needed time, and they also require the teaching knowledge and skills to educate their patients adequately so...
that they can be full partners in the relationship. This requirement presents a challenge for many HCPs since they initially have to determine the education plan for each patient. This takes practitioner time and effort (Hopp 1983).

The existence of several models of patient education, as discussed above, can, in itself, be influential on the feelings and attitudes of HCPs as they serve as patient educators. Some HCPs may only be familiar with one model; some may know that there are two, three, and multiple hybrid models that they can use in practice. Having more than one option may seem to be beneficial, but the choice may also serve to confound the issue. Multiple models provide choices and options for the HCP. Presented with these choices, though, a HCP may feel comfortable using one model, but not as comfortable in the other(s). Another HCP may feel equally comfortable using various models. However, even if the HCP is expert at using two, or three models, there is still the matter of selecting the most appropriate option for each patient.

Health care professionals need to be experts not only in diagnosis and treatment, but also as patient educators. Cooper (2002) argues that HCPs, “...need to become, if they are not already, experts in adult education. They need to understand both its theoretical base and its practical implementation.” Berliner (1994), working in the more general context of ‘teaching’, has written about professional expertise and explains that in order to be an expert in an area, several criteria must be met. These involve analysis, selection, and implementation. First of all, experts are able to analyze a given situation quickly. This analysis helps them select the most appropriate strategy to use in the situation. Finally, the expert must be able to implement the selected strategy effectively.

Applying Berliner’s notion of expertise to HCPs and the models of patient education, it follows that the HCPs who are aware of the existence of more than one teaching model have to work with this complex process of becoming an expert educator for their patients. Consequently, the very existence and acknowledgement of multiple patient education models can present a difficulty for the HCP who, recognizing that one model will likely not fit all situations, must analyze each patient education situation, select a model that would be the most successful, and then be able to implement that model effectively. This process, in a busy practice, would be required sometimes dozens of times each day possibly presenting a challenge to the HCP’s comfort, confidence, and effectiveness as a patient educator.

Having to practice in an environment where there is a choice of options may present challenges to the health professional and these challenges can have an influence on how HCPs feel about patient education in their practices. Not only does the HCP need to have a high level of understanding of the various models of patient education, he/she also has to be able to select the
model that would be the most appropriate for each patient. Having done this, the HCP should then be able to operate competently within the model selected. Sometimes, the best model might not be the one preferred by the patient, and this can provide further challenge for the health professional (Coulter 1999; Lakshmi 1999; Towle & Godolphin 1999). Besides the challenge of selecting and operating effectively in the optimal model for each patient, HCPs also face other factors that may influence their perceptions of patient education.

To summarize, a number of issues exert their influence on the HCPs in their day-to-day roles as educators for their patients. The ones discussed above include: multiple models of patient teaching, society’s changing expectations towards patient education, and patient expectations. In the next section, I will discuss additional influences on the HCP as patient educator.

IV - Influences on Perception, Attitudes, and Feelings

Above, I have discussed the literature related to some of the major influences on health care professionals’ perceptions, attitudes, and feelings about patient education and their role as teachers for their patients. There are several remaining aspects of patient education that may have positive or negative effects on the confidence and comfort levels of the HCP as a patient educator. Many of these have been described in literature related specifically to patient education or in literature related to teaching. Some of these various aspects may present barriers or challenges to the HCP and some may serve as aids related to teaching patients.

Pre-service Curricular Content

While they may be taught that patient education is an important element of professional practice during the training or pre-service education of HCPs, there is very little curricular content intended to teach health care professional students how to become effective teachers for their future patients. The ability of HCPs to teach and to teach well is assumed (Burkhead, Jones, VonCannon & Hu 2003; Cooper 2002; Ritchie, Stetson, Bass & Adams 2002; Yetzer 2005). This should not be surprising because teaching looks like a simple task. Kilbourn (1998), writing about teachers, says the complexity of teaching is often not recognized by beginning teachers or outsiders. Consequently, content aimed at teaching future HCPs to become effective patient educators is, for the most part, left out of the busy and full curricula of professional health care college and university programs. Donkers Ainsworth and Hagino (2006) explain the practice habits of health care professionals when they say that, “…chiropractic practice behaviours can be reasonably predicted by their educational experience.” If HCP students are not taught both that patient education is an important element of professional practice and also how to become
effective patient educators for their patients, they may not automatically incorporate this into their practices. Newly graduated HCPs then, may underestimate both the value and challenges related to their roles as teachers in patient education when they enter their profession. This underestimation may affect their feelings of confidence and comfort as well as their effectiveness in this aspect of their practice.

*Available Time in Practice*

Many HCPs work in very busy practices where they see dozens of patients on a daily basis. Their very full schedules allow little time for discussion and conversation with their patients. HCPs are taught to work quickly during their training. In fact, it has been reported that HCPs in training might even be reprimanded if they spend too much time with one patient possibly indicating that some instructors do not place a high value on patient education (Cianciara & Miller 2003; Williams, Cantillon & Cochrane 2001). Effective patient education takes time and if spending time with patients is not being positively reinforced during pre-service education, then HCPs in practice might continue to spend minimal time with patients thereby reducing the patient education effectiveness as well as influencing the perceptions of the HCPs (Parochka & Paprockas 2001).

Time spent with patients is also related to reimbursement. Health care is a business and in private practice, HCPs must generate enough billing revenue to meet expenses and earn an income. Patient education can be both therapeutic as well as preventative. Few HCPs are eligible to bill for preventative interventions and so, time spent on this aspect of patient education may be minimal or even non-existent (Parochka & Paprockas 2001). Also, billing is often based on providing a specific service, so once that service is completed, the HCP may not be able to bill for time spent on patient education interventions. That is, a visit to a doctor may involve an examination and writing a prescription. Examining the patient and writing the prescription are the acts for which the doctor can bill. Additional time spent discussing the condition with the patient may not be a billable service and hence, with a full waiting room, the HCP may not spend, or be able to spend very much educational time with the patient which may be an issue when the HCP considers his feelings and attitudes as a patient educator or to the barriers to effective patient education.

*Communicating with Patients*

Patient language, educational background, and literacy levels may also be challenges to how comfortable and confident the HCP feels when serving as a patient educator. These may also limit
the effectiveness of the HCP’s teaching. Even if working in the same language as the patient, health care communication is full of complex words and technical jargon. At the best of times, HCPs need to ‘translate’ technical terms into lay words. This can become a more difficult task if the patient cannot communicate in the same language as the HCP does. Patients without sufficient literacy skills to be able to read and comprehend materials provided by the HCP also present possible challenges to the HCP’s comfort and confidence (Harden 2000). Likewise, patient education backgrounds may also have an influence on these and possibly on the ability of the patients to learn the material.

The communication skills of the HCP may also exert some influence on the patient education experience and the comfort and confidence of the HCPs (Davis & Chesbro 2003; Jones, Hampshire, Moult, & Hill 2001). Besides being able to ‘translate’ technical jargon into lay terms so patients can understand and take part in the conversation, the HCP must be able to converse with the patients in a manner that facilitates an effective educational experience. Some schools have recognized the importance of HCP communication skills and have devoted parts of their curricula to address this, but this intervention has primarily been for the purpose of conducting the initial patient interview during which the clinician derives the patient history, signs, and symptoms and not for the purpose of improving the skills of the HCP as a patient educator. Few if any schools devote curricular content to education aimed specifically at patient education and improving HCP students’ knowledge and skills in this area (Burkhead, Jones, VonCannon, & Hu 2003; Kendrick & Freeling 1993; Mariotto 1999).

Wadey and Frank (1997) discuss the matter of patient anxiety and stress. These factors may influence patient retention and learning. Patients under the stress of a serious health care condition may not be able to understand completely the information provided by the health care professional. The HCP caring for a stressed or anxious patient may not feel as comfortable or as confident as when teaching a patient in a less stressful situation. Together, these aspects may influence patient education effectiveness.

**Sharing Authority**

Some authors have discussed the reluctance of the HCP to give over authority for decision making to the patient (Saint Lamont 1999; Towle & Godolphin 1999). This reluctance may stem from the belief that that the patient can never really become an equal partner in the HCP/patient relationship due to the vast differences in training and education (McGuire, McCullough & Weller 2005). Hence, HCPs may experience some difficulties when faced with a patient who has the expectation of being treated as an equal partner in the health decision-making process.
Similarly, HCPs may be faced with challenges to comfort and confidence when the model that they feel is best, in a particular situation, is not the model in which the patient wishes to operate (Charles, Whelan & Gafni 1999; Coulter, 1999; Lakshmi 1999). For example, the patient may want the HCP to be in charge of all pertinent decision-making. After all, the HCP, from the point of view of the patient, is the expert with all the training and education. The HCP, on the other hand, may believe in a model of shared responsibility for the treatment and case management decisions. The opposite scenario can also arise. Both of these can have influences on HCP effectiveness as well as on feelings of confidence and comfort in a patient education experience.

Paradigm Challenges

Finally, much of our modern health care practice is based on a mechanistic, cause and effect system of operation (Papa & Harasym 1999). Weathers (2000) writes that the results obtained in a health care intervention are fairly predictable and are, for the most part, in direct response to the cause. He explains that, in modern western health care, the principal paradigm for practitioners is one in which “the application of intelligence and hard work will yield a desired result in a fairly predictable way” (Weathers 2000). The great majority of the processes of assessment, diagnosis, and treatment are all based on a cause and effect paradigm. Educators understand, though, that teaching and learning are not as directly connected to the same cause and effect paradigm. A given disease will, for example, produce a specific set of signs and symptoms. A certain medication will produce predicted effects and side effects. A specific exercise will cause predetermined and predictable physiological or anatomical adaptations. Educators know through experience, though, that delivering the same lesson, in the same manner, to different learners will not necessarily cause the same learning effect. This paradigm difference may have an influence on how the HCPs feel about and perceive the nature of the patient educator role. Having to work in these two paradigms, and having to do so simultaneously, and at least competently, may prove to be difficult, or at least present a challenge for HCPs.

V - Summary

In the above, I have reviewed the literature pertinent to the overall area of research in this study. The literature available has been organized based on a number of themes that emerged. These include:

(i) the establishment of the HCP-patient relationship,

(ii) concepts of patient-centered care,
(iii) the definition and purpose of patient education and the role of the HCP,  
(iv) the objectives of patient education,  
(v) the models of patient education, and  
(vi) the influences on the HCP’s perception, attitudes, and feelings as a patient educator.

While some aspects of patient education have been well researched and reported, other aspects have not had the same scrutiny. What is not included in the literature is a thorough examination of patient education from the standpoint of those who are responsible for ensuring that patients are, indeed, educated appropriately. Researchers have not studied how HCPs feel about their role and responsibility that requires them to be educators for their patients. We do not know how HCPs perceive patient education and whether they consider it to be an aid or a burden in their practices. Nor do we know how important they believe patient education is in their practices. HCPs may feel comfortable and confident acting as patient educators, or they may feel that they were not prepared well in their pre-service education. Also, we do not yet know what, if any, changes related to patient education are made by health care professionals over the course of their professional careers. If patient education is indeed an important element in our modern health care system, then we should have a much better understanding of this element from the viewpoint of the health care professional. Consequently, this study involves areas of patient education in professional health care practice that have not been well-researched. These areas center around the nature of the patient education experience from the point of view of the health care professional. The research questions to which I endeavour to find answers derive from the aspects of patient education for which answers have not yet been found by researchers. These questions were presented in Chapter 1.
Chapter 3

Methods

My role as researcher was to serve multiple functions, as interviewer, reporter, and interpreter. The fact that I have been a Certified Athletic Therapist for more than three decades gives me an advantage over researchers who are not HCPs since my participants were able to communicate with me, as a colleague, knowing that I have experienced many of the issues they deal with on a daily basis. Further to this, the participants would not feel required to translate or explain technical terminology or clinical situations as they would have had to do if they were interviewed by a person who was not a health professional. Being a HCP also was a benefit in helping me provide interpretive commentary during the interview analyses sections of this report.

For the purposes of examining the nature of the patient education experience from the point of view of the HCP, I collected information from eight health care professionals, namely doctors of chiropractic, through serial interviews. While a single interview is more like a snapshot, capturing only an instant in time, multiple interviews gave the HCP participants an opportunity to recollect and reflect on incidents and experiences related to their serving as educators for their patients throughout their careers. Over the course of the interview series, which spanned several months, the participants were able to consider their feelings and attitudes, their successes and failures in case management and outcomes, and perceptions of their own experiences as patient educators. This process provided me with a great volume of data; transcribing the interviews yielded some 450 pages of data to analyze. The multiple interviews were also useful for triangulation and to assist with estimation of the data’s trustworthiness. If a doctor described the same incident or similar perceptions in both interviews, I could be assured that the information had a reasonable level of veracity and accuracy.

In order to understand the nature of an experience, the qualitative approach has been frequently and well used by researchers. Since HCPs serve as teachers for their patients, then it would be useful and appropriate to employ a qualitative approach to learn about the nature of the patient education experience from the standpoint of health care practitioners. As Erikson (1986) advises, a qualitative approach is best when looking for the answer to the question, “What is happening here?” Using a qualitative approach will help with gaining a specific understanding of patient education as it allows for the “documentation of concrete details of practice” (Erikson 1986). Qualitative research into areas of education is important since this can lead to an
improvement in educational practice which, in this case, would mean an improvement in health
care services. This study, then, uses a qualitative, interpretive approach in an attempt to
understand the feelings, attitudes, and behaviours of HCPs as they fulfill their daily role of being
teachers for their patients and how these may have changed over the course of the doctors’
careers.

For this study, I used an interview format, as suggested by Glesne (1999) that is both
structured and open. The interviews were structured in that I had formulated a specific set of
questions to ask the participants. (see Appendices C & D) They were also open, thereby allowing
me to develop new questions and follow areas that were not initially anticipated. Kvale (1996) is
also a proponent of this interview model and refers to it as the semi-structured interview design.
He writes that this type of interview helps researchers understand “the lived daily world from the
subjects’ own perspectives.” Through this type of interview format, I attempted to obtain the
participants’ perceptions and feelings about patient education, an element of their practices they
experience every day. This interview design allowed me to ask the same questions to each
participant and also provide opportunity for the participants to contribute additional related
information. This process also allowed me to collect information from participant HCPs that
addressed issues of past and present behaviours, perceptions, and feelings related to patient
education. Interview topics spanned the participants’ years of practice so they were able to relate
and explain how they felt about and used patient education as they entered professional practice
as well as how they feel about this topic in their current practices. Further, HCPs were able,
during the interviews, to speak about their opinions and values, their feelings, their knowledge
and experiences as they act as patient educators. They were able to tell me about the changes that
have taken place as well as the reasons why they have made those changes.

Narrative accounts of personal experiences can become valuable research tools in helping
one to understand attitudes, beliefs, and feelings about the participants’ experiences. Since this is
exactly what I wanted to discover about the participants in this study, I selected the interview
method that would allow the participants to offer in depth responses and relate elements of their
personal stories. Brady, Corbie-Smith, and Branch (2002) writing about new doctors support this
position stating that, “…narratives provided us with an understanding of the interplay among the
(doctors’) interactions with patients, their own personal issues, and their struggles during discrete
stages of their professional development.”

To obtain data and information from health care providers, I scheduled two interviews with
each of the participants. I anticipated that the first and second interviews would be separated by
about one month, but this was not always the case. Based on the doctors’ schedules, some
interviews were separated by only a few days, while others were weeks apart. I address the rationale for the planned time period below. When information appears to be conflicting, or unclear, a brief third interview was planned to be used if or when necessary to clarify any comments made by the doctors in response to my questions. Ultimately, these were not required. Multiple meetings and discussions with the same participants provided me with an opportunity to work in a situation that resulted in an abundance of data, as mentioned earlier. Further, interviewing each participant two times allowed for the conversations to yield details and information that single interviews might have failed to capture. Participants, through the multiple interviews, were able to go back and offer information that may have been forgotten or missed in the previous interview. Also, with two interview meetings, I was able to seek clarification for commentary that might have originally seemed to be ambiguous or incomplete. In addition, the multiple interview process provides a chance to re-cover certain topics and this can be useful for triangulating the collected data to add to the evidence related to data reliability. The first of the interviews focused on the participants’ early years of practice following graduation as chiropractors. The second interviews focused more on the perceptions of the participants related to their current professional clinical practices and also on the changes that they had made with regard to patient education in their practices.

Scheduling the interviews was affected primarily by the doctors’ schedules. Consequently, the original plan of spacing them with a month between the two meetings could not always be arranged. It is desirable to have some space between the two interviews for two principal reasons. First, allowing some time span between interviews was less intrusive on the busy practices of the participants. Second, this time period allowed the participants some time to reflect on their patient education experiences. They might have been able, during this interval, to recollect events or stories to help illustrate their perceptions and the nature of patient education in their practices, as they perceived it.

I originally anticipated that the two principal interviews would each be 70-90 minutes long. This estimation was fairly accurate as most of the interviews were in the 75-85 minute range. Besides writing field notes during the interviews, I also made audio recordings of the full conversations. Immediately following each interview, I also wrote some personal notes about important aspects of the interviews. The key parts of the interview tapes were transcribed by me. This aided in the reporting, description, and interpreting the information provided by the participants. I chose not to use a transcription service for this process. Transcribing the interviews personally allowed me to review the conversations personally and get closer to the information. It also allowed me to edit and omit small parts of the interviews when the conversations drifted
away from the topic at hand, although this editing was not a frequent occurrence since, for the most part, the doctors did not tend to go off on conversational tangents. In addition, this type of intensive data review helped me to add to my knowledge of the practice context for each of my participants. In doing so, I had a better understanding of the unique responses of each HCP and the specific aspects of their practices that either make it different from or similar to the practices of the other HCP participants.

**Participant Selection**

To recruit and select participants, I invited doctors of chiropractic who had current practices in the Greater Toronto Area and who had been in practice for several years, no fewer than five years and no more than ten. Initially, I made contact with a few chiropractors who met the criteria and who I knew. After meeting with them, I asked for their recommendation of other chiropractors who they thought might be willing to participate. I then contacted the recommended doctors to determine their interest and continued with this process until I had a sufficiently large participant group. As it turned out, I had met all of the participants in the past. Inviting doctors who I already knew, and who also knew me as a health care professional colleague, I believe, assisted in developing a comfort level for both the participants and myself during the initial interview and also helped letting the doctors feel comfortable and relaxed during the candid discussions of their feelings and attitudes. One advantage of having participants who know the researcher is that there already exists a mutual respect and professional relationship in which both parties can be assured of each others’ integrity and sense of confidentiality. This appears to have worked well in this study. This idea is supported by Glesne (1999) writing about familiarity between researcher and participants who, if they get to know the researcher, “…less readily feign behavior or feel the need to do so; moreover, they are more likely to be frank and comprehensive about what they tell you (the researcher).”

I should also mention that while I knew the participants to varying extents, at the time of the interviews and during the period of my study, there existed no professional relationship between the participants and myself. That is, we did not work together nor was there a HCP-patient relationship during the full time period of my study.

**Analytical Framework**

The data are derived from the two semi-structured interviews conducted with each of the participants. The initial interview focused on the HCP’s first one or two years of professional practice and the second interview was centered on the most recent one or two years of practice. In
addition, the second interview also included questions dealing with any changes that the HCPs had made or undergone related to patient education in their practices as well as their reasons for making the changes.

The data were analyzed in three layers: descriptive, interpretive, and inferential. The descriptive layer deals with a reporting of answers and comments made by the HCPs during the two interviews. The interpretive phase is closely related to this. Since the HCP participants were being interviewed by a fellow HCP, the language and terminology used and clinical situations discussed may not be familiar to the lay reader. Hence, I have added my own interpretive explanations in this section to assist the reader in understanding the meaning and context of the participants’ responses and comments, in some cases, the clinical processes taking place. The final layer is inferential in that I examine the data for themes and trends, possible reasons for these, and information relationships that have become apparent during the interview analysis.

The first two layers are addressed in sections dealing extensively with each of the individual HCP-participants’ interviews (Chapter 4) while the final (inferential) layer is addressed in a section (Chapter 5) dealing with the whole group of participants. Further, in the individual analysis sections, most of the data presented and interpreted is divided into two parts. The first of these, the “early years” deals with the doctors’ first years of practice. The second part, “current practice” is concerned with the participants’ most recent years of practice. Two categories are not so subtitled. I discussed the practice experience and patient groups under one heading for each of the doctors. Also, the changes that were made by each of the doctors were similarly discussed under only one heading since these were primarily related to their current practices.

The analytical coding or categories I used were developed from the research questions presented earlier and also from the detailed analysis of the interview data. In both the sections dealing with the early years of practice as well as the most recent years, the data fell into seven fairly specific categories which became evident during the analysis. A description of each of the categories is written below. The seven categories were:

1) Practice experience and patient groups
2) Function of patient education: Early years and current practice
3) The HCP’s role in patient education: Early years and current practice
4) Nature of patient education interventions: Early years and current practice
5) Key beliefs and feelings: Early years and current practice
6) Perceived barriers to effective patient education: Early years and current practice
7) Changes related to patient education
For each of the participants, I have written an extensive descriptive and interpretive analysis of the interviews in Chapter 4. The above categories appear in each of these analyses. These categories encompass both the interview questions as well as the responses of the participants. Most of the comments and participant responses fall into one of the seven categories outlined above, but some overlapping was evident in that the specific way a participant expressed or framed his/her ideas suggested that those responses touched on more than one category. This occurred when the HCP’s response showed a linkage or connection between two or more categories.

**Practice experience and patient groups:** The description of the HCPs’ practice experience and patient groups includes the chiropractors’ comments about the types of practices in which they have worked since their graduation. These practice experiences include locums (in which a chiropractor fills in for a short time for a doctor in an established practice) which can last for a few days to a few weeks. Many new graduates begin practice experience in locum positions. These give the new doctor a chance to experience real professional practice and earn some income before committing to opening a private practice. As will be seen later in this report, some of the study participants, as new graduates, had experience as associates in a practice. Associateships are permanent positions as opposed to locums. Typically, an established practice might have more room than is needed and a second or additional doctor – the associate – is brought in to work in this space. Usually, the associate doctor pays the doctor-owner a percentage of the revenue generated from patient visits. All of the doctors in this study, who began working as associates and in locums, eventually went on to open their own practices.

Patient populations can also vary widely and depend on the nature and type of practice as well as on the location of the practice. Small towns in Ontario have a very different patient demographic from practices in downtown Toronto. Patient populations in ethnic areas can be different in some respects, from patient populations in other areas or neighbourhoods. Also, patient populations may differ because of income, education level, literacy levels, and other factors. The significance of these factors and how they may relate to patient education is explained in the interview analyses.

**Function of patient education:** Just as physical treatment has an important role in a chiropractic practice, so too, does patient education. The category that covers the role of patient education in practice includes the comments and responses that tell about the perceptions of the doctors related to how they used, or thought they could use, patient education in their practices. This section deals with issues of the purposes and functions of patient education as it relates to various aspects of health care practice including the process of obtaining informed consent for examination and
treatment, issues of treatment choice, patient compliance with the treatment plan or plan of management, and prevention of aggravation of the condition and future injuries.

**The HCP’s role in patient education:** The role of the doctor as a teacher for his/her patients includes comments on how the chiropractors perceive their own roles related to patient education. This section is also concerned with the importance of the perceived role as well as whether the study participants view patient education as a duty and required responsibility, as an adjunct to their practice, or as an integral component to the care they provide for their patients. The discussion also includes comments on the relative importance of patient education in relation to the other aspects of care, such as physical chiropractic treatment. Whether or not the patient is viewed as a partner with the HCP is also covered within this section. In subsequent chapters, I have written that some of the doctors also reported that they were asked by their patients for information related to care from another practitioner. The study participants had to decide whether or not to make up for patient education that was either not done or inadequately done by other HCPs. This section includes their responses and comments on this matter that is one that is frequently encountered by health care professionals.

**Nature of patient education interventions:** The discussion of the nature of the patient education experiences includes information on what an external observer would see if viewing a patient education intervention or session. In this category, the HCPs describe their educational (teaching) strategies and techniques, the teaching resources they use, and the driving force behind the education (the doctor or the patient).

One important element of patient education is the direction of information ‘flow.’ In very many cases, as will be seen in the chapter dealing with the interview analyses, the information to be learned by the patient flows from the HCP to the patient, but this is not the only possibility in a learning situation. Miller’s (1996) is helpful in presenting the various teaching modes or positions. He identifies three of these namely transmission, transaction, and transformation and I provide a brief explanation of each of these here as they may apply to a clinical patient education situation.

Through their comments, it becomes evident in this category as to whether the chiropractors used, or use, a transmission, a transaction, or a transformative teaching approach. In a *transmission* approach, the communication is essentially one way. This could involve the doctor simply deciding what the patient needs to learn and then just talking about this to the patient or giving the patient a pamphlet to read. About this, Miller writes, “Learning in this form can occur by reading a text or listening to a teacher’s explanation. (J. Miller 1996) Teaching characterized by transmission is clearly a doctor-centered approach to patient education. The great majority of
the patient education experiences of the doctors in this study is of a transmission nature. In an educational session characterized by *transaction*, there is a meaningful two-way dialogue between the doctor and the patient. The learner, or the patient in this case, is generally, according to Miller’s description, seen as a “problem solver.” (J. Miller 1996) As such, both are contributing to the educational process and both make decisions on the material and information that needs to be learned. In a transaction approach to learning, there is, “…more room for individual differences, more respect for diverse understandings, and more points of view (R. Miller 2000). A teaching approach characterized by *transformation* involves an inclusive, patient-centered teaching style. Miller (1996) says that, “The aim of the transformation (learning) position is the development of the whole person.” In this approach, each patient is unique in terms of the patient education strategy and the patient is clearly viewed as a true partner in the whole management of the health care condition or issue at hand. There is no fixed “curriculum” or set of information delivered by the HCP; rather, both the patient and the doctor collaboratively decide on what needs to be learned, when, and how the information will be passed along from one to the other. Very little transformative patient education was reported by the doctors in this study. One possible reason for this is that, for example, in obtaining an informed consent for treatment by the patient, the doctor is required ethically and legally to explain to the patient, in an understandable way, the risks, benefits, and alternatives associated with treatment. So, in this aspect of clinical practice, there is a fixed “curriculum” of information that must be passed along to the patient. In other areas of practice, (besides that of informed consent) however, the doctor can and is free to take on a teaching approach based on transaction. Few, however, seem to do this. Even though some doctors state that they are holistic practitioners and focus on wellness care as much as on treatment for conditions, there was little evidence of transformative educational interventions, an approach that is characteristic of holistic education.

Key beliefs and feelings: Throughout the interviews, doctors were able to express their beliefs, feelings, and attitudes towards patient education in their own practices. Their comments and responses reflect how they feel or what they believe about the value, importance, and necessity of patient education, about their comfort and confidence levels while serving as patient educators, about what they feel is most important to and for patients, and how these views influenced the inclusion of patient education in their practices. To clarify this explanation, I shall provide just one example here. As will be seen later in this report and concerning this category, several of the doctors believed that, in their early practices, the best way to satisfy patients’ expectations was to achieve a quick resolution of their symptoms. To that end, the doctors felt it was best for them to focus on what they could do best, which was to deliver highly skilled
physical treatments. Patient education was often ignored, or minimized. Frequently, patients left the practice dissatisfied because the expected quick result was not achieved. This belief on the part of the chiropractors is one that eventually changed. Later on in their practice careers, as they became more experienced, the doctors realized that in very many cases, a quick resolution of symptoms was not possible. The value of patient education then became apparent to these doctors as they began to use this intervention to assist patients in modifying unrealistic or unattainable expectations.

Perceived barriers to effective patient education: Several barriers to the effectiveness of patient education also became apparent during the interviews. Some of these barriers were intrinsic in that they centered on the HCP and involved factors or elements over which the doctors had some degree of control. These elements included the HCPs’ beliefs and attitudes, time allocation, skills and expertise as a teacher, and their view of their roles as patient educators. Other barriers were extrinsic in nature since they could not be controlled by the doctors. These barriers centered on the patient and included patient time allocation and interest in learning, patient attitude, language and literacy issues, cultural and ethnic background and values, and financial issues.

Changes related to patient education: The final category includes the changes that the doctors made in the time between the first two years of practice and the present as well as possible explanations as to why the changes occurred. These changes may be specific to just one of the above categories or they may span several categories for the doctors who made broad-based changes to their beliefs and practices. Almost all of the participants made relevant changes related to patient education in their professional practices and this section outlines these changes and also provides, in some cases, the doctors’ own explanations as to why they made the changes.

Ethical Considerations

Three principal issues must be addressed related to ethical concerns of qualitative interview research. These include the matter of informed consent, confidentiality and anonymity, and institutional review and regulations. I discuss each of the three below and how they were considered in the development and progress of this study.

Informed Consent

While this study posed minimal risks to the participants, they still had to be informed of and protected from those risks that might potentially exist. Consent means little if the participants do not know or understand what is being asked of them or to what exactly they are consenting. The
participants in this study were both informed as to the risks, even though they were minimal, and the potential benefits of the study. They also needed to understand their role in the process and that they would be free to withdraw from the study at any time. To these ends, I sent each participant a letter informing him/her of the details of the study. The letter informed the participants of the purpose and intent of my study and outlined their role and time commitment. In order to complete the process of obtaining informed consent, the letter also provided the participants with the opportunity to ask any questions of clarification that may have arisen in their minds. Once they were fully informed as to the nature of the study, the conditions of the interviews, and the matters related to confidentiality, then I, as researcher, was assured that their signed consent to become a participant truly was an informed one. The participants also needed to know that this study did not intend to assess, evaluate, or make judgments on the quality of care provided in a HCP's practice. Nor did it intend to quantify the amount of patient education that takes place in a patient visit. Good or bad, effective or ineffective patient teaching was not for me to determine within the scope of this study.

Confidentiality and Anonymity

Further to this, I informed all the research participants in the above mentioned letter of the measures that were to be taken to ensure and preserve confidentiality. The identities of the participants were kept in confidence. In this report, referring to the participants only by pseudonyms that do not reflect their own names protects the identities of the HCP participants and keeps their information confidential. Only I have knowledge of the true identities of the participants.

Institutional Review and Regulations

The University of Toronto, as a research institution, has established a stringent review process and regulations that must be followed related to all research involving human participants. The appropriate ethics board reviewed my study. Data collection did not begin until the ethics review had been successfully completed and the study design was approved. All of the participants would have completed, in their pre-service education, a course on research design. They therefore had expectations and some information about ethical issues in research. Satisfying the university’s ethics requirements would be an expectation for the participants and they perhaps they felt more comfortable providing personal views and opinions knowing that a rigorous ethics process has been completed.
Chapter 4

Interview Analyses

In this chapter, I have written a detailed individual analysis of the interview responses of the eight participants. Each of the participants’ analyses presents the interview data organized into the same categories. I have tried to portray each of the participants accurately, using in many cases, their own words, descriptions, and explanations from their two interviews, even though I have sorted and organized their comments and ideas into the seven categories. These seven categories were discussed and explained in the previous chapter. For convenience, they are:

1) practice experience and patient groups
2) function of patient education: early years and current practice
3) the HCP’s role in patient education: early years and current practice
4) nature of patient education interventions: early years and current practice
5) key beliefs and feelings: early years and current practice
6) perceived barriers to effective patient education: early years and current practice
7) changes related to patient education

Amy

Practice Experience and Patient Groups

Amy was in her eighth year of practice when we met for her interviews. She has had only two different practice experiences since graduating from her chiropractic college program. Initially, she began working as what she called “an independent contractor” in an established practice, in central Toronto, operated by another doctor of chiropractic. Amy described this doctor as being a “holistic-minded chiropractor” which is relevant since she had an influence on the way Amy practiced at that time. In this practice, Amy worked with her own patients half-time and the other doctor did the same. Consequently, Amy had the opportunity to establish her own practice with her own patient load. Amy told me that she, “learned a lot from her (the other doctor) personally” and began to practice in much the same way as the other doctor.

About six years ago, Amy opened her own practice in a building not too far from the above practice. She had more space than she needed in the building and opened it up to other HCPs.
Now, there are several different health professionals in four different disciplines in this same building, but they all operate independently. Amy practices three days a week currently.

About her first practice, Amy said that it was, “a little more family oriented because it was more residential.” She would see people who worked at the end of their work days and at other times, she would see those who were at home during the days. Most of her working patients were in white collar jobs. Many of them had university degrees, although some did not work. The patient population was primarily Caucasian and all of them spoke English well.

Now, Amy said she sees patients between the ages of twenty to sixty years old. She does have a few children in her practice. About seventy percent of her patients are female and many of them work in the area. She told me that in general her patients are, “really educated, really smart, really into self-development…well-read.”

**Functions of Patient Education: Early Years**

In her first practice experience, Amy used small group classes for her patients. These were designed to teach new patients about her approach to chiropractic and provide them with some general chiropractic information. Amy acknowledges that there is an orthopaedic component in many of the conditions she sees and she does address this with her care. However, she also believes that there are other causes of the conditions her patients bring to her. Some of these, perhaps many, do have a mechanical orthopaedic aspect, but Amy also believes that other causes derive from chemical, emotional, as well as physical factors. In her classes, she taught this information to her patients so that they would understand her approach and how they could help themselves. She told me:

> When I first started, I did a class every week…a spinal health care class for my patients…Ideally, it was when they were brand new patients… Initially, I copied (my colleague’s classes). The three forms of stress – chemical, emotional, physical. I really talked a lot about that…

Amy did not use the informed consent process as an educational one to any great extent. She would have her patients read and sign the consent form. She told me that, “less than ten (patients) have had questions” about this process. Likewise, Amy did not see that patient education had a place in addressing problems with patients complying with her treatment schedule. She explained, “Probably at the beginning, I didn’t even want to deal with it (compliance). If they wanted to go, fine, I’d let them go. I wouldn’t try to wheel them back in.”

She did, though, use patient education to assist with the choice of treatments she used. She would explain to patients the various treatments available and then allow them to reject any with
which they were not comfortable. Some patients are apprehensive about spinal adjustments; some are apprehensive about cervical (neck) adjustments. If, after her explanations, a patient did not want to have his/her neck adjusted or manipulated, then Amy would provide alternate treatment, although she would explain to the patients what types of treatment she would recommend. About her patients influencing the choice of treatment, Amy said, “I always respected what people wanted. So if they didn’t want to have their neck adjusted, I’d use activator (a hand-held device that delivers small, directional forces to the spine.)”

After practicing for a time, Amy began using patient education to try to teach patients to understand the scope of chiropractic care. She felt that many of her patients had a limited understanding of the range of conditions for which chiropractors can provide effective care. She would feature, or focus on, various conditions and ask patients if they knew someone with one of those. Then, she would use this as an opening to explain to the patient how chiropractic care could have a positive effect. She explained this patient education function telling me:

There was a period of time when I just did conditions to educate them (patients). Patients think chiropractic is good for this condition, but not for that. So, to overcome that, we would always put up ‘Who Do You Know?’ For example, ‘Who do you know who has headaches?’ Next month, ‘Who do you know who’s pregnant?’ Next month, ‘Who do you know…’ who has this, has that? The idea was to expand what chiropractic was and what was possible with it.

Unlike most of her colleagues who participated in this study, Amy did not see that patient education played much of a role in patient satisfaction or in establishing appropriate patient expectations, except for one area. She felt that the greatest influence on patient satisfaction was not how well or how much she taught them, but rather the rapport that she established and maintained with a patient. The only aspect of patient expectations she felt had to be addressed was that of the duration of care. When I asked her about whether she found that patients came in to her with unrealistic expectations, Amy told me:

No. I’d say the opposite. Like what is actually possible and what people had experienced, I don’t think they ever had expectations wrong, for the most part…I guess I did educate them on time. Like healing time. Every process takes time.

**Current Practice**

When Amy discussed how she perceives the function of patient education in her current practice, she told me that it is an integral part of the care she provides for her patients and is included in all aspects of her services. Amy feels that her patients in her practice experience a
very non-traditional form of care. Hence, she uses patient education from the first patient contact to assist in preparing patients for what they will experience. In this regard, she tries to teach patients, through various means, what to expect from her and from her care. She said about patient education now:

> It’s in everything I do. It’s a component of everything, at least I hope. Like I said, from the way the first phone call is handled, from sending them to the (practice’s) website, to having them watch the video, filling out the forms, before they even walk in the door, they have quite a clue about what they are going to expect…and it’s going to be difficult from going to a medical office and it’s maybe different from another chiropractor’s office.

Amy feels that patient education is useful for teaching patients about the different causes of stress on their bodies and also explains to them about the concept of subluxations and how these can interfere with health. Subluxations in the chiropractic paradigm may not be easy for patients to understand and hence, Amy uses various forms of patient education experiences to try to have them learn and understand this concept and what her role is in addressing these. She uses an extensive patient questionnaire to begin to teach patients about the various concepts she is trying to convey by asking about a series of specific life aspects. This helps the patient focus on these and also assists with the establishment of individual patient goals to be achieved from her care. She went on to explain:

> …my questionnaire talks a lot about emotional, chemical, and physical stress. And when they come in the office, all the paperwork follows that kind of philosophy, so I actually tell them that I am looking for subluxations and I tell them what that is and they actually read what that is, even before I do the (physical) exam… (the form) is a personal history and asks not only about those three stresses, but it asks specifically to rate a variety of other life things on a scale from one to ten. Energy, concentration, memory, focus, sleep patterns, social life, career, nutrition. So they rate all those things and what they would like to have as a goal.

The obtaining of the actual informed consent process, per se, is not an important educational opportunity for Amy. She feels that by the time patients have come to this point, they have already been taught about her care and what to expect from her. Consequently, she told me that she uses a standardized consent form prepared by one of the chiropractic bodies. She also mentioned that, “maybe like one out of forty or fifty (patients) want to talk to me about it.” In these rare cases, she has patients delay signing the consent form until their questions have been addressed.
For Amy, in her practice, patient education is important in giving patients the knowledge to help manage their own health. She feels that if she has been able to teach patients well, then they will know how to keep themselves healthy and also when they need to come in for treatment. Amy told me that if she is successful in teaching this to patients, they will know almost instinctively what they have to do in order to keep themselves well. When I asked about this role of patient education, Amy explained:

- If I could get them to learn it on a ‘gut level,’ that would be my preference. Like an educational thing. If you’re feeling under the weather at all, that’s not when you don’t come in for your adjustment. That’s specifically when you do come in for your adjustment. That’s a little piece of education.

Patient education is also important, according to Amy, for helping to establish and reinforce in patients the positive results that come from effective chiropractic care. She wants to teach patients not only to notice positive changes in their health and well-being, but also make the connection that these changes were the result of their care. When I asked Amy about using patient education to help patients see the cause and effect connection, she said:

- Absolutely. Yes. It’s definitely learning. That’s like the whole key to education in a chiropractic office to me. To have them (patients) make the connection. So, it’s not just, ‘Right now I’m feeling better.’ It’s, ‘Right now I’m feeling so much better because (of the chiropractic care).’ So because they are under chiropractic care, then they started to learn a bit...because we’ve had all these interactions...The first thing about patient education is connecting what their results are to their chiropractic care and then making that togetherness.

Amy also believes that patient education has an important function in not only teaching patients about the benefits of chiropractic, but also in helping them learn about the full scope of chiropractic care. Doing so can also be an effective business strategy in that patients may be encouraged to suggest or recommend chiropractic care to their friends and family members. She does this by promoting the sharing of positive experiences by her patients. She explained these roles of patient education in her current practice:

- Whenever someone has a ‘win’ – these are like referral strategies in a way – we talk about it again and again, but in different ways looking at a different perspective. And, ‘Have you shared that with other people? What do other people say when you tell them?’ So, education, too, is for them to go out and educate the public about what chiropractic is because there is so much misunderstanding about chiropractic. So a big purpose of my
educating them is so they will go out and tell other people that real story – their story – which is their real story.

Finally, patient education, for Amy, is also important in specific situations with some patients. When patients have serious or degenerative conditions, she tries to teach them that the condition could worsen despite her care. On the other hand, she also explains to patients with these conditions that continued and regular chiropractic care could slow or even reverse the conditions. She feels that patient education has the role of allowing patients to make treatment choices about how they want to address their conditions. Amy told me about this aspect of patient education:

When things (patients’ conditions) are that bad, you have to convey it to the patient so they know right now there’s a possibility of something and you don’t necessarily have to go down that road. I’ve seen degenerative conditions reverse…It’s not for me to have them act on it, but it’s for me to at least convey that at least there’s a possibility (for improvement of the condition).

The HCP’s Role in Patient Education: Early Years

When beginning her professional practice, Amy was influenced in her approach to patient care both by her chiropractic college curriculum as well as the doctor in whose office she was working. While her college took what could be considered a relatively conservative approach to chiropractic that focused on an orthopaedic model, her colleague in practice had a much broader view of chiropractic care taking a more holistic approach to health care. Both of these avenues can be successful in caring for patients. Hence, Amy tried to encompass elements of both in her patient education. She told me that she saw her role as an educator for her patients as one in which she would transmit a great deal of information to her patients. At that time and as a new practitioner, she did not have her own patient education role completely sorted out. Nor did she have her approach to chiropractic care completely organized in her mind. She felt that it was necessary to deliver a great deal of information to patients in order for them to understand what she was telling them. Amy told me about her ideas related to her patient education role:

I don’t know what I thought, but what I did was like dump a lot of information on them (patients)…and I think it was too much…at the beginning…I felt like that was required in order to have them ‘get it.’

In her first years of practice, Amy would very occasionally see patients who came to her asking questions or wanting to find out about information related to their care from other HCPs. While some of her colleagues in this study indicated that this was a fairly frequent occurrence for
them, Amy told me that for her, patients came asking her for this kind of information, “Sometimes. Not very often.”

**Current Practice**

Now in her practice, Amy sees her role as a patient educator as one in which she teaches her patients what is possible through chiropractic care and her view of this goes beyond simply a successful resolution of a patient’s current problem or condition. Taking a holistic approach to the care she delivers and the health improvement opportunities she offers to patients, Amy now believes that she should be educating her patients so that they can, if they wish, take full advantage of these in improving their overall health. She explained her thoughts to me saying:

…I understand much more now…If you don’t tell them (patients) what’s possible - it’s up to them to choose to do it or not do it – but this is an education thing I understand now. That it’s not for me to tell them to do it, or not to do it. It’s for me to tell them what’s possible, and it’s for them to choose. Whereas before, I wouldn’t even tell them what I thought was possible.

Amy went on to tell me that she does not feel that she should measure her success based solely on patient outcomes. Rather, while this is a factor, she wants to use her teaching role in order to educate patients on how much they can gain from her care and then letting the patient choose how much or how little to commit to a specific goal. Her role is one of opening the patient’s eyes to what is possible and then, having empowered the patient as a partner in the care, she lets the patient identify personal goals and commitment to achieve these. Amy discussed this view of her patient education role and how it can have an effect on a patient’s quality of life:

Now I kind of work on ‘take no credit; take no blame’ philosophy, but before, I took a lot of things personally, and I only wanted to do the best for somebody. What I’ve learned is that I cannot be married to the (case) outcome. I can only give this person the best that I can give them on this day and be present with them, and do what I can do. The outcome, I can’t say. I’ve had crazy things happen to people where I would have never said, ‘this is what’s possible for you.’ But they are like, ‘Is this possible, because this is what’s happening to me?’ … I want to jump into the more meaningful stuff in people. Now I want to help people find bigger things, like the work that they are going to love.

Amy believes that her role as a patient educator goes beyond the traditional role of a health care professional. She often spoke of her preference to use the term “inspiration” instead of education when discussing her teaching role. She felt that this would better encompasses her
holistic views of health care and about chiropractic specifically. When I asked her about her perceptions of her patient education role in her current practice, Amy told me:

I don’t call it that any more. I really have been trying to shift it to thinking about inspiring them (patients) and not educating them…for people to get the really big picture, it’s more of an inspirational thing than an educational thing… I don’t really look at it as education any more, even though it may be. You know, if you look at something in a bit of a different way, it just gives it a different spin. My hope is to inspire people around chiropractic.

Amy continued her explanation telling me that she wants to inspire people, “to see what they can be.” For her, this goes much beyond just delivering physical treatment as a chiropractor. Given that she believes that there are physical, emotional, and chemical stressors in our lives, she wants patients to understand how they encounter these in their daily lives and what they can do to minimize their effects. She told me about some of her patients who changed their jobs based on their understanding of how the job contributed to the above stressors in their lives. Amy said that when she sees someone who is in a very poor situation, she gets excited since she knows that there are a great many gains that can be made with that patient. She told me:

When people first come in, the worse they are, sometimes I can almost not jump out of my seat, because I’m so excited because I know what that can be and so inspiring them to be what they can be – like way beyond ‘this doesn’t hurt any more.’ So, I talk to them about what I consider the big picture a lot, which is social well-being, physical well-being, chemical well-being, career well-being. It’s that. And some people are really into it, so I’ll talk it up even more. And some people are very black and white and they just want it like that, and I’m glad to go with what they want, right? So, I feel out the waters. Go along with what they value. And go along that path…I’m almost a coach, in a way.

Nature of Patient Education Interventions: Early Years

Early in her professional experience, Amy emulated some of the practices of the doctor in whose practice she worked. This doctor held weekly small group classes for her patients as a part of the education process. As these seemed to be successful, Amy began offering these classes, too, with the encouragement of her practice colleague. While these classes were designed for new patients in her practice, sometimes patients would not attend until later in their program of care. These classes, often an hour and a half long, introduced to her patients Amy’s concepts about chiropractic care at that time. The class content dealt with general health and chiropractic care information, not with the specifics of individual patient cases. The content was the same in each
class. Amy mentioned to me that she felt this was important for both the patients and for her. While she said that patients often asked quite a few questions, her patient instruction at this time in her career seems to be one that is of a transmission nature. She told me about these classes saying:

When I first started, I did a class every week – a spinal health class for my patients. Initially, I copied (the other doctor’s) – the three forms of stress: chemical, emotional, physical. I really talked a lot about that… I needed to do that same class every week for myself. Sometimes new patients (would attend) and sometimes when they were more into their care.

Amy recounted to me her recollection of one her classes that still stands out for her. Her classes were centered around a set of slides which she would project for the group of patients. During one of her classes, the projector broke down and she had to react quickly so the group’s time was not wasted. She adapted her class and found that it was one of the most enjoyable she had taught. Amy also felt that the patients also enjoyed the experience. She related her memories of this one class to me:

I remember the best class I ever gave. Probably the biggest class, just by fluke, and the slide projector broke. And I gave the whole class by holding up a slide, reminding myself of the slide, and then passing the slide around. And it was the best class because I had to do it on the fly and it was unusual. I created a lot more interaction among the people and it was way more fun. That was the best class I ever gave, and the most fun. A lot of the people in that class ended up being patients for a long time… It was a lot more interactive. I was probably more relaxed. I was having fun. I was less serious.

The group classes included general information that would be useful to most, if not all patients. Amy also needed to address individual issues for each patient. In her first years of practice, she did this through a summative report of findings after her history taking and physical examination. The report was often just a set of brief handwritten notes for the patient. Amy also used an approach to patient education which she called “bait and switch.” With this approach, she addressed the patient’s most important problem and then, once having the patient experience some success, she then went on to suggest other areas that could also be addressed. Amy explained some of this early patient education:

Before, I did more like a hand-written report of findings. I explain chiropractic from the beginning. There’s an expression ‘bait and switch.’ I used to do it, but not know I was doing it. They’d come in to fix X. I’d fix X and then tell them there’s also this Y. and now we can do all this b,c,d,e,f,g… And so, it’s up to you. We can address it all or not.
At this time in her career, Amy used a few educational aids. She told me that she used spine models that showed different stages of degeneration. Amy also used wall charts to help illustrate the information she was trying to deliver. She said that she occasionally used informational pamphlets, “…a little here, a little there.” Amy also said that at this time, she did not use any technological means of teaching her patients.

Amy did experiment with different ways of delivering information to her patients. For example, she collected a file of information on different topics which she would post in her waiting area for patients to read. This material was frequently changed so patients would often see new and different information and ideas. This material tended, according to Amy, to be quite general and not necessarily specific to any one patient. She told me that she had:

…a file of information from other doctors…we did so much (educational) stuff. I had a patient of the month up every month; that was an educational thing – testimonials. I would do contests, monthly themes. We would develop like a lot of that stuff and I would constantly ‘steal’ from other people (HCPs) – the patient media – I would put that in…I’d put up research stuff. People don’t like that as much – only if it’s super simple. A lot of times, I’d put this (information) right on the front desk with a flipper (small flip chart) so they can look at it while they’re standing there.

**Current Practice**

Current patients in Amy’s practice begin their learning even before they come for the first appointment. She has developed an interactive web site for her practice which she uses both to educate patients and to collect information from them. When patients call for an appointment, Amy’s chiropractic health assistant (CHA) begins delivering some educational information to the patient over the phone. In addition, patients are instructed to visit the web site and view a short video about what they can expect from their early visits. Patient history questionnaires are also completed online prior to the first visit. Amy feels that this approach to teaching her patients is effective based on her feeling that she now gets very few patients who just come in for a ‘quick fix’ treatment. She explained this approach to me:

(patients who say) ‘Just crack me; I don’t want to know.’ I don’t feel like that happens very much any more. Back then, definitely (it did)…Before they come in, they’ve already been educated on my web site. They fill out the paperwork and watch the video (both online) before they come in. And my CHA is trained to speak to them in a very specific way, whereas before, that wasn’t the case.
When I asked Amy if patients knew why they had to complete the extensive questionnaire about their health and life issues, she told me that they did not yet have this understanding. She takes the time to go through this explanation on the patient’s first visit to her. Once the patient is comfortable and opening pleasantries have been completed, Amy begins teaching the patient about what she plans to do and how she will accomplish this, often through making analogies to help the patient understand the human body. For example, she explains a chiropractic subluxation by using a traffic analogy. Amy said she continues her explanations during her physical examination telling the patient why she is doing a test and what the finding may mean. She outlined some of this process to me:

They come in and we have our little connection and I just let them talk about whatever’s going on for them. When they are finished talking, I say to them along the lines of, ‘Let me tell you for a minute to tell you about what I do and how I go about doing it.’…the nerves go from your brain, down your spinal cord through your arm to your hand. And you can imagine this is like a highway. Chiropractors look for traffic jams on that highway. If you have traffic jams, it’s something I’m going to be able to help you with. We call those traffic jams subluxations… We go into the examination and I’m educating them during the exam… ‘The reason I’m doing this muscle testing is because those muscles are supplied by nerves that come from here. The reason I’m checking your reflexes or your sensation is because of that (reason).’

Amy also spoke about the evolution of her website and how it has changed since she first put it on line. She is making what she believes to be effective use of newer technologies in order to assist with her patient education process. The earlier versions were not interactive. Now, in addition to using her website to educate new patients, she also uses an online service to help to educate her continuing patients with information and questions for them to answer. This service prompts patients to go to the website to answer questions and also sends feedback information to Amy about each patient’s responses and comments. About how her site has changed and how she uses it, she said:

I had a good website before that was not interactive. This one’s much more interactive and it’s quite good, but not the ideal website. It has a really good video on what to expect. It has all my forms on it. It has a really good thing about who I am…Everybody who is a new patient becomes a member. In the first few months of membership, there’s a little link and they go through their questions. It’s a Socratic method of learning. They give you (the patient) a little spiel and then you answer a, b, c, or d. If you answer right, they tell you why it’s right. If you answer wrong, they tell you why it’s wrong. And you
have about five questions that take about two minutes and you get that every week for the first X number of weeks. There’s different levels of patient (questions) – the new patient, the kind of middle of care, and there’s the wellness patient. They get different questionnaires, Socratic questionnaires…They (patients) get an e-mail with a link and then I get feedback on whether or not they have completed them (questions). I also get feedback on their feedback. They are feeding back to the website, ‘oh, this stuff is bullshit,’ or, ‘this stuff is great.’ And I get it back. Sean thinks this is BS and Joanne thinks it’s the best thing of all time. That lets me know how to deal with Sean and how to deal with Joanne, and they (the service) actually make recommendations on how to deal with that person.

Now, in her practice, Amy’s patient education is somewhat different from her early years in that now she tries to focus much of her teaching on a patient’s individual case whereas before, she would deliver information that would not necessarily be specific to one patient. She tries to point out the changes that she finds in her examinations and use these to guide her patient teaching, linking the changes in a patient to chiropractic care. While this instruction is individualized and based on each patient, she still uses a teaching approach that is essentially transmission, with information flowing from her to the patient, but she moves towards transaction with some patients and perhaps even extends to a transformation approach on occasion. Amy explained her teaching to me and what an encounter might look like:

When I was doing patient education then (early years), I was never using their changes, whereas now, I am constantly talking about their body, their stuff, and what’s changing there…you come into a person and you connect with them. You tell them what’s going on from your perspective and really going with your gut on, ‘oh, you are having this, having that’ and nine times out of ten you hit it if you are focused because then you are present with the person…And then I say to them, ‘I want you to notice the difference between walking in and walking out. Can you breathe now?’…I much more pointedly now connect with their positive experiences and link them to chiropractic, whereas in the past, they would have had positive chiropractic experiences and I’d go ‘That’s great.’ And they would go.

Amy continued to describe the kind of learning experience a patient might have while under her care. She mentioned that she tries to ask questions that are more specific and related to the individual. Then she selects or modifies the information she decides to teach to that patient. In her early practice, the information she would present would be more general; now she tries to base her information on the individual needs of the patient. This seems to be teaching that results from
a transaction with the patient and depending on the situation, could also extend to becoming a transformative teaching experience. Amy explained:

…the whole thing about ‘do they get things visually; do they get things auditorially; do they get things kinaesthetically?’ I knew I should figure that out…Now I ask more pointed questions in those regards. As I grew in practice, I tried to understand the receiver of the information. And I change the information to more meet the receiver, whereas before, I was just ‘bang’ whether you received it that way or not.

Besides using her website and on-line service, Amy also uses a few other educational aids to assist with her patient teaching. Much of her patient education is done through verbal explanation. Also, she does now print out an individualized report of findings for patients on their second visits. In her office, she uses posters with spine models and x-rays, both the patient’s own and normal films, to help explain information to her patients.

Amy feels that she takes a holistic approach to chiropractic and health care. While she uses an orthopaedic model to explain and address some conditions, she also told me that she goes well beyond this limitation and tries to provide care and help that will have an effect on her patients’ health and lives. She told me about what she feels would be her ideal interaction with a patient in her practice. When she comes close to realizing this ideal, her patient education could be seen as transformative, or at least approaching this level of teaching in which the patient education aspect of her care moves towards becoming holistic and concerned with the whole person and not just the condition. She went on to relate her ideas on this to me and how she tries to be proactive in helping patients make connections between improvements and her treatment:

In my perfect world, in my perfect chiropractor-self, I know exactly what to do; I just can’t do it every day. I really work towards that. I would connect with the person (patient). I would be completely present. I would feel exactly what was going on with them, to the best of my ability. I would convey that to them. I would tell them something about themselves that was true. I would clear (treat) it. I would show them the difference between clear and not clear…I would teach them the difference between functional balance and structural balance. So, in my ideal world, I would send them off with, ‘OK. I want you to look, when you are at work, and see how much more present you are. See how much better your memory is this afternoon. See how much calmer you are with your children today.’ And I would plant a seed every time.
Key Beliefs and Feelings: Early Years

Amy, even when she started practice, believed that patient education was very important in the care she provided. While she had little experience on which to base this belief, she was influenced in this by the doctor in whose practice she worked and some of the practice management seminars she attended. Both of these influences convinced Amy of the importance of patient education, even though she told me that she thought that patient education was important:

Because other people told me it was. That’s the real answer…When I started, I didn’t know anything (about patient education)…Coming out (of school), what I so take for granted now, I didn’t even get that. I didn’t get the connectivity of it. I kind of trusted that what (her doctor colleague) said would happen, did.

Related to this, Amy did not have a high level of confidence as a clinician and teacher. She said that this was due to her lack of clinical experience and not knowing the extent of what could be possible through effective chiropractic care. Amy knew that she wanted to have a wellness based or holistic practice, but her own lack of experience was a causative factor in her low confidence level. Amy explained her early feelings and how her feelings and confidence changed saying:

I think I was in the process of trying to achieve a really wellness based practice. I always had to overcome my own discomfort. It was always a battle against my own stuff, which I feel is imparted by a kind of fear in my education. So, I had to overcome that. Because of visits to chiropractors who looked at what is possible, over the years, I just got more and more confident. I was less confident then. So, while I had a lot of ‘book smarts,’ I didn’t have emotional, spiritual smarts about chiropractic. And so, it was always overcoming what I felt uncomfortable with and then I’d get more and more comfortable as the years went by.

Amy, in her first few years of practice, believed that the influence that would affect her confidence level the most was whether or not a patient stayed under her care. Patients who remained in her care reinforced her clinical approach and served as an indication to Amy that she was doing something right and this would have a positive influence on her confidence. On the other hand, if patients left her care, then she felt the opposite. Amy recounted her thoughts on this measure of success:

…the only thing that would change my confidence at that time was if people stayed under care. If they didn’t stay under care, then it did not help her confidence. I tied my confidence to people’s results and whether or not they got it then. I’m less like that now.
Current Practice

Now in her practice, Amy has some very strong feelings about chiropractic and how she chooses to practice. She feels that while chiropractic can be useful for acute injuries and orthopaedic problems, she also believes that it can have effects that extend much further, perhaps even influencing many quality of life aspects. This belief has a great effect on what and how she tries to teach her patients. Amy explained this philosophy or belief to me:

My practice isn’t in any way an acute care practice. I’ve been looking after people for years and years and I’m under care myself for twenty years, so when I talk about the benefits of chiropractic, I’m talking about how it can elevate your entire life style. So a lot of the things I focus on are energy, concentration, sleep patterns, the ‘happiness factor’ at home and at work, and how to elevate all of that. And that’s the enjoyment of chiropractic for me.

Amy has also spent some time reflecting on how she practices both as a provider of physical care and as a teacher for her patients. She believes that she has become much more competent at being a clinician and has divided her progress into various phases that are characterized by different levels of competence. Amy feels that when she started practice, she was barely competent by her standards. Now she feels that she is much more competent and sometimes even expert, although she resisted using that word. Amy explained how she categorized her levels of competence as a health care professional:

I look at it like unconscious incompetence, conscious incompetence, conscious competence, and then unconscious competence is the highest level. First you have no clue. Then, you have a clue that you have no clue. I was at unconscious incompetence for quite a long time, and then I was also at, and still am occasionally, at conscious competence. And quite a lot of the time, I was able to get to unconscious competence, but I’m constantly back and forth between those top two.

Amy also has strong feelings about how we as a society educate people to view health care. She feels that people in general are taught that they should be willing to put responsibility for their health in the hands of health care professionals. People, she feels, have learned to value the taking of short cuts to get the desired results. If people are in pain, they take a pill. If an athlete wants to improve, he may take drugs. Amy feels that this view is opposite to her own philosophy regarding chiropractic and how it can enhance one’s life. Her view of the possible wide-ranging benefits of chiropractic is shared by some, but not all chiropractors. When I asked her why she thought patient education was so important, she explained her thoughts on this saying:
People are anti-educated in chiropractic philosophy. They are educated that if something hurts, take a pill, or don’t take responsibility, or somebody else will fix me, or it’s like totally the opposite philosophy (from mine). And I think chiropractic philosophy is a really nice way to live your life. A lot of people don’t even know that other things exist. So, when I find out that something exists that resonates with me, I would go for it. It’s also like the possibility of them looking at a higher level of expression of their life.

Tied in with this view of chiropractic, Amy believes that the key to successful patient education is being able to have an effect on patients’ value systems. If she can find out what a patient values, she may be able to use that knowledge to shape her approach to educating the patient. Amy seems to have learned, through her experiences, that effective education involves more than just having a patient acquire new knowledge and skills; she also believes that effective patient education causes patients to internalize the information which could also influence what patients value. She acknowledges that patients may still learn information or skills that could be useful, but the real power of education is its ability to have a positive, and perhaps emotional, influence on one’s value system. She offered a few comments on patient education and patient values saying, “They have to emotionalize it. They have to emotionalize it and connect it to their life experience in a positive way that will have the greatest impact.”

Now, Amy judges her own success and confidence based on feedback she gets from her patients. When patients tells her how they may have explained their experiences, or explained chiropractic to a friend or relative, Amy feels confident that she has indeed made a positive influence on the lives of those patients. She tries to encourage patients to share their personal stories amongst themselves in her office and when this happens, she feels encouraged and confident that her interventions have been successful since she hears patients tell about how her chiropractic care has had a positive effect, not only on their conditions or injuries, but also on their lives. When I asked Amy to tell me how she now feels about her confidence as a patient educator, she told me:

When I feel confident is when I get a story back from somebody about how they explained chiropractic to somebody, or what they experienced that linked it. That’s when I feel confident. Not in my delivery of it, but in my receptions of their story. We try to promote like a community in the reception area where people are talking to each other, so often, if I have a patient coming out and I have a patient who’s been there for a long time, I’ll introduce them and say, ‘Can you tell your story to her?’ I enjoy listening to that.

Finally, unlike some of her colleagues who participated in this study, Amy is unsure as to the connection between her patient education efforts and patient satisfaction. She agrees that patient
satisfaction is an important parameter as it is an indicator of how well she is doing her work and also a factor in having a successful practice. Some of her colleagues mentioned that they thought patient education was a key factor in influencing patient satisfaction. Amy is not quite as certain about this connection. She explained her thoughts on this possible connection:

If they (patients) feel loved by me and cared about by me and cared about by our office, and if they feel like they’re at home in my office and that they matter, they’ll have a high patient satisfaction. And if they don’t, they don’t. And as to how much of that is education, I’ve got no idea.

*Perceived Barriers to Effective Patient Education: Early Years*

In her first years as a health care professional, Amy remembers encountering factors which served as barriers to the patient education she was trying to accomplish. Some of these were related to the patients themselves or influences on their lives. For example, Amy feels that the world, or our society, is a source of barriers to effective patient learning. When I asked her about her perceptions of patient education barriers in her early years of practice, Amy explained her views recalling that one of the principal barriers was the:

Outside world. So much negativity. Now I pay it almost no mind…but before, I felt like I was constantly battling against everybody… Every five or six patients is a scared person…they have to overcome their own stuff. I didn’t understand that before.

Some of the other barriers Amy encountered involved patients not allocating enough time to spend with her and patients who had attitudes that interfered with their ability or willingness to learn from her. When I asked her about patients making time for her educational efforts, she said, “I had time, but a lot of people wouldn’t make time to come to the class.” She continued to recount examples of patient attitudes that got in the way of the effectiveness of her patient education. Amy told me about patients with a resistant attitude who would say, ‘Just crack me. I don’t want to know.’ “I don’t feel like this happens very much any more, but back then, definitely.”

Amy also recognized that some of the barriers to effective patient education derived from her and her lack of knowledge and experience when she was a new health care professional. She did not understand how to find the best route through which to educate her patients and she tended to use a one dimensional as opposed to a diversified approach in her teaching that was based on patient learning preferences. Amy explained that she did not know that one key to successful patient education is linking the education to a patient’s values and without this link, her education efforts might not be very successful. Amy offered a few comments on her recollections:
I didn’t know that (the importance of patient values), number one. And number two, I didn’t begin to know where to ask, to begin, and I didn’t understand tying in to what they (patients) value. If you tie something in to what they value, then they are going to learn, to want to learn. Then the whole thing about (learning preferences) do they get things visually, do they get things auditorially, do they get things kinaesthetically?

Current Practice

Patient-related barriers that interfere with the effectiveness of Amy’s patient education still exist in her current practice experience. She feels that one of the major hurdles that she as a teacher has to overcome is to try to counter the effect of patients having unsupportive friends or family members. She knows that some of her patients encounter people who feel that chiropractic or the information Amy is teaching is without value and the patient is wasting time and money being in her practice. While she may see a patient only a very few times each week, the patient likely has more frequent contact with the unsupportive person or persons and frequent reinforcement of their feelings to the patient creates a hurdle which would need to be overcome for patient education to be effective. Amy told me about her perceptions of this barrier:

You know what the biggest one (barrier) would be? If they have an unsupportive family or spouse. And I don’t mean just unsupportive. I mean like anti-supportive. That’s probably the biggest barrier… Imagine like you’re trying to do something for someone and every time you go home and the person tells you you’re nuts, and you’re going to hurt yourself, and you’re going to cause a stroke…I’d say one out of every fifty (patients) have a major problem, like have a support person, or a mother, like, ‘whatever you do, don’t let them (chiropractor) touch your neck.’ Like that kind of (negative message).

Amy still encounters barriers based on her ability as a clinician and teacher. While she realizes the importance of making her teaching relevant to patients by trying to link what she is teaching to the values of patients, she sometimes has difficulty doing this. One of the problems comes from trying to identify what it is that each patient values; the second difficulty is trying to adapt or deliver the educational information in a way that successfully links it, in the eyes of the patient, to the relevant value or values. Amy explained her understanding of this barrier saying:

It’s of utmost importance to identify what that person (patient) values, and if you can figure out what they value and connect their care to what they value, then they always want to hear about it (educational information). But if you can’t figure out what they value – and that took me many years and I’m only moderately good at it now – but I
couldn’t do it all…I would love to be the perfect communicator. That question is, if I can figure out what they value, I can communicate with them; if I don’t, I can’t.

Her own time during the clinical day could be a potential barrier to patient education effectiveness and Amy recognizes this potential difficulty. She told me that she has developed what she feels to be an effective strategy to deal with this potential barrier. If she does not have enough time to address all the patient education she feels needs to be done during a patient appointment, and if she is in the midst of a busy part of her appointment schedule, Amy offers the patient an opportunity to return to her office later in the day when there is a time window and she will spend the needed time with the patient. She told me about this scheduling strategy:

If I don’t have enough time, then I’ll invite them back later in the day when there’s a break. Or, you know in Star Trek when they talk about ‘the one and the many’?

Everyone’s scheduled and everyone has a time. If somebody comes in and they need more time, I want to spend more time, but I can’t spend more time now or I’m going to take away time from other people. So, I think they are pretty clear on that. So, I’ll say, ‘Go out and see (the CHA) and find out when you can come in.’ So, I put it out there to them and it’s up to them to chose to take it or not. There’s only a certain amount of time.

Changes Related to Patient Education

Since beginning her chiropractic practice, one of the main changes related to patient education that Amy has made relates to her belief in the importance of patient education. Amy said she always felt that patient education was important, but the reason for this feeling has changed for her. When she started, she was told by her more experienced colleagues that patient education was a valuable component of her care. Since she respected and trusted these colleagues, she adopted this belief because they told her it was so. Now, Amy has her own professional experience and confidence on which to rely and help with her own beliefs. She said that now she still places a very high value on patient education because her own experience tells her it is important. She commented on this change saying about the importance of patient education:

…because other people told me it was. That’s the real answer. Now, I actually really believe it whereas before it was kind of like, this is what they are telling me… I’m more experienced now, not with doing it, but with the results of chiropractic. I have more confidence in chiropractic…I feel more confident at it now. I believe it more. Like it’s more truthful now than it was then. Like, I never felt that I wasn’t telling the truth, but now it’s more like I’m in the know.”
Amy also has made some alterations in her approach to the timing of her patient education focus. Initially, she did most of her teaching very early in her patients’ courses of care. She concentrated much of this teaching in her small group classes. Now, she continues with patient education throughout the weeks, months, or years that patients are in her care. About this change in when she teaches her patients, Amy said:

When I first started, I felt that my role was really to do it (teach patients) at the beginning and now I feel that I do it all the time. I did it all at the beginning and then never did it again, or rarely did it again. My hope is that every visit is an inspirational, slash educational, visit.

Even though Amy does much more patient education now, and this extends all through a patient’s course of care, Amy feels that she finds patient education to be much easier for her at this time in her practice. Before, Amy viewed patient education essentially as a finite task that took place early in the doctor-patient relationship. Now, it continues as long as a patient is under her care, but for Amy, this teaching responsibility seems to be less difficult. When I asked her if patient education was more or less difficult for her now, she told me, “Oh, much less (difficult). Like, it’s much easier now.”

Amy explained that her current view of patient education has also changed. Now she sees it as an integral part of her practice and one that is difficult to separate from the other components. She feels that because of this integration, patient education is less of a challenge to her than it was in her first few years. When I asked about the level of challenge she now finds with teaching her patients, Amy said that it was:

Less (challenging). It’s like my new behaviour. It’s my behaviour in practice. So, I’m not trying to do it. I’m just doing it because that’s part of how I do it (practice). I use muscle testing and that’s education, right?

Finally, Amy offered some reflective thoughts about her own personal and professional growth. She said that she feels like she is a work in constant progress, constantly changing. When she looks back at her practice, Amy feels as if she was constantly searching for new information that made sense and seemed valuable to her. If it did, she tried to incorporate some this new information into her practice. Amy told me:

The only thing is that I feel I’m a constant work in progress. I’m constantly striving to do things better…I feel that everyone deserves to have the whole kit and caboodle and I want to have it at a higher and higher level all the time…When I started, I was doing everything. But what I was actually doing was I was trying to find the pieces that fit me. So I was doing everything. And then slowly, I was figuring out what resonates right with
me. I always tried other people’s stuff and I (asked), ‘Did it feel good? Did it not feel good? Why is this working for so many other people and not for me?’ Because I didn’t like it and it didn’t suit me…I would go to people for information. Take it in. Make it my own. Try to use it. And that’s just how it’s been.

Don

*Practice Experience and Patient Groups*

Don was in his eighth year of chiropractic practice when I interviewed him and he had quite a varied range of practice experiences since his graduation. Prior to going into his own private practice, where he had been for four years, he spent the previous four doing locums, that is, filling in for chiropractors who were temporarily away from their own practices. Most of these placements were brief, usually one to two weeks long. Don mentioned that he often returned to the same practices a year or so later and sometimes treated the same patients again. Most of these locum placements were in smaller communities in Ontario and he noted that patients in these towns and villages did have much less choice when it came to the selection of health care professionals than people who live in larger urban centres.

At the time of our interviews, Don was practicing in central Toronto in a relatively affluent area. He describes his practice as a “generalized practice” where he sees a broad spectrum of patients. While he does see some children and seniors, the majority of his patients fall into the thirty to fifty year old age range. About seventy percent of his patients are women and he estimates that two thirds to three quarters of his patients had been to chiropractors prior to coming to him.

Many of his current patients have at least some university education and he describes them as “white collar” workers who are subject to a great deal of stress in the workplace. About his current practice patients, he says they are, “…more strapped for time and money” compared to his previous small community patients.

*Functions of Patient Education: Early Years*

In the first few years of practice, Don felt that he was “playing a role” in the practices he was visiting; he was filling in for the absent doctors and so he tried to adapt the way he practiced to emulate or imitate, as best he could, the way the regular doctor practiced. Thus, he did not delve deeply into patient education issues and his teaching usually involved just delivering, “general information” and answering patient questions if they were asked. He restricted his educational
efforts to information to patients about, “...why you got into this situation and what you can do at home.” He explained that, “this would be something across all health care providers; you’re supposed to educate them generically about their body (and how) their activity level may affect them...” Essentially, in his first years of practice, Don viewed patient education as an, “...adjunct to therapy or to make someone aware to consent to a treatment.”

While admitting that this was a rather superficial approach, he also explained he was not certain as to the limits of his own responsibility and may have been lacking in confidence as an educator for his patients. Consequently, he said that he usually:

...would give a cursory explanation, but more often there was no explanation. I did not place a big emphasis on educating the patient because I was not exactly sure what I was doing, what my role was, and what my goals were.

Current Practice

Now, Don believes that patient education plays an “atypical” role in his practice in that he sees himself as taking a more holistic approach to health care than the typical urban chiropractor. He says that his approach to patient education involves delving into aspects of patients’ health beyond the limits of a particular injury or condition. He begins with the process of obtaining an informed consent for examination and treatment from the patient. During this process, Don says his educational focus is, “...more getting people to understand the intent, the goals behind what I do. Obviously, it (treatment) is to bring them relief, but it’s also to help them understand how we think differently being chiropractors.” He feels that patient education is intimately connected to both case outcomes as well as patient retention. Don, therefore, spends time educating his patients from their first visit. He wants his patients to,

...learn why they are feeling better and try to value and appreciate the service which a) helps in their healing process and b) also helps with retention of the patients, meaning that they realize the value and then at least have the choice to stay with a longer term care schedule to get more benefit because they actually understand what I’m trying to achieve.

Further to this, he feels that patient education has a role in teaching the patients that they have several choices to make regarding their care. One of their choices is to consent to care and if they do so, this gives Don an opportunity to make additional inroads with the patient, both on an educational level and with reduction of their symptoms through his physical treatment. If patients do consent, then through their early course of treatment, they will have an opportunity to develop confidence and trust in his advice and care. He explains,
I’ve come to where I try to give them up front what the options are to most people’s care, because there seems to be a pattern there…so I try to get a commitment to a preliminary stage (of treatment) so I can show them what I mean and give them some confidence that I know what I’m talking about.”

He elaborated on this aspect of patient education in his practice saying that one of his techniques is to tell patients what will happen after a period of treatment. Usually, with cooperative patients, a result is reasonably predictable, so this is not fortune-telling at all. Don went on to explain that, “…then when it happens, they knew that I expected them to have it happen, and then when it does happen, again, it builds confidence not only in them, but in me.”

When issues related to patient compliance emerge, Don again uses patient education to address these. Similarly, he likes to, “…give them choices.” He says that the role of patient education in this situation is to, “…make them aware of the implications of their choices, just so they are aware of how it’s (the choice) going to impact the quality of care or the length of time it’s (recovery) going to take.” He wants to ensure that compliance to the treatment plan is, “…always their choice.”

With many patients, Don uses patient education as one of his primary modalities. He reports that sometimes, it can be effective at changing the paradigm of how a patient perceives his/her health status and care. He refers to, “…those light bulb moments…” that illustrate for him that patients have experienced a, “…shift in consciousness when they become aware and perhaps part of the reason why the problem’s there, and that it’s in their control without a great deal of effort necessary to improve the situation.” He goes on to say that, “…the education starts with changing their paradigm, having them really become more self-aware, and then building confidence with small victories” such as improvements in their conditions or health status. Once this happens, Don reinforces the educational message and helps the patient to see the cause and effect relationship between the treatment intervention and the change in the condition. He says that, “…with some people, it takes repetition before they are aware that it’s (improvement) happening in their body…so you may have to remind them…” and explain the connections. He actively points out the differences he finds to the patients and relates these both to what he has done clinically and to the activities of the patients, such as home exercise, or avoiding injurious postures or situations. Don wants the patients to see the linkage between these interventions and the results experienced by the patient and he employs educational strategies that work towards this end.
The HCP’s Role in Patient Education: Early Years

While practicing in locum positions, Don felt that it was not his responsibility to do a great deal of patient education. Essentially, he was filling in for the absent chiropractor and just carrying on with the established plan of management. He would see very few new patients in these practices. He did feel that, when he did undertake some patient education, it was his role to help, “…the patient understand the process of why they’ve gotten to the state they are in and the process of how they are getting out.” In doing so, Don said that he tried to bring, “…relevance to the experience they are having, giving them the context for the experience they are having…” He was able to accomplish this when the patient opened the door for an educational intervention by asking a direct question. He explained how he perceived the expectations of his role while working in someone else’s practice:

The ball was really out of your hands, so you could talk to them (patients) about what they’re experiencing and say well this is where it’s coming from; this is probably how it happened. But in terms of connecting it to what I was trying to do, and why and how long, there was a big disconnect there because it wasn’t my procedure…so you would just implement the other person’s plan, skirt the issue of education and really connecting, and that was my experience. I would just subjugate it (patient education), not even think about it and I would just take on the role of what that person (local DC) did. And often, it wasn’t stressed that I was to educate them in a certain way. It was just go in, this person’s scheduled, small talk, this is what’s going on. Answer questions if they’re directly asked. Keep it specific to what they’re experiencing at the time and doing your job and moving on.

Don explained that patient education was not seen as one of his roles and yet he perceived the link between patient education and the business of running a practice. This involves delivering consistent educational message to the patients and having this information fit in with the treatment and interventions being delivered. A locum doctor may very well not know what the practice doctor has taught to his patients, and so Don tried not to risk delivering a message that might be inconsistent with the previous teaching. He said:

It (patient education) was taken out of my hands. It was not my responsibility, so it’s like you do not even deal with it, because usually patient education and chiropractic practice is tied up with the business aspect of trying to keep the patient and so what you tell them is important because it needs to be consistent with what’s been said before. You’re building a case because a lot of times, your services are already misunderstood, so you’re trying to reinforce the message making it relevant to their case and then trying to see
them through to where you want to have them go…and that’s something that often times as a locum, I was not faced with.

As a locum doctor, Don perceived his role as one of carrying on the process started by the practice doctor whom he was replacing. As such, he thought that introducing new concepts of patient education content with his temporary patients could possibly cross into an area that was, “…outside a person’s (patient’s) comfort zone.” After all, he saw these patients for a week or two and did not know them well, nor did he have a detailed understanding of what they had been taught prior to his arrival in the practice. He also stated about patient education in a locum situation that:

…it’s more work than you really want to take on. So why not just do my job, and do it well. They’ll like me. They’ll refer people in. And they’ll get better... My role was to show up. I could address questions about the ailments. I could make analogies and educate them as to why I was there…I did not have to manage them longer term.

Current Practice

In his current practice, Don perceives his current role related to patient education as one of empowering patients and making them partners in the case management process as opposed to just being passive recipients of care. He told me that:

My role is to have the person understand what my role is, so there are no misconceptions…people become empowered if they learn about what their body is actually doing…most people need to be almost retrained at how they look at their body.

Don goes on to explain that he perceives this role for himself because he now has, “…ultimate confidence in my ability to help people get well, mostly because I’ve come to the place where I know that the person (patient) holds the power. Their body does.” He feels that his role as a patient educator includes harnessing and directing the patients’ ability to realize that they have a great deal of control over their own recoveries and he does this through teaching his patients.

In his patient education, he tries to accomplish his goal of making patients partners by pointing out and reinforcing the connections between the decisions and actions of the patients and changes in their signs and symptoms. About changes that occur and how he acts on these, Don told me that:

…even if they are not aware of it, I’ll show them, or tell them. I’m finding the difference. Even if it’s short of what I expected, I’ll tell them immediately…I find it useful to feed
back as much as I can whenever something relevant or significant occurs so that it’s immediate…

Now, Don wants his patients to be able to make their own meaningful decisions about their own health and he feels that it is his role and responsibility to facilitate the patients’ being able to do this. Don sees his role as an educator as being responsible for providing patients with the information and feedback they need to be able to achieve this level of decision making. He explained:

As I’ve become more experienced, I’ve realized how vital it is that if I am going to have them make the decisions that I think are in their best interest, I need to provide them with the information they need to make the decisions. I can’t make assumptions (that they know the information already).

Both now and in his earlier experience, Don found himself addressing issues and answering questions posed by patients that were related to the care they were receiving from other health care professionals. He sees this as a problem in our health care system and explained his experiences and approach to this scenario. He said about the lack of effective patient education is, in his opinion:

It’s a huge problem. I find what bothers myself is that people are coming in having huge decisions made for them or even having suggestions made to them whether it’s surgery, medication, side-effects, hospital procedures, and nothing is explained to them…and they (other HCPs) don’t bother putting into layman’s language what the diagnosis is, the ramifications. You have very brief contact with the doctor and nobody else is allowed to tell you anything. So, for many people, they come to you worried. You put them at ease, explain what words mean, what their options are, how they have to advocate for themselves and put it into perspective.

Nature of Patient Education Interventions: Early Years

Early in his practice experience, Don, as mentioned did not make much effort to initiate extensive patient education as an intervention in his locum placements. At times, he said that he tried to avoid or “skirt” patient education opportunities. When he did provide information to patients, he tended to provide “cursory” information that was not too complicated and perhaps not even specific to the patient. He explained that, “…my patient education was general information, which I think a lot of other health professionals give.”

He would, in some practices, have access to various educational media such as printed materials and pamphlets. At some locations, there were wall diagrams and charts. He rarely used
these resources or referred directed patients to specific brochures, although he did mention to patients that they were available should they be interested in taking them for their own use. One practice had educational video tapes for the patients to view, but these were passed out to the patients by the administrative staff members and he did not specifically suggest to patients that they borrow or view these.

Don explained that most of the patient education that was done involved verbal responses to questions posed by patients. He employed a teaching style that was essentially transmission in nature. Describing the patient teaching he undertook, Don used terms such as, “…giving them the context…just letting them know…you give people some facts…help yourself (to pamphlets)…giving people an explanation.” At one point, he also said about his early years in practice, “The education was more of a one way…I”m going to give you this information. It wasn’t a dialogue.” These terms and comments indicate that the flow if information was primarily one way, from the doctor to the patient, which is characteristic of a transmission mode of instruction. There was very little in Don’s interviews to suggest that he deviated from transmission of information and employed either transaction or transformative models of instruction.

**Current Practice**

Now in his practice, the nature of Don’s patient education efforts appears quite different. While he gave basic, almost simplistic information to his early patients, he now says about his teaching, “That’s all I talk now is metaphor; it’s all metaphorical. Over time, it has gone from being very textbook and technical to being paraphrased example.” Don suggests by these comments that instead of using anatomical and physiological terminology to deliver and explain information to his patients, he now uses analogies and “metaphors” to, as he says, “bring context” to the patient’s experience.

While trying to do this to assist in patient learning, Don has expanded the collection of educational resources that he has at his disposal. For example, he now routinely gives his patients a written summary of the treatment goals specific to each stage of treatment and he also has the patients read and sign a statement, as a part of their informed consent process, that says, “Health care is my choice. I have read and agree to the above products and services. I consent to ongoing chiropractic care and I am aware that I am encouraged to ask questions and bring up concerns.” Once they agree to this, he gives the patients their own copy which usually includes his treatment plan so, “…they know the start and finish. They know what my focus is. They know what I expect from them, and the client and patient satisfaction since implementing that strategy has
been phenomenal.” Don obviously sees an important link between patient education, compliance, patient satisfaction and case outcome and has taken these steps to ensure that he exploits this linkage in his case management processes.

Don, even though having made major changes to his teaching techniques, still relies on transmission instruction to a great extent. For example, he explained that when he gives patients a document to read, he would usually:

…sit down next to them and paraphrase what is actually written, explain it. I draw from what they have actually been experiencing and remind them of the big picture goal. Remind them of where we have come from. And I bring it to the piece of paper and paraphrase what’s on the paper and actually show it to them. And they sign it.

This explanation seems to indicate that, at least as far as introductory patient education goes, Don is directing the process and deciding what information is delivered and how to deliver it to the patient.

In his practice, Don has added, and uses various other educational aids such as three dimensional anatomical models and wall posters that include, “…charts showing how they can expect to improve. And anatomical charts showing nerve, nerve distributions, and how what they are feeling relates to what I am finding.” He also has developed a basic website for his practice. While this does not include a great deal of patient education content, he has added links to different web sources of instructional information that he feels is appropriate for his patients.

He also feels that one the keys to successful patient education is repetition, so Don, at least with a number of his patients, repeats and reinforces previously given content. He explains:

With some people, it takes repetition before they are aware that it’s (recovery/healing) in their body. Either they don’t admit it, they didn’t feel it, yet there is a discernable (difference)…you can show it to them, but they may not have been very aware of it, so you have to remind them.

Don’s current practice involves patient education that is based on repeated delivery of the same message. He does this through repetition, as mentioned, through feedback, and through attempts to improve patient confidence in both themselves and in him. Don spoke on his patient education efforts saying that his efforts involved, “…consistently applying the same type of educational process, feedback, and boosting confidence…”

Even though Don sees himself as one who can help change patients’ paradigms related to their perceptions of their own health, most of Don’s teaching in his practice still involves delivering information through a transmission model of instruction. He says that he tries to, “stick to a pretty standardized protocol” and uses terms like, “…give them up front …give them
the big picture…make them aware…not to give them more than I need to…” which are indicative of a transmission mode of teaching in which he directs both the content and delivery of the information to be presented. He does show, with some of his comments, that he sometimes moves towards a transaction instructional model with some of his patients, namely those who he describes as skeptics. Don describes these individuals as “active learners” who are more discerning and may not accept what he says at face value, as do many other patients. Instead, they challenge the information and may ask questions to get a better understanding. In clinical situations with these patients, Don may adopt an approach that is based on transactional instruction since the patients actually participate in a more meaningful dialogue.

**Key Beliefs and Feelings: Early Years**

Many of Don’s early beliefs about patient education were influenced by his positions as a locum doctor, replacing a temporarily absent chiropractor. As such, he spent only a week or two in most practices and did not have his own practice patient population until much later. As a locum chiropractor he said, “It’s more filling in, playing a part…and move on.” He did mention that he believed that patients, both in his locum experiences and in his present practice, think that they are more educated about their health and health care than they actually are. He supposes that this may occur because we are face to face with so many health care issues on a daily basis and people have a great deal of second and third hand information from their relatives, friends, and coworkers who relate their own health care experiences. Because of the frequency of health care conversations, he feels that patients think that they have a better understanding of health information that they actually do.

As were many of his colleagues when they began professional practice, Don was somewhat unsure as to both the role and importance of patient education in his profession. He told me that, he underestimated the importance of patient education and that, “I didn’t know where to place the emphasis on education,” so he tended to provide very general information for the patients he was treating. This was also influenced by his desire to avoid delivering educational messages or information that was different from that taught by the regular practice doctor. He did, of course want to address certain areas related to the care he was delivering to avoid confusion. He said, “I want it all to be above board so that their choice is informed.” Consequently, when he did participate in patient education, he tended to deal with facts and generally accepted pieces of information about chiropractic treatment.

Confidence in his ability to deliver effective care was not an issue for Don during his early practice experience, but he did not feel the same about his ability to develop a complete plan of
management and carry it out. He said that, “I was confident in what would happen (following a treatment), but I wasn’t as confident in formulating a plan and going from there.” One of the reasons he uses to explain his feeling was the fact that he was only seeing patients for a week or two as a locum doctor. That would normally entail four to six treatments and so he was not pressured or required to develop long term plans for care and recovery. Being a locum doctor, therefore, gave him a very different level of experience as opposed to a doctor in his own full-time practice and this lack of full-time practice experience likely interfered with Don’s becoming a confident patient educator earlier in his career. It would have been the regular practice doctor, who Don was replacing, who would be responsible for developing the long term plan of management, which would include both the physical aspects of care as well as the patient education components. Consequently, not only did Don believe that patient education was a relatively low priority for him as a locum replacement, but also he was not given vary many opportunities to try to teach his patients on any long term or ongoing basis.

As mentioned earlier, Don did not believe patient education to be very important in the doctor-patient relationship. He believed, as do a number of his colleagues in this study, that the most important aspect of care was the physical treatment that he could provide. He said that he had, “the perception that it came down to technical skill, doing a good job and getting a result…so it (patient education) wasn’t necessary.” Don also thought, at that time, that to focus on patient education could be akin to what he called “coercive practice building” and he wanted to avoid being a practitioner who would resort to this technique in order to develop a financially successful practice. He summarized his treatment philosophy during his early years as, “So why not just do my job (of delivering physical care) and do it well; they’ll like me. They’ll refer people in. And they’ll get better…and isn’t that always the case?”

Don used to believe that the best patients were the ones who seemed to be outwardly compliant and who went along with all that he said, advised, and recommended without question. He used to feel that those patients were the ones for whom education was most successful, but many times that was not necessarily the case and those patients were, in actuality, ones who learned to give the socially acceptable or expected answers. He explained that:

It used to be that I thought a compliant patient who, if I would say something, would say something (respond) that they know, or that they understood it and it really made sense. ‘Oh, thank you, doctor’ very appreciative, very on board. That’s the person who used to make me feel that education was working, that it was positive. So, before I got more experience, it was easier when someone is self-affirming or affirming to what I was
saying and just feeds back to me what I’m saying and just apparently seems to get it. But a lot of times, that’s not necessarily the case.

He also felt, at the beginning of his professional practice experience, that many people would not follow his recommendations, despite what they said to him, and would just do what they wanted to do, in spite of his advice. They would do this even though they appeared to agree with his advice. Don believed that he was not very experienced or skilled at determining which of his patients would follow this route and which would take another course. Also, he found it challenging to find out what the patients were actually doing when they left the clinic in order to determine their levels of compliance with the treatment suggestions. Don told me that:

In the early stages, I definitely felt as though people were going to do what they were going to do anyways. Again, reinforcing the idea that education may not be that effective because people are pretty pre-determined anyways unless you’re forceful in trying to instill a new belief system. It seemed more forced because I wasn’t able to really read people. Perhaps it was the situation of being a locum; I was a stand-in. So, it was more difficult to feel comfortable with knowing what a person is going through, and going on cues and eliciting information, drawing it out of them, so that it could be addressed.

Don took a moment to summarize some of his early feelings and beliefs related to patient education as he saw it. He commented on expectations, content, and confidence as they related to patient education in his initial practice years and explained that:

Patient education didn’t seem important nor was it forced upon me to be important because I just had to fill in the role. There’s two basic branches of education, one of which I felt is coercive and wasn’t relevant to me. I knew it was there, but it wasn’t relevant so I stuck with what I felt confident with…answering people’s questions depending on where they were coming from and sticking to what was in front of me and being able to address it properly and having them feel confident in my abilities.

**Current Practice**

About patient education in his current practice, Don now believes that teaching his patients is much more important than he did before and that chiropractors should have been doing more effective patient education to try to help their patients learn about their health and the power and responsibility they have for this. Don also believes that patient education is critical in getting the patient in tune with appropriate expectations about the relationship with the chiropractor and the aims of care. He stated that:
I would say that (patient education) is vitally important and it’s more important, meaning we haven’t done as much of it as we should (as a profession). And why is it vital? Because as a chiropractor, it has more to do with a paradigm shift…so you need to get people on board. You need expectations that are going to be consistent with what you are trying to offer, otherwise, if the education isn’t there, and they think they’re getting one thing when you are trying to give them something else. So, it’s like starting a relationship with a premise that is unwanted.

Don also feels more confident as a patient educator now and believes that patient education is important in teaching patients about their total health and not just about chiropractic ailments or injuries with they may have. He believes that he has a much better understanding of patient education and that it is important to teach patients broad based health information and by doing so his aim is, “…getting them through the experience, (of recent care) educating them about lifestyle, educating them about the injury and understanding their body, but the bigger picture with the paradigm shift of chiropractic vitalistic philosophy…”

Overall, Don believes that he takes an “atypical” approach to patient education. He feels this because he believes that in his practice, he takes a more holistic view of health care. He says that his, “general approach, the techniques I use, is a more holistic one, a more personal relationship that I form with my patients because I delve into more aspects of their health.” Don believes that effective patient education is almost a necessity for his patients in that he feels that most of them lack a basic understanding of their health and their responsibilities for making themselves better. He goes on to explain that:

…most people do not understand where the source of health comes from, and so most people need to be almost re-trained as how they look at their body so they do become an active partner. They are doing the healing and they are he person who needs to sustain anything I can start with them. So they literally need to be taught. The education is the primary role in my healing modality.”

He now wants patients to learn that they have a great deal of power over their health within them and sometimes, it does not take a great effort on the patient’s part to take this step. He talked about, “…the shift in their consciousness when they become aware of perhaps part of the reason why the problem’s there, and that it’s in their control, without a great deal of effort necessary, to improve the situation.”

Don believes that some patients are better learners than others. He feels, perhaps somewhat unusually, that his best learners are patients who tend to be more skeptical, who question and challenge the information he provides. He said about patient education:
It’s actually more effective with people who are more contradictory, people who are more skeptical…Patient education is about learning. Learning is much more effective if it turns on a light bulb, so people who are much more contradictory, or skeptical, or who take issue will just as easily accept an explanation or education on an injury that they have…they are usually thinking it out more logically and your explanation, they break it down and see how it plays out and if they get a result, it’s a more impressionable experience for them, it sticks with them. So, relatively speaking, it has a bigger impact in that person…they are actually discerning. They don’t just take what you say and note really think about it, but they are patient enough to see it through, to see whether what I say is right or not. They are active learners.

He also experiences a feeling of satisfaction when he sees that he has made an impact on these patients as a result of his patient education efforts. Don explained, “It’s satisfying for me, but I think it’s a bigger impact for that person, again because a paradigm shift occurred and it’s almost as though you have made a big difference in the way that they see the world.”

**Perceived Barriers to Effective Patient Education: Early Years**

In the first years of his practice experience, Don encountered some barriers that he felt interfered with effective patient education. One of these involved the nature of his own professional experience. Working as he did in locum situations in which he was temporarily replacing a chiropractor in an established practice, Don did not introduce very much patient education; rather, he tried to “skirt” this aspect of practice as much as possible to avoid teaching the patient information that could be different from that taught by the regular practice doctor. Consequently, the greater part of the patient education he undertook at this time was primarily reactive and in response to questions raised by patients. He did not want to risk introducing misleading information so, even when he could have taken the opportunity to teach patients, he tended to pass on these.

Don also notes that time may have been a factor that served as a barrier to patient education. Some of the practices in which he worked were very busy and there was not a great deal of time allowed for each patient treatment. With these shorter visits, even patient education issues that were brought up by the patients were handled quickly and perhaps were not as effective learning experiences as they could have been with a more generous time allocation.

In his early experience, Don encountered some patient attitudes that he felt were barriers to effective patient education. Some of these arose because of “…negative attitudes about chiropractors…” that patients had. He felt that some patients perceived patient education as the
chiropractor’s attempt to generate more revenue. Don said that he believed some patients perceived patient education as “…being sold a bill of goods…” by the chiropractor.

He also mentioned that he felt some patients just did not care to learn or others who did not want to hear about what he had to teach them. I would describe these patients as ones who are ready and willing to turn over their responsibility for their own health to the health care professional and therefore they feel that they need not know extensive amounts of information about their conditions. Probably, all HCPs encounter patients like this in their careers.

Other patients seemed to have the attitude that they knew all they needed to know; in some cases, even believed they knew more than the doctor and this certainly created barrier to effective patient learning. Don spoke about them saying:

It’s the patient who knows a little bit about a lot of things…They like to talk, cut you off, finish your own sentence. It’s like their world is already very crystallized. They know what’s wrong with them or what’s at play or they have that superficial knowledge. So, if you ever say something to educate, or challenge, or change their mind…they always steer it around, trump what you’ve said, so that they always come out on top…their world is very set and if you ever try changing some of those tenets as to how they think, how they live, it’s just too challenging. They can’t go there.

Don believed that, in addition to the extrinsic factors mentioned above, he was not confident as a patient educator and that lack of confidence was most likely a barrier to his patient education efforts being as effective as they could have been. He said that the barrier arose from him being, “…more timid, or less confident dealing with people who had issues when they didn’t trust me, didn’t believe me and they put up some kind of fight. That’s the biggest thing from the early years.”

Don also had some comments on the current undergraduate education programs for chiropractors and how it influences the perceptions of new graduates towards patient education. He agreed that pre-service education tends to treat patients as problems that need to be solved as opposed to real people and that he and his colleagues, while trained very well in diagnosis and physical treatment skills, were not as well educated to be teachers for their future patients. He explained further about his feeling that current chiropractic undergraduate education tends to have a:

…focus on academics…the focus is objective measures of education, grade point averages, your ability to diagnose, but the humanistic side is very underplayed. So, again, most health care schools produce technicians versus clinicians.
Current Practice

Now, Don still encounters some barriers to effective patient education. One of these is the length of time patients actually stay with care. He believes that effective patient education is a process that takes some time and patients who undergo short courses of treatment will not learn as much or as effectively as those who remain in his care for extended periods. Related to this is the frequency of patient visits. That is, patient education will not be as effective for a patient who is under care for a long time, but who comes in infrequently as opposed to a patient who is under care for the same length of time, but who has more frequent visits. Don feels that often, one limiting factor for duration of care and frequency of visits is the patient’s financial situation. He said that what is important for effective patient education is:

The total duration – the number of times they come in. It’s more frequency driven that time driven, but both, frequency and time…I explain things to them. I don’t expect them to understand it all because it’s taken me so many years to even have an understanding…It takes time and frequency of visits in order to achieve those milestones. If they don’t come in, then they never experience what I expect them to experience and learn. That’s the biggest, number one barrier…which is usually a financial constraint.

Don does not perceive his own confidence, experience, or expertise as a teacher as a barrier any longer. He told me that he, “…can sit if front of pretty much anybody and do my best to relate what I know and what I want to do with them.” Also, time does not seem to be a barrier in his current practice. He now allows for visits of different durations so that people who need more patient education will have an adequate time period to learn from him.

He still does run into some barriers presented by patient attitude. For example, Don said:

From time to time, there are people who think they know more that they do. And no matter what you say to them, they are resistant. They know what they know and they don’t want to learn anything else.

Don did not report that patient language and literacy has ever presented a problem to effective patient education for him. He has always practiced in situations in which his patients were fluent in English, had adequate literacy skills or better, and were sufficiently educated.

Changes Related to Patient Education

Don’s understanding and use of patient education has undergone quite a bit of change since he began practicing. He said about patient education that, “I did not understand what I did as much as I do now. And I didn’t respect it as much. .I did not place a big emphasis on educating the patient because I was not exactly sure what I was doing…” Now, he feels that he has a much
better comprehension of the purpose and power of effective patient education. Don told me about one patient who was instrumental in teaching him about the value of patient education. He had returned to a practice one year after filling a locum position there and he saw some of the same patients that he treated one year before. One lady stood out and he recalled treating this person during his previous locum. He said that her spine had changed remarkably and this showed him what was possible with long term care combined with effective patient education provided by the regular chiropractor. Don explained:

   It was an eye opener for me because it was a one year pre/post (assessment) with somebody who had regular care and I could see the result of the person who was educated properly to understand what was trying to be achieved. She stuck with it long enough and then I saw the visible, tangible results not having had the experience of being able to manage patients through a length of time long enough to prove to myself. I think that goes right to the crux of how education has morphed for me.

Don now has a greater realization of the importance of his role as a patient educator and he now feels that he has made “huge” personal improvements as a teacher for his patients. He said that, “I think I take more seriously my role as a patient educator than I did before. I think I have a better sense of the gravity of my position.” In addition, he feels that now his:

   …attitude towards patient education has more to do with giving people a relevant experience in health care that makes them better. It is the bigger component of their healing process than what I do or why they got into their problem…I feel a bigger sense of responsibility now. I underestimated what I could do for people. I underestimated how much I needed to take responsibility to make sure I could do that (teach) for people because I didn’t know any better.

Basic patient education delivered by a chiropractor is required to include the diagnosis as well as the benefits and risks associated with treatment, and the alternative ways of addressing the patient’s problems. While some health care professionals deal only with these elements of patient education unless the patient asks relevant questions, patient education may end when the above content has been presented. Don feels that patient education, as he has explained above, can and should go beyond this basic level and he has altered his own practices to reflect this belief.

Don’s confidence as an educator has also changed to the point where he feels more comfortable with his role. He told me that, “It’s less challenging for me to do it because I’m more comfortable with speaking, (and) knowing what I want to teach.” But he also says that, because he now sees the awesome importance of patient education, there are still some challenges for him. He explained this seeming paradox as follows:
It’s challenging because I’m asking them (patients) to make a bigger contribution, whether it’s cost, frequency of care, things they need to do at home, and to consistently apply it through their care plan in order to get the result I want…It’s more challenging now because of how important I feel it is. I used to think that what was most important about what I did was my technical excellence, but now I’m at an experience level where I’m proficient at it. So the importance of patient education becomes even more important than my technical skill to promote compliance, to promote the referrals, to change people’s behaviour. It takes repetition and a lot of effort.

His understanding of various patients as it relates to patient education also evolved. Initially, Don felt that seemingly compliant patients who never objected to anything he said were the best learners. Now he feels that these patients are not getting as much as they could from his teaching. He feels that patients who think for themselves and who he describes as being skeptical of new information are the best learners. They are discerning and willing to question and challenge him and his teaching making them better learners in his opinion.

Don’s views on the connections between patient education, outcomes and patient satisfaction, and his practice success have also evolved to the point where he believes these are all inexorably linked together. He said that he eventually came:

…to the realization in my head that I could have a busy practice and not give in on patient care. So those two work hand in hand. The common thread is that I could still apply my trade, get good results, and it makes me more motivated to get more patients in, because I know I can help them, which is what I’m in it for, and, I can actually have some material benefit by having a busier practice. So, I’m driven internally and externally.

Reflection on his professional philosophy has lead Don to change his views and practices related to patient education. He said that he made a conscious effort to examine and re-examine what seemed to work and what did not. Don explained to me that:

I think the biggest thing that I have done in my patient education is to consciously seek out areas where I thought I assumed things without actually bringing them up, and as a result, there were question marks as to why some people responded well and some did not…I think making assumptions before was a problem and not verbalizing, not bringing up areas of concern…not addressing potential barriers. Now I do.

He also feels that his views of patient education are still evolving and that he is trying to deal with patient education now in a more systematic way with his patients. He wants to be more consistent in his approach and also deliver a relevant message to his patients about their long term health. Considering his current practice, Don told me that:
My day-to-day work with the patients is fine, but I still think there are some areas where I do not convey all of my expectations and possibilities. I kind of skirt them. It’s been an evolution of being inconsistent and not having procedure to being more consistent with my education with no procedure. Now I’m being more consistent with short term procedure and I’m becoming more consistent with long term procedure. What I mean by this is telling them up front what the big picture is.

Ed

Practice Experience and Patient Groups

Ed began his professional practice about ten years ago and has had experience in a variety of practice situations in various locations. After graduation from a USA-based chiropractic college, he started working as a doctor of chiropractic in a couple of locum positions, one of which was a long-term placement. Following these, he worked as an associate in another practice on a part-time basis. At the same time, he began his own practice and worked there, also on a part-time basis while it was growing. About five years after his graduation, he opened two private practices, one in a rural area and the other in a small town in the north east USA. This practice was in a seasonal town and his patient population would fluctuate. During vacation season, there was a great many more people in the vicinity and he often saw patients who injured themselves while on vacation. Ed would normally see these patients just for a few visits to address their acute injuries. Once the vacation season was over, the populations of the town and the practice would drop significantly. Ed operated these practices for five or six years. A couple of years prior to his interviews with me, Ed joined a practice in mid-Toronto with several other chiropractors. In addition, until he built up his own patient load, he was filling in for a chiropractor in the north part of the city.

The patient groups for which Ed cared differed with the location of his various practices. In his early rural and small town practice, he saw patients who he described as, “blue collar, farmers, and factory workers…” Ed told me that he thought that most of these patients would have a high school education and he did not recall any problems with patient language or literacy.

When interviewed, he was seeing patients in both of the Toronto practices. In his private practice in mid-Toronto, he said about his patient population, “It’s everything. Toronto is a mix of every nationality you can think of.” He felt that most of his patients in this practice had what he described as, “…at least college level (education).” Most of his patients there are adult, but he does see some children as, “…as young as two or three years old.” In the north Toronto practice,
many of the people in the practice are of Asian descent, reflecting the population of the local community. He said, “There, there really is a language barrier. Some of the Asians don’t really speak English.” He was not really sure of the education level of the patients in that practice.

*Functions of Patient Education: Early Years*

When Ed began professional practice, the issues surrounding obtaining informed consent from the patients were not as much in the foreground as they are today. Consequently, he did not see the informed consent process as an important patient education opportunity or responsibility and so he did not spend too much time teaching patients about what providing their consent meant. The tenet that was held by many in the field was that of implied consent. Ed explained his recollection of the requirements in his first years of practice:

Well, informed consent wasn’t really an issue back then. If they (patients) showed up and filled out the paper work, you could pretty much work on them….if you came to a chiropractor’s office, he was going to touch you. It’s a physical job. That’s a given…By showing up, you were sort of agreeing to care.

When he started in the practices of other chiropractors, Ed was sent by them to various practice management seminars. One of the goals of these is to teach doctors how to manage their patients in a way that would optimize the growth of the practice. Part of the program involves aspects of patient education and often, the attending doctors are provided with scripted information to deliver to the patient at specific times. Consequently, Ed was encouraged to use what he learned in these seminars when dealing with his patients. He described his experience and thoughts about these programs:

When I first graduated, the doctors I was working with were with a couple practice management groups and so all the patient education stuff (was included), I really had the benefit of learning all the stuff, the health care classes, way to say things…we had a lot of scripting, which I don’t really care for…how to answer the phone and all of that stuff was pretty much taught to me. It wasn’t like something I had to come up with on my own. It was all there in the manuals. If you had a question about anything, you could call them up. They always had advisors you could call…

One of the patient education strategies these programs taught to Ed was using small group classes for teaching information to patients. He referred to these as “health care classes” and he did use these in some of his early practice experience. The role of the classes was to teach patients about basic, general information about chiropractic, not information that would necessarily be specific to any one patient. Some of this information involved trying to establish
reasonable patient expectations about the length of time a full recovery might take. Ed found that quite a few patients, if not taught about this aspect of care, would stop coming for treatment after a few visits when their symptoms were reduced or resolved. He explained this reason for these health classes saying:

That’s one of the reasons why we had the educational classes. I still feel that today. As chiropractors, we’re not medical doctors. We’re not coming in doing surgery, cutting something out, sewing you up and sending you home. To treat it, to have something corrected, it takes several visits. To get people out of pain, we usually take a dozen or two dozen visits, so you’re looking at a month or two months. But to make a full correction, it can take a year, or two years, or longer, depending on how it is. And if people are expecting to come in and in one visit have everything fixed, it’s not going to work out…So if they do not know that up front, they are not going to follow through. If they are expecting one or two visits and then ending up needing fifty over the course of a year, there’s such a disparity that it’s just not going to happen.

Besides using patient education to help patients develop reasonable expectations, Ed feels that patient education is also closely tied to patient compliance with the program of care. Patients need to know in advance what will happen, how fast it might happen, and how important it is to observe the treatment regimens. In this regard, patient education also played a role in terms of prevention of future problems in that if a patient did not follow the full course of treatment, the condition may return. Ed went on to explain:

Well, that’s part of the reason why you let them know up front that probably this is going to take at least two dozen visits just to get you out of pain. If they feel better before that, that’s fine. If you tell somebody that it’s only going to take four or five visits, and it takes a dozen visits, then your compliance goes way down. They get frustrated and say I’m not going to do this anymore. So, definitely, it’s (patient education) one of the main things for patient compliance…you need to educate them to let them understand that this is what’s going to happen so that they’ll stay and follow through with their care.

Ed realized that patient education that addressed patient expectations and prevention also had a bearing on patient satisfaction. If patients knew what to expect and were educated to follow through with the full course of treatment, they would be more likely to attain a full recovery as opposed to those who left treatment early and then had their conditions return. The former group would likely be more satisfied with their care. Patient satisfaction is important because patients who are satisfied with a chiropractor’s services will be more likely to return to that doctor when
they need future treatment and also to refer others to that doctor thereby helping with the success of the practice.

**Current Practice**

Now, in his practices, Ed uses patient education to assist with the development of patient partnerships. He feels that patient education can help get patients on side with their chiropractor and once this has occurred, they can both work towards the same goals. Patients also need to learn that they have responsibilities as partners and these extend beyond just showing up for treatment from the chiropractor. Ed explained his views to me saying:

The patient is on your side right off the bat. Patients have to be partners because they have work to do at home. It’s not just my treatment that will make them better. They need to do their exercises and do their part.

Ed also feels that patient education helps patients make sense of chiropractic treatment. Since the treatment is primarily physical and has a mechanical component, he believes that, once it is explained to his patients, they will understand what the treatment is designed to do. He does not feel this is the case, however, with medical care as the treatments often involve a biochemical component which is much more difficult for patients to comprehend. Ed went on to discuss his views of patient education:

And people like going to their chiropractor. I think when you explain chiropractic to them, it just makes more sense. If you talk about medicine, it’s a lot of chemistry and it does not make sense. So they have to go on what they are told. There are a lot of (medical) procedures that are uncomfortable or unpleasant. People don’t like going to the doctor or dentist; people love going to their chiropractor. You feel better when you come out; you feel looser. In general, it’s easier to educate people about it (chiropractic treatment) because it’s simpler. It just makes more sense to them...People don’t like going to the dentist or doctor; they go when they have to. People enjoy going to the chiropractor, for the most part.

Patient education, in Ed’s current practice, fills the function of teaching people not only about chiropractic care, but also about general health issues. He feels that people do not have enough information about their health, how to keep themselves healthy, and when they should be consulting a health care provider. Hence, he uses patient education opportunities to try to teach this information to his patients. When he does this, Ed feels that what the patient learns also helps with patient compliance since his teaching, he feels, helps prevent frustration or discouragement on the part of the patient. Ed explained his perception of this role of patient education:
Most people have no idea about chiropractic, so (patient education is) to educate people about health in general, because most people don’t really get much information about health. It’s mostly disease care and crisis care and treatment of symptoms as opposed to education about overall health. One of the things that helps out with is compliance. A lot of times, patients expect that with one or two visits, everything is going to go completely away. So you need to tell them these things up front so they don’t get frustrated or discouraged. Let them know it’s going to take maybe two or three dozen visits…before the correction is totally completed. So, if somebody comes in thinking it’s going to take one or two visits and it’s going to take fifty, they can be upset.

Ed does not now see patient education as having an important role in the process of obtaining informed consent from his patients. While he does acknowledge that information is passed on to patients before they consent to examination and treatment, he does not see this as a major focus for patient education. Ed’s approach to this process seems to be one that ensures the regulatory requirements are fulfilled. He said about this process:

I never really looked at it (informed consent process) as an educational tool…informed consent is just when they fill out their regular paper work. I have the informed consent (document) in there that they have to sign before they can be treated…They read it and we discuss it and I have them sign it in front of me…What we’re required to do it to talk it over with them. It says on the top of the informed consent, ‘I have discussed with my doctor…the inherent risks’ and things like that.

By explaining to the patients what can be accomplished through chiropractic care, Ed uses patient education to help determine the patients’ objectives and desires that they wish to achieve through his care. Some may only want to get symptomatic relief and others may want long term care. Ed feels that both he and the patient need to be on the same track and so, he teaches each patient about the different possible objectives and then tries to determine what it is that the patient wants. When asked about the role of patient education in determining treatment choice, he told me that:

…the first thing I usually try to determine is if the patient is interested in symptomatic relief, if they just want to get out of pain, or are they interested in a corrective phase than then there’s also wellness care after that. So, I want to try to address that right up front, too, so that we’re all working towards a common goal…People can get a little confused about that and I have to explain that as well. And so you have to educate them there.

Patient education and patient satisfaction are still closely connected in Ed’s current view. He feels that patients need to know and understand the goals of care as well as other issues such as
the length of time complete recovery might take. Without this information, he feels that patients are more likely to become dissatisfied with their chiropractor. Consequently, Ed uses patient education as a tool to help his patients understand as much as they need to about his care and, if he can achieve this through his teaching, he feels his patients will be satisfied. He explained to me about this by saying:

The first thing that pops into my mind is that sometimes, when you’re coming in to get adjusted, you’re going to be sore for a couple days following the adjustment, kind of a muscle soreness, even though the original pain should change a bit. People would be happier if they would expect that. People come in and they’re sore a couple days later, they can ask, ‘What did you do (to me)?’ Letting people know what’s going to happen lets them feel a little more comfortable as well…They’ll be more satisfied if they understand that it’s going to take a little while.

He continued discussing patient education and its role in teaching patients about their responsibility in the doctor patient partnership and how what they do, or do not do, will have an influence on their recoveries:

If you don’t educate people, and they come in for two or three visits and they don’t get better, they may quit and go around saying, ‘I’ve tried that (chiropractic care) and didn’t get better.’ They have to do things at home. They have to do their exercises. Use the ice. All those things contribute. Then, in the office, we get some nutritional counseling…drink water to stay hydrated. All those things are educational that will help the patient feel better if they are doing them.

Managing risk in a health care practice is an important concern for the health care professional. Generally, risk management encompasses both reducing the incidence of adverse affects from treatment and also reducing the likelihood of possible litigation. Ed now sees that patient education in his practice can be an important part of a risk management strategy. He said about his views on this aspect of patient education:

The incidence of anything happening in with a chiropractor is so low. The most common thing might be that you crack someone’s rib or something like that. I think if you explain ahead of time that I need a certain amount of force to move the bone, but we’re not going to try excessively to adjust you. If they fill out the consent form, they realize there are some risks possible. I’ve had some patients when I may have cracked a rib. They were sore for a month or so. Nothing came of it. But I think if they did not know what was going on and they just got hurt, I think you’d have a much greater chance of being sued or having a case come up.
The HCP’s Role in Patient Education: Early Years

In his first years of practice, Ed saw his role as a patient educator as one in which he had responsibility for teaching his patients about how to become and remain healthy in addition to delivering information about chiropractic care. He felt that his patients were deficient in this knowledge and tried to fill this gap through his patient education efforts. He said to me that his role was:

…to teach them (patients) about general health. A lot of people have such terrible information about that. There’s a lot of bad information out there and basics that people don’t know. Like people don’t understand just the role of something as simple as water.

So there was a lot of information I could give them outside of chiropractic.

Ed also ensured that he fulfilled the then very basic requirements for assuring that his patients consented to his examination and care through the delivery of essential information about chiropractic care and the treatment and risks.

He was also faced with situations in which his patients would ask him about information that they needed to understand from health care professionals in other disciplines. When this occurred, Ed told me that he would minimize the information he provided since many of the questions involved areas of care or treatment that were beyond the chiropractor’s scope of practice. For example, he would generally not address issues related to prescription drugs that were posed by his patients. Ed explained his experience with this situation:

Occasionally, what came up most is people ask me about drugs and medication and my canned answer is, ‘I’m not a medical doctor. I can’t give you any medical advice.’ In the USA (his original country of practice), that was the law… ‘by law, I’m not allowed to give you any advice on medication whatsoever. It’s out of my scope of practice.’…The advice I would give them probably would get me into trouble.

Ed also mentioned that, even in his early years of practice, he saw the benefit of taking something of a team approach to dealing with his patients. He saw it as his role to foster this relationship and one way that he did so was via his patient education efforts. Ed said that he felt that the team approach felt right to him, even though he indicated that he was the team leader and it was his team. He went on to explain some of his views saying, “I never liked scaring people into treatment. It just doesn’t feel right to me. I would rather educate them so they are on my team and that are not scared not to come.” He continued with a few comments about the doctor-patient partnership that he tried to develop. Ed explained that, “Patients have to be partners because they have work to do at home. It’s not just my treatment that will make them better. They need to do their exercises and do their part.”
Current Practice

When I asked Ed how he perceived his own role as it related to patient education, he told me that he sees his responsibility as including a holistic approach to health. He does not now restrict his patient teaching to the specifics of chiropractic care, or a chiropractic approach to patient conditions. Ed feels that he can and should be helping his patients to attain and maintain their total health. He is hopeful that by doing this, he may be able to have positive effects on people’s lives, even if those effects might not be seen until years later. Ed offered some commentary on and examples of his views explaining that he felt his teaching role is now:

...as a healer, not just a chiropractor. I always think my job is to help people get better and that can be on any level at all. If people want to come in and just get their bones crunched, they won’t learn anything at all. But as a healer, you can give them information that can last them the rest of their life. So, if it’s a chronic problem, you can show them a stretch that can help them for the rest of their life. You teach them the benefits of drinking water. Dehydration can kill people over a long period of time. Eating the wrong food and bad foods...that can have a detrimental effect on people’s lives...If you can turn somebody in the right direction, who knows? They may not get diabetes. They may have lower cholesterol. These are the things that can change people’s lives over five or ten years...From an education point of view, you can make some serious changes to a person’s health.

As happens to many of his colleagues, Ed continues to encounter patients who seek out information from him about the care they are receiving from other health care professionals in different disciplines. For example, he told me that he often sees patients who come to him with questions related to their medical care. He does try to address the concerns that fall within his scope of practice and also tries to explain to patients that for some conditions, medical doctors and doctors of chiropractic may have very different approaches to treating the same diagnoses. Ed provided some comments on his views of the difference he sees between medical doctors and chiropractors and told me about his experience with patients seeking out this type of information from him:

That happens all the time. For example, the (medical) doctor says I have arthritis, which technically is just swelling in the joint and I always say, ‘You probably do have arthritis.’ And my question to them is what are we going to do about it...I don’t think that it’s a matter of (the information being) insufficient or incorrect. It’s that we have two different philosophies. Chiropractic philosophy is different from medical philosophy. Medical philosophy is based on treating a certain set of symptoms with a drug, whereas
chiropractic fixes the symptoms with adjustments. A lot of times in chiropractic, we’re not as concerned with your symptoms as we are with what we find with joint dysfunction or things not moving properly.

**Nature of Patient Education Interventions: Early Years**

When he started practice, Ed was sent by his associates to practice management seminars which included information on teaching the chiropractors how to use patient education. What was taught to the attendees was a very prescribed program of patient education. Much of the material was scripted for the doctors and much of it was laid out in a specific order to be presented to the patients. From the way Ed described his seminar experiences to me, it seems that the chiropractors were taught to be ‘teachers’ for their patients who relied solely on a transmission style of instruction. Describing the seminars, Ed said, “…I had the opportunity to go into these (educational) practices (seminars) up front, and they taught us all this stuff, and so I had learned it and I was saying all that stuff (to my patients).” At the seminars, Ed learned to use small group classes for his patients. In these, he presented standardized general material about chiropractic.

He explained the classes to me saying:

Well, you would have a health care class in the office for the patients. So, any new patients who came in went to what they would call a health care class…They were only for new patients because the population in general, even if they were going to a chiropractor, don’t really know much about chiropractic, so it was kind of an educational seminar. This is how chiropractic works; this is what we do, talking about subluxation and nerve flow. Sort of a range of topics because what you find is people tend to ask the same questions all the time, so after a while you can address most of those questions up front before they are talking and asking all those questions every visit when they come in. So, you sit everyone down and give them a presentation so they know what’s going on.

Ed explained that even though the health care classes included standardized information, usually presented in the same order, each group of patient-learners had its own unique qualities. Some groups were animated and involved, asking many questions, while others were quiet and withdrawn. Ed indicated, as expected, that he enjoyed the groups which were more active and participative. The health classes were usually scheduled at the end of the treatment day to allow for additional time, if needed. About the various patient group types, Ed said to me:

…every time you give a class, a health care class, it depends on who’s there. Sometimes, you cannot even make eye contact. Everyone in the room is quiet and real shy and maybe they don’t want to be there. Other times, you get people, who even before you greet the
patients, have a bunch of questions. Usually, one person starts asking questions and other people say, ‘Oh, I was wondering about that,’ and you get a whole good group of really interested people and the whole class goes pretty well. So, it varied each time you did one. Sometimes, they sit there like a bump and you do your spiel and leave. Other times, the patients get interactive which makes it fun because it’s always the same presentation, you know.

Ed had access to and used a range of educational aids in his early years of practice. In his health care patient education classes, he used a series of pictures on a stand. The pictures would be anatomical or diagrams of spinal subluxations. He usually would also have a three dimensional anatomical spine model and a plastic spine model. The practice management seminars also encouraged the use of specific handouts to be given to patients, in order, on their first seven visits. Further to this, Ed was furnished with a manual by the seminar presenters, which he occasionally used, and that included patient education information spanning fifty visits. When asked how long he continued with patient education after the health care class and the first few visits, Ed mentioned this resource and also that he usually took a rather laid back approach to follow-up patient education. He said:

It (patient education information) was in the manual. They had like the first fifty visits or so, things that you could say or talk about. For the most part, I didn’t do that. I just fell away from what they were supposed to give. I would usually address their complaint that day and talk to them. If it came up in conversation, I would address it.

While he used the health care classes for teaching generalized information to his patients, he also took time to address each patient’s specific needs during a visit. In these sessions, Ed would address the individual diagnosis for each patient and what he felt needed to be done to get the patient on the road to recovery. He called these sessions the Reports of Findings, the content of which was based on what Ed found in each patient’s history and physical examination. He went on to explain this process which seems to be one of transmitting information to his patients:

Those (health classes) were pretty much general information. The specific information for each patient would be found in the report of findings. In the report of findings, you wouldn’t have a bunch of people there, just maybe their spouse or family, and you would put their specific x-rays up, if you took x-rays, and explain to them what you found…And explain to them what’s going on in your spine…It’s very specific to the case, and with that you do give them a packet… with some home information with the exercises and things like that, and their treatment schedule that you have come up with
for them. That should all be written in the report of findings (packet). That would be specific for the patient. General information would be in the health care class.

Ed also discussed with me some of the nature of the patient education material with which he was presented at the seminars and which he was expected to deliver to his patients. Much of the material was prescribed and developed as a script for the chiropractors to repeat to their patients in an approach that was based on one way transmission of information. The information was developed to elicit specific and predictable responses or questions from patients. One of the intents of this approach is to find ways to have patients continue to visit the practice. Undoubtedly, some doctors feel this is good for the patients’ health and well being, but it cannot be denied that having patients come to the practice over an extended period is also a good business strategy. Some doctors are very committed to this approach to patient education; Ed told me that he did not feel that it worked well for him. Ed explained his views on this approach to patient education and about an unpleasant experience when he deviated from the scripted approach:

What I would like to throw in is that I really don’t like scripting. It’s almost like you have to say things word for word. It makes me feel inauthentic. And I think patients pick up on that. Even if they don’t pick up on that, I don’t like the way it makes me feel. And that’s one of the things I didn’t like. Working in some of the other doctor’s offices, some of the doctors wanted me to script. I had to have it memorized the way it was supposed to come out. Like if you say it this way, the patient will react like this…and I didn’t like that…One doctor, he had me do a patient’s report of findings and unbeknownst to me, he was recording it. It was supposed to be scripted, right out of the book. I tended to ad lib and he didn’t like that at all and got upset at me. I didn’t work there too long.

**Current Practice**

The process of obtaining an informed consent for examination and treatment from patients presents the chiropractor with both a responsibility and an opportunity for patient education. Some doctors use this opportunity to present quite a bit of information to patients; others just ensure that the regulatory requirements are met. Ed seems to be closer to the latter group in his approach to the informed consent process. About this process, he said that he gives the patients a form with information which they read and sign. Ed explained:

They read it and we discuss it and I have them sign it in front of me…What we’re required to do is to talk it (treatment) over with them. It says on the top of the informed
consent (document), ‘I have discussed with my doctor…the inherent risks’ and things like that.

In Ed’s current practice, he uses varied approaches to patient education. In his own practice, since it is not yet very busy, he takes a one-on-one teaching approach. He speaks with each of his patients individually, during their scheduled visits, and tries to teach them the skills and knowledge he feels that they need to know. On the other hand, the practice in which he is filling in for another doctor is quite a bit busier than his own with 150 to 160 patients visits each week. At that practice, he uses the small group classes with the patients as well as trying to deliver some information during treatment visits. In these classes, that last about forty minutes, newer technologies are used. Specifically, Ed teaches these classes using a computer assisted presentation as opposed to the first classes which were lecture based with a few teaching aids.

About the nature of these current classes, Ed told me about some of the differences in teaching to groups as opposed to individual patients:

At the doctor’s office I cover at, we have a Power Point presentation. What we have before was pretty much just a lecture. Everybody’s required to come for what we call ‘The Doctor’s Report’… It explains different kinds of care and wellness care and things like that. And we like to do it with a group of patients because they ask questions that are asked all the time. Things we want to tell everybody, regardless of who they are, about chiropractic, since generally, they don’t have a good idea of chiropractic and how it works. The Power Point presentation covers a lot more information than I could present to a patient just talking, because they get the visual. It’s always the same, a little more uniform. When I cover information one-on-one with a patient, their questions get answered, mostly auditory, and the little booklet. I think people may remember more (from the class session).

Ed also explained how he presents his individualized report of findings to patients now. This information is based on the patient’s diagnosis and the treatment plan he is suggesting for each patient. Patients with similar diagnoses can have varied treatment plans. These can be affected by other health issues, personal schedules and goals, and work and life requirements, and other factors. Presenting this information to a patient is an opportunity for Ed to educate not only the patient, but also a spouse or other family member in order to try to create or encourage other supportive influences for the patient. (Family members are also invited to attend the group classes.) The spouse, for example, can remind the patient to do the prescribed exercises, assist with dietary alterations, and discourage behaviours that might be deleterious to the patient’s recovery. Ed explained this meeting:
…when I do the report of findings and the doctor’s report, we like them (patients) to bring a family member with them so that everybody’s on the same team. Sometimes, you tell the patient what’s going on and the spouse is going, ‘Why are you doing that? It’s a waste of your money.’ Whereas if everyone is there and they’ve seen the x-rays, and they know what’s going on, well, you’ve educated everybody. Everybody’s on the same team and then you can all work towards a common goal.

Ed went on to explain some details about the report of findings experience and how the material is individualized for the patients. During this visit and in subsequent visits, Ed might use a spinal diagram as well as wall charts and anatomy book illustrations. He gives his patients a printed package of material. While some of the information in the packet is rather general, other information is based on the patient’s diagnosis and specific plan to assist with recovery. Ed described the material for the report of findings packet and also a second piece of information given to the patient during the visit that includes the first chiropractic adjustment (which could be the same visit as the report of findings):

In our office, I always prepare a report of findings booklet which has information about chiropractic in general, what a subluxation is, some pictures of the spine and nerves and where they innervate, what some of the patient expectations are, what my treatment schedule is for them. On the back page, it has some basic general exercises. We have for the first visit, a handout in what to expect after your first adjustment and different educational materials, but I also try to explain what’s going on.

**Key Beliefs and Feelings: Early Years**

In his first years of professional chiropractic practice, Ed was sent by his associates to practice management seminars which instructed the doctors how to educate their patients by using specific ‘scripted’ material and information. Ed went along with the advice of the presenters in these seminars because he did not have the personal experience on which to base his own patient teaching. He believed what was said and taught by these people who held themselves out to be experts in their field. Even though, as mentioned previously in this report, some of the techniques they taught made Ed feel somewhat uncomfortable, since he had no experience to counter their instructions, he often went along with their ideas. One of the messages they taught was that specific messages must be ‘taught’ to patients and Ed believed this, since he had no other experience-based option. Ed explained why he believed what he was taught in the seminars to me saying:
When I started, I believed that it (patient education) was important, but probably mostly because I was coached from the seminars I was taking. They would tell you patient education was important and you have to do all this stuff (teaching patients). This will help the patients understand what is going to happen and all that. But you don’t have any experience at that point. You don’t know if it’s going to help or doesn’t help.

He did rely, however, on feedback from his patients as to how successful his patient teaching was. One of the goals of the packaged patient education was to try to keep the patient in the practice for an extended period. Ed told me that if a patient did not return to him after a few visits, then he took that as meaning he was not very successful in educating that patient. He explained:

    If the patient wasn’t around after a couple of days or a week…’Oh, yeah. It feels great. I don’t need to come in any more’…then I’ve failed in my job to let them understand how chiropractic actually works.

Ed also discussed his views of chiropractic care and patient compliance. He suggested that if a doctor is very successful at resolving a patient problem, this early success actually works against patient compliance. He feels that patients will be more compliant when they are motivated to come in for treatment and one major influence on this is pain that a patient may be experiencing. If the chiropractor is able to get the patient out of pain quickly, then this motivational factor is eliminated. Ed’s comments below underline one important reason to educate patients about their conditions. He feels that patients need to understand the difference between feeling better and full recovery. Ed explained his feelings on how rapid reduction of symptoms can affect compliance:

    It’s a funny thing about chiropractic though. If you do a really good job and the patient gets better quickly, there’s less patient compliance, because pain is a big motivator for them to come in. Obviously, I don’t think anybody does that consciously, but if you’re hurrying up and not doing a good job on the patient, they tend to stay around a lot longer because their pain is still there.

In his early years of practice, Ed also believed that he felt confident as a patient educator. Much of this confidence was based on the fact that he had the experience of the practice management seminars which armed him to some extent with the information he was to present to patients. He did feel, however, somewhat less confident in his abilities as a communicator. Looking back on these years, Ed felt that part of this feeling resulted from his lack of clinical experience with patients. He explained some of his recollections in this area:

    I felt more confident at the time because I had all the education behind me…I felt confident. I knew my stuff. I felt that I knew what I was talking about… It was more the
communication to patients (that was problematic). That’s funny. That was more my problem then, was being able to communicate what I knew to patients. Trying to dummy technical terms down into layman’s language. Just trying to explain things that I knew in layman’s terms without the background that they have. Sometimes, it’s not just the words that you are using. It’s a whole paradigm and a whole area that it fits into. You have trouble explaining those to a patient because it’s like a different language.

One of the important feelings Ed discussed was his dislike for the strict scripted approach to patient education as promoted by the practice management seminars. He also said that did not feel comfortable with the “scare tactics” that he believed some doctors used with their patients to keep them in their practices. These tactics may be the result of the dogmatic scripted approach to patient education which attempts to limit the chiropractors’ options in what they teach to their patients. Hence, some of the messages seem to be overly harsh and potentially frightening to patients. He said about these feelings of scripting and threatening education techniques:

…some of the doctors wanted me to script. I had to have it memorized the way it was supposed to come out…and I didn’t like that. Still don’t care for it. I didn’t like the scripting…There were sometimes scare tactics like, ‘You have this subluxation. You have to get it fixed or you’re going to die.’ I believe it’s important (to inform patients), but it’s not going to kill them today or tomorrow. You’ve got plenty of time to work on it. I never liked scaring people into treatment. It just doesn’t feel right to me.

Current Practice

Unlike many of his colleagues who were participants in this study, Ed believed from the outset of his professional career that patient education was important. As he explained earlier, this belief was the result of his attendance at chiropractic seminars which espoused a particular approach to patient education. Currently in his practice, Ed still believes that patient education is important, but now, this belief is the result of his personal experience and reflection on his successes and failures. He went on to explain his views of patient education as it fits into his practice now:

So, now I think patient education is really important because from experience I know if I work on this person and three visits later, I haven’t done my job and educated them, they are going to go, ‘Well, why do I need to come in? Why should I be here? I don’t need this anymore.’ And if you can’t have good reasons for them to be there and show them some documented cases or research, or at least make a reference to it (the patient will not return).…If someone has bony changes in their neck, I know that problem has been there
for at least five years, so I can’t expect it to go away in a couple days. And the patient needs to know that, too. But the patient only knows what they are feeling and so you need to educate them on that, or at least let them know when this comes back we still need to work on it.

Ed also believes that patient education is important with all conditions, regardless of their severity. If a patient has a minor condition, but is in pain, he/she will be motivated to attend for treatment because the patient wants to get out of pain. Patient education is important in this case, according to Ed, because when the pain is gone after a few visits, without effective patient education, the patient may very well cease to attend visits and will miss out on the opportunity for a full recovery. On the other hand, Ed believes that patient education is important for those without very painful symptoms, but for different reasons. A patient may have a degenerative condition that is not very painful yet. Ed feels that he needs to educate these patients to teach them the importance of attending for chiropractic care over an extended period to try either to reverse the changes or slow the degenerative process. Ed explained his feelings on patient education as it relates to severity of the patients’ conditions:

If the patient is in a lot of pain, if they are already severely in pain, they are already motivated to come in. So they are not a problem there…What I found is that without patient education, the patient is going to disappear as soon as they’re out of pain. And the real benefit of chiropractic is in the prevention and the things that come after the pain is gone, total health and decreased nerve impediments, good joint function, and better range of motion, flexibility…The problem is when you see a lot of degeneration problems on their x-rays, or in your examination and they are not in a lot of pain. This is where you have to educate them. The problems that you are seeing are probably going to get worse and at some point, they are going to cause you problems later on down the line…Some say, ‘I don’t feel so bad.’ Well, they really should have that worked on. We need to do some work here because we don’t want you to have problems in the future.

Ed also believes that some of his patients are better learners than others and one of reasons for this is gender-related. This is a belief that was not mentioned by any of the other doctors participating in this study and Ed did not expand on his reasons for holding this belief. He told me that he feels that:

…women tend to listen more than men. Men generally let it go (wait longer to seek care) longer than women do. And then they leave earlier, probably because of the education. They don’t tend to stick around and listen to what’s going on.
Ed was working in two practices during our interview sessions. In one, his patient education was all one on one. In the second, a major element of the patient education included a small group class taught by the chiropractor. Ed believes that the small group classes are very effective teaching and learning situations and he would like to institute these into his own practice when he has enough patients to make it logistically possible. He explained to me some of his feelings on why the group sessions are successful:

In a group setting, too, just like in a classroom, if somebody asks a question, it probably benefits the whole group. Whereas in a one-on-one situation, there would be some questions that (one) would not even think to ask. In a group, someone else may ask it and that would be a benefit to (all of) them. It’s more fun in a group situation when people ask questions. The Power Point’s always the same so the only difference is when people ask questions...I feel confident that I’m getting through and making a connection there...We’re planning on it (introducing classes) when we move to our new location.

One of the partners is working on a Power Point...we’re hoping to start it when we get a little busier.

The connection between patient education and patient satisfaction is an important one for Ed. He believes that patients need to be educated in order to get a successful resolution of their symptoms and also to receive the full health benefits of a course of chiropractic care. Without this, patients may very well not be satisfied with their care or the results. In order for patients to achieve the best results, Ed believes that they must be educated as to their responsibilities and also about the length of time a full recovery may take. If this education happens, patients will likely get excellent outcomes and will be satisfied. This will result, according to Ed, in patients returning to the practice when they need care and also referring others to the practice, which in turn helps the practice grow and be successful. He feels that since he has improved as a teacher, his patients are more satisfied. Ed spoke about his perceptions of these interconnections saying:

I’d say it’s (patient education) very important for all the reasons that we’ve already spoken about. If a patient’s not there, if they only come in for two or three visits, they’re not going to get better. They’re not going to have a positive outlook on chiropractic. They’re not going to refer more patients. They’re not going to get any long term, lasting effects. They’re not going to learn anything that’s going to change their health...Without education, it’s (chiropractic care) not going to do you much good...Patient satisfaction is better now just because of the reason that I can explain things a little bit better to people. I know what people are expecting...and what they want answered. I can answer more to the point.
Ed also told me that now he feels quite confident as a patient educator. This, he feels, is a result of his increased clinical experience. Ed believes that he is now better able to translate technical terms into more patient-friendly language and he has more and better examples with which to explain various concepts to patients. In addition, the information he is trying to convey is what he believes to be true and accurate, based on his experience. He said about his current feelings of increased confidence:

I feel confident. When I give lectures, I feel confident because, first of all, what I’m saying makes sense to me and I can put it into terms that the patient can understand now. Probably better than I could before. So, I’m more confident now. Just because I have different analogies and more terms, layman’s terms, that still convey the same information as before. When I first graduated, I remember almost stumbling trying to figure out the right things to say, almost translating from medical terms to plain English. I feel more confident about that.

Finally, Ed wanted to say that he now feels that one’s professional health care practice and also patient education is unique to the chiropractor and is also fluid and constantly changing as the chiropractor’s professional and personal experiences change. His life experiences change him as a person and as a professional and these cannot help to alter both the information he teaches to his patients and his way of doing it. Ed discussed his belief about the constancy of change by commenting:

The only thing I’d say is that chiropractic is personal based on the practitioner. The education I’m going to give my patients changes as I change as a person, as I change as a doctor. As my understanding of chiropractic changes, it’s going to change what I’m telling my patients. It’s dynamic. It changes probably day to day, definitely from patient to patient, and over the years. I know I’m a bit different now than when I first graduated.

**Perceived Barriers to Effective Patient Education: Early Years**

Like some of his colleagues in this study, Ed encountered some barriers to the effectiveness of his patient education efforts. Some of these barriers were patient-based and others derived from Ed himself. Ed provided me some comments about the barriers he experienced. When Ed was using the small group health classes in his first years as a chiropractor, he mentioned that some of the classes were better than others as learning opportunities. He suggested that one of the main reasons for this was the mix of patients in any particular group. Some groups were very lively and asked on-topic questions, while other groups were collectively more withdrawn and quiet. These groups seemed to be more passive and listened, but did not actively participate in
any kind of dialogue. Ed described these groups saying, “Everyone in the room is quiet and real shy and maybe they don’t really want to be there.” With groups like this, learning may be less likely to occur and this presents a barrier to the effectiveness of the patient education Ed was trying to accomplish.

Patient attitude also presented barriers to patient education in Ed’s early professional experiences. He recounted a couple of his recollections regarding some of patients and their attitudes which got in the way of their learning. Some patients seemed to be resistant to learning. Others claimed they did not have enough time to attend classes, and some just were not compliant with the suggested plan of care. Ed explained:

I remember one of the health care classes I gave when I was first working there. I gave my whole lecture and all that and just asked at the end of the class, ‘Well, I hoped you learned something here today.’ And one woman was like, ‘No. I didn’t learn anything at all.’ And sometimes people just won’t show up. They say, ‘I don’t have time for this’ and things like that and they usually won’t make their appointments anyways. In general, they are non-compliant all together.

One patient who Ed remembers actually caused a change in his practice based on the patient’s attitude towards learning. This patient, Ed believed, just did not want to ‘go back to school.’ So, he initially refused to attend the health care class. Despite Ed’s explanations and encouragements, the patient did not want to attend anything called a ‘class’ with a group of other ‘students.’ Consequently, Ed wound up changing the name of the small group sessions so that it would not evoke memories of schooling. Ed recounted his memories about this patient:

…there was this one big guy, a big biker kind of dude, and because it was a health care class, he didn’t like the idea of going to class. He didn’t want to go to class. So, this is not a catholic high school or anything and I’m not a nun or anything. I’m not going to hit you with anything. It’s just that it’s required. We would like you to come in and we’ll talk to you about it. He came in, but…that’s why they changed the name to ‘The Doctor’s Report’…because people do not like the idea of a class. Sometimes people are resistant to change and resistant to the idea of a class. Some people just are. They just don’t want to go to class.

One other barrier to patient learning that derived from the patient classes was the length of the session. Ed found that after a time, people started to miss the points he was trying to make. He felt that people would lose interest or the ability to focus on his presentation after about twenty minutes. Consequently, he tried to deliver what he thought was the most important information within this time span. Ed recounted his experiences saying:
Usually, we would schedule those (classes) at the end of the day or we scheduled a certain period of time, so we could run over if we had to, for the classes. It was more we had the time in the office to do it, but people’s attention span was short, so you really had to hit the high points in the first twenty minutes or so. Sometimes, you wouldn’t get through all the information…

Finally, one other barrier that derived from the patients was related to their previous experience of being treated by another chiropractor. In some cases, when patients had prior chiropractic care experience and then came to Ed for care, they had preconceived ideas about the nature of the care and about what they may have been taught. In situations where the previous doctor held a much different chiropractic philosophy from Ed’s, he felt that the patient might not be a very willing learner. At times, this presented a barrier to the patient education efforts Ed was attempting. When I asked Ed if patients’ previous chiropractic experience presented a barrier to the effectiveness of patient education, he responded:

I would say yes. If they had been to other chiropractors who didn’t tell them what was going on, then that’s what they expect from you as well. If they were used to being treated only when they were in pain, then that’s what they expect from you. And you have a big job of trying to re-educate then.

Ed also told me that during some of his early practice experience, he was not very busy and in these situations, he tended to fall out of the practice of taking time to educate his patients. Now, he recognizes that this could have been a barrier to effective patient education; if he was not actively teaching his patients, it would obviously be difficult for them to learn. He explained about his quiet practices:

The only problem I had with it was I would get away from it (patient education), get lazy. After a while, you stop the health care class. You stop doing it, and you do your thing. You’re working on people without really letting them know what’s going on…It’s (patient education) one of those things that if you’re in a busy practice and you’re seeing lots of patients, you do it all the time. But if you only have a patient every once in a while, you kind of get out of the habit of doing the health care classes and then it’s easy to just work on them and not do the patient education.

Time was also an issue that affected Ed’s patient education in his early practice. Ed mentioned that one of the practices in which he worked was very busy. For example, he told me that on one day in this practice, he saw and treated seventy-one patients. Consequently, he would have very little time to talk to patients and teach them the information they should have. This was an extreme situation, but in practices that are very busy, the doctor’s time can be a barrier to
patient education effectiveness. Ed also explained that the practice management seminars which
he attended taught the doctors to act as if they were in busy practices all the time, even if they did
not have a great number of patients. They wanted the doctors to get used to working in busy
practices and one way to do this was to teach them to spend minimal time with each patient. Ed
described his experiences:

They do teach you at these seminars to act as if you are already that (very) busy. And
another thing, they tell you only to spend so many minutes with patients…they said,
when I first got out of school and I was taking these courses, they were saying to treat the
office like you were already seeing ten to fifteen (patients) an hour. Even if you weren’t
busy, they wanted you not to spend too much time talking to people or whatever…Some
of these high volume practices, I worked with one doctor at first, he was like that. ‘I want
you to see two patients every five minutes.’

Ed also found that his inexperience as a clinician also presented a barrier to effective patient
education. When taking patient history and doing the physical examination, Ed remembered that
he had to concentrate at a very high level to discern physical changes in the body and to try to
determine his diagnosis. He also did not work as quickly and needed more time, as a new doctor,
to perform these tasks. Consequently, he was not able to carry on much conversation with
patients. Now that he is more experienced, he need not focus so intently on his examination and
he can begin to educate his patients by talking with the patients while examining them. He
explained this barrier to me saying:

…that was a problem for me because I couldn’t evaluate people as quickly as I can
now…And now, I’m more comfortable. I can find something almost as soon as I put my
hands on them, so it’s easier for me to carry on a conversation. When I first started, it
took all my focus and concentration to find anything. And so it’s hard to carry on a
conversation and be that intently focused on trying to find out what’s going on and
what’s wrong.

Current Practice

Now in his practice, Ed still sees some barriers to the effectiveness of patient education in his
practices. Again, some of these derive from the patients while others may be more related to
himself. One barrier that Ed encounters is related to language and literacy issues. In the practice
in which he is filling in for another chiropractor, there are a high number of ethnic patients, many
of whom are Asian and many of these do not read or speak English very well. He told me that:
The locum I am doing right now is primarily Asian; the majority is Asian up there. Caucasian is probably a minority. There, there really is a language barrier. Some of the Asians don’t really speak English…It’s kind of hard to communicate even which way to lay on the table, much less the other things we were talking about like dietary and drinking water. A lot of stuff on the Power Point presentation I’m sure they miss because they don’t even understand face up or face down on the table. I’m sure they’re missing a lot of the educational portion of it…I would say literacy would be a factor because some of the information we hand out is written. If they don’t speak English and don’t read it, that’s major.

Other patient-related barriers are the result of patient issues involving time and/or money. Some patients feel that they do not have the time to attend for treatment and education sessions. Others feel that the cost of chiropractic care over an extended period is too great for them. Both of these issues interfere with the patients’ opportunities to learn about their conditions and their health. Ed said, “We do lose patients all the time who are just, ‘I can’t come here that often. I can’t do that.’ A lot of times, it’s money. ‘I can’t afford to do that.’”

Ed also feels that some patients he sees are just not good or efficient learners. He told me that he is not sure of the reasons for this, but he does see patients who do not seem to learn the information he is trying to teach them very well. He does not suggest that these people have an attitudinal problem that gets in the way of their learning. He does say that this learning issue could be related to their education level, but he is not certain about this as a cause. Ed explained his experiences to me saying:

There’s some patients for whatever reason, you tell them the same things every visit and they never seem to get it. They keep asking, ‘What is it?’ Why do I have this problem? Why does it keep coming back? How did the bones get out of place?’ And you explain it to them every visit and they never seem to understand. They just keep asking the same questions every time they come in. Other people understand and get it. So some people seem to understand what you’re talking about and other people never seem to understand what you’re talking about…they’re not resistant to it (education). They just don’t seem to be able to grasp it or understand what’s going on. I don’t know why that is. Some people are just harder to get through to, I guess…it could be (their educational level)...I don’t know it’s their educational level. It’s more their ability to learn. I’m not sure they have a lower education…Some people just don’t learn well.

When I asked if he thought that this barrier to learning might result from the patients’ individual learning styles or preferences, he told me that:
Some people’s education is going to be auditory because you’re talking to the person about what’s going on and some people just do not learn well listening. That could be part of the problem. We have some models that we show. Some people just don’t understand.

One barrier that Ed feels is related to himself is that, when he is not busy for a while in his practice, he admits that he tends to fall out of the habit of focusing on patient education. He mentioned that he did have this experience in the past and that he recognizes that it is not the best way to practice. Ed has reflected on this and realizes that it is an area in his professional practice that needs change. He told me that when he notices this happening, he actively tries to counter this tendency. He said:

We don’t have a (slide) presentation (in his private practice), so I do explain (information) to them. Now, I’m trying to get back into that. I had gotten away from that for a while. I had gotten lazy because you just tend to fall out of practice of doing these things (patient education).

Changes Related to Patient Education

Over the years since he has begun professional practice, Ed has experienced some important changes in how patient education fits into the care that he provides for his patients. For example, when he started practice, the practice management seminars he attended taught the doctors how to educate their patients though a very rigid and scripted approach. While Ed says that he did not like this approach, he still often used it because he had little else on which to rely. In addition, he was encouraged by his associates to follow this method of teaching patients. The scripts included material for as many as the first fifty patient visits. Now Ed says that he no longer follows this rigid approach. He told me:

I was working in other doctors’ offices. Sometimes, they were telling me what to say. There was some scripting and things like that. You had to say things just right. I hated all that…That’s different to how I practice now…Now, I can make up any type of educational program I want to.

Ed says that one of the reasons he has changed his approach to carrying out patient education is because of his increased experience as a clinician which also makes him more comfortable as a patient educator. He told me that he found patient education to be less challenging now, telling me:

I’d say it (patient education) was more challenging then. I feel more comfortable with it now. Plus, I didn’t have much to say…Now, it seems like a difference, now I have
experience. When I started, I was going to these chiropractic education seminars. Now, I have the experience…and I’m more comfortable with the information/material. I’ve been exposed to it for ten years now…I feel confident. Plus fielding peoples’ questions…and even if you didn’t have a good answer the first time it’s asked, you think about it…and then the next time that question comes up, you have a pretty good answer for it; you know what to say.

Ed also mentioned that one of the changes he has made relates to the amount of time he now devotes to patient education in his practice. He said that he spends more time now on teaching his patients than he did before. Ed had mentioned that in his early years, he was taught at his seminars not to spend too much time on patient education. He also recalled that when his practices were not busy, he fell out of the habit of focusing on patient education, a habit he is now working on reversing since he now understands some of the positive effects of patient education. Ed described his perceptions of this change and why he is building this into his practice:

I would definitely say I use more (patient education time) now than I did maybe a couple of years ago. When I first graduated, I was implementing all these things because I was taking classes. Then I fell out of it for a while. And now, I’m trying to implement it (patient education) again and get back into the education and let people know what’s going on…I know that patients who are not educated or who don’t know what you’re trying to do aren’t going to be good patients. They are not going to stick around. They are not going to get the full benefits of chiropractic. That just comes from experience.

Erica

Practice Experience and Patient Groups

Erica had been practicing as a doctor of chiropractic for almost nine years when we met for her interviews. She had a varied experience after graduating, working in locum positions in Ontario as well as in associate positions in another country overseas for six months. Her locums in Ontario were primarily in smaller communities and were mostly short term, lasting usually two weeks, although she did fill one position for several months. She did this type of work for almost three years before opening her own private practice with a couple other chiropractors in central Toronto.

Erica enjoyed her locum experiences and thought that they were valuable for her professional development. She described her thoughts on her locum experiences to me saying:
That experience was great because you walk in and your job is to treat the patients exactly the way that that chiropractor does. So you take on their philosophy, their office flow, how they interact with their patients, their staff. And if you’re really dogmatic about how you think you should practice, it’s very difficult in locums. You’re basically trying on someone else’s life for a couple weeks. You get to learn a whole lot because the techniques I got exposed to and that I did, I might not have done, the practice management models that I saw, that I probably wouldn’t be interested in, but worked really well. It gave you context for how things worked, and you probably wouldn’t have done that if you had walked out (of school) and set up your own shop. You got exposed.

She also found her out-of-country experience to be both enjoyable and valuable. Erica worked in two different practices in urban settings. The philosophy and approach to assessment and care was somewhat different from that which was emphasized during her chiropractic education in Canada. While the treatment regimens and protocols were different, she found them to be effective. Erica remarked, “…I’m glad I had that experience because it changed how I practice now.”

Her locum experience practices were populated by rural and small town people. Many of them were blue collar workers and were very appreciative of her work and the time she spent with them. In her overseas practice experience, her patients were, “…younger, more fitness oriented people, and the other practice was in a wealthy neighbourhood and it was all high end people, busy, make lots of money, no time, busy, busy, busy…cut to the chase.”

Erica’s practice in Toronto is moderately busy and she sees a range of patients. She said about her Toronto practice patients that she has:

…a range from really, really wealthy to artists who make a living what they’re doing, but there’s not a lot of fat. A pretty diverse population. I would say mostly Caucasian, Asian, a little bit of everything. The neighbourhood we are in is not really diverse, so there’s not a lot of Americans, and there’s not a huge population of Asians.

She said that about eighty-five percent or more of her patients have university degrees, and that the great majority of them are very well educated. She very rarely encountered patients who were not literate and conversant in English.

*Functions of Patient Education: Early Years*

In her locum experiences, Erica had to use the same educational approaches as the doctor whom she was replacing. She said that, “…when I walked into a practice, I was able to take on that persona for the two weeks” and, “when I worked in their practices, I did their thing…” She
said that she did not spend too much time on patient education in the locum appointments. Erica said about the time spent on patient education, “I don’t think I did a lot of it in the beginning.” This was similar to the other study participants who also had locum experience. She provided the mandatory and required information to patients especially concerning the informed consent process and she recognized that one role of patient education is that of risk management. Erica explained her use of patient education in her early experience:

I used it for everybody before I treated. I went through the whole work. The risks, the benefits. It’s a necessary step. If you don’t inform, you don’t get a license. I follow the rulebook…I’m not going to get into trouble for doing (treatment without consent.)

She also mentioned that even in those locum positions, she still gave patients the opportunity to get involved in decision making about their care and treatment. Erica believed then, and still does, that patients who take a passive role in the relationship will not get as much benefit from her care as those who are actively involved and patient education can help patients become involved. She said to me that:

I always like to get the patient involved in the decision making because if I’m doing something to you, then you’re not going to get it. If you’re making the choice yourself, then you’re learning, and it’s always been that way.

With regard to treatment choice in her early years of practice, Erica tried to teach the patients enough so that they could make some kind of decision about the course of their care. For example, she told me that she would make a recommendation to the patients about what she believed would be the optimal course, then explain alternatives before having the patients provide input as to their desires. Erica told me, “I would say, ‘This is the ideal. What I’m suggesting is the ideal. If not this, then you won’t get the result as quickly, but we’ll still get there.’”

Even early in her practice experience, Erica saw a link between patient education and patient compliance with the treatment plan. One of the reasons that Erica felt patient involvement was important was because it was her belief that patients who learned well about their health were more compliant than those who did not learn, or who were not educated by their HCP. About this, she told me that:

I would say that if you got it across to people, then they stuck with me. If they didn’t get it, or they just wanted to get out of pain, then they weren’t going to comply completely. So, ultimately, if they get it, and they’re willing to go through with the plan, they’ll stick with it (treatment).
She also recognized though, that patient education, at least in her early experience did not work equally well with every patient explaining that, “You’re going to give some people information, and they’re still going to make up their minds and do exactly what they want.”

Current Practice

Erica, in her current practice, takes a rather unusual approach to health care which encompasses not only standard chiropractic care, but also a more proactive and holistic approach to health care. She considers not just the mechanical causes of injuries, but also directs attention to other possible stressors that can affect health and wellness. Given this non-traditional approach, Erica feels that she must use patient education to inform her patients about the way she deals with health care. She said that one of the functions of patient education in her practice is for:

….explaining what my approach was like…and explaining how long it would take them to get better, and what I was going to do, and what they would experience. It was trying to get them to understand a little bit about what was going on in their bodies…I really have to explain to people to get them to understand, otherwise they’ll find what I do too overwhelming.

She implements some patient education right from the initial contact with the patient, usually a phone call to arrange an appointment. In Erica’s office, the doctors take the calls, so they can provide accurate information to the patients and help with the development of realistic patient expectations. She explained that she is teaching the patient:

From the first phone call to get an appointment, telling the patient what my focus is…that I don’t practice traditionally, so that if they are coming here, they don’t expect a particular experience based on a past experience. I would say it (patient education) starts from the moment they book the appointment.

Erica also continues to use patient education as an important component of the process of obtaining informed consent for treatment from her patients. This involves both printed and verbal information presented to the patient. Printed forms are used to provide information to the patient about the type of treatment she plans to deliver. For each of the different techniques she plans to use, there is an explanatory section on the forms. She created these forms along with her partner, so the information included for the patient is specific to her practice and not generalized to include all chiropractic care.

In addition to this, Erica makes and explains a recommendation about what she thinks is the absolute best treatment plan for each patient, but then allows the patient either to accept or
modify this recommendation thereby allowing the patient to become involved in the decision making process. She related to me what she tells patients at this time saying:

I’ll say, based on my findings, and what’s presenting in your body, this is what I would ideally recommend for you. Ultimately, it’s your decision. We can modify that. Let’s say they can’t make it in for a week, or they can’t do the exercise schedule, we can modify that. You won’t get the result you’re looking for as quickly. You will get to the end point; it will just take a little longer.

She does this because she feels that educating patients to be able to make some reasonable decisions helps get them actively involved in their own care and the management of their own health. Also, she feels that patient education, at this point in the doctor-patient relationship, is important because it can prevent patients resisting or resenting what they might consider losing control of their situation to her. She explained why she makes sure that she teaches the patients about their treatment choices:

If you give them the option, it (resentment) happens less frequently. People get their backs up when they think they don’t have a choice. If they know there are different options, they usually pick the best option. But if they don’t think there are any options, then they get their backs up. They have a choice of this or this. They may not like either one of them, but they have a choice.

Now, in her practice, she also employs patient education to deal with patient compliance with the treatment plan as well as with issues of preventing further injuries or conditions. Erica tries to teach her patients how important it is to stay with the treatment program and their home program activities. As far as teaching related to prevention, she feels that people need to learn not to ignore subtle changes in their bodies that may be a signal of injury or illness. Erica said:

I do a lot of that because quite frankly, I find that people need to feel things in their body…they need to follow the steps and they need to pay attention to their body. Most people learn very, very early on in life to ignore things in their body…We learn to override a lot of things in our body and part of what I do with my patients is to get them to learn, or remember, what the language of their body says and what it means to them.

Erica also feels that patient education is directly tied to patient retention in her practice. Because she takes a rather non-traditional approach to health care, as mentioned earlier, she must teach patients who may have pre-conceived notions about chiropractic care about her approach. Without this teaching, she feels that patients would desert her practice. Erica explained this to me saying that:
If my patients didn’t understand what I do, they’d never come in the door, because the techniques that I do are just that little bit away from the centre that if I didn’t explain what I was doing, they wouldn’t understand. And if you don’t understand, then you get scared, and then you don’t come back.

Finally, Erica told me that she wants her patients to become responsible partners with her in the management of their recoveries and health. In order to do this, the patients must be able to participate in the decision making process. This involves not just the decisions as to the type and frequency of her treatment, but also decisions on the part of the patients about the myriad choices they make during each day that can have positive or negative affects on their health and recovery. They need to understand that they have a responsibility to themselves and Erica tries, through patient education, to get patients both to understand and accept this responsibility. She explained her feelings on this matter to me:

My patients are always partners in their (health) management. I always present them an option. ‘This is what I’d like to do with you. This is why I’d like to do it to you. If that can work with your life, if that’s something feasible, if I ask you to do exercises this many times a day, is that something that you’re going to be able to do?’ And they’ll either say yes or no. I’m not going to get mad at them, but I need to know realistically what they are willing to do because it’s going to affect how long it’s (recovery) going to take. So, I’ll bring me to the table if you’ll bring you to the table. You have to make them responsible.

The HCP’s Role in Patient Education: Early Years

In her early years of practice, Erica, as mentioned, did not devote a great deal of time to patient education initiatives. While she did try to teach patients in a way that made sense to her, she was still constrained by two restrictions. The first was that she, as did many of her colleagues, believed that patient education, except for the regulatory requirements, was not a critically important component of chiropractic care. The second was that, in her locum positions, it was her job and responsibility to operate the practice as the local chiropractor did. This is relatively simple to do in terms of the delivery of physical treatment and care, but it is more difficult to determine exactly what information, if any, was taught by the local doctor and how he or she may have taught it. Consequently, Erica as well as others in locum situations tended to avoid delving deeply into patient education issues. They do not want to risk telling the patient something that may be perceived as contrary to the message delivered by the local chiropractor, so the locum doctors tend to answer patient questions, provide the education that is required by the regulatory
bodies, and perhaps only a little more if it seems to be important at the time. In this regard, Erica was no different from her colleagues. She did not try to alter the way the patients were treated or the information they were taught by the local doctor. She explained this to me saying:

I go through how they do their patient management, how they want things done. If they want them (patients) to stand on their head in the second visit, they stood on their head on the second visit. It’s because my attitude when it came to a locum was, ‘It’s not my job to change. It’s my job to provide the standard of care that’s acceptable in that practice and that people want from that practice.’

Erica went on to outline what her perceptions of her teaching responsibilities were when working in other doctors’ practices. For the most part, her perceived teaching responsibilities revolved around the basic information that is required to be taught for the informed consent process. She also tended to avoid discussing information with which she was not comfortable especially in practices in which the local chiropractor had a practice philosophy that was different from her own. Erica told me that:

I think I had an obligation to at least provide them (patients) a diagnosis, what I expected to happen in their body because of treatment, what their treatment options were, and the risk/benefit ratio of what I did. That was my minimum. I avoided the whole realm of subluxation based, that whole model…it didn’t resonate well with me. I would say that was the basic.

Even if she encountered a patient who seemed to have patient information that appeared to be erroneous or poorly understood, Erica avoided re-teaching the patient. When faced with a situation like this, she would refer that patient to the local chiropractor when he or she returned to the practice. She felt that this was, “…not my area” and she would tell the patient, “I’m not familiar with this. Maybe you should take it up with the (local) chiropractor.”

As did most of her colleagues who were participants in this study, Erica also faced the situation in which her patients came to her with questions about their diagnoses and treatment from health care professionals in other disciplines, especially medical doctors. She felt that this happens much more in smaller communities since they were often working in extremely busy practices in areas of the province that may be considered under-serviced for health care. She said about this experience:

Do you know what I saw a lot of in a small town? ‘My MD is sending me for this test. What is it?’ I spent a lot of time explaining medical procedures. Their (patients’) MD’s didn’t take the time to explain because their practices were overwhelmed. They weren’t explained because generally in a rural community, the MD’s are maxed out because
there’s not enough of them to meet the demand. So, I ended up doing a lot of patient education for surgeries and procedures. Some patients would be terrified and wouldn’t know what they were going in for.

**Current Practice**

Now, in her practice, Erica views her role as a patient educator differently from the perception she held in her first few years as a health care professional. She seems to have taken a broader view, not just of patient education, but of the total service she provides to her patients. Erica told me that she takes an individualized approach her patients, not only looking for the best way to relate to them, but also recognizing that each patient presents with a different set of needs and circumstances. About her current role as a patient educator, Erica said:

What my role is has changed significantly. Starting with the problem…where do we have to go? What changes do we need to make in your life? What are the signs that things aren’t working the way they are supposed to?

Currently, she sees her role as one who has the responsibility to impart health care knowledge and skills to her patients so that they can be more independent in maintaining their health. Erica does not want her patients to become dependent on her; rather she wants to use patient education to create a situation in which her patients can, for the most part, keep themselves healthy, but when they feel that something is not quite right, they will come to her for care before the situation worsens. In this regard, her role as a patient educator is about building effective health care partner relationships with her patients. She says that now her role is about:

…how you get past the point where people think they are dependent on you. If you give them (patients) the skills that that can take away, then they are never dependent on you. They may choose to come and see you because they feel something in their body; then that’s their choice. But if something is not resolving and they have to keep coming back to you, then you are not doing your job…My role in patient education is to help a person understand their body; then they do not need to be in my office. They have the skills to understand what is happening. When they (patients) come to my office, it’s not because they are in trouble; it’s because they know they need to be adjusted today.

In serving as a teacher for her patients, Erica is willing and tries to take various approaches to her teaching, recognizing that people have preferred ways of learning. She said that she does not always teach the same material in the same manner to her patients. Her approach varies based on how she perceives the patient. Erica explained her approach to patient education and her efforts to meet her patients’ learning needs saying:
It depends on the person (patient), how they learn? Are they a visual person? Do they need to see it? Are they auditory? So they need to hear it? Do they need to pick up something and touch it? They use words to describe things, ‘I hear what you’re saying. I see what you’re saying. I’m feeling that.’ You start to pick up what kind of learner they are and give them the information the way they need to hear it.

Erica continued to explain two different approaches to patient education, one she does not use and one she does. She contends that doctors who use the first would be ones who tend to encourage patient dependence on the chiropractor. The second, her preferred approach, she feels encourages patient independence with the chiropractor serving as a health care resource to be used when the patient feels it is necessary. She told me that a doctor using the first approach might say to a patient:

‘Come and see me three times a week. Then you’re going to see me two times a week, then one time a week, and then we’re going to do maintenance (continuing treatments).’

What does that imply to you? It means that you’re not going to get better. You (the patient) can’t survive without me (the chiropractor).

Erica then went on to state what she might tell a patient about her approach to patient education and health care. She said that her message to make the patient more independent of her may be something like:

I’m going to give you the skills and tools so you can take care of yourself. You’ll know when you need an adjustment. Then you can come and see me. But you’ll also know whether you need to drink more water, when to clean up your diet. Are you exercising enough, or not enough? You need to rest; you need to sleep. You become your own doctor.

While Erica does still encounter patients who ask for information or explanations about the care they are receiving from other health care professionals, this does not occur as often as in her early years. She explains that she feels that in a large urban setting, patients seem to have access to more information about their health although she did not specify the sources of this information. About patients asking her for help understanding their care from other HCPs, Erica said that she gets these requests, “Not as much anymore. I found that more in the smaller towns (where she had locum positions). I’m pretty central, urban, so the patients seem to have more information.”
Nature of Patient Education Interventions: Early Years

Early in her professional practice experience, Erica dealt with patient education responsibilities as they came along. She, while working in the practices of other chiropractors, did not devote a great deal of time or energy to patient education, tending to focus on the basic information that was required to be presented to patients. She said she did not approach patient education systematically and took varied approaches to teaching her patients. She did not use any small group classes and generally taught her patients individually. Erica told me about the nature of her early patient education experience from her point of view saying:

It was kind of one-on-one. There was no method that I used for patient education. A lot of people adopt a particular program for their patient management (which includes patient education). I was trying to feel it out, see what I was comfortable with.

For the informed consent process, Erica told me that she used both information sheets that included the required information on risks and benefits of treatment as well as the alternative approaches that could be taken. After asking the patients to read the information, she would explain the information to them. She said, “For informed consent, you go down the sheet with them. You explain the risks and benefits. You explain the options for treatment. You basically take them through it…”

She said that the majority of the information was delivered to her patients verbally during one-on-one chats. Occasionally, she would use other teaching resources. For example, she did use printed information sheets as mentioned above. Also, she would sometimes use, “…a visual aid if it was available….sometimes videos. Sometimes posters. Some (practices) had signs (about) talks that they gave a couple times a week.” Erica told me that she found the videos to be “aggravating” and so she let the practice chiropractic health assistant handle the distribution of these to patients. She also used “commercially made” pamphlets, if they were available in a particular practice. Erica said that sometimes, she also tried to teach by making patients feel something in their bodies. This might be a stretch, a contraction, a tension. She explained that she did this because, “Usually, by making them feel something in their body…because if you anchor it in the body, they get it a little better.”

During this period of her practice experience, Erica appeared to use a teaching approach that would be characterized as transmission. She directed virtually all aspects of the education. She decided what information would be taught, the order, and the method of communication. While patients did have the opportunity to ask questions, which she would answer, the communication flow seemed to be essentially unidirectional, from her to the patient.
Current Practice

Erica, in her current practice takes an approach to patient education that is quite different from her first years as a chiropractor. Realizing the importance of patient education as a component of the care she provides for her patients, Erica told me that she books her own appointments and begins teaching the patients as early as possible. Often, this begins when the patient first calls to make an appointment with her. During the phone conversation, she tells the patient something about her approach to health care, which she describes as not the traditional chiropractic approach. This conversation is used to help develop realistic patient expectations and prepare the patient for an experience that, Erica believes, might not be the same for the patient as it would be in another chiropractor’s office. When I asked her about when she first introduces patient education to her patients, Erica told me:

From the first phone call to get an appointment, telling the patient what my focus is…that I don’t practice traditionally, so that if they are coming here, they don’t expect a particular experience based on a past experience (in another chiropractic practice). I would say it (patient education) starts from the moment they book an appointment.

She uses a variety of materials for patient education. For example, she has information sheets, which she and her partner wrote, that explain the various techniques they use for physical treatments and these are given to patients. Erica also uses “a couple brochures” available from different chiropractic associations that deal with general information about chiropractic care and the importance of patient compliance. In addition, she has printed pages that also teach patients about anatomy and physiology. She also has charts on her wall to which she refers during her visits for treatment and she also keeps an illustrated anatomy textbook in her office so she can show patients anatomical structures and relationships. Erica also has and uses a three dimensional spine model and a white board.

The great majority of her teaching, however, involves Erica talking with her patients. She told me that she uses mostly verbal explanations and that she tends, “…to go over things several times” recognizing that patients may not grasp all the information the first time it is presented. The repetition also can serve as reinforcement for their decisions about compliance with the agreed program.

Erica told me that she does not use the same teaching techniques with all patients and this is one reason why she has and uses a fairly wide variety of teaching materials. As mentioned earlier in this report, Erica knows that patients have different learning styles or preferences and she said that she tries to determine the best approach to take to teaching each patient.
Even though she tries to employ unique strategies to teach her patients, Erica explained that she takes a rather systematic view of the information she wants to deliver. She and her partner have developed a multi-step process to organizing the information they think patients need to know and understand so they can become actively involved in making decisions about their own health care. This information extends beyond the typical mechanical approach to injury as used by many chiropractors and involves dealing with anatomical structures, body chemistry, and various stressors of different natures, all which she believes can be detrimental to one’s health status.

While much of her teaching, even with her various approaches to patient instruction, is of a transmission nature, Erica had some comments which suggest that her patient education, at times, involves more transaction and perhaps even touches on a transformation level. She said about her views of patient education in her current practice:

If your patient education is static, if you only have one way of doing things, then (only) that kind (static) of patient exists. Is the experience about you (the chiropractor) or about the patient? If the experience is about them, then you will modify, change, open, look for a connection, look for a way in that reaches them. If you can connect and make it (patient education) applicable to their lives…but if it’s all about what you’re going to give them, and you’re going to change them….It’s all about what they’re going to experience. One of my first questions when they come in is ‘What do you want from this experience?’ And then they will give you their goals. They’ll give you what they want to do and then you can give them other options, other opportunities…I’m happy to do as much or as little work as that want to do. The thing is, if you don’t meet someone where they are, you scare them away. Then you’ve lost your opportunity.

**Key Beliefs and Feeling: Early Years**

When she began professional chiropractic practice after graduating from her pre-service program, Erica seemed to take a formulaic view of patient care. She said that, not having a great deal of patient care experience, she relied on her undergraduate training to determine the course of care for a patient. She also felt that, except for the delivering the information required by the regulatory bodies, patient education was not too important and did not play a very significant role in caring for her patients. Added to this was the fact that she, for the first few years, was working in practices operated by other doctors of chiropractic and she was wary about teaching information to patients that might contradict that which was presented by the local doctor. She did not want to change patients’ thinking or confuse them. Further, she relied on locums for her
income and did not want to be seen as someone who would disrupt a practice while the regular doctor was away. She said about her recollections of her case management in her early years:

I would say that my case management was probably a little more conservative. That was your experience. You came out of school and it was very, ‘we do this first…we do that.’ There’s not as much play because you don’t have as much experience. You don’t have six cases that presented like that, where you know what the outcomes were like. So, you go on your best guess versus your experience. And you’re a little more tentative, whereas if somebody gave you resistance if you came back on your patient management, you might feel a little bit self-conscious about your choices.

As a part of her care, Erica knew that she had to do some patient education as required by her professional standards. Going beyond this level, however, was not a priority for her as she was not convinced that patient education would make a great deal of difference in the patients’ recoveries. When I asked Erica about how she perceived the importance of patient education in her early years of practice in locum positions, she told me, “I wasn’t sure. I wasn’t sure it had any value other than (informed) consent. I could try out the systems in the context of who that person (local doctor) was, but for me, I could take it or leave it.”

Being in locums or in practices operated by other doctors, Erica was not pressured to spend much time on patient education. Rather, the opposite was true. She told me that she chose to avoid patient education initiatives whenever possible so as not to risk disrupting the relationship between the regular doctor and the patient, which, she thought, might happen if she taught patients some information that was different from that taught by the regular doctor. She explained to me that her:

…goal as a locum was to see as many patients as possible for that doctor and for them to be as delighted with the treatment as that could humanly be. And if they needed me for a locum in the future, I was going to be that person.

Even in her early years, Erica realized the importance of patient satisfaction. She felt, though, that having satisfied patients was the result of both her physical care and the “rapport” the patient felt with her. She did not say that she felt that patient education played a major role in developing this rapport. When asked how much she thought patient education was a factor in patient satisfaction, her answer was a blunt and decisive, “None.” She went on to explain about her perceptions of patient satisfaction:

They were happy with how I was with them. How I adjusted. The rapport. If they thought I was a good person. If they felt comfortable. Whether they find rapport with you. Whether they find a commonality, a connection with you…then the treatment will go
well. If they can’t, if there’s no way for you to find that commonality, I don’t care how fabulously they adjusted, they will hate you.

Even though she did not have an overall belief that educating her patients was very important after the informed consent process was completed, Erica did have some feelings that it could be a little more valuable with some patients, depending on their conditions. With regard to the value of patient education related to the severity of patients’ conditions, Erica did feel that patient education was somewhat more important in situations in which patients were suffering from a more severe or serious injury. She explained her thoughts saying, “Years ago, I would say that the less severe, like muscle strains and sprains, were less important.”

**Current Practice**

In her current practice, Erica believes that patient education is important for all her patients and she tries to focus on this aspect of care. While in the past she believed that patient education may have had some value for patients with severe conditions, she now feels that it is important for all those under her care. She believes this because now she understands that even a minor condition may be just the first hint of or precursor to a more severe condition. Patient education and judicious treatment can head off the serious condition. She explained to me she believes this:

…because the first twinge is the early warning sign, and if you don’t pay attention at that point and learn what they mean for you in the context of your body, then you’ll get something more severe later on. If you can learn earlier, then you can take care of that. She continued to explain her current belief that patients all need to learn despite the severity or seriousness of their conditions. Countering her previous views on this from her first years as a doctor, she now says that, “Now it’s all the same. You’re in my office. You get to learn about your body.”

She believes that the effectiveness of patient education is all dependent on the patients, what they want from the experience of being under her care, and how much responsibility they want to accept for themselves. Erica told me about her feelings on how effective patient education will be saying:

It depends on what they want from the experience. Do they want a fix, or do they want to learn? Do they want to get out of pain, or do they want to get out of pain and learn about their body? It’s all about responsibility. Who do they want the responsibility to lie with? Me, to get them out of pain, or them, to take care of themselves?

Erica now sees that being a good teacher for her patients has a secondary effect in that it can also be a strategy for building her practice. She knows that is she is an effective educator for her
patients and can teach them how to take care of themselves and see her when necessary. This will assist with both patient retention as well as increasing referrals. She said that her goals for patient education include sending:

…them (patients) away with the skills and tools they need to take care of themselves.

Then every once in a while, when they need an adjustment, they’ll come in. And they’ll send fifteen people, because you’re the one who gave them the tools to look after themselves. I’ve yet to have that backfire on me.

She believes that one of her successful strategies to ensure patient education is to ensure that she takes what she sees to be a patient-centered approach to her care. If Erica does this, then she takes a major step forward in moving the patient toward a high level of satisfaction with her care. About the experience of being treated by her, Erica explained:

It has nothing to do with me. It depends on if you want the experience to be about the patient, or you want the experience to be about you. I happen to want it to be about them.

If you put them first, you don’t get into trouble. If you put your ego first, then nobody can survive without you.

Erica feels that aspects of patient education present challenges for her in her practice today and will continue to do so. She explained that some of the challenge derives from her desire to take an individualized approach to all her patients in how she teaches them. She said about her view of patient education’s challenge in her practice:

It’s always challenging to a point because you’re trying to tailor things to that person’s life and experience. Some people, it’s easier to find the connection than with others. The education part is not hard, it’s finding the connection with the person.

She continued her thoughts, telling me about her feelings of confidence as a patient educator. Erica feels that for her, while the challenge lies with finding and making a connection with a patient to open the door for effective patient education, once she has done so, she feels a high level of confidence as a patient educator. She looks for feedback from the patient to help her determine that the important connection has indeed been made. Erica said about this:

Once I have a connection (with a patient), I’m pretty confident. There’s a certain willingness that you get (from patients)... When the light goes on... that ah-ha moment, and they get that shift, either in that belief system, or their body, or their diet. It doesn’t matter what the shift is, but they get it.

Erica also believes that patient education in her practice presents a challenge for her because she feels that she has developed greater goals for what she would like to accomplish in her doctor-patient relationships. She used to have the principal goal of getting her patients out of pain
and so she thought that her physical treatments were the most important. Now, she says that her goals for her patients include presenting them with opportunities for personal development especially related to their own health care. She told me that patient education, for her, is:

...more challenging now because the point is different. Before, my goal was to get you out of low back pain. Now my goal is to give you an opportunity for growth. That’s a bigger goal. An opportunity for growth is an opportunity to have whatever experience you need to have in my office. That might be just to get rid of low back pain, but it might be to change how you approach your life.

Erica also believes that one important key for her patient education is that the information she imparts to her patients must be believed by her. She must feel that it is authentic and true for her. Often, when in her locum positions, this was not the case and she did not have complete faith in the educational messages she was delivering to her patients. Now, she feels the opposite must be true and she needs to have complete faith in her teachings. She explained:

When I was doing the locums, I was just giving them (patients) information and the problem was that the information I had to give them, as a locum, was not necessarily something I believed in. It didn’t ring true for me; it wasn’t authentic. I believe that now I work very effectively; it’s a lot easier working from a place of authenticity...For the most part, the patient education material that I’m using, those are my thoughts, my words. So it carries through when somebody reads it. They are reading me.

She believes that there are a number of chiropractors practicing who are not happy with their accomplishments because they are not achieving their full potential as health care professionals. One of the reasons for this, according the Erica, is because they are teaching and delivering information that they do not believe is absolutely true or “authentic” for them. She says that she believes some of the information they teach does not “resonate” with them and this leads to a degree of dissatisfaction with their own professional practices. This belief stems somewhat from her experiences working in other doctors’ practices. Erica explained to me that she makes:

...no judgement on how they practice or what they did. I still, to this day, make no judgement on how they practice or what they did because they meet people at the level that they are at. I may not practice this way, but as long as the person who owns the practice comes to work every day and loves what they do, they are making a difference helping other people...If they hate what they do, then that’s when I think they are in trouble. And there are a lot of discontented chiropractors out there. They haven’t found their role with their patients...I think a lot of chiropractors struggle because they haven’t figured out what their role is, what they do best. And because of that, they can’t find a
way to practice. I’ve got no problem with a subluxation-based chiropractor who honestly believes wholeheartedly that their job is to optimize the health of everybody in the world. But if you do that, and that doesn’t ring true for you – it doesn’t resonate in your system – you can’t be believable. You can’t speak with any sort of authenticity, and people won’t get that shift.

Perceived Barriers to Effective Patient Education: Early Years

In her first years of practice, Erica, even though she did not place a great deal of value on patient education, still perceived some barriers to the effectiveness of the teaching she did do. Some of this difficulty arose from the fact that she had not yet conceived how her patient care fit together with her personal beliefs and goals. Her approach was not yet fully organized. She had not organized the patient information systematically and had difficulty teaching this to her patients. She told me that she had not completely put her own ideas in order and, “So when you don’t have that solidified for yourself, I think it’s really hard to communicate in a systematic method to your patients so that they get where you’re going where you want them to go.” She told me that she struggled to find her own “comfort points” in conveying information to patients, especially since she feels that her approach to chiropractic care is somewhat non-traditional.

Erica also filled some locum positions in practices in which the regular doctor had a chiropractic philosophy that was quite different from her own. She called these “subluxation-based practices” and the doctors subscribe to a different paradigm from her in how they view and practice the chiropractic profession. When working in locums, she tried not to diverge from the way the regular doctor practiced and also tried, when necessary, to reinforce the same elements of patient education as the regular practice doctor. However, since she did not always agree with the philosophy of the practice doctor, she felt that the little teaching she did do was probably not very effective and created some level of discomfort for her. She explained her feelings saying, “In really subluxation-based practices, I didn’t buy that. It really didn’t work for me as a patient. So, it’s just not how I thought…I just wasn’t comfortable with that.”

She also feels that her lack of experience as a teacher for her patients may also have served as a barrier to the effectiveness of her patient education efforts. She felt that she had not solidified the way she wanted to practice her profession and this likely presented a barrier to her teaching and consequently, to her patients’ learning. When I asked her about other incidents of barriers in her practice, she said:

There are lots of them in which I think that if I had explained a little differently, the patient would have responded better…I think in the first couple years of practice, there
are so many other variables and you’re trying to get everything under control that it takes a while for your focus to get to patient education…For me, in the beginning of practice, it was very tough. It took a long time to put my patient management (information and protocols) together.

Time allocation also was a barrier to effective patient education at times for Erica. Working within practices operated by other doctors, she had to fit into their appointment schedules. Some of the chiropractors who she was replacing booked their patients very close together and Erica now feels that this limited time may have been a barrier to the effectiveness of the patient education she did try to do. She told me that when working in these practices, “There were lots of situations that the patient would have preferred to have a little more time with the practitioner.”

As did her colleagues in this study, Erica also encountered patients who had attitudes which, she felt, interfered with effective patient education. For example, in the overseas practices in which she worked, Erica told me that it was not uncommon to have patients who did not care to learn to help themselves. This attitude was evident in some patients in Ontario, too. She said about these patients, “They didn’t give a crap. Their attitude was, I don’t care what you do; just get me better...It didn’t matter what I was doing, they were going to do it their own way. Stubborn.”

In some of the rural practices in which she worked, Erica also had patients whose attitudes limited their learning. Often, these people’s attitudes were based on faith and trust in her. Consequently, patients felt that they did not need to learn and were happy to turn over responsibility for their health care to her. She said that her rural patients would tell her, “You’re the doctor…I trust what you’re delivering here.” Erica felt that the message being delivered to her by these patients was that she did not have to take the time to justify her treatment plan to them. She was the expert and they had complete trust in putting their health matters into her capable hands.

For her patients in practices situated in urban settings, Erica perceived different barriers to the effectiveness of her patient education efforts. She told me that she felt that urban patients are “more complicated” and that they have “less patience...more stress.” She found that because of these factors, she needed to repeat herself to patients, “constantly, because if your (the patient’s) plate is full, there’s not room for anything else.”

Finally, she discussed her perceptions of barriers to patient education that she feels are evident in new graduates. Erica believes that while her physical treatment and diagnostic skills were well-developed during her pre-service curriculum, she does not feel the same way about her knowledge and skills as a teacher for her patients. She also believes that this is quite common for
new graduates from chiropractic programs. The lack of experience of new graduates as teachers may create barriers to the effectiveness of patient education, especially in situations in which the information they had at their hands to teach was not exactly what they believed to be true for them. In this case, she equated patient education with trying to sell something, which would be hard for young professionals, especially if they did not believe in what they were trying to sell, or teach. As this situation had an effect on Erica, she told me about her thoughts on this feeling:

I think about new grads coming out is that they need to have experience outside...so they are not looking for answers on paper. Patient education was ‘selling’ because the models that were out there were not what I believed. If you believe something, you can teach it. If you believe it and you know it to be true at your level, but if it’s not something that resonates with you, you’re ‘selling’ it. You’re selling an idea and that’s not as effective.

**Current Practice**

Erica does not see her own expertise as a teacher for her patients as a barrier to the effectiveness of her patient education efforts. While she says, “I think I could be more effective” she also says that, “I don’t think I’m incompetent at what I do.” She is one who likes to take professional development courses that expand her skills and knowledge as well as provide her with new and different treatment techniques she can use with her patients. Her reasons for doing this are for her own personal and professional growth as well as for her patient care. She explained her reasons for taking so many courses saying, “The more you learn, the more you implement, the more you change.”

Besides the fact that she believes she can continue to improve both as a doctor and patient educator, Erica did not mention any other barriers to effective patient education that she feels derive from her. She did, however, point out several perceived barriers that arise from her patients. One of these involves patient time allocation. In her current practice, she places a high value on patient education and stresses patient learning. Consequently, she allows for appointments of ample length so she can not only provide physical care, but also introduce new information and reinforce previously taught information with her patients. Some patients, though, do not seem to want to spend so much time with her and this detracts from their learning experience. Erica explained that some of her patients are so busy in their lives that they will not take enough time to allow her to teach them effectively. They tell her that they are too busy for all she wants to do with them. She said, “I’ve run into a few cases, like the high-powered business person, big ego, who doesn’t value your time. I’ve run into that occasionally.”
This type of person, Erica feels, has unrealistic expectations about how long it will take to recover from whatever condition they have. They want and expect fast and positive results. Erica said about them, “They think everything can be done likety-split because they’re used to paying to get everything done like that and they haven’t figured out that the body does not work like that.” Some of these patients eventually realize that they need to alter their expectations in order to get a satisfactory resolution to their conditions. Others, according to Erica, do not, but keep coming to her for care when their conditions flare up.

She also feels that barriers to learning can arise from patients who seem to have too much information and who may not be able to arrange this in the proper context. The result is that they mix up the information received from various sources and this confusion may interfere with the patient teaching she is trying to accomplish. Erica described this situation which she has encountered rarely in her current practice and the way she has dealt with those people saying:

Then I’ve run into the person who’s been everywhere. ‘Well, my acupuncturist says’…or, ‘My herbalist does this.’ So, the way I deal with that is to tell them, ‘Well, if this one thinks this, and this one’s doing this, and they’re all doing such a great job, what the hell are you doing in my office?...If you’re happy to talk about everybody else’s opinion, I’m happy to listen and you can pay me to do that.

Changes Related to Patient Education

Since beginning her work as a chiropractor, Erica feels that she has made some major changes related to patient education in her practice. She not only sees her own role as a patient educator differently, but also she has broadened the scope of the information she teaches to her patients. Originally, she limited the teaching she attempted with her patients since she was working in practices owned by other doctors and also because she had not yet fully sorted out the information she felt patients needed to learn. Now, she and her partner have developed a rather systematic approach to organizing this information for their patients. Instead of taking a rather standardized approach to teaching, as she did originally when discussing informed consent and other aspects of care with patients, she now tries to use individualized approach to teaching with each of patients. Erica told me that she begins educating patients based on their prior knowledge and the needs they have when they come to her for care, and these variables are different for all patients. She said about this change in her approach:

So, that’s where the biggest shift in focus is for me, is from taking a patient from where they’re at. Now, it’s starting where they are at and how can you take that forward and using that….What my role is has changed significantly. Where do we have to go?
changes do we need to make in your life? What are the signs that things aren’t working the way they are supposed to?

Erica went on to discuss the changes she sees in her role as patient educator. Initially, in her locums, she viewed her role as one of teaching enough to satisfy the regulatory requirements and also to keep the regular doctor’s patients happy during his/her absence. Now she sees a more expanded educational role for herself that focuses on the knowledge and skills patients need to be able to take care of themselves and to know when they need her expert services. Erica said:

What my role is has changed significantly…Years ago, I didn’t know that it was my job. I didn’t know that the teaching part was more important. It’s (teaching) how you get past that point where people think they are dependent on you. If you give them the skills that they can take away, then they are never dependent on you. They may choose to come and see you because they feel something in their body. Then that’s their choice. But if something is not resolving and they have to keep coming back to you, then you are not doing your job.

Erica feels that she has made great changes to the reorganization and expansion of the information that she teaches to patients. She explained to me that many chiropractors begin and end their patient teaching dealing with structural information. This approach is limited to just the anatomy and mechanical function of the musculo-skeletal system. Now, Erica goes far beyond teaching just about the structural stresses on the body and tries to help patients learn that they need to pay attention to stresses resulting from other aspects of life. For example, there are, in her view, emotional and chemical stressors, too, and patients have to understand that all of these need their attention to maintain good health and to recover when something goes awry. With this knowledge, patients are able to make informed decisions everyday that will affect their health. She told me that in her own practice, she has started teaching by:

…emphasizing the other aspects, other than structural – emotional and chemical – that’s when they (patients) got it because that was something that they could take away. There were more things they could do for themselves. Once you can do things for yourself, that empowers you and once you are empowered, you realize you have choice.

Because she and her partner have worked hard to organize the information they believe into their patient education, Erica feels that now she has become a good patient educator. What she is teaching to her patients is what she believes to be true and accurate as opposed to the material she taught as a new graduate. She explained these changes to me:

When I was doing locums, I was just giving them (patients) information and the problem was that the information I had to give them, as a locum, was not necessarily something I
believed in. It didn’t ring true for me; it wasn’t authentic. I believe that now I work very effectively. It’s a lot easier working from a place of authenticity then to try on something…For the most part, the patient education material that I’m using…those are our thoughts, our words. So it carries through when somebody reads it. They are reading me.

Finally, Erica told me that now, patient education plays a much bigger role in her practice. One explanation for this is that she sees a change in herself which amounts to a shift in the paradigm of her perceptions of how she wants to practice. She told me that now, “I’ve shifted from being the chiropractor who delivers adjustments to the person who’s teaching, or letting people (learn and) remember the skills that they need to take care of themselves.” She sees a greater role for herself as a health care professional, that being not just to help patients recover from their conditions, but also to help patients grow. Erica explained this objective to me:

It’s (patient education) more challenging now because the point being is different. Before, my goal was to get you out of low back pain (for example). Now, my goal is to give you an opportunity for growth. That’s a bigger goal. An opportunity for growth is an opportunity to have whatever experience you need to have in my office. That might be just to get rid of low back pain, but it might be to change how you approach your life.

Josie

Practice Experience and Patient Groups

When we met for the first interview, Josie was in her seventh year of chiropractic practice after graduation. Following her graduation, she continued to complete some graduate studies and so her private practice was small. At this practice, in central Toronto, she saw a range of patients, but tried to focus on those involved in sports activities. She continued with this for two years and then joined a private practice which was being operated by three other chiropractors. Josie says that she practiced full-time, but this was divided between two locations. She worked at the chiropractic office and also at one of the local university clinics treating recreational and competitive athletes. There, she works together with a multi-disciplinary team of healthcare workers.

She describes her early practice as a, “…typical family practice” and her patient population consisted of, “some kids, some older people, some middle-aged – a wide demographic.” She also saw competitive and recreational athletes as she had an interest in dealing with sports injuries, as many of her colleagues do. Her patient population was predominantly white-collar and quite a
few 30-40 year old women. She describes her patients as, “middle class, upper middle class” and “pretty white-washed.” Most of her adult patients have a university education.

**Functions of Patient Education: Early Years**

In her early years of practice, Josie reported that she did not use much patient education. One reason for this is her early belief that what patients wanted was quick relief and a rapid solution to their physical problems. This will be discussed in greater depth later in this report. For the process of informed consent and whether or not she viewed that as having an educational component, Josie said:

I guess it inherently is because you can’t get consent without explaining at least the bare minimum of what’s required by the (regulatory) college. So, yes, in some way, you are educating.

It seems, by this statement, that Josie did not do much more than fulfill the basic regulatory requirement for obtaining informed consent from her early patients. Further, she notes that began practice before the recent increase in regulatory stringency related to obtaining informed consent from patients. Josie continued on to state that the education she did to address issues of treatment choices with her patients was quite vague and because of this, she did not spend much time on patient education. For example, she told me:

I don’t think I was effective at setting a plan of management, so instead of educating the patient and saying ‘this is what I think, this is how many visits you need’ I was really vague, like ‘oh, you know, it shouldn’t take that long’ and then you kind of go treatment by treatment basis in terms of when I want to see them again instead of really setting out a plan.

Josie uses a number of different techniques besides chiropractic adjustments to treat her patients (ie. acupuncture). She told me that, in her early years of practice, she would usually leave it up to the patient as to what treatment choices to make. Once again, she reports being rather vague in her explanations of the various techniques and not giving the patients, “…a solid reason why…” she would recommend one over another.

Considering the use of patient education related to issues of patient compliance as well as patient expectations, Josie said, once again, that she used educational interventions both minimally and somewhat ineffectively in her early years of practice. She explained:

I did a bad job because how could they be compliant if I wasn’t actually giving them a solid plan of management in the beginning? So, I would very often maybe in the first years of practice, see someone three or four times and then never see them again because
I had never articulated to them why they should be complying with something. And that gives the patient the expectation that they should be better in three or four visits and they don’t need to come back any more.

Evidently, she believed that it was the lack of patient education, or of effective patient education on her part, that led to the development of unrealistic and unattainable expectations by the patients. Ultimately, lack of effective teaching led to patients leaving her practice prematurely and this was one of the causes for her to reflect on her uses of patient education and make changes.

Josie reports not using patient education at all to address issues of prevention of injury or re-injury when she started practice. She recognized that this approach was ineffective as, for many of her patients, their conditions re-occurred. About using patient education to teach prevention, she said, “I was definitely not doing that at the beginning so it was a lot of ‘treat them three or four times’ and they’d get better. Then a month later, the exact same thing would happen and they’d come back.” According to Josie, she eventually recognized that the lack of effective patient education interventions was one important reason that prevented her practice from thriving and also accounted for the early and premature departure of patients from her care.

Current Practice

Now, Josie uses patient education to address many of the elements involved in patient care. She says that due to an inquest into the death of a patient following a chiropractic treatment, certain aspects of the informed consent process have become much more stringent and she has incorporated these, along with patient education into her practice routines. She goes on to explain:

First of all, after the inquest, the informed consent procedures got a lot more specific. The CCO (College of Chiropractors of Ontario) has got a lot more paperwork-heavy when it comes to your patient, so not only do you have to have informed consent for chiropractic treatment, you have to have informed consent for every technique you do. So, I have to have informed consent for acupuncture…then there’s a separate consent for that (cranial-sacral therapy). So as a part of your consent procedure, which can take fifteen minutes to get through all the forms, you’re explaining different techniques, what the benefits and risks are, to them before you can even start working on the patient. So that’s one reason it has kind of evolved into what it has.

Not only has Josie begun incorporating patient education to a much greater extent in the informed consent process, she also now sees a purpose for this intervention to address issues of treatment choice and feels that patient education can play a role in allaying patients’ trepidation
and anxiety related to chiropractic care. Further, from her statement below, it is evident that she now sees patient education as an aid in establishing realistic time expectations for the patients. She explains how patient education now helps her and the patient early in the course of care:

The focus of the first visit is not on treatment, unless someone’s in the acute phase. More on information gathering and explaining things to patients, giving them their options…because we get some people who come in, especially with the stroke issue, who are really nervous on their first visit. So I take time to explain things to them and if they want some treatment, just to get started, and then on the second visit, go through a more formal report of finding, with handouts, some information that they can take with them and more specific information on the plan of management, so I want to see you this many times a week, for this many weeks. This is what you need to do; this is what I need to do. So, a lot heavier in those first two sessions to kind of set the plan of management in motion.

Compliance, or rather the lack of it, can become an issue that is deleterious to the patient-HCP relationship and can have a negative effect on the case outcome. Further, lack of compliance can alter the feelings of the HCP in many situations. This was true for Josie, but in her current practice, she has taken steps to alter this situation. She told me that patient education can serve the function of helping patients comprehend their own roles and also the issues involved in getting themselves better. Josie says that she:

…was getting frustrated with lack of compliance from patients and the more informed…the more information you give them, then they understand why you’re trying to do something. And it sets up expectations. In the beginning, (early practice) you’re rushing to get someone better. You think, ‘Oh my god! They’re spending this money. They should get better.’ When really, you’re selling yourself short. I wasn’t giving myself enough time to be successful and I was setting up unrealistic expectations for patients of how long it takes to get something better.

She now uses patient education in an attempt to circumvent patient compliance problems by teaching her patients about reasonable goals and expectations related to their prognoses and recoveries. The added benefit if this is that she has alleviated some of the issues that had become frustrating ones for her in her first few years of practice.

Patient education for the purposes of teaching patients how to prevent injuries, or re-injury is also employed by Josie in her current practice. She feels that she is “a lot more open speaking of prevention” and that most of her patients need something of an active exercise program both to
aid in their recoveries and as an aid to assist with preventing further injury. She also tells her patients:

Passive care will get you this far and my role is this. Your role is...here’s your homework. This is what you have to do at home. This is what you need to do exercise-wise. Adding in those extra components and really educating the patient on their responsibility on their care. I think that’s a big thing that people miss out on.

In Josie’s current practice, patient education is a key to assist in bringing the patient into a shared partnership with her. She explained that patient education did play a role in getting the patient more involved in his/her care and participating in the decision-making process. About this, Josie said:

…without that education component, there’s that level of ignorance there, and if you don’t give them the proper education, they do not know what’s going on with their body, and their ability to know what’s going on with their body, without the proper education, you’re taking that ability away from them....you’re taking their ability to actually have control of their body away from them.

Education can have a proactive role in Josie’s practice, too, and she says that effective teaching helps her patients associate their behaviours with their recovery and with prevention of further health issues. She goes on to state:

…If you give them the information, throughout your plan of management, you’re teaching them how to recognize certain signs and symptoms in their body and ‘when I feel this way, I should do this.’ ...So, it’s giving them that information so they can notice these different symptoms in their body and they can make those choices for themselves.

So, then, that gives them the ability to take charge of their health.

Josie also sees patient education serving a function in other areas namely to build trust in the HCP-patient relationship and also as a strategy for managing risk. Building trust with patients is important to improve patient satisfaction levels and thereby keep patients in one’s practice. Managing risk is important for all professionals and especially for health care professionals. Josie sees patient education as a tool to fulfill both of these purposes. Education helps bring patients to accept some responsibility for their own health and in doing so assists in reducing the risk of an unfortunate case outcome which might possibly lead to professional liability issues for the HCP.
**The HCP’s Role in Patient Education: Early Years**

In the early years of her clinical practice, Josie did understand that she had a responsibility, as a health care professional, to educate her patients to some extent. She also said that she did have some difficulty coming to grips with this role and still maintain a professional demeanour:

> I think I knew that it was my responsibility to educate my patients, but I think I was confused on the difference with providing someone with good information and feeling like I was trying to be a used car salesman and getting them in the door.

Josie also said that many of her colleagues went to ‘practice management and growth’ seminars at which they were encouraged to use a scripted approach to recruit and keep patients. She did not approve of that approach feeling that it was less than authentic, and so sometimes, in an effort to be different from her colleagues who relied on scripts, she said or taught very little to her patients:

> …here was this whole faction that you were kind of opposed to, like the more subluxation-based chiropractors, that went through a practice management program, with scripted patient education materials, like this is what you say, and it was almost a revolt against that kind of practice, that you completely went in the opposite direction, so you didn’t say anything at all…which doesn’t make any sense at all, since we have the title and privilege of ‘doctor’ which implies that you’re going to teach, and I kind of didn’t.

**Current Practice**

In her current practice, Josie perceives her role as a patient educator differently from her early years as a HCP. Now she sees her responsibility as a teacher involving trying to educate patients so that they can be involved in decisions regarding their health in a meaningful and not just a superficial way. She still struggles to some extent with balancing both the amount and complexity of the educational content she tries to teach to her patients. About her current views of her role, which she sees as one that continues throughout the course of care, Josie said:

> I think it’s important to give the patient enough information so they can make accurate decisions for themselves. So, you don’t want to give them the wrong information, and you don’t want to give them too little information so they get the wrong idea about something, but you also don’t want to bombard them with information that they can’t understand. So, it’s a definite process, like I don’t think all patient education is done in the first two visits. I think you present them with information in the beginning, but as you’re treating someone, you get a dialogue over time, and they get a better understanding as to what’s going on, why they should do things, why things are
important. And then your role is to give them information and also be a sounding board so they can come back with questions.

Further to this, she expanded on her role that she described as one of being a ‘sounding board’ for her patients. Like many of her colleagues, she fields questions from her patients related to their care by other health care professionals in different disciplines. Often, she feels that for these patients, the teaching by the other HCPs was either ineffective or even non-existent:

When I think of the education that I do, I spend an awful lot of time answering questions because people have been to other health care practitioners and have been given some kind of information and they don’t understand it. So then I spend time trying to explain what the family doctor was trying to tell them, or what the surgeon was trying to tell them….It hasn’t been explained well, or it hasn’t been explained at all.

Josie is not unique in mentioning this aspect of her serving as a teacher for her patients. Other participants in this study have also mentioned that their patients ask them questions related to the care and information they receive from other health care professionals. Some choose to deal with these questions, as Josie does, and others tell their patients that they are not qualified to respond. Josie does have experience working in multi-disciplinary settings and so she likely has learned more about other health issues that do not generally fall under the umbrella of the chiropractic scope of practice.

Part of her role and responsibility, according to Josie, is to build an ongoing relationship with the patient in which she facilitates the patient decisions. She also recognizes that at the beginning of the relationship, she is in a position of authority both because of the fact that she is a health care authority and that she is in a position of power to make some key early decisions:

I think that part of your relationship with your patient is (that) you’re in a position of authority and you’re going to dictate more how treatment is going to go. But once you get to a certain point with a patient, it’s more that you’re working with them to achieve what they want. And you’re more of a facilitator for what they’re doing. At the beginning, you’re more in an authoritative position in that you’re dictating what’s happening, but I think as your relationship with the patient goes on, especially if you’re treating someone with a chronic (ongoing) problem, and you’re seeing them on a regular basis, your role turns to more of facilitation, helping them make the right choices to support their healing process.
Nature of Patient Education Interventions: Early Years

Looking back on her early years of practice, Josie acknowledges that she did not use patient education to a great extent. What she did do seems to be primarily of a transmission nature and mostly verbal. She said, “I think in the beginning, it was mostly just talking to them. Sometimes, I used spine models.” Josie added to this, “I wasn’t using any brochures, or presentation material.” She would invite the patients to ask questions, but not encourage this. To the patients, she would say, “If you have any questions, let me know.” About various media, she did mention that she had a couple charts on the wall, one of which illustrated a theoretical model of various causes of ill health. She would occasionally refer to these when talking to a patient. Josie, as many of her colleagues mentioned, felt that her physical treatments were most important. This idea ties in with her educational efforts in her first few years. If she was able to achieve a good result, then she:

…would be believable to them. My thought was that if I could get a quick result, fast, then they would believe what I had to say. And be more open to hear what I had to say and why something was happening…There was a certain level of trust that was established…so because they got a result, they would be more open to listening to what I had to say versus telling them a whole bunch of stuff that may or may not happen, which is kind of backwards at the same time.

Her comments emphasize the transmission in her educational approach when she said that it was good for patients to be more open to “listening” to what she had to say. She briefly mentioned that the increased credibility may possibly have moved her slightly towards a transactional approach when she said, “I think it opened the door. It definitely opened the door for an easier dialogue.” Besides this one brief comment, Josie did not say anything further related to the increased credibility because of the good clinical results leading to a great deal more educational interaction or transaction between the patients and their doctor.

The patient’s background and education also influenced the nature of Josie’s early educational efforts in that she would consciously try to alter the terminology she used to speak to the patient. About this issue, Josie explained:

So, if I was dealing with someone who was a kin (kinesiology) student, or who was a recreational athlete, or who had experience in health care, it would be easier for me to do patient education because I was speaking with someone who already had familiarity with the language (meaning vocabulary) versus someone who did not understand the terminology.
Current Practice

Now, Josie’s patient education efforts still reflect a transmission mode most of the time. She consistently used phrases like, “you’re explaining the different techniques,” “mostly talking on your (her) part,” and, “…you give them (patients) the information.” She also alludes to patient education being akin to delivering a set of information to patients. She said that her, “…role is to give you (the patient) the right information…” and “…if you don’t give them the proper education, they do not know what’s going on with their body…” This approach is highlighted again when addressing issues related to nutrition. Josie explained, “So, it’s giving them that information so they can notice these different symptoms in their body and they can make those choices for themselves.” While this comment suggests that Josie tries to empower her patients through education and make them partners in the decision making process, she still primarily teaches using a transmission mode characterized by a one way flow of information from the HCP-teacher to the patient-learner.

Only occasionally does Josie suggest that she sometimes uses a transaction, two-way, teaching approach in her current patient education efforts. She mentioned this when speaking about the process of obtaining informed consent in her current practice:

With informed consent, it’s a lot of dialogue between the patient and me. I’ll use spine models. Depending on what the condition is, I’ll use a lot of anatomy textbooks…I’ll go through a lot of the anatomy…touch the patient. Have them fire certain things (contract specific muscles)…so a lot more interactive with a visual component…so they can kind of put two and two together with what they are doing and what they are looking at at the same time.

Further to this, Josie suggested that having a patient under her care for a period of time also had an influence on the nature of the patient education in that she is able to move more towards a transactional approach. She explained:

I think part of your relationship with the patient is (that) you’re in a position of authority and you’re going to dictate more how the treatment is going to go, but once you get to a certain point with a patient, it’s more that you’re working with them to achieve what they want. And you’re more of a facilitator for what they’re doing….I think you present them with information in the beginning, but as you’re treating someone, and you get a dialogue over time, then you get a better understanding as to what’s going on, why they should do things, why things are important. And then your role is to give them information and also be a sounding board so they can come back with questions.
In these comments, Josie mentions the fact that she now does more than just speak to patients, as she used to do. While perhaps a mix of transmission and transaction, we can see that now she also uses more visual media, such as textbooks and three dimensional anatomical models, as well as the patient’s physical movements in order to assist her with teaching the patient. She also said that she has some diagrams in her office on wall charts and posters and she also sometimes uses pamphlets, both those developed in her practice and also some which are available through other sources. Josie also told me that her practice has a website to which she sometimes refers her patients for links to specific information-based sites. Besides these strategies, she still invites patients to ask questions, but does not seem to emphasize this type of educational opportunity. She does this through comments like, “If you have any questions about anything that we’re doing along the way, just let me know.”

**Key Beliefs and Feelings: Early Years**

Josie’s early attempts at patient education were mitigated by the feeling that she was not very confident as a communicator. This was a roadblock to her assuming a position of authority early in the doctor-patient relationship. She explained her feelings:

I would say that it was more a lack of confidence in communicating and in patient education and instead of taking charge of a patient interaction and giving strong recommendations of what you felt and “this is what you need to do,” there was more, “I’m just out of school, a new graduate, still in a residency program,” feeling that you are still more of a student than a practitioner. And so being scared to say, “this is when I want to see you; this is what you need to do; this is what’s going on,” and so I lacked confidence in communicating that to the patient….you know theoretically that education works and you need to be doing different things at home, but not having the clinical experience to go with the theoretical knowledge, giving you a lack of confidence in communicating that information to the patient.

Josie also felt, in the first years of practice, that she was doing a disservice to the patients if they did not get a quick result from her treatment. She said, “…these people are paying to see me, I need to get them better fast and out the door.” This belief fed into the development of unrealistic expectations from patients about their recoveries and about their own responsibilities in making themselves better. This has been discussed earlier in this section.

Defining or determining a specific approach to take towards patient education was difficult for Josie as a new HCP. She knew that she wanted to undertake some patient education activity, but she did not want to sound like she was preaching or selling chiropractic care to her patients.
She essentially had difficulty finding a balance between appropriate patient education and indoctrination. Josie elaborated on her feelings explaining that she did not want to sound like “…a used car salesman…” and yet still fulfill her responsibility to educate her patients:

She went on to explain that her approach to patient education at the time was at least partially shaped by her feeling of not wanting to be perceived as one of those doctors, like some of her colleagues, who use patient education primarily for building their practices through a scripted educational approach that borders on coercion of the patient, and sometimes, even resorts to establishing a level of fear in the patient that without chiropractic care, one’s health will erode rapidly. About the practice management programs that teach chiropractors this approach, Josie explained her feelings:

(It’s) a marketing tool and it’s very scripted and it’s very dependent…The practice management programs do a really good job of educating patients; I don’t really agree with the content they are using, but they really do put a big push on talking to their patients and engaging them in a dialogue….So, in the beginning, it was you didn’t feel that you wanted to sell them.

Josie admits that these scripted approaches can be effective at educating patients, but feels that what information is delivered to the patient is not appropriate and she disagrees with both their approach as well as their content.

As mentioned earlier in this report, Josie believed that patient education was less important than achieving quick resolution to the patients’ symptoms and she felt that it was the latter that would satisfy the patient. Hence, she minimized her patient education efforts and concentrated on the physical aspect of her care:

I think it was more important for me, for them to get some kind of physical result versus the education as to what was going on. I think I thought that I would educate them, get them on board with treatment, by having a quick result versus me giving them a full picture as to what was actually going on.

Josie had some experience working in a multi-disciplinary setting with other health care professionals such as medical doctors and athletic therapists. This experience gave her the opportunity so see others as they educated their patients and also to see other approaches to various conditions. In these environments, Josie said she felt more confident as opposed to working alone in her clinic and she credits this valuable experience with helping with comfort toward patient education. She explained further:

I think I always felt more confident as a patient educator when I was working in a multi-disciplinary setting because there was always someone there to back up what I was
saying. So, I felt more supported in communicating things to the patient and also allowed me to see how other people did patient education. So it gave me a little bit more of a springboard to go from and a little bit more confidence in communicating. (and)...working with (different professions) with lots of clinical experience helped teach me to communicate and helped me hone my skills and that was good for me…

Also, in her early professional years, Josie said that two aspects of her practice seemed to cause feeling of frustration. These two areas were patient compliance, or more precisely, a lack of this, and the fact that her practice was not growing as fast as she would have liked. The realization of this became a factor that helped her alter her clinical approaches, especially those involved with patient education. She went on to say:

I think the biggest thing was lack of compliance and my not increasing income motivated me to do a better job in educating my patients….lack of compliance and getting frustrated because the practice wasn’t growing the way I would like it to was a big motivator for me to get better at patient education.

Josie also mentioned that she did not feel sufficiently prepared to be an effective patient educator when she graduated from chiropractic college:

Clinically, I felt prepared. From a patient education perspective – no, I don’t think so…I don’t think we (new grads) realized how important patient education is from a practice management point of view….I think we are now graduating a lot of really good diagnosticians who have no idea how to communicate to their patients, because they are so caught up in having some kind of evidence to back up what you are doing, that skill of talking to the patient is not there.

Like many of her colleagues who participated in this study, Josie believed that she received an excellent education as far as becoming a very good diagnostician and also in the delivery of physical treatment. Also, like many of her participant-colleagues, she acknowledges that patient education was not a focus of her pre-service curriculum, even though there is no dispute as to its importance as a part of health management. She suggests, above, that one possible reason for this is the emphasis on evidence based practice. That is, treatment decisions should be based on sound evidence that a particular course of care would be both safe and effective. As a new graduate, Josie tended to focus on that concept and while she could find solid evidence to support a particular treatment, she had difficulty finding similar hard evidence as to the efficacy of patient education. Hence, according to Josie, she and her newly graduated colleagues tended to underestimate the value and importance of patient education in their practices.
**Current Practice**

In her current practice, Josie now believes that patient education is much more important. She feels that it is intimately linked to patient satisfaction in that effective patient education is used in, “setting up a more realistic expectation for them.” Part of this process involves sharing some of the decision making with the patient. Effective patient education also helps the patients understand their own responsibilities in their own recoveries and the connections between their actions and the effects on signs and symptoms. About this aspect of patient education in her practice, Josie said that:

I think it’s empowering to the person (patient) that they realize that they have just as much or a bigger role in managing this condition. I think it helps the outcome a lot more to a patient to make them better….without the proper education, you’re taking that ability away from them…giving them that information so they can notice these different symptoms in their body and they can make those choices for themselves. So then that gives them the ability to take charge of their health…. (without this information) then they go out and they don’t pay attention to what’s going on, and hurt themselves again, and they wonder why it happened again.

Patient education has become important for her practice since Josie now believes that it plays a role in helping the patient feel comfortable with chiropractic care. Josie explained that she thinks that patient education, “takes the fear out of it (chiropractic care) for some people because some people have been to chiropractors and their biggest complaint is that nothing was ever explained to them.” Josie feels that education that makes a patient feel comfortable with treatment helps with patient satisfaction, as explained earlier, and also with two other important aspects of professional health care practice, namely risk management and building trust. If people trust their HCPs because of effective education and positive results, and because the risks, benefits, and alternatives of care have been explained to them, then patients will be less likely to engage in activities which will retard their recoveries and will also be less likely to initiate complaints about the care they have received. To add to this, Josie remarked, “I think it’s part of your role as a chiropractor, to educate patients. I think that’s within your scope. I think you would be somewhat negligent if you didn’t do it.”

Josie also now feels that patient education has become important to her practice success. In large urban settings, patients have many options from which to choose for their health care. Patient education can be a key element in a successful practice in that it can help convince a patient that chiropractic can be a safe and effective care option. In addition, she feels that taking
the time to work on effective patient education can help differentiate her from her numerous
chiropractic competitors. She goes on to explain:

I think it’s a consumer’s market out there when it comes to health care and I think that
people have the option to go to anyone, whether it’s a chiro, or an osteopath, an athletic
therapist, a massage therapist, or a physio. I think the first thing is that patient education
is yourself. You want people to come to you and know why they should come to you
instead of going next door to see someone else. I think that’s one reason why patient
education is so important. It’s different in a small town, but in Toronto, you can spit on
another health care professional in any direction. So, what makes you different from
anyone else? You have to articulate that to patients and that usually comes through in
your patient education process.

Josie also explained that she believed that patient education is now important with all her
patients, both those with acute (sudden onset) and those with chronic (long-lasting or recurrent)
conditions. She does acknowledge that with chronic conditions, she has more time with the
patients and this allows a greater opportunity for her patient education efforts. The extended
period of treatment, and hence education, provides an opportunity to make significant changes.
Sometimes, she says, “…you’re trying to change attitudes, usually towards how they feel or how
they are doing something…” and this just takes more time to accomplish. Having said that, Josie
also feels that there are some patients with whom patient education will be more effective than
with others, despite their diagnoses.

Patient income and education levels also, according to Josie, have a bearing on patient
education and patient learning. She said that she expected that the higher the patients’ level of
education, the better the learner they would be. However, this does not seem to be the case in her
experience:

The big surprise for me in the last couple years is that, in the beginning, I was under the
assumption that if somebody can afford to be seeing me, that was the person who would
be more compliant. But since I’ve been in practice, it’s been more the people who can’t
afford treatment who are actually committed to getting better and feeling better. And the
people who can well afford to be coming on a regular basis have been more the people
who want the quick fix, in and out. I have found that quite surprising over the years.
She speculated on the reason for this as possibly being related to one’s ability to work. Josie
explained:
Maybe they know at some level that…it’s in their best interest to be healthy because they have a limited income, and if they are injured or hurt, they can’t work. They will be in a much worse off position than somebody who has quite a lot of money.

**Perceived Barriers to Effective Patient Education: Early Years**

As with most, if not all, new health care professionals, Josie encountered certain issues that became barriers to effective patient education. One of the internal barriers, as stated before, was Josie’s own lack of confidence as a communicator when she began practice. Josie said that she felt she was, “…still more of a student than a practitioner” and that, “I lacked confidence in communicating to the patient.” She discussed this barrier by saying that her lack of confidence was closely tied to her lack of clinical experience. She explained that new grads like her, “…know theoretically that (patient) education works…but not having the clinical experience to go with the theoretical knowledge…giving you a lack of confidence in communicating that information to the patient.” This lack of clinical experience made it difficult for Josie to educate her patients because she was not able to establish a long term plan of management; rather, she made treatment decisions on a day to day basis. In this situation, she was not able to determine either long term treatment or educational goals and strategies. She went on to explain:

I don’t think I was effective at setting a plan of (case) management so instead of educating the patient and saying ‘this is what I think; this is how many visits you need; this is what’s entailed’ I was really vague…then you kind of go treatment by treatment basis in terms of when I want to see them again instead of really setting out a plan.

Josie’s lack of confidence was also identified as a barrier in that she was fearful, early in her practice years, that patients would perceive her as a charlatan or quack. Josie told me one barrier she felt was:

My fear that people would think I was kooky or a ‘whack job’ about what I was doing. My fear that people would think they were getting ripped off or I was communicating info about a plan of management that would have ten or twelve visits in it. I would say the biggest barrier was myself… my own lack of confidence in communicating why people should do things and what was going on with them.

She also mentioned that she found it challenging to ‘translate’ technical medical terminology into words that patients would understand may have been a barrier that interfered with patient learning. She believes that this problem is not peculiar to her practice saying, “I think it’s pretty common for health care providers, especially when they start out.”
Barriers to effective education that were intrinsic to patients were also encountered by Josie. While she mentioned that she experienced difficulties with patient literacy levels or language, she did run into patients whose attitudes got in the way of their learning. Regarding patient language, in her first years of practice, Josie encountered only one patient who was not completely fluent in English and this obviously interfered with educational efforts. About patient attitudes being an educational barrier, Josie said that she did encounter some athletic patients, “who didn’t care what you had to say. They just wanted to play…It’s a challenging patient population.” Further to this, she went on to say that, “Some people just aren’t interested. Like there are patients who don’t want to know; they just want me to fix them.” This is a difficult problem to address in that some patients do not understand their roles and responsibilities in helping with their own recoveries and some just do not want to take on or accept that responsibility; they are happy to turn over responsibility for their own health care to others, namely their HCPs.

Josie also felt that, with some patients, her age may have proved to be a barrier to effective patient education especially when she was treating a patient who was significantly older than she was at the time. She explained:

Sometimes, I think it was difficult because I was young, because if they (patients) thought I was too young, and because I was young, they wouldn’t believe what I was saying and they wouldn’t take seriously what I was saying….the difference in ages especially when I was in my late twenties and I had a fifty year old man, or someone who would be around my parents’ age and feeling that (to them) I wouldn’t be believable.

**Current Practice**

Now, in her practice, Josie identified some issues that she perceives as barriers to effective patient education. One of these, related to herself, is just her own occasional lack of personal motivation to work at the details related to patient education. For example, she told me that sometimes she had, “…just been lazy at ordering educational materials, so it’s a lack of pamphlets and information to give to people.” She does not feel that her own expertise at teaching is a barrier, nor are patient language or literacy levels.

She still believes that patient attitudes can become barriers to their own learning especially if they feel that their health care professionals are not taking them seriously. She tries to prevent the formation of this barrier by deliberately taking time to explain information to patients and to discuss their problems. Josie told me about one of her patients who had a rather complex shoulder problem and who had been to several different HCPs. After carefully explaining the problem to him, he told her, “Nobody had ever explained to me what was going on before. I didn’t realize
how certain things that I was doing were causing problems.” His message to her helped Josie reinforce her efforts to try to make patients feel like she was taking them seriously by taking time to educate them, when other HCPs may not do so.

Patients can also have other attitudes that can become barriers to effective education. Josie related that she sometimes encounters patients who, “…never hear no matter what you say. They come in with their own agenda and it doesn’t matter how much you say, or how much information you give them, it’s not going in.” She went to elaborate about how some patients are not willing or able, to take on at least some of the responsibility to assist with their own recoveries. Josie said she feels that:

…there are people who choose not to do the things to make themselves better; it’s almost that they want to be in pain. Or it’s easier to be in pain than it is to do the work to get them out of pain, is probably more accurate. If somebody else can’t fix them, they are not really prepared to do what it’s going to take to get better. So the process that they would have to go through to feel good all of the time is an awful lot of work and they are just not prepared to do that.

Some patients have other life issues which can interfere with their recoveries and their patient education. Josie mentioned that some of these issues might involve cases in which lawyers were involved, in which there may be psychological or emotional overlays, or in which patients may not have family members who support their recovery efforts. If lawyers are involved, sometimes, it is to the patients’ perceived advantage not to recover too quickly as this might lessen the merits of their legal cases. Emotional and psychological overlays may include patients who are pain-focused and have lost their ability to understand that they have some control over their decisions regarding their recoveries. Not having supportive family members who assist and encourage patient recovery can also be problematic and can get in the way of patient learning about their conditions and how they can help themselves.

Changes Related to Patient Education

From the time she began practice until the present, Josie has made major changes in both how she uses patient education and also how she perceives its role in her chiropractic practice. Explaining some of the reasons for her changes, she indicated that many of her changes were purposeful and intentional. For example, Josie told me about her process of obtaining informed consent and how and why this aspect of her practice has changed. She explains that she began practice before the results of a coroner’s inquest into a patient death following chiropractic treatment. One of the inquest results was a recommendation for chiropractors to be more
complete and include more information in the informed consent process. Josie goes on to explain how she felt when she first started:

In the beginning, when I first started practicing, it was before the inquest was in full swing and there wasn’t such a push on for informed consent. And especially with the issue of stroke and chiropractic and cervical spine (neck) adjusting, it hadn’t been in the papers as much so it wasn’t as…you needed to get consent, but it wasn’t as detailed as what you were doing with people. So, I think in the beginning of practice, not that you would skip over and deceive a patient, or not tell them, you might not go into as much detail on some things…you don’t want to tell people that you’re going to hurt them, but you’re already trying to ‘fake it – make it’ a little bit and then you’re telling them that something that might deter them away. But you don’t want them to run out the door because of the informed consent. I think that my consent has gotten ten thousand times better, especially since the inquest, just because you have to do it.

Increasing her clinical experience also helped Josie with her patient education. Early on, she knew that she did not spend much time or effort on patient education and this led to her feelings of frustration due to lack of patient compliance. She explains her early deficiencies by relating them to her lack of confidence as an educator and teacher. She also now realizes that one of the reasons she is much better at patient education is because of her increased confidence which is a result of her growing clinical experience. She explained this to me saying:

It took me a while to be confident in how I wanted to practice and not feel judged by my peer group, and once I got to a point where I was confident that I could rely on all my treatment techniques, then I became confident in communicating that to my patients.

Josie also realized that poor or ineffective patient education can, and for her did, lead to unfavourable case outcomes. She told me about a professional soccer player with an unusual chronic injury who wound up missing a full season due to ineffective patient education on the part of the sports medical team, of which she was a part. They, collectively, did not educate him well on the condition nor did they give him a strict plan of management or guidelines for him to follow. She says that they, “…were pretty wishy-washy about it to a point where it got so bad that he lost a full season” and “…looking back on it, if he was educated properly about the severity of what was happening to him and if we had been more firm…there might have been better compliance. But hindsight is 20-20.” This was undoubtedly an unfortunate situation for the patient, but it also helped Josie understand the role and importance of effective patient education. Her reflection back on this case may have been one of the reasons why she began actively to change her patient education focus.
Josie also credits her experiences working in a multi-disciplinary setting for making her a better patient educator because, she says, this experience, “…allowed me to see how other people did patient education, so it gave me a little bit more of a springboard to go from and a little bit more confidence in communicating.” She goes on to add that working with HCPs, “…with lots of clinical experience helped teach me to communicate and helped me hone my skills and then that was good for me when I was on my own…” Josie feels that her experiences in her own clinic and working with others improved both her communication skills and also her confidence and these changes, she believes, made her a better teacher for her patients.

Besides becoming somewhat frustrated with issues of patient compliance, another motivational factor that helped influence changes in Josie’s patient education was the slow growth of her practice. On reflection, she realizes that what she needed in order to improve was more confidence and more clinical experience to back up what she was teaching to her patients. She explained:

I think the biggest thing was lack of compliance and my not increasing income motivated me to do a better job in educating my patients…Lack of patient compliance and getting frustrated because the practice wasn’t growing the way I would like it to do was a big motivator for me to get better at patient education and then as my skills and my confidence increased at what I was doing, then I didn’t have the same insecurities about communicating what I was doing with patients…

Now, Josie feels that she, “…actually puts more effort into patient education,” and provides not only more, but also more comprehensive information for her patients. She says that she now gives:

…much more information to my patients now than I did in the past. And I think I’m more forthcoming about what’s going on, and what they’ll need, and there’s definitely more of a discussion, especially in the first two visits, about chiropractic, about their conditions, about the treatments I use, about why I use them, what benefit that will be for the patient.

Issues of compliance and practice success are important for Josie. She now sees patient education as an important strategy to achieve her goals. In addition, for her now, patient education is used to build trust and as a successful strategy for risk management. If her patients know about their care and if they trust her, not only will positive case outcomes become more frequent, but also, she will reduce the chance of patients initiating complaints about their care.

While she still employs principally a teaching mode based on transmission, she has added other educational resources including 3-D models, diagrams from text books, wall charts, print materials, and a practice web site. Some of her comments also suggest that she occasionally
begins to teach using more of a transaction approach entering into a two way conversation about the patient’s case. In this situation, the patient approaches the role of becoming a partner in the health care decisions. For example, about this in her current practice, Josie explained:

I think you present them (patients) with information at the beginning, but as you’re treating someone, and you get a dialogue over time, then they get a better understanding as to what’s going on….and then your (her) role is to give them information and also be a sounding board so they can come back with questions…once you get to a certain point with a patient, it’s more you’re working with them to achieve what they want and you’re more of a facilitator for what they’re doing.

Josie also spoke about her role as a patient educator in her current practice. She said, “I don’t think my role has changed, but I think my perception of my role has definitely changed. What I think today is that it’s a bigger part of our scope of practice as a chiropractor. It’s up there with adjusting.” She also pointed out that now, she spends much more time on patient education and her efforts have been reinforced for her with both a decrease in frustration from patient non-compliance and also a satisfactory growth in her practice. She sees a close linkage between these aspects of practice and patient satisfaction. She feels that patients who are better educated are going to be more compliant with the treatment plan. With better levels of compliance, positive case outcomes should result. Satisfied patients will return to her practice when they need to do so and will also refer others to her care. For Josie, improving her patient education efforts creates a positive situation for both her patients and herself.

Kelly

Practice Experience and Patient Groups

Kelly has been in practice for just over seven years. Initially, she practiced as an associate in a smaller bedroom community near Toronto. The practice was situated in a building with several other health care disciplines. She remained in this situation for two years then began working in a variety of locum arrangements, filling in on a temporary basis for doctors who were away. This experience lasted about 1.5 years after which she began her current practice in a business/commercial area of downtown Toronto.

In the first few years, her patient population was varied and included “moms, and children, and seniors” during the day and “business people commuting from Toronto” later in the day. She describes her patient population as a bit of both white collar and blue collar. The patients’
education level was mixed and she rarely had patients who were not English speaking Caucasians.

Her current practice involves patients who range between their mid-twenties to sixty-five years old. “Most people work in an office setting, so a lot of administrative people working at computers, sitting at a desk, high stress.” She has many people working for banks and legal firms who are all well-educated. Language and literacy levels are not issues in this patient grouping. Most have good insurance coverage for her services.

**Functions of Patient Education: Early Practice Years**

For Kelly, patient education played some minimal part in the important area of obtaining an informed consent from the patients. Patients would be provided with a printed consent form including key information. They would be asked to read and sign it. About this procedure in her first years of practice, Kelly said, “If I remember correctly, they got the form. They signed it. That was about it.” She would normally ask if patients had questions and address these.

She reported that there was little patient education involved with treatment choices or case management decisions at that time. Kelly said that she would, “educate them a little bit, but not a lot.” A similar strategy was reported for issues involving patient compliance and adherence to the treatment plan. “You end up talking to people and saying it’s important for you to be adhering to the treatment plan.” Using patient education as an intervention to address prevention was not a common practice for her. Generally, her practice was symptom focused. If a patient had problems, he/she was told to come in; the strategy was one of being more reactive than proactive.

**Current Practice**

Kelly responded that now, her patient education interventions are different. “I talk to people now about being more proactive than reactive. It has changed, for sure.” she said. Her process for obtaining an informed consent reflects the change in her practice. Now “they don’t sign it” right away. Instead, the patient reads the document and this is followed by an initial examination and consultation process. “I use a spine model and describe what’s going on. And then talk to them about the risks and benefits…then ask them if they’d read the informed consent and if they’d like to sign it.” She also provided an opportunity to address patient questions. She also has started using some information pamphlets about basic chiropractic services. ‘I’m starting to use more pamphlets and printed material.”

In terms of treatment options she talks to them about “different things as well. We can do adjustments, spinal manipulation. We can do mobilizations. We can use activator. It’s all about
what their comfort level is….some people would like to know about their options.” Her patient education practice related to patient compliance continues to involve talking. “A lot of it’s verbal. People who are acute, you have to get them to understand that they have to come in a little bit more frequently to get it better.” In addition to this, Kelly also uses demonstrations and printed illustrations that include instructions to teach patients how to perform certain exercises correctly. She said that she spends time “Showing them stretches. I have some (exercise) diagrams. They are good because they have the visual as well as the description.”

**The HCP’s Role in Patient Education: Early Years**

As an associate in an office, Kelly felt that she could not deviate too much from the educational messages being delivered by the senior doctor, but still felt that she had to deliver some information. She would determine what she felt the patient needed to know and then deliver it verbally. She says, “I think I talked to people about what I thought was important, and that was probably it.” Discussing her perceptions of her role as a teacher for patients, she said that she felt that patient education was, “More of an adjunct” as opposed to being a major responsibility for her. Explaining this further, she said that her view was skewed by being in such a closed pre-service environment and could not comprehend and make sense of the fact that people did not know and understand the benefits of chiropractic. This lack of comprehension on her part led her to believe that patient education was not a major responsibility of hers because she believed that most of her patients already knew the information about the care she could offer and therefore, she saw little need to teach it to them.

**Current Practice**

Now she has realized that people do not know as much about chiropractic or their own personal health as she once believed. Consequently, she now views her role as a patient educator differently from her early years and sees herself as a guide for her patients. Kelly stated that:

I think it’s (her role) is really important. (When I started) practice, I didn’t think it was very important…people in general don’t know about their health. They are looking for someone to guide them and help direct their decisions….eating better, sleeping better, sleeping on your side or your back and not your stomach, that’s basic stuff that people don’t know.
Nature of Patient Education Interventions: Early Years

In her first years of practice, Kelly used a teaching approach that was essentially transmission of information to her patients. The great majority of her patient education time was spent talking to patients. About talking to patients, she said, “That would probably be the biggest thing that I would do.” She also occasionally used a 3-D anatomical model of vertebrae and she had a poster on spinal degeneration on the clinic wall to which she may have referred, depending on the case. Kelly also reported that her patient education interventions were inconsistent and were influenced by some of the seminars she attended.

You get all geared up and learn about talking to people and mentioning certain things (in seminars). I’d say I would have run hot and cold. Like if I learned something new, I’d share it. But otherwise, I wouldn’t.

She mentioned that she recalls the impetus for requesting information was on the patient as opposed to her introducing the delivery. “I was a little less proactive in applying information.” So, if the patient came up with and asked a question, she would deal with it, but she was not always the one to bring up the topic or information during a patient visit.

Current Practice

Now, Kelly still uses a transmission teaching approach, however, some of her teaching goes beyond that to a transactional level. Kelly still uses a great deal of verbal education with her patients, but she has introduced the use of available pamphlets with basic information for patients. What she does now in terms of patient education depends, in part, on the patients and their previous treatment experience.

If a patient comes in and they’ve never seen a chiropractor before, I never treat them on the first visit and I give them some information brochures to take home with them. I try to go through it through the conversations that we’ve had (during the visit) and then what it (the printed material) does is either re-confirm it or it might answer some of the questions for them.

As mentioned earlier, she also has begun using printed materials with illustrated exercises for her patients. This reminds and reinforces the exercise demonstrations she does during the patient visit. In addition, she also refers patients to a web-based stretching program that people can access at their desks or at home, and that leads patients through a set of range of motion exercises. She continues to use 3-D spinal models.
Still attending some seminars, she says that some of these advocate using a scripted approach to patient education which she does not do. “I’ve gone to seminars where they talk about talking and people laying down, and you give them sound bites of information. Not my style.”

Kelly has recognized that many of her current patients have very busy lifestyles. Consequently, many of her patients do not want to, or are not able to spend a long time on their appointments with her. This influences her current patient education in that she focuses on giving people information and reinforcement on the few aspects that she feels are the most important, thereby trying to impart the most valuable information in the least amount of time. She said:

Time is huge. Time is big. Huge. People are honest. I’ll ask them how’s the stretching coming. (They’ll say) Oh, I haven’t been doing is as much as I should.” Her response is, “OK. Let’s revisit it again. Down here, giving people a full page of stretches is a waste of time. I give them one, maybe two at a time, and then go from there. So, if you keep it simple, they are more apt to be able to do it.

This example also highlights Kelly’s recognition of the importance of repetition in patient education and her willingness to repeat information for patients. When asked about what she thinks it is that makes patient education effective, she answered, “I’d say more repetition. You see people over a period of time, so you are always re-visiting.” When she does this, she may take a slightly different approach and alter the way in which she explains the information to the patient. “I try to explain it a little bit differently.” Also, she mentions that sometimes, patients ask for her to review some information again, often because they forgot it. These requests from patients have reinforced her feelings that one of the keys to effective education is, for her, repetition and re-explanation.

**Key Beliefs and Feelings: Early Years**

In her early years of practice, Kelly discounted the importance of patient education. She believed that her patients already knew and understood everything they needed to know about chiropractic. She explains this belief by recalling her years in chiropractic college and being surrounded by those involved in the practice of and training for the profession. Her colleagues, teachers, friends all had major commitments to the profession and this skewed her perceptions of the general population. She explained that she and her fellow students were:

…so indoctrinated into the chiropractic environment. You live, eat, and breathe chiropractic. Your friends are chiropractors, and it’s very much your life. So, it’s easy to lose sight that people outside that don’t know anything about it.” (In college) “…we’re so enveloped in it (chiropractic) you think how can everybody not get it. You believe in
what you do, and then you kind of go (to her patients) ‘Don’t you get it?’ and people look at you and say no, I don’t understand.

In her first years, she felt that patient education was redundant, an adjunct to her physical care, and not a key or important element of practice. She recalls, “I think as a new grad, I was very short-sighted, in retrospect, because I thought, well, why don’t other people get it? I didn’t understand that.” When she began practice, she thought that her patients already knew and comprehended the valued of chiropractic and why it was important for their health. She also believed that what patients wanted most was physical relief from their problems. She said:

I would say that the satisfaction came from physical care because you were providing symptomatic relief so they were moving better. They felt better. They moved better. They had less pain. And they went, ‘OK. I’m better’ Once the pain’s gone they felt they didn’t have to come back to you.

But she realized that patients were not necessarily completely recovered, especially if they had a chronic or long-standing condition. She would tell her patients, “You know what? If you’ve been dealing with this for five years, and I’ve seen you eight times over a month, it’s not better. So you need to keep coming back to me.” Eventually, she began to realize that effective patient education was necessary to have the patient understand his/her own situation regarding recovery and length of care.

Kelly did have some experiences in her early practice that helped her feel confident as a patient educator and clinician. These cases were all long-term patients with fairly serious injuries. Hence, they required care for a continued period. She relates the story of one man’s case. He was injured quite badly at his workplace and required many treatment visits over a period of several months for a spinal injury. His recovery was slow and the fact that he was required to attend by the Workplace Safety and Insurance Board (W.S.I.B.) may have been a factor in his not leaving care even after his slow progress. Nevertheless, this gave Kelly the opportunity to extend her patient education interventions over an extended time. While her patient education began as transmission, this is one of the cases in which some transaction teaching began to take place between the teacher and the learner. When asked if she was always responsible for initiating patient education initiatives and deciding what topics would be addressed, she responded that, in this case, they both were involved in this. She explained that the participation involved:

Probably a little bit of both. Probably me providing a little more information. Maybe 80-20. He would come in and say, ‘I did this. Could it be because of this?’ and then we’d talk about it. So, yeah, I’d say 80-20. I took more of the initiative.
The patient introducing an educational topic is an example of his involvement in determining what he needed to learn at that time, and Kelly, in her willingness to discuss this information with the patient, showed that she acknowledged the patient as a partner, at least to some extent, in the management of this particular case.

**Current Practice**

In her current practice, she works with busy, white collar business people who have very full schedules. Kelly believes that many of them are willing to turn over responsibility for getting them better to their HCPs. She says:

The people in this demographic, they don’t really care if it’s a subluxation or mechanical back pain. ‘Just fix it.’ They have a problem; they need it fixed. They don’t have enough time in their life to be down.

She realizes that this is not the best situation and she believes that the patient must take some responsibility for assisting with their health care. For example, in terms of prevention, she told me that she would educate her patients who travel frequently on business and tell them:

Before you go on your next business trip, come and see me. Six hours to go to England. You’re going to be staying in a hotel all week. Different bed. Different pillow. You’re going to be lugging your laptop, your suitcase. Come and see me before you go. Come and see me when you get back.

In teaching her patients this, she demonstrates a recognition of the importance of patient education for her patients and has increasingly incorporated this intervention into her current practice.

She now believes and understands that patients do not know and understand how to take care of themselves in terms of basic health issues. She says that we do not do a good job in the education system teaching people, “…how to be healthy. The people I see, I talk to them now about being more proactive than reactive…” and she feels that this approach has been effective with patients. She continued, “…people don’t know about their health…” and she believes that they are looking for their HCPs to be guides to lead them, or assist them with managing their health. One reason Kelly feels this is because of her perception of the difference between various mainstream health care professionals. One great difference she sees is between medical doctors and doctors of chiropractic. She explained that she feels that, “They (MD’s) work in illness care and we (DC’s) work in wellness care. I have this conversation with the guys (MD’s) I work with all the time. I like what I do. I keep my patients healthy.” This idea is one that is commonly held among the chiropractic community. Many chiropractors believe that regular chiropractic care can
be helpful in maintaining good health. Having said this though, chiropractors do see many people who initially seek out their care when they have an injury or health related condition, so in this respect, chiropractors also work in “illness care” to some extent. Kelly’s view, even if it sounds rhetorical, is also reflective of her attention in addressing prevention issues and being what she refers to as “proactive” in terms of health care even after a patient’s condition or injury has resolved. Further to this, Kelly now believes that patient education is important in terms of setting realistic expectations and also influencing patient compliance in a positive way.

I think if people are more educated to understand how their body works, they are more apt to understand why they are seeking treatment and why the things I am suggesting can work. And then they’re more compliant and they stick with the treatment plan. It’s a win-win.

Kelly now believes that, no matter what the diagnosis, patient education is important and in at least some way, she tries to individualize what she says about which patients she takes time to teach, “I’d say all of them. I try to educate no matter who it is. Talk to them about their particular situation.” She can do this because she feels that, “most people are open to it” although she recognizes that not all of her patient population is willing to put in an effort to learn.

Perceived Barriers to Effective Patient Education: Early Years

For Kelly, in her early years, several barriers to effective patient education became apparent. For example, she reported having one patient who was illiterate and therefore could not read the informed consent document. For most of her patients, though, literacy and language did not present a barrier to learning. She also remarked that time was not a barrier as she recalls her patients generally having adequate time. One barrier that became evident to her arose with patients who come to her with unrealistic expectations. They may have it pre-set in their minds. ‘I’m going to give you 3-4-5 visits. If you can’t help me, I’m out of here.’ Those people, no matter what you say, they’re going to walk away from treatment anyways even if you suggested they come and see you 12 times.

Finances also became a barrier for some patients. While many of her patients had insurance coverage for her services, there were those for whom chiropractic visits presented a difficulty because of their personal finances. While this obviously had an effect on patient compliance in terms of coming in for care, indirectly, patient education was also affected. If patients did not come in for visits, then Kelly had no opportunity to offer them any educational experience at all.

While she felt that she was a good communicator and was able to teach, one barrier to effective education derived from Kelly’s own belief that patient education was not very
important. “I would say more of a barrier would have been me. I didn’t realize…hindsight of course…the importance of patient education back then.”

Current Practice

Language and literacy issues continue to be non-problematic for communication in her current practice. Also, patient finances do not present barriers since her patients all seem to have excellent insurance coverage from their employers. She does not perceive her own skills as a patient educator to be a barrier.

In her current practice, Kelly still encounters barriers which interfere with effective patient education. One of the most common for her is patient time. In her early practice patients, “…were in the office for maybe 45 minutes and it wasn’t a problem. Whereas down here, 15 minutes, Gotta go. I have a meeting.” She also mentioned that patient attitude to learning can present a barrier. “Yeah. Sometimes. They just want to get out of pain and not be bothered with the rest.” She does say, however, that having to deal with patients who display this kind of attitude is a rare occurrence. Similarly, she has occasionally had patients whose personalities presented barriers to learning. They were very “high strung” and felt that they knew everything they needed to know.

Changes Related to Patient Education

Kelly has made important changes related to patient education as an element in her practice. For example, she admits that she now believes patient education to be important for her patients, whereas as a new grad, she did not feel it was important. Hence, she spends much more time on patient education now than she used to. She described patient education as an adjunct to her physical treatment in her early years. Now patient education is a key element that is much more a part of the total care she delivers to her patients. Believing this, Kelly has also increased her repertoire of teaching techniques. She still spends much of her patient education time talking to patients, but she also has used 3-D models, posters and charts, pamphlets and handouts, as well as some web-based information that patients are directed to access on their own.

She has adopted a philosophy of trying to teach her patients to become more pro-active in their health care. In her early years, her treatment philosophy was more reactive and she would only see patients when they had problems or were symptomatic. Also, in early practice, Kelly seemed more focused on symptomatic relief; now she sees herself as a holistic practitioner and while she still deals with symptomatic patients, she also is committed to wellness care and offering chiropractic as a preventive health care intervention. In doing so, and by having success
with this approach, she is more confident and sees her role as a patient educator differently from her early years in practice.

I perceive my role a little bit differently. I think having more experience and being more confident and knowing that you’re good at what you do, and that you can help people make a huge difference…it’s taken me years to learn that I’m good at what I do.

Besides accounting for the changes by her realization that she is more experienced and confident with her skills, she also explains that it took her some time to realize that most people do not know or understand the basics of personal health care and how to take care of themselves. Her role now includes a willingness to take on the responsibility of being a teacher and health care guide for her patients. About this, she says, “I’m not just a chiropractor who adjusts. That’s one thing I do. But talking to people about how their body works and educating them about their health and well-being – it’s all part of it.”

She also acknowledges that she realizes that patient education can improve patient satisfaction by helping set reasonable expectations. Satisfied patients generally become compliant patients and will not leave care prematurely. Keeping patients in her practice until they are completely recovered is not only good for the patient; it is also good for her and the success of her practice. “You have a vested interest in educating them (patients) and helping them. You want them to come back.”

Norm

Practice Experience and Patient Groups

Norm had been practicing as a chiropractor for seven years at the time of his interviews with me. After graduation, he began working as an associate in a chiropractic practice in central Toronto and continued there, three days a week, for approximately two and a half to three years. During the later part of this period, Norm worked on establishing his own private practice in the north-west part of the Greater Toronto Area. Since leaving the associateship, he has been working full-time as a chiropractor dealing with both general practice patients as well as physical assessments for patients involved in insurance cases.

While in the associate arrangement, Norm saw a variety of patients. He explained his views of the patients groups he saw saying:

There were two different types of patients. There were walk-in patients who were pretty much blue-collar, ethnic, the majority being (European). And the second type was motor vehicle accidents, so there was all different types of work status and ethnicity.
At his private practice, Norm explained that many of his patients were involved in motor vehicle accidents. He said about them that they were, “…a little bit more white collar and mixed ethnicity.” Many of these patients were immigrants to Canada and were older. He also had many patients who were of Mediterranean descent, but who were born in Canada and these were generally younger.

In all of his practice experience, he said that he had about ninety percent of his patients who could converse in English, but he did encounter some who spoke only Mediterranean European languages. Since he was bilingual, he could speak with many of these patients.

I should also mention an interesting fact about Norm’s experience. As a university student and as a chiropractic student, Norm gained experience working with other health care providers. In university, Norm was a student member of the athletic therapy staff and as such, he cared for athletes who were injured. While doing this, he worked under the supervision of experienced certified athletic therapists and so he was able to learn as he helped care for injured varsity and recreational athletes. While in chiropractic college, Norm was a part-time member of a multidisciplinary rehabilitation clinic staff where, once again, he was able to learn from working alongside the experienced health care professionals who staffed this facility. This work becomes important in the discussion of Norm’s views and uses of patient education since he had significant experience with this aspect of practice and had many opportunities both to see and use patient education with real-life patients. This experience, I believe, may have had an effect on patient education in his professional chiropractic practice. Norm was the only participant in this study who had extensive health care work experience prior to graduating from a chiropractic college.

*Functions of Patient Education: Early Years*

Patient education, for Norm, filled a very important function in his practice. He said that for him, patient education, “…has a critical role in my being a health care practitioner.” Norm’s patient education would commence with the process of obtaining an informed consent for treatment from the patient. He presented patients with pre-printed consent statements and asked them to read it on their own. Then they would sign the forms indicating their consent. His follow-up to this was to ask the patients if they did read the document and if they understood it. He acknowledges that most of the patients would just sign it without paying too much attention to it. A small number of patients, though, would have a concern over certain aspects of the content of the document, specifically the section on potential risks of treatment. For these patients, he would take time to explain the subject further. Usually, though, patients did not ask about these issues.
He said, “To be honest, most people had no problems with it. I’d say over ninety percent would just sign it because you’re at a doctor’s office, so just sign it.” While he understands that this is a type of patient education, Norm also said about the informed consent process, “I didn’t find it a big educational thing. To me, it’s just paperwork that had to be done.”

Norm used patient education to tell the patient what he, “…believed was wrong and at the same time, explaining to them what they can do to make their condition even better.” He would provide information about the home care they could do for themselves and offer them the opportunity to ask questions.

For Norm, patient education was involved in treatment choices. After explaining the condition to the patient, he said that he addressed the different ways to approach the problem. Some of his patients, especially the older ones, were wary of cervical manipulation and did not want this as a part of their care. As a part of his patient education protocol, Norm said he would go over the various types of treatments he could provide to see if the patient was concerned about any of these. For example, Norm explained that he:

…would educate them on rehabilitation, electrical modalities, heat, ice, stretching, exercises, soft tissue massage. So depending on the patient’s concerns, if there were any, I’d make sure that I didn’t do certain treatments on certain patients….At the same time, I’d try to educate them on manipulation. I’d tell them that at no time should they feel any pressure that I, as a chiropractor, have to adjust their neck, or back, or joint…I never try to convince them, but I would educate them, you could say.

He went on to explain to me that he would begin treatment at the point where the patient felt comfortable with the treatment choices and he would avoid the use of specific treatments or techniques that caused concern for the patients.

Patient education also played a role in dealing with issues of preventing conditions from getting worse and from re-injury for both patients with work-related injuries and for those with athletic injuries. He said that, “The most important thing I have found is that education is important to stress the importance of how to do things to prevent getting into this condition again.” For example, Norm explained that this type of patient education became quite important when injured patients were planning to return to work. They needed to learn that they might not immediately be ready to resume full duties and might need some modified work assignments and a graduated return until they were completely fit for full work tasks. He said that he would, “try to teach them properly how to bend, how to lift, carry items. I would try to tell them not to lift more than a certain weight, depending on their condition and capabilities.” For the patients recovering
from athletic injuries, Norm also felt that patient education fulfilled an important function when the patients were resuming their sports activities. He went on to explain that:

They want to go back to play their Friday night hockey, or tennis, or golf. I have to really emphasize. Take it easy. Don’t go hitting a big bucket of balls at a driving range. Take a few at a time. Take breaks. Things like that.

Norm also reported that, in his early years of practice, patient education was important for helping patients develop reasonable expectations for their treatment and recovery. He said that this was especially important for athletic patients who often arrived at his practice with unrealistic expectations about how soon they would be able to resume their athletic pursuits. About some of his patients with athletic injuries, he told me:

Their expectations were just ridiculous… (They’d say) ‘I’ve got to play soccer tonight’. Or ‘I’ve got to play soccer by Thursday’. Or, ‘We’re in the playoffs.’ I’d say no. You’re out for three weeks minimum, or four weeks, six weeks depending on the injury. You’d always have to explain to them…They just had false expectations.”

Unrealistic expectations can also lead to situations in which patients have too much, or blind faith in their health care practitioners. Patient education can help patients develop the knowledge to advocate for themselves and to take appropriate actions to aid in their health management.

Norm told me the story of one of his patients who had failed orthopaedic surgery for a serious knee injury. The patient was eventually referred to Norm for care while still seeing the orthopaedic surgeon post operatively. The patient was suffering from pain and disability in his knee which was not improving despite the fact that he was cooperative and compliant with treatment. Norm, fairly early on in their relationship, realized that this man would be best to seek a second opinion from another orthopaedic surgeon, but the man was reluctant to do so since he believed that the original surgeon was doing all that was possible to help him. Norm explained the man’s reasons for not wanting to get a second opinion:

Because he had no clue what was wrong with him. He just thought that his doctor (surgeon) was taking care of him – sending him for rehab, sending him for cortisone shots, sending him for ultrasounds. So, he thought he was getting everything done, but bottom line was that he was wrongly taken care of.

Norm reported that he worked hard educating this man about his injury and how his knee should be recovering and improving function and eventually, this education helped the man to realize that he did indeed need to consult another specialist. It was this decision which eventually led to his recovery. Norm went on to tell me that:
So, I think with the education showing him what the knee joint’s all about, telling him about what his range of motion should be, about strength and how to start strengthening is. Telling him to read up on his anatomy and what the knee joint does, and where he would be in five or ten years with his bad knee. This gave him the strength and education to second guess his doctor and to ask for another opinion.

Current Practice

As it did before, patient education still plays an important role in Norm’s professional chiropractic practice. He said to me about patient education:

I’d say (patient education is) at least 50-50 importance with the treatment. Even though I’d always thought that education was an important part of the treatments, through years of practice, this has just reassured me that it is. It hasn’t kind of faded to the back burner. It’s still a top priority of mine.

Norm uses patient education in his current practice to empower his patients to help them assist with the decision making processes that go on during the course of a doctor-patient relationship. For example, regarding the possible choices of different types of treatments that he might use, Norm takes time to explain to his patients the various modalities and therapeutic procedures. He said that it is,

…not as if they get to pick what they want. I inform them about every machine we have available, what the purpose of the machine is, what the benefits are, and if they find that they are not particularly happy with one type of treatment, then we won’t use it. If they say that they like ultrasound or the laser, then we’ll stick with that.

Related to the choice of therapeutic interventions, Norm now also employs patient education to help with teaching the patients about the importance of adequate treatment frequency letting them know that there is an optimal number of visits per week for healing and recovery. He said that he will use an analogy comparing this aspect of treatment to something the patient likely already knows. Norm explained:

I tell them the importance of regular treatments versus sporadic treatments. I explain the importance of regularity and frequency using the physical exercise model. If you work out three or four times a week, you’ll see results. If you work out once a week, you won’t. Same thing for treatments. If you are going to come here once a week, or even twice, or three times in two weeks, don’t expect miracles in one month’s time. So, I let them know.
Norm admits that while he tries to have patients become partners with him in the treatment and recovery processes, he sees this as an unequal arrangement. The patients have some, but not the same level of control, as he does. He refers to what he calls, “the team approach” and in a team, not all the members have equal authority. Carrying on with this team analogy, Norm said, “I’m the captain. If I lay off, I’m sure the patient would lay off, too.” As the captain of the team, Norm explained that he is the one who makes some of the decisions, like deciding what patients need to know about their conditions and their responsibilities in carrying out their home rehabilitation exercise programs. He said that:

I’m always open to suggestions (from patients). If they told me (that) in the past, they used to have an injury and they found this type of exercise to work for them…as long as I see the exercise and I don’t think that it will cause any further injury…”

The HCP’s Role in Patient Education: Early Years

In the first few years of his professional practice, Norm viewed his own role as a patient educator as an important one and he honestly wanted to help patients with their recoveries as a top priority. He did not want to be seen just as a technician who treated patients with machines or ordered exercises as he felt this would reflect poorly on him and his abilities as a doctor. He also recognized that through his role as an educator for his patients, he could influence the growth of his practice. He went on to say:

I felt like I was their health care provider, not just plugging them into a machine or telling them what exercises to do. I felt like (this) would reflect on my abilities as a professional, not only for further referrals from their medical doctors. They’d say, ‘Dr. Norm did a really good job. He talked to me.’ Which is a really good way to increase your business, but being in this profession, for patients who really care about getting better, you’ve got to go that extra mile for them, so they will remember you and for them, so they will not cause further injury.

This explanation goes along with Norm’s ideas that education had a critical role in his early practice and if this was so, he then, as the teacher for his patients, also felt he had an important role to fill in his patient education initiatives. Part of this role, as mentioned earlier, is to be the “captain” of the doctor/patient team and lead the patient towards and along a road to recovery. He took a leadership role feeling that it was his responsibility to decide what information the patients needed to learn and then take the time to teach this to his patients. Norm also felt that his role as a patient educator involved helping his patients to make informed and wise choices about their respective responsibilities and expectations as they progressed through their treatment and
recovery. He would do this by teaching patients about the various types of treatments he could offer, about the importance of their compliance with the treatment program, and assisting patients with developing reasonable goals and expectations related to their recoveries.

Norm explained that, as the leader in the relationship, he was the one who began the patient education sessions with his patients and also determined the information with which he should start teaching the patient, usually opting for a very basic beginning. About his patient education efforts in his early years of practice, he said, “I always start it (patient education). I’m the one to initiate it…I always have to imagine that they don’t know anything about it. So I always have to start from the beginning.”

**Current Practice**

Norm continues to play an important role as a patient educator in his current practice and continues to look for opportunities to teach his patients about their conditions and their health. He explained that he takes time during each visit to teach patients about these subjects. He told me, “…we do it during treatment. I feel that if I can get ten minutes in while they are in the IFC (interferential current therapy) or ultrasound, I can get my point across.”

As are many of his professional peers, Norm is also faced now with having to take time to teach patients about issues related to the care they are receiving from other health professionals. He accepts this responsibility as part of his role as a health care provider. He explained that this is not an infrequent occurrence and he does not seem to resent this role explaining that some doctors even direct their patients to ask him for an explanation. He regularly fields questions about, “x-ray results … physiotherapy … medications… forms from the insurance…MRI results…” and other subjects.

To meet his obligations as a patient educator, Norm continues to treat his patients on a one-to-one basis, using the time with the patient as an educational opportunity. About this style of practice, Norm told me that, “My philosophy hasn’t changed. It's a lot of patient-oriented treatment. I still try to spend as much time as I can with the patient….Try to spend as much time with the patient. It hasn’t changed.”

**Nature of Patient Education Interventions: Early Years**

During the first days of his professional practice, Norm’s patient education efforts were characterized by a transmission mode of teaching in which information to be learned by the patient essentially flowed in one direction, from the chiropractor-teacher to the patient-learner. As Norm described the patient education in which he took part, he consistently used terms such as, “I
was telling the patient…I’d show them…I’d always tell them…you tell them what to do…I inform them…I tell them the risks, the benefits…” Norm acknowledges that he does invite patients to ask questions, which he would answer, but in general, he decided on the information to be taught and learned and how this was to be done.

As far as teaching techniques went, most of his patient education involved him speaking to the patients during each of their visits. Normally, in the first few years of practice, Norm saw his patients three times a week and so patients were given information at this interval. He did have instructional anatomical posters on the clinic walls and he would use these to help with his teaching because he explained that, “I used these because I always learn best through visual.”

In one of his early practices, Norm had and used informational pamphlets for his patients. In the other practice, the doctor-owner, “…didn’t believe in pamphlets, so he never bought any there.” At that practice, the patient education was all verbal with some reference to wall posters.

Norm often prescribed home exercise for his patients at this time. These would generally be designed to strengthen specific muscles or to gain range of motion through stretching. He would explain the exercises to the patients and then demonstrate them. He said that he would, “…try to teach them properly how to bend, how to lift…” Norm would do this through both explanation and demonstration as he told me that he would, “…demonstrate to everybody, even if someone was very athletic and knew his way around the weights. I’d say, ‘watch what I’m doing and let me know if you do it any other way.’” At one point in our meeting, Norm told me that as he taught exercises to his patients, he felt that he was almost like a personal trainer who would explain and demonstrate the correct exercise positions and techniques.

**Current Practice**

In his current practice, Norm continues in his education initiatives much as he did during his first two years. He still teaches his patients primarily through transmission of information to them. Most of his teaching still takes place through speaking to the patients and he does this during almost every treatment visit when the patient is receiving therapy via an electrical therapeutic modality such as ultrasound. He says that he thinks that he may have been guilty in the past of too much talking and he consciously tries not to do this with his current patients.

As far as his frequently prescribed exercise prescriptions are concerned, Norm still explains and demonstrates the exercise for the patients. He explains to the patients the importance of adequate treatment frequency as well as trying to ensure that they have correct exercise techniques. He explained to me:
I tell them the benefits of three times a week or four times a week. The course of their treatment, modalities, active care, passive care…it’s all explained to them…especially lifting, because everyone thinks they know how to lift, but they don’t…things like that.

Norm now uses a greater variety of what he calls “assistive devices” in his patient teaching. Besides posters hanging on the walls of his clinic, he also now uses three dimensional anatomical models, various pictures, and displays. He continues to use brochures to augment and assist with his patient instruction, but he says that these tend to be ones based on, “…generalized concepts of chiropractic and treatment. The brochures are basically the benefits or chiropractic and such. Everybody has a different injury, so I don’t have twenty-five different pamphlets.” The brochures that he does use come from two sources: some are available through chiropractic associations and a few were created by Norm himself. He says that he very rarely uses instructional videotapes or CD’s and he has used the internet, “…on a couple occasions.” Norm does use photocopied home exercise booklets to remind patients of their exercises and for patients to use as log books to record their home activities and exercises.

**Key Beliefs and Feeling: Early Years**

In his first few years of practice, Norm believed that patient education was very important for some aspects of his practice, but not so important for others. For example, as far as compliance with the treatment program, Norm emphasized patient education in virtually every visit. On the other hand, during the process of informed consent, he believed patient education to be of minimal value. Rather, he completed this process because it is a mandated responsibility for chiropractors and all health care professionals. About this, he told me, “…we’d go through the informed consent. I didn’t find that a big educational thing. To me it’s just paperwork that had to be done. I had to make sure that they understood it.”

As mentioned, Norm felt that patient education was quite valuable in some areas of his practice. He, even in his early years, saw the connection between patient satisfaction and patient education. He realized that patients often had unrealistic expectations and unless these were modified, the patient would be dissatisfied with his care. Consequently, he took time on each visit to teach the patients what he thought they needed to know, and for some patients, what they needed to know was how their treatment and recoveries would progress. He spoke to me about patient satisfaction and patient education in his first years as a professional:

I can only speak for the patients that were interested in getting better…I found that the patients that were educated wanted to get better. Mentally, they were reassured that they would get better…I got a lot of good feedback, was given a lot of little gifts, just because
(of) how they got better with education, the whole treatment plan, patient satisfaction. 
They’d always tell me they’d refer anybody to me.

Norm believed that one of the keys to his patient satisfaction was spending time with each patient during a visit and he would use this time as a teaching opportunity. He said, “…my bottom line is the more time you spend with a patient, if you spend your time effectively, you’re doing your job…during that time, I’d be educating them. We’re always talking.”

He spoke about unrealistic expectations of patients and explained the problems they presented. Referring to some of his former injured athletic patients, he said:

Their expectations were just ridiculous…You’d always have to explain to them…however, a lot of them thought there were scouts out in the bleachers, so they’d go out and play and the next day, they would tell me that I was right and they aggravated the injury…The bottom line is they’re adults and they make their own decisions, so if they wanted to play, they could go ahead. They just had false expectations. And I would strongly advise them of that from the beginning.

Overall, Norm reported that he believed patient education to be quite an important part of his care during the first few years of his professional practice. This was a view that differed from many of his colleagues who believed that their physical treatment was far more important than patient education. He said about patient education’s importance in his early years of practice:

I’d give it an eight out of ten, very important because I incorporated patient education in my treatments. So, as stated earlier, as I treated, I educated. It was kind of like the whole package. That’s how we were taught in school. That’s how we did our undergrad, our volunteer work, so spending time with patients, educate patients, treat patients, answer all their questions, even if they are on insurance forms. Spend time. Make sure you spend time with your patients…It’s part of my package, part of the whole package, part of who I am as a practitioner. Not a rich one, but a good one…

Norm mentioned that he recognized early on that spending time teaching patients individually would possibly interfere with the number of patients he could see and this limited the growth of his practice to some extent. Nevertheless, he did not opt for a practice management style that would maximize revenues by stressing high volume and retention of patients. Some chiropractors subscribe to a philosophy whereby they almost coerce their patients to come in for treatment. They may even resort to indoctrination and possibly ‘scare tactics’ to retain their patients even after their injury or condition is resolved. Norm said he does not believe in this type of strategy. He explained his feelings about his colleagues who choose to practice in this manner:
I think everyone would like to make more. Some people can go to the other end. I always call it the ‘dark side’… I tried to make them better as fast as possible. I’m not into this maintenance thing where you have to come for life.

Unlike many of his colleagues who participated in this study, Norm felt quite confident as a patient educator even early in his practice experience. He believed and suggested that this was due to his experiences before and during his chiropractic education when he worked as a student member of multi-disciplinary health care teams. He explained his early feeling of confidence saying:

…having worked in rehab for so many years (before graduation), not that you’ve seen everything, but you feel confident about what you can tell somebody. You never doubt yourself; you don’t hesitate. You can always back up yourself. There’s patients that you knew exactly what to tell them. Even the ones that were somewhat educated, being in university, or going through therapy, or being a hockey player for all these years and having injuries, they know what to go through; you just knew. They’d ask questions in detail and you just knew. You could back yourself up, so you knew…

Current Practice

Now, in his current practice, Norm continues to believe that patient education is a very important and valuable part of the treatment he delivers to his chiropractic patients. He feels that patient education is at least as important as the physical components of the care he delivers. This has not changed since he began his professional practice. He explained:

I still consider it a majority role in my whole treatment portfolio. I’d say at least fifty-fifty importance with the treatment. Even though I’d always thought that education was an important part of the treatments, through the years of practice, this has just reassured me that it is. It hasn’t kind of just faded to the back burner. It’s still a top priority of mine.

When asked if he now feels differently about patient education than he did when he started practice, Norm explained his beliefs by saying that:

I always thought it was important from my training, however, it just reassures me. Like I said in the beginning, it’s a very important aspect of the whole treatment plan. I’m very happy that we were taught that education was important. It’s not like I’ve had to learn this on my own, now, through various experiences. It’s been the same.

Having said this, Norm also feels that, while he and his student colleagues were taught in their pre-service curricula, that patient education was important for chiropractors and their patients, the students were not well-prepared to be teachers for their future patients and it was his
previous student work experiences that helped him become an effective patient educator. Norm said about his pre-service education, “The actual curriculum... no. The curriculum was pretty poor in terms of patient education.”

Norm believes that patients will do better if they feel that they have some control over their conditions and by learning about their bodies, their conditions, and their health, they will start to gain some of this control. He uses patient education initiatives in order to help his patients learn the above and by doing so, they start to comprehend that they can have positive influences over their health and recoveries. By learning about their conditions, patients feel that their lives are under their control and not being ruled by their conditions. He feels that his patient education empowers the patient by returning control of their lives to them. Norm told me:

Most people complain to me, when they are stressed or depressed, that they have no control over their daily activities. So, because of these injuries that restrict them, they lose control of their effectiveness in the household, in the work environment, in society...once I think that the patient understands what’s actually going on with them, they get a better understanding of their body. So, when they get a certain pain, they know what’s good pain, bad pain. They feel like they can get more control of their daily activities again.

Norm also feels that, while patient education is important for all patients, it is even more so for patients who have serious injuries as opposed to minor injuries. He explained that with a serious injury, there is just more information for the patient to know. The exercise program might be more extensive. The treatment period will likely be a longer duration. More complications may encroach on the condition and affect the recovery. Norm went on to say that with serious conditions, there are:

...more things you have to do to take care. And you start getting into other things. Work-related. Home care. Home chores. Child care. Don’t pick up little Billy that’s thirty-five pounds from the crib. Things like that.

He also believes that there are factors that influence how effective patient education will be with different people. Norm feels that patients’ previous experiences with injuries, health, and fitness may also be important in determining their willingness to accept patient education. Other factors may do the same. He said that:

People who have taken care of their bodies in the past, who work out, or are at least active in sports, generally accept patient education a lot more than your couch potato. Also, patients who don’t like taking medication, they respond a lot better than people who just take Tylenol when they have a pain.
Perceived Barriers to Effective Patient Education: Early Years

As did his colleagues in this study, Norm perceived some barriers that interfered with effective patient education during his first few years of practice. He, too, encountered patients with attitudes, or other traits, that got in the way of effective learning on their part. Norm explained to me that poor patient attitude was the number one barrier to effective patient education. He recounted what he felt was the key reason for these attitudes, saying, “Motor vehicle (accident) patients who don’t care. They are in it for monetary values. That’s by far number one.”

Another type of patient attitude that presented a barrier was exhibited, according to Norm, by those patients who thought they knew quite a bit of information about health and/or their own conditions, but in reality, they knew little, or what they did know was incomplete, inaccurate, or erroneous. Sometimes, they claimed their source of information was another health care professional. The information may have been erroneous, or more likely, the patient may not have fully comprehended or remembered it. Norm said:

I’d get a lot of patients thinking they know a lot, but they know a little. A lot of times, I’d hear, ‘my massage therapist told me this,’ or, ‘my physiotherapist from the other clinic told me this,’ or, ‘my family doctor says this.’ That would be a barrier, actually, the MD’s. How do I try to convince this person if the information is wrong, especially with heat and ice. Heat feels so much better. So trying to explain to people who think they know was toughest.

According to Norm, patient age also presented a barrier to patient learning. Older people, especially immigrants, may have been fearful or felt they were too busy to complete home exercise programs, for example. He told me:

I found older patients were more hesitant. It’s hard to tell someone, probably from fifty on, if they had never had a serious injury, or even a whiplash or fracture, to get them to do their proper exercises on a daily routine. It’s just never going to happen. I guess because they never used to do any type of exercise. And again, we’re talking about a lot of (Mediterranean people), a lot of ethnic people, who came from a poor country and just worked all their lives. So, they didn’t have time for play or exercise. So, they just thought, I work. I’m healthy. If you try to explain to them that they had to bend their necks, or that had to do their sit ups, or whatever, it was a big time barrier.

Norm also explained how he felt that ethnicity also may have been a barrier to effective patient education, although he felt that the greatest barrier was created by a mix of age and ethnic background. Many of his European patients were willing to attend visits for his treatments, but
were not prepared to participate in active exercise programs, perhaps feeling they were not experienced enough to know how best to care for them. He explained:

They’d come in for the passive care, no problem. They’d say, ‘I’d try to do it, but it hurts.’ They think pain, ‘Oh, I’m not going to do it. The young doctor probably doesn’t know what he’s talking about.’ They didn’t give it a chance. That was the biggest hurdle, trying to explain to them that you’re going to get a little worse before you get better.

One other barrier to effective patient education that Norm encountered during his first few years was the duration of a patient’s treatment. With longer durations, he was able to accomplish much more education. Patients who needed only a few visits, however, often were not under his care for a long enough period for him to be able to educate them effectively. He explained to me:

If someone hurts their back a little bit shoveling snow, they’re going to be better in two weeks. How much education can you put in there, two treatments, three treatments, four treatments? But if you have someone for eight weeks and treat them a lot more, you can educate them a lot more.

He also had some patients who he described as “passive” and Norm felt that this passivity also may have been a barrier to their education. These people were prepared to turn over the whole responsibility for their recoveries to Norm, as their doctor, and thought that they needed to do no more than show up for their scheduled appointments. Norm believed that these patients felt that he would make them better and they did not have to do anything themselves. Norm discussed those patients saying:

Some people are more passive than others. Some people come to the clinic; they thought that just by going there, they did their part of rehab. ‘I came here. You’re the doctor. Go ahead and treat me. You’re getting paid for this.’

**Current Practice**

In his current practice, Norm continues to encounter barriers to the effectiveness of patient education. He has occasionally has patients who do not speak English, or who do not speak it very well and this obviously presents a difficult hurdle to overcome. Now, he also feels that the patient’s schooling level may also present a barrier. He said, “Intelligence, like education. Lower end people who haven’t finished high school do not respond as well (to patient education) as those who have finished high school. That’s definitely one (barrier).”

He still sees age and ethnicity as possible education barriers with some patients. Norm tried to explain his perceptions and experiences with these factors. He told me:
I don’t know exactly what it is. I just find that Europeans in general listen less. Maybe age with ethnicity. People who were not born in this country – first generation – maybe it’s because I’m younger than them and they don’t look at me as a doctor, or maybe it’s because they never did any form of exercise/stretching in their home country. It was mostly work, work, work, make money. It was tough after the war. Things like that. It’s almost like their mentality is, ‘I’ve come to see you; you cure me. I don’t want to do anything. I go to the (medical) doctor, he gives me pills. I get better. I come to see you. Crack my back and make me feel better. Don’t tell me to go and do stretches and lift weights.’ They think their part of the partnership is just showing up and paying their bill.

Norm also believes that some patients are driven by desires other than just getting better and this motivation may also create a barrier to effective patient education. He once again refers to patients who were injured in motor vehicle accidents (MVA), especially when there is a lawyer involved in their cases. He describes patients like this and explains what might be the driving force that mitigates their motivation to recoveries from their injuries:

It’s the MVA patients who are only there because they think there is a pot of gold at the end of their settlement and they are only coming here because they have been advised by their lawyers to come here. Those people don’t care what you say to them because they don’t really want to be here. Those are the most frustrating patients.

Norm had more to say about his patients’ level of schooling as it affects his patient education efforts and their learning. He now feels that a high level of education may be involved with a patient attitude that creates a barrier to the effectiveness of patient education, although he is somewhat unsure of a direct relationship between the barrier and the patient education level. Some of these patients seem to feel that they know a great deal about their health and how to maintain it. Whether this attitude is directly related to education level, Norm is not certain. He tried to explain his thoughts on this:

One thing about highly educated people… I don’t know if it’s because they’re highly educated… but there’s some people who think they know everything. They are the ones who, even though they may have a university degree, they know nothing about their bodies or taking care of them, but they think they know everything. Those ones, you have a barrier. You try to tell them, but eventually what happens is one of two things. They never listen to you and they still get better from the treatment and time, or two, they re-injure themselves because they did something stupid outside the clinic and then at least you could say, ‘I told you so.’
**Changes Related to Patient Education**

Unlike the other participants in this study, Norm had quite a bit of experience caring for patients. As mentioned earlier, he had the opportunity to work with other health care professionals and this taught him quite a bit about incorporating patient education into his professional chiropractic practice. Because of this learning on his part, Norm has not made great changes related to patient education in his practice as compared to the other study participants.

According to his statements in both interviews, Norm had always thought that patient education was a very important component of the care he gave to his patients and he always took the time to try to teach his patients what he thought they needed to know. Norm explained some of the changes he did make saying:

I used it (patient education) then (early years) and I still use it now. I might have tweaked it a little bit. I might be more proficient in what I have to say. I might have a few more experiences to look back on, but I haven’t really changed anything from my first two years regarding patient education… because of the practices that I’ve been involved in.

Norm also reported that he may have become a better teacher for his patients with his experience, but he said that these changes were not very great. His comments do not indicate that he actively chose or tried to change how he taught his patients, and they also suggest that he may not even be completely certain that change has occurred. He went on to discuss what he feels may have changed related to his own teaching:

I’ve probably become a little better with examples. I’ve probably improved. I haven’t noticed the improvement. It’s not a drastic improvement. I have more and better examples now. I have more history, so I can resort to previous patients (cases), to educate, to give examples. I can probably get to the point a little bit easier. That’s what I believe; it might not be. I don’t know. I think I can probably come out with a little more information for the patient than I could before.

He also feels that now, in his current practice, patient education is a little less challenging for him as a chiropractor and patient educator. He also mentioned that he feels more confident when serving as a teacher for his patients and relates these changes not so much to active decisions to change, but rather to more of a passive evolution that he went through during his years of practice. Norm said:

It’s (patient education) probably less challenging because I’ve done it so long, however, in a way it could be more challenging because you’re always trying to think of more examples and you’re trying to get a little bit more specific. In the past, I tried to be more basic to the patient, using more layman’s terms. Now, I give the patient more credit for
what they know. They know more than I perceived them to know, so I try to go a little bit more in depth with injuries. But, overall, (patient education is) probably less challenging because it’s been done so many times now.

When asked about how confident he feels now compared to his early days, Norm told me that his confidence has increased. Once again, he relates this change to his experience as opposed to an active plan to make changes. He said that he now feels he is:

More confident. Just because of more experiences. A lot more treatments under my belt and I have seen a lot more patients, so I have seen a wide spectrum of patients, of personalities. I can relate to them more. Hopefully, I can get through.

While he may not have made great changes, Norm thinks that there may have some been some changes in his patients. He believes that, compared to the time he started practice, his patients seem to be more willing to go along with and comprehend patient education. He feels that the reasons for this are multi-factorial and relate to changes in Canadian society. As he explained this to me, he mentioned some societal components such as the Internet and free access to schools. Norm told me:

I think overall, patients….. it may come down to education. As we go, there’s smarter people, more people going to school…with the Internet, a lot more easy access to information. If you have pain, you’re going to read up on it. Whereas people who have less education probably wouldn’t care (about learning). ‘I’m just going to go to my doctor.’

He did not suggest that he thought the use of the Internet was problematic by giving erroneous information to patients. It has been suggested in other papers that easy access to the Internet by patients may be the cause of patient misconceptions about their health or their injuries. Norm has not experienced this in his practice very often and on the occasions when patients have inaccurate or incomplete information, he said, “They may have just read, or been told by a friend. They come and ask me and I try to set them on the straight path again.”

Sam

Practice Experience and Patient Groups

At the time of our first interview meeting, Sam was in his ninth year of chiropractic practice. Much of his general practice work has been involved with various components of rehabilitation. Initially, he worked as an associate chiropractor at a multi-disciplinary rehabilitation facility. He later became clinic director for this clinic and eventually a part-owner. He left this position and
now practices in a smaller, commuter community at the north end of the GTA as well as at a sole-practitioner office in Toronto’s west end.

He describes his initial patient population by saying, “…I had a lot of people where English was a second language, a lot of, dare I say, ‘street people’…it was a rough area.” About his present patient population north of Toronto he stated that it is a very different patient demographic group:

It’s completely different. There’s no language barriers whatsoever. The people are far more wealthy. They don’t expect everything to be third party payor, whereas (in previous locations) where I was, nobody would pay a cent for anything; that’s just the way it was.

He also states that he felt the education component of practice would have been far more important in his earlier locations than in the more affluent areas where he practices.

**Functions of Patient Education: Early Years**

Sam stated that patient education played a “big role” in his early practice experience as it was a part of the clinic’s protocol for rehabilitation patients. However, about patient education related to the informed consent process at this time, Sam told me that:

It had a bit of a role in that they had to understand what they were signing, what they were consenting to. I can’t say that I spent any time with them at that point, talking about the course of recovery.

This may have been the case since patients were required to attend for treatment in order to continue to receive their insurance benefits. It is possible that, under these circumstances, both the practitioner and the patient might not devote much energy to the informed consent process.

Sam seemed to spend more time and devote more effort to patient education related to treatment choices:

A lot of people would ask me what I would think of various other routes of treatment and I had to educate them on typically what my opinion is on the intervention, how effective I think that intervention would be. Sometimes, they would even ask me stuff on things I’m not qualified to speak on, like medications or the appropriateness of surgery.

He did not state that he introduced many of the educational topics during this time, but instead responded to issues raised by the patients, for the most part. It seems fairly common for chiropractic patients to ask their DC’s about information related to care by an HCP of another discipline and Sam reports this as well above.
He did not use patient education much to address concerns of patient compliance, but it seems that it would be up to the receptionist, for the most part, to reinforce the educational message for patients who were non-compliant and not attending their scheduled visits:

I’d say it’s not so much education; it’s more my receptionist getting on the horn and calling them and reminding them of the importance of their participation in the program, so certainly an educational role would have come into play…

There was some effort put into patient education related to prevention of further injury. Sam said, “Sure, sure. We’d discuss issues of prevention with them as well…education on prevention and then the whole thing when they are out of the (treatment) program.” This kind of education would usually involve teaching the patients how to return to work and activities of daily life without reinjuring themselves or aggravating their conditions. Sam adds that another component of this education might, for some, involve whether or not the patients should continue to come in for maintenance treatment or care.

**Current Practice**

Sam says that patient education “plays a similar role” in his present practice environments. About the informed consent aspect, he says that, “It’s always important to explain to the patient what’s wrong with them, what the treatment they’re receiving is, and the outcomes. So, in that regard, I’d say it’s really the same role.” He reinforced this perception later in our conversation by saying, “I’m finding that education is extremely important. I think it’s very important that patients know what they’re getting and why and what’s in the future for them.”

For treatment choice matters, Sam says that patient education, now, plays a role, but is not much of an issue, unless, “…they are not responding to the treatment that’s given, or if they have any queries about other possible routes, then certainly it would.” In addition to this, when he does his regular re-evaluations of the patient conditions and feels that an alternate route might be best, he said “I’ll sort of explain to them why I feel they should change or why I feel they should extend and get more (treatment).”

Sam seems to see education more as a way of encouraging patient compliance with the prescribed program of care. As such, he appears to devote more energy and time to patient education after the patient has started his program. For example, he does devote relatively more energy to teaching patients who have an active care component as a part of their care. As a proponent of using active exercise as a part of his treatment protocols, Sam recognizes the importance of patient education in terms of prevention and using exercise to help with this goal. About this, he responded:
You teach them how to do their exercises. The ultimate goal is to discharge them with a self-directed exercise program in order to maintain their gains. They have to be shown what to do and why to do it. That, of course, is all part of education. That’ll always play a role, I think.

The HCP’s Role in Patient Education: Early Years

When he started professional practice, Sam believed that as a health care provider, he was obligated to fulfill the role of a patient educator and that patient education was something he had to do. Sam also mentioned that he saw his role as one of delivering a package of information and encouraging patients to be compliant with that. Sometimes, though, this was a frustrating responsibility for him. More on this feeling will be presented later in this discussion.

Sam also was presented with patients who would come to him as source for information or for advice. Sometimes, they would come for a second opinion. He would also field questions from patients who received no, inadequate, or ineffective patient education from other health care professionals. “I would get patients from other practitioners in the clinic that had nothing to do with me…” for information or to answer questions. While not turning these patient requests away, he did mention that sometimes, “This would tick me off” because it seemed to him that other HCPs may not have been doing their job in terms of educating their own patients.

Current Practice

Now, Sam states that his own role related to patient education has not changed. “I’d say it’s the same. It’s still my responsibility. I think it’s an integral part of treatment.” He relates a recent case of a patient with a very unusual set of circumstances. She was being treated for a metabolic disorder by a medical doctor and came to Sam to address what seemed to be a typical chiropractic condition. When she did not respond favourably to the course of his treatment, he had to convince her, through patient education, that she needed to see a specialist which she was reluctant to do. He had to teach her that her condition, which originally appeared to be a ‘chiropractic’ problem, was actually one dealing with her medical condition. Eventually, she acquiesced and it was determined that the medication prescribed by her M.D. was the cause of her problem. He changed the medication and her symptoms resolved. Sam felt it was his role to be an effective patient educator in this case and that patient education was a key component of the case outcome.
**Nature of Patient Education Interventions: Early Years**

While Sam mentioned that he did not devote too much energy to some aspects of patient education, such as the informed consent process, for other aspects, he worked quite hard and tried some different strategies. For example, his first clinic hosted “weekly education sessions on different topics” for small groups of patients. If there were not enough patients for these sessions, then he said, “I would just talk to them one on one about whatever seemed to be the issue.” He also used pamphlets with his patients on topics like ‘understanding whiplash.’ For a while in his practice, when this kind of session was funded by OHIP, he, “…used to have a physician come in once a week and do a large class on drugs…his classes would be 30-40 people at a time…he would show videos occasionally.” Other strategies used by Sam in his initial years of practice included demonstrating with skeleton models and utilizing a white board for notes and diagrams.

For the patients who were prescribed exercise, each had his/her own set of exercise sheets with diagrams to reinforce and remind the patient how to perform each movement correctly. He also reported frequently using his radiology text book so he could show patients X-ray images of conditions similar to theirs. This was not done routinely, but rather in response to patient questions or interest. For example, sometimes patients would say, “My X-rays showed this. I don’t have my X-rays with me, but can you show me what it looks like?” In response, he would refer to the appropriate images in the textbook:

> …what I would do is take out my X-ray text book and show them a typical plantar spur, what it looks like. Here’s somebody with the same problem as you and they could see the bony outgrowth. I’d do stuff like that. Or if people had arthritis…’Can you show me arthritis?’ and I would.

While Sam did seem quite open to answering patient questions of all sorts, which may indicate his willingness to move toward a more transaction approach, his most frequently used mode of education was primarily one of transmission. He felt that there was a ‘package of information’ he had to deliver to the patients and he did this primarily through talking to them, either one on one, or in group sessions along with the use of some aids.

**Current Practice**

Sam continues in using a transmission approach to patient education. His educational interventions, in all areas of practice, are described by him as, “definitely verbal,” “largely verbal,” and “mostly verbal explanation.” Some little written component appears in the printed informed consent document and the use of some pamphlets. He reports that he has occasionally used printed Internet information in response to patient queries, but this is not routine and is on a
“case by case basis.” For some patients, specifically those covered by motor vehicle insurance, he is required to give the patient a printed document about understanding the facts of whiplash. He reports that, “I’m obligated, as a practitioner, to give them that on day one. I always have.” Even though he does do this routinely, as required by the insurers, he also says about this document:

I don’t even go through it with them, to tell you the truth, I just say, ‘here’s an information package explaining to you what the nature of typical whiplash are and what the outcomes are. You can read that….It’s up to you.’

He continues to use individualized patient exercise sheets to remind patients of their active exercise component and how to do the program properly. These include both, “pictures and words” along with information on, “…how many sets, how many reps (repetitions), how often to do them.” Having their own printed and illustrated programs at home also serves as a reminder of the patients’ responsibility in helping to make themselves better.

When asked about whether he introduces patient education or waits for the patient to bring up topics, Sam told me, “Sometimes I do; sometimes I don’t. It’s hard to say. I’d say there’s a core component I do on my own initiative and then there are others that I do wait for patients to ask me.” This underlines his earlier described approach that he feels there is a specified or fixed set of information that he needs to deliver to all patients.

Sam varies the amount of time he spends on patient education. He seems to spend less education time with those patients that are more compliant. He said:

If I could see that the person is really compliant and they are going to do what I say, then I’m going to say, you know what – maybe I don’t have to spend so much time educating this patient because they are self-motivated and smart anyways.

**Key Beliefs and Feelings: Early Years**

In his first years of practice, Sam reported sometimes feeling frustrated that the patient with whom he was working was not learning and his patient education efforts were for naught. He told me:

Sometimes it was frustrating because I would feel that despite my best efforts, the message still just wasn’t getting through, or I just knew that nothing would come of it. I’d feel like I’d done an excellent job with these people and I’d just know – I’d damn well know – that when he goes home, he’s not going to do anything I showed him.

So, even though Sam felt like he worked hard to educate the patient, as he was obliged to do, sometimes he had a gut feeling that the patient would not be compliant with the educational
instructions or plan of management. In these cases, he would, “…hope that they are compliant,” but this did not seem to be the case with at least some of his patients.

In addition to feelings of frustration about patient education efforts, Sam also reported that this aspect of his duties could be challenging for him, at least with some patients. He explained that, “…basically, it’s always challenging when people don’t want to hear what you want to say, even though you know it’s in their best interest to do so. And that happened on countless occasions.” It is possible that Sam’s challenging patients did indeed not want to hear what he was saying, or it is also possible that they were not responding favourably to his teaching which Sam suggests later in this section as a possible reason.

Sam also held strong beliefs about patient expectations in his first few years of practice. He felt that often, patient expectations were less than appropriate and said, “I think patients sometimes have unrealistic expectations in that they want the earth, the moon, and the stars every single visit for free. They want to get better in 24 hours after ten years of pain.”

Continuing in this vein, Sam also commented on patient unwillingness to accept responsibility for assisting in their own recoveries saying, “They want to do very little in terms of their own role, but they want the biggest outcome. So, patient expectations certainly play a role, for better or worse.” He also acknowledged that some patient expectations were appropriate and led to satisfied patients. Sam reported that:

Some of the patient expectations are positive. They come in and say, ‘Wow! I didn’t expect you to spend so much time with me; my doctor (M.D.) only spends thirty seconds with me. You’re here spending ten minutes with me. Wow!’

In his first few years of practice, Sam felt that patient education was not very important. He stated:

At the beginning, I thought the physical treatment alone was the single most important component and I think that I gave more credit to what my treatment was able to provide than it probably was at the time.

This feeling, which is not an uncommon one among this study’s participants, eventually changed for Sam and this will be covered later in this discussion. He felt, as most participants did, that he was, “…well prepared from college” in diagnostic and physical treatment skills, but now he realizes that, “…it’s just not the whole story. You know, college teaches you to be excellent diagnosticians, excellent treatment practitioners…” Sam, as well as his colleagues in this study, learned that the physical aspects of their care, like diagnosis and treatment, are the most important, but they did not learn as much about effective patient education.
Reflecting back on a possible linkage between patient education and patient satisfaction in his early practice years, Sam said he did see a connection:

I suppose, to tell you the truth, yeah, I think some people were happy that I took time to explain to them what they have as opposed to a doctor saying, ‘Here’s the pills. Don’t worry what they’re for; just take them’…I think the fact that you explain it to them, explain what treatment you think is best for them, courses of recovery, and all that…I think a lot of them did appreciate it in the long run, or they felt relieved…

The realization of this possible connection may have been one of the reasons for any change that occurred in Sam’s perceptions of and feelings towards patient education in his current practice.

Some aspects of practice helped him feel a level of confidence, namely positive feedback from his patients. He explained some of his experiences saying:

I had many people thanking me afterwards. I had people thanking me for a) taking the time to explain to them, b) thanking me for being a positive reinforcement, thanking me for doing everything for them that I did. Photocopying stuff. Looking in the textbook. Even doing something on the internet.

While these messages of gratitude obviously indicated a level of satisfaction among his patients, they also accounted for a feeling of increased confidence by Sam. Related to this, he also realized the connection between the care that he provided, patient recovery, and patient satisfaction and explained that:

It made them appreciate my services and (made) their overall rate of recovery better, I think. Because the more they understand, probably the more compliant they are going to be and the more compliant, the better they’ll feel.

By realizing this, along with his increasing experience and seeing more patients, Sam believed that his confidence as a health care provider improved.

For the patient demographic with which he worked in the first few years, Sam believed that financial issues were quite important to them, often being a driving force. Sam recalled to me:

One thing I was told when I graduated (from chiropractic college) the number one question I’m going to get in practice is, ‘Is chiropractic going to cause a stroke?’ Number one patient question. When I got in practice, the number one patient question was, ‘Are you totally covered under OHIP?’ Number one. EVERY patient asked me that. Patients didn’t care about stroke. Who’s going to pay for this?

This patient priority affected his own feelings about patient education, too, as he explained his belief somewhat fatalistically, “With those people, you know educating them on healthy lifestyle isn’t going to do it. They don’t care.”
Current Practice

Now, Sam believes that patient education is important in his practice and he also feels that there are a number of factors that can have an effect on the efficacy of the educational interventions. Sam feels that, “Things like their level of education. How smart they are. That plays a role, too…” in determining how effective patient education might be. In addition, he said, “…language barriers or cultural beliefs of pain, I think, also play a role, too.” He also believes that patient expectations can influence patient learning and case outcome and outlined his ideas:

Some people have the expectation they have to be 100% pain free. Other people have the understanding, ‘I may never be 100%, but at least I’m functional.’ And that’s what I think the right attitude is. So, yeah, patients’ beliefs and education would certainly play a role there.

Sam feels challenged with his patient education interventions in which he feels that, “…the patient doesn’t want to be educated; it’s always going to be hard.” He believes that he, “…can almost tell in advance, before I even say hello to them, if they are going to be difficult or not.” He uses, “…physical demeanour, language, age…” and patient lifestyle habits to make this determination. Further to this, Sam believes that some patients are almost beyond all educational efforts. He related some of his experiences that illustrate his feelings on this:

I’ve had gang members. I’m going to educate a gang member, that has a bandanna, has probably previously (been) shot? I’m going to educate him the importance of maintenance care? Come on! They don’t want to hear it. Or a 90 year old woman with multiple compression fractures, that walks with a walker. It’s tough. It’s really going to be tough.

This indicates that Sam probably puts some effort and time into educating all his patients, but this statement also emphasizes his feelings of fatalism and frustration about factors that he feels may pre-determine the undesirable outcome of his educational efforts.

There are instances in his current practice, though, when Sam does feel particularly confident as a patient educator and in fact, he states that this is not a rare occurrence. He says:

…there’s been so many of them. I’d say whenever I educate someone and I see that they’re following what I’m saying, or I see that they’re getting what I’m saying, or I see that they’re asking questions to further their own knowledge and education, that’s very rewarding, and I think it’s my experience and confidence that led them to that, as well as their own desire and willingness.”

Seeing that the patient is compliant with the treatment plan is one of the indicators that Sam uses to gauge his patient education success and his confidence level. Further to this, when he
experiences an educational intervention that becomes more of a transaction and not just transmission, when patients begin to ask him questions, then these experiences also adds to his feelings of confidence.

Perceived Barriers to Effective Patient Education: Early Years

Recalling his perceptions of possible barriers to effective patient education in Sam’s first years of practice, he identified several issues and factors which may have served to prevent or interfere with his efforts at teaching his patients. One of these concerned patients who had some psychological overlay associated with their injuries or conditions. Sam mentioned that some patients were, “…pain focused…” or experienced another psychological “block” which prevented the patients from learning despite what Sam describes as his “educational efforts.” He does acknowledge that these were extreme situations, as opposed to common ones, and when he had these patients, he often referred them to a specialist and/or a psychologist to assist with overcoming the barrier.

As mentioned earlier, he also felt that financial issues presented barriers to some of his patients in his early practice experience. Sam reported that many of his patients could not, or were reluctant to pay for regular treatments and felt that either OHIP or their insurers should be covering the complete costs. This belief by the patients did prevent some from attending as often as they should have thereby missing both physical treatment as well as patient education opportunities. Related to this is the factor related to litigation that helped to motivate patients in one direction or another. For those patients involved in motor vehicle accidents, for example, Sam explained that:

Some patients were extremely litigious and they didn’t want to hear anything from me, or sign any document, or read anything unless they ran it by their lawyer first. So, right away, there’s a barrier. I’d try to explain and they said ‘I don’t care. I’m not listening to you until I talk to my lawyer’…There may be secondary gain or litigious issues that effect patient education.

Secondary gain would involve the view by the patient that he/she could reap greater financial rewards if the injury appeared to be worse, or if it took a longer time to resolve. Hence, patients with this view may be very reluctant learners and may be only minimally compliant with the plan of management.

While Sam did not perceive patient literacy skill level as a barrier, he did state that patient age sometimes interfered with some patient learning and compliance. He said, “Age is another factor. I treated a lot of elderly people there and I think a lot of them were reluctant to be in an
active (program) for that very reason.” Sam also felt that, “The younger the people, the more receptive they were (of patient education).” For HCPs, this is not an uncommon issue with prescribing active exercise for older patients who are in some degree of pain. Older patients’ previous experience has taught them, in most cases incorrectly, that when they have pain, they should be resting, not exercising. Newer approaches to health care, especially related to musculo-skeletal conditions embrace judiciously prescribed active exercise as an effective and safe treatment intervention. Older patients, though, have long been instructed to avoid activity when something hurts and this old belief may get in the way of implementing appropriate programs for some patients. Sam found difficulty in getting patients to change their beliefs.

His own expertise as a patient educator was also identified by Sam as a possible barrier to effective patient education. He associates some of this with a type of fear in being a new graduate.

I was extremely under-confident at the beginning. I don’t want to say ‘afraid’ of patients, but you come out of school thinking basically everybody’s going to sue you. It’s scary. You’re watching every move that you do, every word that you say…I think with confidence and experience, that changes and you become more accepting.

Being so cautious, he was perhaps reluctant to teach patients beyond a safe set ‘package’ of information.

Sam also identified patient attitude as a barrier to effective patient education, “…because sometimes they didn’t like what I was trying to teach.” He believed that some patients had the attitude, “What do I have to listen to this for? Why do I have to do this exercise? I know you’ll tell me ten times they’re important; I know, but I don’t care.” Some patients are reluctant to accept responsibility for helping to manage their own health conditions and this kind of patient attitude may very well be what Sam experienced in is first few years and described above.

Another patient attitude that was evident to Sam was exemplified by those patients who did not want to work, either on the job and/or as a part of their recoveries. He explained:

…I think it’s because exercise is work and people don’t want to work. Most of them aren’t even working at their jobs because of their injury. So, they don’t want to do any type of physical component whatsoever….I think it’s sheer laziness on the part of the patient.

He does go on to explain that, in some patients, this attitude is possibly related to a fear of exacerbating the injury. In other patients, it may very well be sheer laziness as Sam described. For others, who may be receiving wage replacement benefits, according to Sam, they may prefer
to be injured and getting paid even though they are not going to work, as opposed to having to work at their jobs in order to earn an income.

Finally, Sam also identified the level of patients’ schooling as a factor that affected patient education. He believed that the lower the patient’s level of education, the greater the barrier to effective patient education. He also mentioned that he did have some patients for whom English was not their first language and this probably interfered with effective patient education.

**Current Practice**

Sam reports that he, “…would say that the same barriers ten years ago are the same barriers today.” Having said this, in his current practice locations, Sam reports that financial issues interfering with patient compliance and patient education are virtually non-existent. He describes finances now as being a, “non issue” as it relates to patient education and attending scheduled appointments. He does feel, though, that he still encounters patients whose motivation is dominated by their lawyers and what he calls, “legal barriers.” He goes on to explain, “If the patient’s represented and the lawyer says, ‘Don’t ever get better,’ they won’t. Or they won’t be compliant with what I tell them. That certainly plays a role as well.” So, while he admits that this kind of patient is much less frequent in his current practice, he still does encounter them.

While language does not present a barrier in his current practice, he noted that time, which was not previously mentioned, is sometimes a factor now. Sometimes, when he is quite busy, he acknowledges that he may not have as much time as he would like for patient education.

While he does not now regard his expertise as a patient educator as a barrier, he does recall cases in which he had difficulty teaching some patients.

Oh, I’ve had situations when I could not get through to a person, but I don’t think it’s because of me that I can’t get through to them…I think I’m a good communicator. I certainly have good language skills and I think my knowledge base is good enough that I can effectively educate someone provided they want to be educated.

In saying this, Sam again underlines the potential barriers presented by patient attitudes.

Finally, in his current practice, Sam identifies the Internet as a possible impediment or barrier to effective patient education. With patients who he describes as “self-directed,” he explains that they may seek information which may affect his teaching role and may also either cause them to form certain opinions, or alternately may become a source of anxiety for the patients. Sam explained:

…now with the advent of the Internet and all the stuff, I find that some patients are motivated to self-educate. So, I find my role as an educator has gone down, in some
respects. Having said that, there’s a danger of over-education, too. They go on the Internet and they read 50,000 articles by different people. They can get scared. They can get over confident. But it’s information overload out there and it’s so readily accessible that for a motivated person, in a sense, they don’t even need to go to me.

He goes on to state that with so much access to information, patients often accept inaccurate and erroneous information as correct and this stands in the way of his trying to educate the patient with accurate and appropriate information.

**Changes Related to Patient Education**

Since his first few years of practice, Sam recognizes that he has made some significant changes related to patient education in his practice. He acknowledges that his perception of the importance of his physical treatment has altered to the point where he no longer feels it is the single most important aspect of his care. Now, he realizes that the health care service he offers encompasses a much broader spectrum. He goes on to explain this change saying:

I can honestly say that now, in retrospect, I thought I was doing more than I really am. And then you start to realize that it’s not just chiro (physical) treatment. It’s a whole global sphere. It’s education. It’s understanding. It’s psychology. It’s placebo, to a degree. It’s everything, everything….You know, it’s somewhat of a wake up call in that regard.

Sam explained that, “In my first few years, I was over-confident. I think I was naïve and I felt that my treatment was going to be best and that’s it. And I think that’s ‘new grad syndrome.’” He goes on to state that he feels this is not uncommon among his peers and that many new chiropractors have yet to learn the full benefits and importance of patient education in their practices:

I think a lot of new grads think that, and after a while you get humbled and you realize you’re not the cat’s meow and that it’s very important to integrate an overall educational program into your patient’s care, not just think that I can give them my services alone, not ask any questions, and it’ll be much better.

Related to this is Sam’s perception that perhaps he has also become a better teacher over the years. He suggests that his improved effectiveness as a clinician may be at least partially due to this change although he does also mention that his different patient demographic also may be a factor.

Maybe with experience, I’ve become a better educator; that’s true. But I think that the patients are more receptive to it and I know there’s no language barrier….Maybe over the
course of time…I have learned from experience and become a better educator, passive learning, I guess you’d call it.

On reflection, Sam acknowledges his successes as a clinician and relates some of this success to patient group changes and some to his improved skills and knowledge as a patient educator. However, his last comment above also indicates that he did not actively set out to become a better teacher. He attributes his changes to ‘experience’ and refers to what he calls ‘passive learning’ on his part as opposed having made a directed, purposeful decision to change for the better.

Sam suggested that, while he does see his role as a patient educator as the same, he also reports that his instructional methods may have changed over the years. He mentioned, “I’d say the role is the same. I would say maybe my methods are a little bit different, or maybe my participation in it (patient education) has increased… (but) my role as educator has stayed the same.” He goes on to expand on the possible changes in his “methods” saying, “I think in the latter years, I have started to use different media types like the Internet; I’ve used models, whereas before it was largely verbal.” On this topic, while some of his instructional techniques may have changed, he says that the amount of time he now spends on patient education is:

…about the same…it also depends on the patient. If I find that the patient wants it and is receptive of it, I will increase the patient education part for them because they appreciate it. But for someone that I know isn’t going to care…I won’t. I’m not going to waste my time.

This statement illustrates Sam’s continued perceived ability to judge or predict how effective patient education interventions will be with a particular patient and then, based on that judgment, he decides what educational intervention, if any, to use.

Related to the challenge of patient education for Sam, he reported that he now finds patient education to be, “…a lot easier” for him now and he attributes this to the different patient population on which he now practices. He also says that he feels more confident now as a patient educator and suggests that the reason for this change is that an increase in confidence, “…just goes with time and experience.” He also feels that this increased level of confidence permeates all aspects of his practice, saying, “I’m more confident with everything now, I think. With my treatment, with my assessment methods.” He attributes this to an “evolution” that happened for him and for many others.

I think that’s true for virtually every practitioner out there. Any discipline. I think it’s just the same. Time and experience make you wiser. That’s just how it is. You don’t hear of many people who get dumber. With experience, it just doesn’t happen that way.
Sam acknowledges that he did not purposely set out to change; rather it was for him a normal, evolutionary process experienced by HCPs as opposed to a specific, self-directed, goal-oriented plan to change.
Chapter 5

Thematic Analysis of Participants’ Responses

This chapter deals with my analysis of the sixteen interviews with the eight participants. Up to this point, I have dealt with each of the participant’s interviews individually; in this section, I look that the group as a whole and consider the responses of all of the participants. While the individual interview analyses focused on describing and interpreting what the participants reported, this section presents my view of the data that includes both a reporting of what the participants said in the interviews as well as the inferences that I was able to make based on their responses. Considering the group as a whole, I attempt to provide information about the trends that emerged from the eight doctors’ responses, comments, and explanations which they gave during their interviews. In some cases, consensus on various aspects of patient education was seen; in other cases, a range of responses demonstrated their different views, perspectives, and beliefs about patient education in their early years and current professional practices. The material in this section is divided or organized using the same category headings that I used in the individual analyses thereby providing consistency of construct and process.

Practice Experience and Patient Groups

This section is essentially descriptive and includes background information on where the participants practiced and the patients groups they saw, both in their early and current years of practice. As background factual information, little inference or interpretation is either needed or included. All of the participating doctors had been in practice between five and ten years following graduation from their chiropractic colleges. While they were all practicing in the Greater Toronto Area at the time of their interviews with me, they reported a broad range of experiences before settling into their current practice situations. When interviewed, all of the doctors were in practices that were different from those in which they began their professional clinical work and all of them had ownership positions in their current practices. Also, all of the participants began their professional experience in practices operated by other doctors. Four began as associates while three others worked filling locum positions, temporarily taking the place of doctors who were away from their practices. This seems to be a common strategy for new graduates as they learn about different practice models and strategies while earning a reasonable income and exposing themselves to no overhead practice costs. All they would need to practice in locum positions would be their provincial licenses and professional liability insurance,
essentially minimal costs for a health care professional. Working in another doctor’s practice, either as associates or as locum doctors, can provide a great deal of clinical experience for new chiropractors. Newly graduated doctors need to learn how to deal with different patient populations, with a variety of support staff members, and how to provide effective care for patients in various clinical models that may be based on chiropractic or health care philosophies that are different from their own. All of these lessons can be learned while working in an established practice.

This group of participants had a wide range of early practice experience. While half of the group practiced only in Ontario, four had practice experience outside the GTA in smaller or more rural communities. Three of the doctors even had locum or associate experience outside the country. The participants reported that they dealt with quite a range of patients that spanned socio-economic, ethnic and cultural, language, and education spectra.

Functions of Patient Education

The participants in this study related a number of views pertaining to the function of patient education in their practices. They reported wide ranging possibilities for the various roles patient education could serve. Most of the doctors recognized and mentioned the regulatory requirements of providing patients with basic information during the informed consent process although five of the doctors did little more than provide the patients with a printed consent form. Regulations require chiropractors and all health care professionals to inform patients as to risks, benefits, and alternatives associated with treatment and care, and also to answer the patients’ questions. Two of the participants spoke about the changes in regulatory requirements surrounding the informed consent process in recent years and said that they had addressed these increased and more stringent requirements in their clinical processes. These changes resulted from an extended inquest into the death of a patient following chiropractic treatment. Even though no direct link was found between the death and the treatment, chiropractic regulatory authorities made the informed consent requirements more stringent. Three of the doctors in this study mentioned the effect of the inquest on their own informed consent process.

The doctors were divided as to how they perceived the care that they provided to their patients. One group of four tended to focus on dealing with the injury or condition for which the patient was seeking care. For this group, patient education seemed to centre on how the patients and the doctors could treat the condition and what the patients themselves could do to assist in the process. The other half perceived their care as being more holistic in nature. While these doctors did treat the condition or injury that was of concern and also addressed this in their patient
education interventions, they also reported that they spent considerable clinical time teaching their patients about health care in general, what they could do to remain healthy, both physically and emotionally, and also how they could improve the quality of their lives via alterations in their lifestyles. Both of the approaches can be successful and by having access to doctors who take different views of health care, patients have a choice in practitioners.

Another function of patient education that was discussed as being important to the group related to the linkage or connection between patient education and patient satisfaction. Seven of the doctors reported that they eventually realized that patients who were effectively educated by them seemed to be more satisfied with the overall care delivered by the doctors. The satisfaction was perceived through a number of ways. For example, four participants mentioned that patients who were satisfied with their care tended to remain as patients in their practices. Participants also said that satisfied patients referred other patients to the doctors’ practices which is an obvious desirable outcome for practice success and growth. Related to this is the aspect of risk management and some of the chiropractors said that patient education would help not only in making patients satisfied with care, but would also reduce the likelihood of patients initiating complaints against a doctor. On the other hand, those patients who seemed to be dissatisfied left care early or after a few visits. The doctors might not know specifically why patients left their practices, but often, a health care professional gets clues to how patients feel about their care. For example, a patient may ask questions or make comments that would lead the doctor to believe that the patient was not completely satisfied. Sometimes, during follow-up phone calls, patients may express their displeasure. The point is that patient education can be an important element in achieving patient satisfaction which is a desirable goal for both doctors and patients.

Patient expectations can also be a source of concern in a chiropractic office. Six of the participants came to the realization that many patients had unrealistic expectations related to their care and specifically to the length of time that their recoveries would take. For patients to expect an unrealistically rapid result was not unusual and several of the doctors actually supported and fed into this expectation early in their practices by believing that their top priority should be to deliver to their patients physical treatment that might lead to a rapid resolution of patient symptoms. These new doctors eventually realized that this could often not be done and patients would then be upset at their lack of rapid progress. In their current practices, the consensus opinion from the participant group is that patient education has an important role in helping doctors and patients set realistic expectations especially as they relate to the duration of care and how long a full recovery might take.
Six of the participants in this study also discussed the role of patient education in addressing the matter of patients’ responsibility for their own health care. This idea was often expressed by the doctors through the metaphors of “team building” or “establishing a partnership” between the doctor and patient. Patients need to be taught that they have a role to play both to assist with recovery and also to help prevent relapses or reoccurrence of their conditions. This kind of responsibility often involves the patient performing specific exercises, avoiding certain activities or postural positions, and the home use of heat or ice applications. Patient responsibility also involves patients attending their clinical appointments for treatment. The participants reported that without effective patient education related to teaching patients about their own responsibilities for assisting with their care, the case outcomes might very well be unsatisfactory.

Seven of the doctors interviewed also mentioned that they saw patient education as having a role in addressing issues of patients complying with the treatment program and patients’ choice in treatment or in the creating the treatment plan. That is, with effective patient education, patients may feel some ownership in the decision making process of making the plan for managing their conditions. Patient compliance involves both a proactive approach in having patients understand the importance of attending for regular clinical treatments as well as dealing reactively with patients who are not compliant with the established plan. Patient choice refers to patients having a choice in how and how often they will be treated by the doctor. Five of the doctors said that they told their patients that they could, after being taught about the various treatment modalities, reject one or more types of treatment. For example, patients might choose not to be treated through the use of cervical spine manipulation.

Finally, five of the doctors reported that for a variety of reasons, they did not perceive a very important role for patient education in their first years of practice. Later, they invariably came to the realization that patient education did have a number of important roles to fill in the scope of care that they now provide for their patients. A more complete discussion of this is included in the section on the role of patient education in this chapter.

The HCP’s Role in Patient Education

Doctors in this study reported that they saw several different roles for themselves related to patient education in their professional practice. In some cases, the role of the doctors was influenced by the practice environment in that several doctors began their professional lives working in locum placement positions. In these positions, they were temporarily filling in for chiropractors who were away from their practices for a number of reasons such as vacations, parental leaves, educational courses, and personal leaves. Consequently, these locum placement
doctors tended to avoid or minimize their patient education efforts since they did not want to risk giving the patient information that might be different from that provided by the regular practice doctor. Different information might contradict that previously given to the patient or might serve to confuse the patient and thereby develop a sense of doubt about what the regular doctor is presenting. The locum doctors felt that it was not their role to do much patient education and they definitely not want to upset the practice in any way. Hence, they told me that, as far as patient education went, they provided basic answers to questions from patients and presented very little new information.

When working in their own practices, the participants told me of the different roles they had related to patient education. The first role that was widely expressed was that of ensuring that the regulatory requirements for the informed consent process were competently completed. Patients need to be taught, or informed, of the risks, benefits, and alternatives of treatment in order for them to provide an “informed” consent to examination and treatment.

Six of the participants also stated that they felt that patient education, beyond that required for the informed consent process, was an implicit responsibility of being a health care professional. Hence, all of the doctors continued to teach their patients even after obtaining consent to care. As mentioned earlier, the participants expressed the commonly held idea that they needed to educate their patients in order to help establish realistic patient expectations, especially as these might relate to the duration of care. Half of the doctors indicated that this was not their position when they began practice. At that time, they felt that the best they could do for their patients was to provide physical relief to their symptoms through effective chiropractic treatment. All of the participants eventually came to the realization that getting quick symptom resolution was not often possible and they learned through experience that judicious use of patient education to assist with the development of realistic expectations would be of benefit both to the patients and to the doctors.

Regarding developing partnerships with patients, there was a general consensus among the participants that they had a role in attempting to create these partnerships through patient education. Some spoke about “sharing responsibility” between the doctors and the patients. Others talked about this concept in terms of empowering the patient or teaching the patient effectively in order to dissuade patient dependence on the chiropractor, thereby promoting independence for patients with regard to their own health. Another way this was expressed by some of the doctors was that they wanted to teach the patients to have the skills and knowledge to take care of themselves and to know when they needed to come in for chiropractic treatment. Finally, some spoke about developing a team or partnership with the doctors and their patients.
What did come though in the interviews was that all of these models or concepts had one aspect in common; the health care professional was in control of the learning, although the levels of control may differ. One of the doctors mentioned the team building concept, but also stated that he was the “team captain.” Others shared the idea that the doctors were the ones who were in charge of the educational initiatives. They decided when and what to teach and what the patients needed to know. The doctors also decided on how they were going to present the selected information to their patients. Of course, patients could always ask questions about information that was not presented and they were always free to take the initiative and seek out their own information from other sources, but as far as patient education extends in a chiropractic practice, the common scenario is that it is the health care professional who is in charge of the doctor-patient relationship, or partnership. Of course, the patient does have the power to make the ultimate decision whether or not to continue care with a doctor.

All of the doctors in this study told me that patients asked them about information related to the care they were receiving from other health care professionals, usually in disciplines different from chiropractic. For seven of the participants, this occurred frequently in their practices. For instance, patients would often come to their chiropractors seeking answer to questions they had about their medical care. The doctors in my study handled these encounters in diverse ways. Two said they would evade giving the patient information. They would tell the patients that this issue is beyond the scope of chiropractic and they either did not know the answer or were constrained from providing the information due to professional regulations. Four others tried to provide the patients with as much information as possible even if it was related to surgery or medications, both of which are well beyond the chiropractic scope of practice. That is, chiropractors do not perform surgery nor do they prescribe medications, but that does not preclude them from having useful and accurate information about these forms of treatment which they may have garnered from reading professional literature, working with health care providers in different disciplines, or from other sources. A few of the chiropractors in this study had significant experience working in multi-disciplinary settings and would therefore have quite a bit of knowledge about other health care disciplines which could be useful to patients. One of the doctors pointed out a good reason why she does take the time to try to address these types of questions from her patients. She feels that in some of the under serviced communities in which she has worked, the medical community is extremely busy and overworked. Consequently, they may not have the time to spend providing their patients with all the information they need to know about their treatment or care. In these communities, it is very difficult, if even possible, to get a subsequent appointment with a specialist just to discuss patient questions. This chiropractor feels that as a responsible member of
the health care community, she has a responsibility to address all her patients’ health care questions, to the best of her ability, even if the questions do not relate specifically to her care. Of course, and from personal experience, sometimes the answer would have to be “I don’t know, but here is where you can find the information.”

Nature of Patient Education Interventions

When I interviewed the study participants, they told me how they went about teaching their patients what they needed to know. Most of the teaching was conducted through the doctors speaking to the patients in one on one situations. As mentioned earlier, the patient education experience was overwhelmingly directed by the doctors who usually decided what they would teach to their patients, how, and when it would be done. Most of the time, the participants all used transmission as a mode of teaching to deliver the information to their patients. All the doctors in the study acknowledged that most of the teaching was done through this method. This was demonstrated through their frequent comments about delivering information to patients such as, “I tell them… I give them…I explain to them.” Teaching characterized by transaction was rarely evident in the interviews. Some patients would bring questions about new topics to their doctors or enter into a discussion with them about educational information, but this was not a frequent occurrence. Only a couple of the doctors, who aimed at a more holistic approach to health care, suggested through their responses that they occasionally moved toward a transformative mode of teaching and once again, this seemed to be an exception to the norm.

Besides speaking to their patients, the doctors used a small variety of teaching aids. Commonly used aids included three dimensional anatomical models, usually of the spine or skeleton. Posters or wall charts/diagrams also seem to be frequently used by the doctors to assist with their patient teaching. These may show anatomical diagrams or stages of degeneration. Some posters show other important information for patients. Doctors also told me that they also used illustrations from their textbooks to help explain information and concepts to their patients. Rarely, patient x-rays were used as a teaching tool. The doctors reported very little difference in the variety of these teaching aids from their initial years in practice.

All participants occasionally used printed material for educational purposes. For instance, they all used patient consent forms that included basic and required patient information. Seven used printed material such as individually prepared reports of findings that encompassed the information from the patient examination as well as the course of care recommended by the doctor. Some of the doctors said that initially, these reports were brief and hand written. Later, they prepared more extensive reports for their patients that were typed. The participants also
reported sporadic use of pamphlets and brochures. While in locum positions, those doctors said that they occasionally used pamphlets if they were available. The use of pamphlets and brochures in the doctors’ own practices was rare and irregular. If used at all, the brochures were generally those that are available through various chiropractic associations. One of the doctors, in his first few years, reported that he went to many practice management seminars which equipped him with a series of information handout to cover the first several weeks of a patient’s treatment. Now, in his own practice, he no longer uses these.

Only a small number of the doctors reported using any technological aids such as audio visual or computer based tools in teaching their patients. Two of the doctors who worked in locums told me that the practices in which they were working had informational video tapes to lend to their patients. None of the doctors uses these in their own practices. While she does not have a practice-specific web site, one participant reported that she often refers her patients to a web site that takes them through a specific exercise program that they can perform in their offices or at home. Three of the doctors mentioned that they do have practice-specific web sites to assist with teaching their patients. Only one of these is an interactive site. The others are sites to which patients are referred to read about various topics concerning chiropractic and health care. One participant described her extensive website that she has developed for her patients. She directs her patients to her practice web site even before their initial appointments, using this tool both to inform patients and also to collect patient information on medical history and demographics. Once they begin their treatment, patients continue to use the web site to learn about information, to answer patient education questions, and to provide feedback to the doctor. This doctor seems to rely to a great extent on this latter feature as she feels it helps her to address individual patient concerns effectively.

Group learning does not seem to be a strategy that is popular with the chiropractors in my participant group. Three of the doctors used small group classes in their first few years of practice and they all reported a reasonable degree of success with this teaching strategy. However, now only one continued to use small group classes and that is because, in addition to working in his own practice, he was also filling in for another doctor who was temporarily away from his practice and small group classes are used there. Hence, he continued to use them at this location. This participant did have extensive experience with small group classes in his early practice years and reported that he and his partner are planning to institute these in his current practice. He said that they are currently working on a Power Point presentation around which the group classes will be centered.
One doctor uses a different form of group learning with her patients. She did have experience with small group classes in her first two years of practice, but she no longer uses these in her current practice. Instead, she tries to encourage patients to share their own “stories” with other patients in her waiting area and with other people in their lives. She will often invite or ask a patient who has had a successful result to tell other patients about the positive experience. By doing so she seems to be fostering the concept that learning from peers is at least as effective as learning from the doctor, if not more so.

**Key Beliefs and Feelings**

One of the important ideas that emerged from analyzing the interviews was a doctor’s perception of the importance of patient education depended, to a very great extent, on the his/her individual clinical experience. All but one of the doctors did not regard patient education as an important element of their early years of professional practice. Two of the doctors, when beginning practice, worked with or went to seminars given by experienced doctors who told them that patient education was important, and because of their trust in these people, the newly graduated doctors believed them, but they did not understand why they were told this and they certainly did not have the clinical experience to back up this belief. Their belief in patient education’s importance was based on trust as opposed to direct personal knowledge. Five other participants reported that, when they began practice, patient education was not a very important part of their care. Only one doctor said that he actually knew patient education was important and his explanation for this was that he had had quite a bit of experience working in clinical situations during his university undergraduate experience and also working in a rehabilitation facility during his chiropractic training. Hence, he was able to see first hand, the effects of patient education and how this helped patients achieve a favourable outcome.

Later in their professional careers, all of the doctors who did not see patient education as important in their early years came to view it eventually as a key part of their treatment and care. It appears therefore, at least for this group of doctors, that coming to know this takes some years of experience working directly with patients. One participant, because of his pre-professional experience, learned this early: the other participants needed to see this for themselves through their experience in treating patients for a number of years.

Becoming confident as an educator also appears to take some years of experience to accomplish. The consensus of this group of participants was that they were not very confident as teachers for their patients when they began practice. Later, they all reported that they did become much more confident in their roles as patient educators. Two possible reasons may account for
this lack of confidence. One relates to the belief explained above that patient education is not perceived by new graduates as being important which was reported by the participants. The second involves their pre-service education related to patient education. If a health care professional does not believe that a certain task is very important, then he/she may not spend much time on this task and hence, may not develop a high level of confidence when performing this task. The participants reported that they did not spend much time on patient education in their early years of practice and this may support the suggested reason for their lack of confidence. Further to this, all participants reported that their pre-service curricula did not have much, if any, content that was aimed at teaching new doctors to be effective patient educators. One doctor explained that he was taught in school that patient education was important, but then this value was not emphasized since his pre-service program had almost no content directed at teaching him how to teach his patients. The participants all reported that they did feel quite competent and confident in their other clinical skills, especially their abilities to diagnose and deliver physical chiropractic treatment. This confidence derived from their excellent pre-service curricular experiences in diagnosis and treatment. It would seem, therefore, that the level of confidence expressed by these doctors is directly related to their learning. They were confident when it came to diagnosis and physical treatment because they were well educated in those areas. They reported that they were not well educated as patient educators and consequently, they did not feel confident teaching their patients until such time as they learned how to do this through their own growing professional experiences.

Two additional beliefs were evident from the individual interview analyses. The first of these involves patient knowledge. Three of the chiropractors in the study told me that they believed, through their own experiences with their patients, that patients did not know very much about health in general or about chiropractic and certainly less that they should know. Four explained that they felt that patients did not know as much as they thought they knew about their health. Occasionally, this presented a barrier to patient learning which will be discussed in the next section. The importance of this belief is that it influenced the doctors in their patient education initiatives. After seeing, or realizing that there were deficiencies in patient knowledge, many of the doctors changed their practices related to patient education. Five became more willing to repeat information to patients both to re-teach it and for reinforcement. Five decided to spend more time teaching patients on each visit or to spread out the patient education over the duration of care as opposed to concentrating it early in the course of care. One of the participants believes that our society does not do a very good job educating young people about health and how to be knowledgeable health care consumers.
One of the other beliefs relates to the issue of patient education by other health care professionals in different disciplines. All of the doctors interviewed told me that patients came to them asking about information related to the care they were receiving from other health professionals. The doctors in this study dealt with these questions in a number of ways, some answering in depth while others avoided answering. The issue here though is not what strategy was used to deal with these patient questions, but rather why patients needed to ask these questions. The consensus opinion was that patient education was not well done by many health disciplines, especially by MD’s and medical specialists. One explanation for this was expressed by a participant who told me, that at least in some communities, these health care professionals are over-worked and over-booked. Hence they do not have enough time to spend teaching their patients what they need to know. Since, in general, chiropractors may spend much more one-on-one time with patients, sometimes entailing several visits a week, they may have more time to interact with their patients allowing patients to ask about health issues not specifically related to chiropractic care. One other possible explanation for this might relate to the chiropractor’s individual approach to health care. Those doctors who take a more holistic view of the care they provide teach their patients about topics that are important, but may not be directly related to the condition for which they are seeking chiropractic care. Patients would consequently feel more comfortable asking their holistic chiropractors about non-chiropractic health issues.

**Perceived Barriers to Effective Patient Education**

Two categories of barriers to the effectiveness of the doctors’ patient education initiatives were evident from the analyses of the interviews. I refer to these two categories as extrinsic barriers and intrinsic barriers. The extrinsic barriers derive from the patients or from situations that are not under the control of the doctors. These include, for example, patient attitude or patient allocation of time. These barriers were encountered both in the chiropractors’ early years of practice as well as in their current practices. The intrinsic barriers are those which have their origin within the factors over which doctors do have some control. For example, some of these barriers are the doctors’ schedules and lack of confidence as an educator. These barriers seemed to change as the doctors gained more experience as patient educators. Some that were evident in their early years were not so evident in their current practices.

All of the chiropractors interviewed told me that they encountered patients whose attitudes presented barriers to effective patient education. While all of the doctors mentioned patient attitudes, not all of the barrier-causing attitudes described were the same. Some patients felt that they knew all that they needed to know about their conditions. According to the doctors, this
information was seldom accurate and the doctors believed that these patients still needed to learn additional knowledge and/or skills to assist with their recoveries.

Some patients, according to the participants, do not want to accept responsibility for their own recoveries. They simply want the doctors to “make them better” and do not want to learn how to perform rehabilitative or corrective exercises or do anything on their own except attend for chiropractic treatments. This attitude manifests itself in a number of ways. Some patients refuse to accept responsibility. Others believe that the doctor is the expert and it is the doctor who will “fix” them. Another reason that could account for this barrier is excessive trust. At least one of the doctors told me that some patients expressed a great deal, or perhaps even excessive levels, of trust in the doctor’s knowledge and skill and because of this feeling, the patients believed that the doctor has both the power and responsibility to make them better, even if they (patients) do nothing except arrive for and consent to treatment.

One of the participants reported that he works with quite a few patients of Mediterranean background and he feels that barriers to patient education might derive from their cultural beliefs. He found that many of his patients came from a background in which they trusted in the knowledge and power of doctors. Many of these patients did not attend school beyond a basic level and they seemed to have an inflated reverence for those, like doctors, who have gone through an extensive education career. In their home towns, doctors, lawyers, and other professionals were revered members of their societies and patients would believe that they would take care of the problems brought to their attention. These patients are more than willing to turn over full responsibility for their health and recoveries to their health care professionals.

Age can also be a barrier to patients’ willingness to accept responsibility. For example, a few of the participants felt that some older patients might not believe that a young doctor knows very much. According to the participants who had encountered this, the actual barrier seems to be related to the difference in age between the doctor and the patients. Some patients would have children who are the same age as their chiropractors and often, parents do not want to pay much heed to the advice given to them by their children, even if the children are qualified and educated professionals. Consequently, the advice given by health care professionals who are much younger than their patients might not be followed since the patients might feel that the doctor is too young to know what really needs to be done.

Also related to patient age and cultural background is a patient belief that when they are injured, patients need to rest. Current knowledge in soft tissue injury and recovery tells us that active care is important for rapid and full recovery; rest can actually deter the recovery. Older patients have learned that when something hurts, they should rest, not exercise. Today’s
chiropractors know that both passive care (chiropractic treatment done to the patient) and active care (patient exercise program) are required to optimize healing and recovery, yet this current knowledge conflicts with the long standing belief of older patients who have learned that they should not be exercising at all if they are injured. This is a difficult barrier to overcome since it is seated in a long standing belief and may also be related to cultural background.

Four of participants reported that some patients did not schedule enough time for doctors to teach them effectively. For instance, one of the participants explained that her practice includes a great number of professionals and they are “busy, busy.” These patients want to be in and out of her office as quickly as possible. They do not stay beyond the time needed for the physical treatments. Consequently, this doctor does not have much time to spend teaching them what they need to know. Another participant also mentioned that she had patients who not only wanted fast treatments, they also wanted fast results. These people were often wealthy and were used to, according to her, getting what they wanted right away and were willing to pay for it. This attitude made it difficult for her to teach them effectively about the time full recovery would take and also how much time they should be prepared to spend with her during treatment visits.

One other barrier that was reported by two of the participants related to patients being involved with lawyers. Patients who have injuries or conditions involving legal proceedings or litigation often value the advice of their lawyers over the advice of their health care professionals. One participant explained that some patients in this situation “see a pot of gold” at the end of the road and seem to want to extend the effects of their injuries. Hence, they do show up for their treatments, but they are unwilling to participate to the fullest extent to speed up their recoveries. It would seem that either their lawyers have advised them to adopt this strategy or they have interpreted their lawyers’ advice as such. Consequently, they tend to avoid patient education efforts by the doctor, or they are not very cooperative if they do attend these.

Several other barriers also were mentioned by the participants. A couple mentioned that some patients could not attend for treatment very often due to their own personal finances. These patients felt that they could not afford regular chiropractic care, which is not covered by the government sponsored health insurance in Ontario. If they could not come for regular care, then the doctors would not be able to teach them. One other issue was related to patients’ ability to read and speak English, or a language spoken by the doctor. For example one participant reported that in one of his practices, many of the patients were not literate or conversant in English. Consequently, since he did not speak their languages, it was very difficult for him to teach these patients. He did have access to a chiropractic health assistant at times, who could speak one of the
languages some of his patients understood, but going through a translator also presented both logistical and technical barriers.

Intrinsic barriers to effective patient education are related to factors over which the chiropractors have at least some degree of control. One of these barriers that emerged from the interview analysis was related to doctors serving in locum positions. For these chiropractors, the commonly held belief was that it was not their role to try to accomplish much patient education. Further, they were not expected, as locum replacements, to initiate patient education to any great extent. Consequently, they did not want to risk upsetting either the patients or the regular doctor by teaching the patients new information or information that would confuse them or conflict with that taught by the regular practice doctor. Also, patient education would likely not be very effective if the patient educator was constantly trying to avoid or minimize its content or effect.

While none of the participants cited their lack of expertise as teachers to be a barrier, the commonly held view was that their lack of confidence as teachers or as communicators did present barriers to the effectiveness of their patient education efforts. Some of this was perhaps linked to the view that, in their early years of practice, five of the doctors did not believe patient education was an important element of their program of care. Also, five did not feel confident in teaching their patients because they were not taught to be effective teachers in their pre-service chiropractic curricula. For example, two of the participants explained that their lack of confidence could be partially explained by their inability to “translate” technical terms and jargon into lay or patient-friendly terminology. It is understandable how this would present difficulties and barriers for newly graduated chiropractors when they tried to teach their patients. This is a skill that takes time to learn. Related to this skill is the ability to use examples or analogies to explain patient conditions and treatment aims. One half of the doctors commented that they had improved as teachers and communicators since they became better able to translate technical terms and had developed a broader repertoire of analogies and examples to assist with educating their patients. As a health care professional and a teacher, I can attest that this learning will continue throughout their careers.

Occasionally, the doctors’ schedules were reported as presenting patient education barriers. Sometimes, the doctors had very full schedules and could not spend very much time educating their patients. One participant has developed a strategy to deal with this problem. When a patient does need more time to address patient education issues, she has the patient book a second appointment with her that day so she can have adequate time to address educational concerns. Another participant tries to book longer appointment times with his patients so that he can avoid the time allocation barrier. A third participant reported using a similar approach and tries to
schedule his time so that he spends one on one time with each patient, using this time both for
treatment and education efforts. One of the participants however, told me about a situation in his
early years of practice in which he was advised by both the other doctors with whom he was
working and the practice management seminars he attended that he should not spend much time
with each patient. Even when he was not busy, he was advised to act as if he was and allocate
minimal time for each patient visit. He was provided with specific educational scripts to use with
his patients and these were written to be presented during the course of short office visits.

Finally, three of the doctors mentioned their own personal motivation to teach patients as
being a barrier to the effectiveness of their patient education initiatives. Sometimes, these doctors
just fell into the bad habit of not teaching or doing the absolute minimum that was required. The
reason for this was not expressed by these doctors, but it might be related to professional fatigue
or “burnout.” Teaching takes a great deal of intellectual and creative energy and on occasion,
especially during very busy periods, it is not hard to see how a health care professional can lose
motivation to teach effectively. The key for these participants is that they are able to recognize
when they are losing teaching motivation and make efforts to try to correct the situation. By
recognizing that they sometimes fall into this situation, the doctors who reported this were, I
believe, on the right track in terms of overcoming this barrier.

Changes Related to Patient Education

According to their own reports, all of these eight doctors made significant changes in
different aspects of patient education as it related to their professional practices as chiropractors.
One of these important changes involves how the doctors perceive the value and importance of
patient education as a component of their care. Three distinct perceptions became evident from
the analysis of the interviews. The first involves only one of the participants. He believed right
from the outset that patient education was important because he had previous work and volunteer
experience dealing with patients and experienced health care professionals and he was therefore
able to learn, through this experience, of the value of patient education. Hence, even when he
began his own professional practice, he had and maintained this belief.

The second perception involves that group of two participants who believed that patient
education was important because others told them so. When beginning their work as
chiropractors, they either went to practice management seminars or worked with experienced
doctors who informed the newly graduated doctors that patient education was an important and
valuable tool for them to use. Because the new doctors had faith and trust in these people, they
also had faith in what they were told. They therefore adopted the belief that patient education was
important even though they did not have the experience to inform their decision to believe this. As they gained experience, they told me that they continued to feel that patient education was important, but this knowledge was no longer based on faith in information from others. Rather their belief was now founded on their own growing clinical experience with their patients.

Another group of five participants had a third and different perception of patient education in their practices. When these doctors were new graduates, they did not believe that patient education was a very important part of their care. Rather, they believed that it was no more than an adjunct to the physical care they delivered to their patients and that the physical treatments they could provide were by far the most important part of their care. These participants believed that the best result they could attain for their patients was to have a rapid resolution of their symptoms through physical chiropractic treatment. Eventually, all of these doctors came to realize that many of their patients, if not most, would not get rapid and lasting relief from their pain or dysfunction and that full recovery would entail a longer course of care and treatment. Further to this, they also realized that full recovery would often involve patients taking an active role in their own recoveries and in order for patients to take on this responsibility, patient education would be required. Eventually, these doctors changed their perception of the importance of patient education in their practices and all of them now view this as a valuable and key component of the total package of care they deliver to their patients. The message that emerges from this information is that in order to come to realize the importance of patient education, personal clinical experience with patients is a necessary requirement, at least for this group of health care professionals.

All of the participants in this study now view patient education as a very important part of their practices whereas when they began professional practice, only one knew this to be the case. Four have said that it is of equal importance to the physical treatments that they perform. The doctors’ view of their role as patient educators has also evolved. Because they all learned through their experience of the importance of patient education, they all made changes to how and how much they teach their patients. Most of the doctors told me that they now spend much more time teaching their patients as opposed to their first years as doctors. Several also mentioned that while they used to concentrate any patient education efforts at the beginning of a patient’s care, they now spread their teaching throughout the whole course of care. Five of the doctors said that they were careful to book longer appointments with patients to ensure that they had adequate time to address both treatment and patient education initiatives. While the doctors do not appear to use many more teaching aids in their current practices, they do report using a greater variety of teaching strategies. As such, they all feel that they have become better communicators and more
effective teachers for their patients. Besides spending more time teaching their patients, other changes reported involved the doctors being more willing to repeat educational information, expanding their use and repertoire of examples and analogies to assist with patient learning, becoming more effective at “translating” technical terms into patient-friendly language, and using new technologies such as web-based information to assist with their patient education efforts.

All participants reported feeling that, regardless of their initial perceptions and beliefs about patient education, they have improved as teachers for their patients. This change seemed to occur because of their learning that patient education was important and also because of their increasing clinical experience. These two factors are linked. They need personal clinical experience to gain the knowledge that patient education is important and as they learn this, and gain experience, they begin to change or evolve into what they feel are more effective teachers.

With regard to the effect of their pre-service chiropractic curriculum on their views of patient education and their abilities as teachers, all of the participants reported that as they reflected back on their own education, despite the fact that they were very well educated in diagnosis and chiropractic treatment, they did not feel the same about patient education as a component of professional practice. The group did not feel that they were well-educated as to how to be effective teachers for their patients during their time in chiropractic college. This was something that they had to learn on their own. Questions emerge about the possible effects that pre-service education could have had on how they viewed and used patient education in their early practices. If their pre-service curricula had emphasized the importance of patient education and if they had been taught how to be effective teachers for their patients, would these doctors have held a different view of patient education when they began practice? Would they have practiced differently as teachers for their patients? Would they have achieved better patient outcomes earlier in their professional health care careers? These are questions to be addressed by future studies.
Chapter 6

Final Reflections

In this final chapter, I share my reflections on this study as well as summarize the findings with respect to the four central research questions. I also include considerations and recommendations that might be valuable for future researchers in this area of patient education or those who are involved in health care practice and education.

The purpose of my study was to develop a broader and deeper understanding of the patient education experience from the viewpoint of those who are most responsible for its delivery. These are the health care professionals who deal with and care for patients on a daily basis. In this study, I decided to work with doctors of chiropractic in the Greater Toronto Area (GTA) since I had had the opportunity to serve as a faculty member at one of the principal chiropractic colleges in Canada. This work experience presented me with an excellent understanding of the pre-service chiropractic education curriculum as well as affording me the opportunity to meet and work with many chiropractors. Their experience and insight, along with my own experience as a health care professional, suggested that this study would best be conducted with this group of health care professionals.

For the purposes of this study, education was considered as a process as opposed to an end goal. The working definition of patient education that I used was one that was previously accepted and published in the professional literature. Patient education is defined as, “the process by which patients learn or acquire knowledge about their health status or condition and may involve learning in the cognitive, affective, and/or psychomotor domain” (Piccininni & Drover 2000).

This study is based on my belief that patient education from the perspective of health care professionals is not very well understood and has not been studied to any great extent as shown in the literature review of this thesis. By developing a better understanding of the nature of patient education and the feelings and beliefs of health care professionals, we may be able to improve this important area of patient care. If we understood the experience of both new and experienced chiropractors as they have to serve as teachers for their patients, we may be able to modify the pre-service curricula to prepare them better for this role. That is, armed with a good understanding of the nature of patient education in a chiropractic office, educators might be able to teach their chiropractic students how to be better teachers for their patients. Patient education
that is effective can have a significant influence on case outcomes, as well as other benefits which have been pointed out in the initial pages of this report.

In order to learn more about the nature of patient education, I decided to take a qualitative approach to the issue. Many quantitative studies have been done examining various aspects of patient education; most of these involve a comparison of the results of using various methods of patient education. What had not been done until now is a qualitative examination of the experiences of health care professionals who are thrust into the role of becoming teachers for their patients as soon as they begin their professional practice. Neither have the experiences of veteran chiropractors been studied with regard to their perspectives of patient education in their practices.

My data collection was done using the semi-structured interview approach as suggested by Kvale (1996). I conducted two lengthy interviews with each of the eight participants, all of whom were doctors of chiropractic in the GTA and who had practiced for five to ten years. This design allowed me to ask open ended questions, followed by probes when needed, and gave the participants the opportunity to provide expansive responses reflecting their experiences, feelings, and thoughts about the topic. I believe that the set of questions developed, with the advice of my committee, covered most if not all of the key aspects of patient education in a health care practice. The first of the interviews focused on the early years of the participant’s practice and the second dealt with the most recent few years as well as changes related to patient education that had occurred for each participant. The interviews produced a great deal of data after transcription, most of which was comprised of the responses of the participants to my questions. The list of my initial questions (see Appendices C & D) derived from the four general questions that guided the research. These questions are presented again below followed by summaries of the findings.

Question one serves as an overall guiding question with the subsequent three focusing on various specific aspects of patient education. The details of the responses to the questions are included in the sections of this report dealing with the analyses of the participants’ interviews, both individually and as a group.

**Question One**

**What is the nature of the patient education experience from the point of view of the health care professional serving as a teacher for patients?**

As could be anticipated, there was quite a range of responses that were provided to answer this question. The participants all agreed that one factor which influenced their patient education efforts was the regulatory requirement for ensuring that they obtain informed consent from each
patient for examination and treatment. The key word here is “informed.” In order for the patient to be informed, the doctor is required to teach the patient about the risks and benefits of and the alternatives to treatment. Further, the doctor is required to answer patient questions about these aspects of care. Because of the requirement to inform the patients prior to initiating care, all of the doctors agreed that, to some extent, the role of patient educator was imposed on them.

I should point out here that over the period of time during which these participants had been in practice, the regulations for informed consent had become more specific and more stringent. When they began practice, the concept of implied consent was acceptable. That is, if patients voluntarily came to a chiropractor for care, one could reasonably infer that the patients consented to this care. While most doctors did explain their care to patients, the informed consent regulations were somewhat relaxed. Since that time, and largely due to the recommendations emerging from inquests into patient deaths following chiropractic treatment, the regulatory bodies have revised the rules and expectations for the informed consent process that chiropractors in Ontario must now follow.

Besides being required to perform some patient education in the informed consent process, the participants also reported that they used patient education to address other aspects of treatment. For example, some of the participants used patient education to address issues of treatment choice and treatment planning. Using patient education in an attempt to prevent or address patient compliance issues was also mentioned by several of the participants.

Through my conversations with the participants, it became very evident that the nature of patient education for these people involved, to a very great extent, teaching that would be defined as transmission. That is, most of the information passed in one direction, from the doctor-teacher to the patient-learner. The doctors essentially transmitted the material to the patients. While patients were allowed and invited to ask questions, in general for this group of participants, the teaching was controlled by them and consisted of a unidirectional transmission of information. Only very occasionally did participants make reference to any patient education practice that could be considered as either transaction or transformation in terms of the flow of information, as explained in Chapter 3.

The participants in my study also reported that most of their patient education involved their talking to patients in order to deliver information to them. While all of them used various kinds of teaching aids in their practices, most of the teaching involved personal, one-to-one conversations in which the doctor took a leading position. The list of teaching aids that was used by the participants included posters and wall charts, brochures and pamphlets, three-dimensional anatomical or skeletal models, and textbook images. The participants used all of these to some
extent. Other aids that were used less frequently included demonstrations, patient x-rays, and video tapes. Three of the participants used web-sites that were created for their practices and reported that they referred patients to these for information. Only one of the participants used the Internet extensively via an interactive website and patient on-line information delivery and feedback.

When deciding on what to teach their patients, the study participants fell into one of two groups. One group used an injury- or condition-centered approach to patient education. These chiropractors focused their educational efforts on the condition or ailment with which the patients were presenting. While these participants may have provided some additional information to patients, most of their patient teaching involved that which was related to the patients’ current conditions and how they could best recover. The second group of participants seemed to take a different focus to their patient education. These chiropractors took a more rounded or holistic approach to patient education. While they did teach patients about their present conditions, they also presented the patients with information involving life-style, quality of life, and prevention of illness and injury. From the participants’ own reports, both of these emphases could be successful. Perhaps one explanation for this is that patients would tend to select doctors who could provide them with an approach that meshed with the patients’ own views. Some patients just want to recover from their injuries; others want to be able to benefit from a holistic approach to health care. It was not within the scope of my study to evaluate which of these, if either, was more effective.

The content of the teaching that these participants provided for their patients could be divided into four broad categories.

a) Information about chiropractic and the care that would be delivered to the patient

b) Information about what would be required for the patients to recover from their current conditions

c) Information about prevention of further injury and overall maintenance of health

d) Information related to the care patients received from other health care professionals (ie. MD’s)
Question Two

How do HCPs feel about serving as patient educators in their practices?

The responses to this question were also varied and depended to a large extent on whether the doctors were in their early years of practice or their most recent years. In their first one or two years of practice, how they felt was dependent on their practice situations. Some worked in locum positions after graduation and others entered into associateship practice relationships. While all of the new doctors felt compelled by the regulations to provide at least the minimal information needed for informed consent, the doctors in locums told me that they tried to avoid any extensive patient education. These participants did not feel that patient education was expected of them while they were in another doctor’s practice and they did not want to risk upsetting or confusing the patients by telling them something that might possibly be different from the information provided by the regular practice doctor. Hence, while they did provide basic, simple answers to patient questions, they avoided any extensive patient education interventions. The participants who worked in associateships tended to take on the style of practice of the principal doctors. That is, if the principal doctors used regular patient education with patients, then the associates would do the same, even if they did not, at the time, fully understand the value of the intervention.

Besides feeling that they were required to provide some basic patient education, the participants reported that, in their first years of practice, they also experienced other feelings related to their serving as teachers for their patients. In general, the participants had little understanding of the value or importance of patient education when they began professional practice. At best, they thought it to be no more than an adjunct to the physical chiropractic treatment which they delivered to their patients. In addition, they did not feel very competent or very comfortable in their role as patient educators, even though they were quite confident and comfortable with their diagnostic and treatment knowledge and skills. When I asked for possible reasons for this dichotomy, the consensus answer was that the participants felt that they were not well-prepared by their pre-service curricula to be effective patient educators, but they were well-prepared to be diagnosing and treating clinicians.

As they gained more experience in practice and as they entered into their own practices, the participants told me that they became much more aware of the value and importance of patient education in their practices. No only do they continue to recognize that they have a responsibility to provide patient education, but also, they now see this intervention as being at least equally important to the physical treatments that they deliver. It is not surprising then that the participants reported now feeling much more confident and comfortable when teaching their patients. It would seem that with this group of participants, in the absence of formal preparation in patient
education, significant clinical experience was necessary for them to recognize the value of patient education and to become comfortable and confident when teaching their patients.

The participants also felt that they encountered, and still encounter in their practices, various barriers which interfere with the effectiveness of their patient education efforts. These barriers can be considered as being either extrinsic or intrinsic. Extrinsic barriers are those over which the doctor has no control while intrinsic barriers are those which arise from the doctors themselves. These barriers have been presented and discussed at length in the sections of this report dealing with the interview analyses, so I present here only a summation of them. Many of the participants reported encountering the same or very similar barriers.

The extrinsic barriers that were commonly encountered were issues related to patient attitudes about learning and responsibility for health care. Some patients did not want to learn and others were happy to turn over responsibility for their health care to the health care professional. Patients, on occasion, also relied on their previous chiropractic experience to form their opinions which may have conflicted with the ideas of their current doctors. Some patients became confused with an over abundance of information or with conflicting information from different sources (ie. friends, family, Internet, media). Often, patients had pre-determined expectations about their chiropractic care and these were difficult to address for some of the participants. Several of the participants reported that patients would not allow enough time for patient education; they only wanted the physical treatment and felt they were too busy for educational interventions. Other factors also affected patients’ ability or willingness to learn from their chiropractors. For example, if patients were involved in litigation related to their injuries, they may have let the advice of the lawyer overshadow that given by the HCPs who were treating them. Further, psychological issues such as over-dependence on care or another psychological overlay may also have a negative influence on patient learning. Participants reported that in ethnic areas of the city, they may encounter barriers related to language and literacy. Also, according to the participants’ reports, cultural beliefs may heavily influence the patients in that they may feel that they do not need patient education since the doctor is the expert and must know what is best for them. One other barrier reported was the lack of trust expressed by some older patients in a doctor who was much younger than themselves.

All of the participants reported experiencing or encountering barriers over which they themselves had some control. These intrinsic barriers spanned a range of aspects related to the participants’ feelings, attitudes, and schedules. Some barriers were more evident in the participants’ first few years of practice. For example, most of the participants related they did not understand the importance and value of patient education. Also, several of the participants
mentioned that, in their first years of practice, they viewed patient education as an attempt to “sell” chiropractic care to patients which they felt was distasteful to themselves. Consequently, these doctors spent little time in patient education interventions. Participants also mentioned their own lack of expertise as teachers as well as a degree of discomfort or lack of confidence as patient educators when they began practice. Some of these barriers, they said, stemmed from their lack of adequate curricular preparation as teachers for their patients and that these barriers tended to diminish as they gained experience in practice.

Several barriers still continue to be issues for the participants, even though they now realize the importance of patient education. One example is the participants’ time. Some participants work in very busy practices and on occasion, they may not have enough time scheduled to deal with all the patient education issues that need to be addressed on a given day or during one appointment. A couple of the participants described their own oscillating motivation to teach their patients as a barrier. That is, sometimes, they lose motivation to or fall out of the habit of teaching their patients. They said that they usually recognize when this malaise takes hold and try to take steps to address it. Also, a few of the participants reported the continuing challenge of trying to make meaningful connections with their patients’ value systems. These participants reported that if they can determine what patients value, then the patient education will be effective since the doctors will be able to make connections between the patient education material and the patients’ own value systems. However, since every patient is unique, this is an ongoing challenge and can be a barrier if doctors cannot discover how to link the teaching to the patient values.

Question Three
What attitudes and beliefs become evident when HCPs speak about their roles as patient educators and patient education in their practices?

The responses to this question can be divided into two categories. Some of the response information relates primarily to the participants’ early years of practice while other information is connected primarily to their most recent few years of chiropractic practice. During their early years, while recognizing their role to deliver at least basic information to their patients, many of the participants indicated that they used to believe that their treatment was much more important than patient education. They reported believing that what patients wanted most was a rapid reduction of their symptoms and if the young doctors could provide this, then the patients would be satisfied. To put this another way, the new doctors thought that the best thing they could do for their patients was to provide physical treatment that would result in a quick resolution to the
patients’ physical problems. Patient education, for them, had a very minor role in their treatment repertoire at this time in their careers.

Further to this, for those participants who began their professional work in locum positions, they believed that their role as patient educators was minimal and also not expected. They believed that it was the role and responsibility of the regular practice doctor to take care of educating the patients and that the locum doctors’ responsibility revolved around delivering the same physical treatments as the regular practice doctor. When they were asked questions by patients, they either gave very basic, simple answers, or alternatively, they would suggest that the patients ask the questions to the regular doctor when he/she returned.

For these participants, when they were new doctors, there was a general disbelief in the value of patient education. Since they had not learned much about patient education in school and they did not have vast experience which might have taught them the value of this intervention, it is not surprising that they relied on what they were taught well – diagnosis and treatment skills. One of the participants did have some experience working with patients prior to graduating and thus he had learned, through this experience, the value of patient education. Two other participants related that when they began practice they had been told that patient education was important by ‘experts’ and so, they had faith in this intervention. However, they did not know, for themselves, that it was important. Rather, because they believed the experts, they trusted that patient education had value, even if they could not explain the reasons why this was so.

As they gained experience in practice, all the participants in the study reported that their beliefs about patient education changed from their views in their early years. Ultimately, the doctors came to realize that they could not and should not take the full responsibility for the recoveries of their patients and that the patients had to accept some responsibility for their own care. In order for patients to be able to do this, they had to learn about their conditions and how they themselves could have positive influences on their health. Consequently, patient education became a valuable and important component of treatment plans in order to address the issue of developing a shared responsibility between the doctors and patients.

Some participants spoke about using patient education to build a partnership or team with patients. In this kind of relationship, the patient is empowered to make some decisions. This empowerment comes as a result of the patients learning about their conditions and about chiropractic care. It became clear in our conversations though, that the partnerships were not equal ones; the doctors always had more information than the patients, which is to be expected given their extensive education and experience as health care professionals. Also, the participants decided what information to teach as well as when and how it would be presented to the patients.
In this regard, doctors could influence the decisions made by the patients by emphasizing or even withholding some information during patient education interventions. By doing this, they could exert some subtle pressure to direct the decisions made by the patients. There was no direct evidence from the participants to suggest that they did this in their practices, but it would be difficult not to influence patients to choose the route that a doctor thought best. Of course, the patients did possess the ultimate power to withdraw from the partnership and leave the doctors’ practices.

An interesting set of connections related to patient education and other aspects of practice emerged from the conversations with the participants. They all acknowledged that patient education was very useful in order to help patients establish reasonable expectations for the outcomes of their cases. If a patient thought that he would recover very quickly and did not, then he would be dissatisfied with the care, may even leave the practice, and it would be unlikely that he would return for additional care in the future. This outcome would not lead to a successful practice for the doctor. For those patients who came in with unrealistic expectations, patient education was valuable to help them modify those expectations to ones that were actually attainable. If patients did have reasonable expectations about how their cases would progress, then it was much more likely that they would be satisfied with the care they received. If they were satisfied, then they would more often than not, stay in the practice. Not only would this probably occur, but these patients might also refer their friends and family members to the practice. This outcome would most likely lead to the doctor having a successful practice. Effective patient education consequently leads to realistic and reasonable patient expectations, which in turn lead to patient satisfaction. Patients who are satisfied with their care and recoveries will stay in the doctor’s practice and refer others to that doctor, which in turn lead to a successful practice. In this scenario, both the doctor’s and the patient’s interests are served – clearly a win-win situation.

**Question Four**

Over the years of their practices, what changes related to patient education have occurred in their practices and how have the HCPs’ feelings and attitudes towards being patient educators changed?

The changes that doctors made related to patient education in their practices came about from their years of experience as clinicians and gradually realizing the importance and value of patient education as a component of the total package of care provided for their patients. For this small group of participants, it appears that experience was a necessary causative factor in their arriving at the realization of the importance and usefulness of patient education. This may not always be
the case. It could be possible that doctors who had effective pre-service education in the theory and practice of patient education might enter practice having already learned what it took my study participants years to learn. They did not have the advantage of this pre-service education in their chiropractic curricula and therefore, in the absence of this kind of preparatory training, some years of experience in clinical practice were necessary to lead them to value and view patient education differently from the time they entered the profession. All of the participants in this study reported that they felt unprepared by their pre-service curricular experiences to be effective teachers for their patients when they entered practice, even though they were very well prepared in the knowledge and skills of diagnosis and physical treatment.

The consensus responses about changes made in their practices included aspects of confidence, comfort levels, importance and value of patient education, and time spent on this intervention. The participants all reported that, in their current practices, they felt more confident and more comfortable when serving as educators for their patients, which, given their experience, should not be surprising. They also reported that now, they see the connections between patient education, patient satisfaction, and case outcomes, whereas in their early years, this was not so.

Further, now these participants understand the value of patient education for dealing with issues that extend beyond the informed consent process; they realize that patient education is helpful and now use patient education to help set reasonable and attainable recovery goals as well as to address issues of patient compliance and prevention. They also comprehend the effects patient education can have on improvements in quality of life and lifestyle. Teaching the patients about sharing responsibility for their own recoveries with their doctors was also a commonly reported use for patient education. All of the participants reported that they now spend more time teaching their patients than they did before. This is seen in a number of ways. Some stated that they used to concentrate their teaching at the beginning of the course of care and did little after the first few visits. Now they spread the teaching throughout the whole course of care. Others said that they now take time review information with patients, re-explaining it and reinforcing key concepts whereas in their early practices, they tended to deliver information once and only in one way.

One possible change that could have been made did not become evident, except to a very small extent. While the participants did expand their teaching strategies as they began to perceive patient education differently, they continued to rely on teaching that was characterized by a transmission mode of instruction. Most of the patient education both in the early years and current years of practice relied on this mode of teaching that involves, for the most part, a one way flow of information from the doctor-teacher to the patient-learner. Only very occasionally in
interviews did participants make comments that suggested that they might move towards a transaction or transformation mode of teaching their patients. Those participants who reported that they take a more holistic view to their practice seem to be the ones who would be more likely to move towards the transformation mode since they seemed to be more concerned with health care for the ‘whole person’ as opposed to providing care that focused on a patient’s injury or condition. Certainly, health care professionals do have a great deal of knowledge and information that they need to transmit to patients, but that should not necessarily limit the use of transaction or transformation teaching. If, however, they were never exposed to various types or modes of teaching, it would seem logical that they would tend not to use these in their own patient education initiatives.

**Trustworthiness of the Findings**

The value of any research is influenced to a great extent by the ability of the researchers to establish that their findings and results are worthy of a high degree of credibility or trust. The trustworthiness of qualitative research findings cannot be measured. Rather the researcher must be able to present a body of logical evidence that would lead readers to believe that the findings do deserve to be trusted. Indeed, Glesne (1999) suggests that the credibility of qualitative research is limited and influenced by the ability of the researchers to establish that their findings are trustworthy. With a high degree of trustworthiness established, the reader can rely to a greater extent on the findings; in this situation, the findings become more valuable. In this study, much of the evidence presented to establish trustworthiness grows out of the processes followed. Some of these processes used in this study included prolonged engagement, triangulation, expert review, detailed personal analysis. Added to these is the experience of the researcher as a health care professional.

Prolonged engagement often implies long duration in situ observation by the researcher. Prolonged engagement can also be achieved by communicating with the participants over an extended time period during the interview process and through the use of multiple interviews. The starting status of the interviewer-researcher needs to be established when considering the issue of prolonged engagement. If the researcher is an outsider to the community, then it may take a much longer period of contact for the researcher to claim prolonged engagement as evidence to support trustworthiness. If, however, the researcher is an insider to the community, or in this case the profession, then he has had prolonged engagement with the profession in addition to the multiple interviews with the participants. This is the case in my study; as a health care professional and former faculty member at a chiropractic college, I began this research as an
insider with extensive knowledge of the profession, the codes, the terminology, and the regulations. This inside knowledge and experience assisted with my interpretation of what the participants reported and given this scenario, one can consider that a form of prolonged engagement took place and this can be viewed as evidence of the trustworthiness of the findings.

In this study, initial contact was made via phone call and followed up with an informative letter and informed consent form. Two and a half to three hours were spent interviewing each of the participants. The interviews took place on separate days and were not limited by time, so the doctor-participants could make their answers as detailed as they wished. The interview design allowed for probing questions to be asked to allow issues to be well-explained or explored in depth. Related to this is the fact that all of the participants knew me and also knew that I was a health care professional. This knowledge helped establish an early comfort level in the participants since they were speaking with someone who was known to them and who also shared common education and professional experiences. One effect of this was that there was little “getting to know you” time used during the interviews and so the full interview time could be used to speak honestly and frankly about issues.

Because I used multiple interviews and also since some of the interview questions had a degree of overlap, I could determine if the participants deviated in their responses. Triangulation of data is the use of multiple sources to provide information to the researcher. Not only did the participants serve as sources of data about themselves and their own views and practices, they also provided some information that could be compared to the rest of the group. That is, each participant serves as a separate source of data and represents a unique personal and professional context. Data from the overlapping questions in the first and second interviews can be compared. Further, the data from each of the participants can then be triangulated and compared to that provided by the rest of the group. Much of the information I collected from the participants during the interviews did not diverge to a great extent from that provided by the group and as such, can be trusted. For example, all of the participants reported that they did not feel that they were well-prepared to be effective teachers for their patients when they were in their chiropractic colleges. Unanimous or consensus opinions from the participants help establish a high degree of trustworthiness in the findings.

The individual interviews were analyzed one at a time and I created a draft of each analysis report. As these were completed, I submitted them to my advisor for constructive feedback. While he is not a health care professional and not an insider to the profession, he is an expert in qualitative research and analysis of interviews and conversations. While he could not provide interpretive comments, he could and did provide feedback related to the clarity and description of
the analyses. In response to this feedback, I was able to address concerns and revise the reports as needed. Consequently, I feel confident that with my advisor’s experience as a researcher and my experience as an HCP, I was able to produce comprehensive and accurate reports of the interview analyses that captured the essence of what the participants told me.

In addition to this, I paid very close attention to the transcription and analytical processes. I chose not to use a transcription service, but instead undertook the transcription of all of the interviews myself. While this took a great deal of time, this process allowed me to become very close to and familiar with the details of the conversations I had with the participants. I also completed the analysis myself by developing a code or set of categories into which the great majority of the interview information would fit logically. These categories have been identified and explained in the chapter outlining the research methods used for this study. After interviewing the participants, transcribing the conversations, and undertaking a detailed personal analysis of each of the interviews, I was very familiar with the information provided by the participants and this familiarity allowed me to produce detailed and accurate accounts for each of the interviews which adds to the trustworthiness of the information in this research report.

I would also like to address the accuracy and truthfulness of the information provided by the participants. One may ask, “How do you know that what they told you was indeed true?” Memories can be inaccurate and people may want to hide some of their past errors or failures. However, in response to this hypothetical question, I would suggest that the participants had little reason not to provide truthful information, even if their memories were somewhat cloudy. First, they had been assured that their identities would remain anonymous and were aware of the ethical review approval of the university which added legitimacy to the research. Second, all of the participants knew me prior to being invited to participate. This knowledge provided a level of comfort for them; that is, they were not being interviewed by a stranger. Further, the nature of the research was not evaluative; I was not out to measure or grade the participants’ effectiveness as patient educators and so they had no need to be on the defensive or to provide other than honest and truthful information to me. Indeed, many of the reported comments showed that the participants admitted that they were not very good educators at periods in their careers. Finally, all of the participants knew that I was also a health care professional with very detailed knowledge of their profession, their pre-service education, and also the issues involved in serving as an HCP in Ontario. They would know that if they were to provide less than accurate information, there would be a good chance that I would be able to see this information as being inaccurate. They were honest with me because they knew that if they were otherwise, I would be able to discern this. While this situation may not be a usual benchmark to establish
trustworthiness, it should still be mentioned and considered as a possible part of the body of 
trustworthiness evidence.

**Limitations of the Study**

As a qualitative study into the nature of patient education from the point of view of health 
care professionals, this study relied on data from a relatively small number of participants. While 
the eight doctors interviewed supplied a great deal of information, there are essentially only eight 
sources of data which reflect only eight sets of experiences and opinions. Qualitative research of 
this type benefits from the small numbers of participants in that working with few participants 
allows the researcher to explore the study area to a greater depth than would be possible if a large 
study sample was used. However, accessing data from a small sample limits the generalizations 
that the researcher can make about the findings and the recommendations. This is indeed the case 
in this study and therefore limits the study in some regards.

Further to this, my study relied to a great extent on the memory of the participants as they 
looked back to their early years of practice. Some of the participants had been in practice for as 
many as ten years and the questions in my initial interviews asked them about their first one or 
two years of practice – how and what they did, what they felt, and what their beliefs were at the 
time. While I have no reason to suspect that any of the doctors intentionally provided erroneous 
or dishonest information, the material they did supply relied on their memories which, while 
helpful, might not be completely accurate given the span of years that have elapsed. Even though 
memories may be seen as somewhat unreliable, they still are a source of data and it is better to 
collect and use this information than not to have it at all.

An additional limitation of this study is my lack of experience as an interviewer. As I 
transcribed and analyzed the interviews, I realized that at times some information provided by the 
participants could have been explored or probed to a deeper extent. While I was, for the most 
part, aware of keeping the participants on the topic of the question, I did allow them to complete 
their statements prior to bringing them back on track. Further, I did also pay attention to asking 
probing follow-up questions to the participants quite frequently. This was also evident in the 
analyses, but due to my inexperience, this might not have occurred as often as it could have.

My intention in this study was to add to the knowledge related to patient education from the 
point of view of Canadian chiropractors. Data was collected through interviews with a number of 
chiropractors in the GTA. The data included opinions, beliefs, and practices of the participants as 
well as their comments on the nature of patient education in their practices. The qualitative nature 
of this study has meant that I derived data from a relatively small number of participants in order
to get a clear picture of the nature of their experiences over their years of practice as told to me in their own words. I have noted and described the trends that have emerged from these eight participants, and while those trends are clear and robust, the relatively few numbers of participants does not allow me to make strong recommendations for practice.

Significance of the Study

Contributions to Knowledge

While the findings of the study have been presented and discussed above in the sections dealing with the answers to the research questions, by way of summary, Icapsulate them here as possible contributions to the body of knowledge related to patient education. In the following summary of findings, I will refer back to aspects of my literature review in order to situate my study within the broader discussion of the field of patient education. As I wrote in Chapter 2, as far as I could determine at the time of writing, no study has asked HCPs, or specifically chiropractors themselves as to their views about patient education in their practices. I have argued that this is valuable information to have because of the importance of patient education as discussed in Chapter 1. Nevertheless, some of what was found in this study echoes aspects of the broader discussion in the field about changing attitudes regarding health care professionals and their patients, and I will reference those discussions. While some of these are advocacy and position discussions and not research per se, they are still important parts of the general context of the field.

The conversations with the participants revealed that they recognize and acknowledge a number of functions that patient education can serve in their practices. These functions include the informed consent process, having patients participate in treatment choice decisions, improving compliance, assisting with establishing appropriate patient expectations related to their treatment, improving patient satisfaction, and risk management. All of these functions mentioned by the participants were included in the literature on the field and so, the interviews and the literature do support each other at least in this regard.

Some of the published authors state that patient education is not only important, but also a key professional responsibility for those in the health care field (Lauerman 1993, Sheppard & Charnock 1999). This study concurs with this position in that all of the participants recognized that they had a responsibility to educate their patients to some extent, especially as related to the informed consent process. Further, to this, in their current practices, the participants agreed that patient education was an ongoing process which is in concert with the definition or patient education used to guide this study (Piccininni & Drover 2000).
Patient empowerment through effective patient education is a recurrent theme in the literature. Several authors discuss using patient education to encourage or enable patients to take part in the decision making process related to their health and treatment (Coulter 1999; Grundstein-Amado 2008; McGuire, McCullough & Weller 2005; Piccininni & Drover 2000; Yoon, Conway & McMillan 2005). Participants in this study reported that they, too, tried to bring patients into the decision making process through patient education by making them partners in the process or by using a team approach so patients would accept some of the responsibility for the decisions related to their own health and health care. Related to this, ineffective patient education can lead to a worsening of conditions according to Raine and Griffiths (1996). Indeed, this result was seen in a few cases through case anecdotes related by the study participants.

Patient satisfaction with their care and with their HCPs is also an aspect of patient education. This relation is discussed in the literature and is also observable in this study. Authors have presented the idea that patients who are well-educated about their cases display a higher level of satisfaction with their treatment and practitioners (Jamison 1997; Schattner 1993; Terry 2000). While the study participants did not recognize the connection between patient education and patient satisfaction in their early careers, they reported that they all eventually came to realize this important link between patient education and patient satisfaction. Further, some went on to expand the connection and link patient education with both patient satisfaction and practice building.

This research also showed, albeit with a relatively small number of participants, that these doctors believed they were not well prepared for their roles as patient educators when they graduated from their respective chiropractic colleges. Further, in this study, the participants in general did not spend very much time in their early professional years on educating their patients. This concurs with the findings of Donkers-Ainsworth and Hagino (2006) that the practices of chiropractors can be predicted by their educational experiences. One possible reason for this participant belief and behaviour is that patient education was not stressed in their training as much as being technically competent in the clinical skills of diagnosis and treatment. (Other reasons may involve the lack of recognition, in their first years of practice, of a linkage between patient education, patient satisfaction, compliance, and patient retention.) Indeed, several authors state that health care curricula assume that students will become good teachers and little curricular content is devoted to this objective (Burkhead, Jones, VonCannon & Hu 2003; Kendrick & Freeling 1993; Mariotto 1999). This appears to be the case for the pre-service educational experiences of the study’s participants. The consequence of not including sufficient curricular content is that HCPs may enter practice as ineffective patient educators or believe that
patient education is not very important. The participants in this study suggested that some of them did not believe patient education to be very important when they began their professional practices. Later, with more experience as clinicians, they realized that patient education was indeed an important aspect of the care they provided and could serve several functions. This realization of the roles and importance of patient education supports the positions of the authors referenced above as well as others referenced in Chapter 2.

The literature in the patient education field does not present or discuss, to any great extent, barriers that might interfere with the effectiveness of the HCPs patient education efforts. There is, in the literature, some discussion of pre-service training and the effect this can have on newly graduated HCPs and I have discussed this above. In this study, however, all of the participants perceived that they experienced a wide range of barriers that interfered with the effectiveness of their patient education efforts. As I wrote in Chapter 5, the barriers fell into two categories; some were intrinsic and under the control of the HCP while others were extrinsic in nature and not under the control of the HCP. This information on barriers encountered by the participants may be one of the key significant elements of this study since there is no substantial literature on this area of practice. While it was beyond the scope of this study to discover how the participants dealt with each of the barriers they encountered, the collection and explanation of their experiences (see Chapter 5) may serve to assist future researchers and curriculum designers.

Implications for Practice: HCP Educators

Based on the fact that all the participants agreed that they were not well-educated as patient educators during their pre-service chiropractic experiences, curricular planners should consider my findings carefully and whether or not they should develop curricular content aimed at making new graduates more effective patient educators. The content should provide the HCP students both with theoretical knowledge as well as opportunities to practice and reflect on their own patient education initiatives.

The insights in this study about the HCPs interacting with patients and their increasing engagement in educating their patients could possibly be valuable and grounded portraits for HCP students or even beginning HCPs to study. These detailed portraits and narratives may assist students and new doctors in reflecting on their own developing practices.

Implications for Practice: Current HCPs

Professional literature should be written and material should be developed to encourage and inform HCPs in practice about the possible effects and uses of patient education in their practices.
They should also be encouraged to reflect on their own beliefs and practices related to patient education so that they may be able to find ways to improve the use of this intervention thereby improving patient case outcomes. Those who offer professional development opportunities, like conferences and courses, should be encouraged to include patient education learning opportunities for the HCPs who attend. Lectures and workshops designed to assist HCPs with learning more about the theory and practice of patient education to assist with improving this area of their practices.

**Future Research**

One of my suggestions for future research is to continue study in this area in order to acquire a large bank of data from case studies. If this were to be done, then recommendations of researchers would be more generalizable. In addition to the above, I also suggest the development of a comprehensive survey instrument, based on similar case study research, which could be used to study patient education not only in chiropractic practices, but also in other health care environments. If this were to be done, it would facilitate the collection and analysis of a substantial body of data. This would increase the potential for generalizability to a range of health care disciplines and in turn, assist in improving patient education and health care in Canada.

Recognizing the limitations of the study as explained above, I believe that my own personal experience as a health care professional and former chiropractic college faculty member corroborates the findings I have reported as well as supports the recommendations I make here.

As explained earlier, patient education is an important element of health care with wide ranging effects. As such, we need to know more information about this intervention. Hence, further research into patient education especially from the point of view of the health care professional is recommended.

Having a great deal of data on this topic would facilitate a deeper understanding of the experiences of HCPs as teachers for their patients. To this end, a bank of data based on qualitative study of individual cases should be collected about this aspect of patient education. If this were done, researchers could possibly develop a survey instrument to facilitate the collection and analysis of data related to patient education in various health care disciplines.

To learn more about how HCPs operate as teachers, how patient education actually takes place in health care practices, and how HCPs address teaching issues such as barriers to effective patient teaching, a long-term study could be undertaken which would monitor the patient education done in health care professionals’ practices over a number of years.
Curriculum-related research could be done in order to investigate what, if any, content is included in various pre-service health care curricula and how effective this content may be at preparing HCP students to become effective educators for their patients. Several of the authors referenced in this thesis have suggested that improvements could be made in this area.

**Final Comments**

To the best of my ability, I have tried to discover new and important information about patient education as viewed by the people who are most responsible for ensuring that this process takes place – the health care professionals themselves. I decided to study doctors of chiropractic since I had detailed knowledge of their curricula and their practices in the GTA. I believe that the participants also feel that patient education is an important element of their practices. Evidence for this belief is the fact that all of the doctors I contacted to participate in the study agreed to do so, even though the interviews would take up a large block of their professional time. They, I believe, were willing to participate and devote this time because they believed in the importance and value of the study.

As a health care professional myself, I have seen in my own practice, and also observed in others’ practices, how important patient education can be. It is not an exaggeration to say that effective patient education can be the key to a successful case outcome. Reflecting back on my own early years, I now realize that some of the less than favourable case outcomes I saw could have been avoided had I entered practice as a better teacher for my patients. Like the participants in this study, while I was well-prepared by my pre-service curricula to be technically competent as a therapist, my colleagues and I were not well-educated to be effective patient educators. I wish this were not the case, but of course, at the time, I knew no better. Much like the participants in this study, I eventually evolved into an effective teacher for my patients and I believe that this helps with their recoveries. Indeed, this emphasis on patient education has impressed other health care professionals when they see the positive results with patients. I am hopeful that we, as a society, will be able to improve our health care system through improvements in patient education and that the findings of this study will help with this goal.
References


Appendices

Appendix A: Information Letter and Invitation to Participate

June 25, 2007

Participant’s Name and Address

Dear Dr. ,

I am a Ed.D. candidate at OISE/UT in the Department of Curriculum Teaching, and Learning, specializing in Teacher Development. I am inviting you to participate in this research study entitled “A Qualitative Examination of Health Care Professionals’ Experience as Patient Educators”. My research is carried out under the supervision of Dr. Brent Kilbourn, in the Curriculum Studies and Teacher Development program, Department of Curriculum, Teaching and Learning, OISE/UT.

The purpose of the research is to explore the nature of patient education and the perceptions and attitudes of doctors of chiropractic as they serve as educators for the patients in their practices.

If you agree to participate in the study, you will be interviewed twice. Each interview will last from one to one and a half hours. A brief third interview may be requested for the purposes of clarifying information collected. The questions will focus on your experiences of patient education in your practice as well as your perspectives on serving as educators for your patients. The interviews will be tape-recorded. The information derived from interviews will be kept strict confidence and reported in such a way that individual person cannot be identified. The data obtained will be used in the process of completing my Ed.D. studies at OISE/UT, including my dissertation and any further publications (articles). Should you wish to do so, you will be able to read, comment and approve on all transcript materials prior to data analysis. Permission will be given to my supervisor to view the data if required during the research process.
All audio-tapes, transcripts of tapes and translation documents, field notes, computer disks, and any other confidential information will be kept in a locked cabinet unless being used at my premises. Once the data have been entered into the computer all identifying characteristics will be removed and the original data will be shredded or erased. The ID codes will be known only to me and will be stored in password-protected electronic files. All raw data (i.e. transcripts and field notes) will be destroyed three years after completion of the study. Participation in the project is voluntary. You may withdraw from the study at any time, and no evaluative judgments about your practice will be made.

Your perspectives will be important resources for the development of curricula related to patient education and health care in our province.

I sincerely hope that you will take a few minutes of your time to consider your valuable contribution to this study. If you are agree to participate, please complete and sign the form below. If you have any questions about the study, please feel free to contact me at 905-731-4716, or via e-mail at jpiccininni@oise.utoronto.ca

Yours sincerely,

J. J. Piccininni, B.A, B.Ed, M.Sc., CAT(C)
Doctor of Education Candidate
Dept. of Curriculum, Teaching and Learning
OISE/UT

Supervisor:
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Appendix B: Participant Consent Form

Doctor of Chiropractic – Research Participant Consent Form

Patient Education Study

I, _____________________________, read and understand the conditions under which I will participate. I understand that the data collection method described is supportive and essential to the study. In addition, I hereby grant J.J. Piccininni the right to publish statements made by me to the development in his Ed.D. thesis and any subsequent academic publications.

In any such publications, however, the source of statements made by me will not to be revealed. In other words, I grant permission for the use of statements made by me under the condition of complete anonymity, protected through the use of pseudonyms.

I understand that J. J. Piccininni intends to use these statements for his Ed.D. thesis in education, and possibly for related publications. I also understand that the statements made by me will be subject to Mr. Piccininni’s interpretations with the purpose of describing my perspectives on patient education in professional health care practice. Should I desire to do so, I will be able to read, comment and approve on all transcript materials prior to data analysis.

All data will be collected and maintained exclusively by J. J. Piccininni, the researcher, will be stored in the premises of the investigator in a locked cabinet and will not be accessible to any other individuals. The electronic forms, including audio recordings of information will be stored on the personal computer network of the researcher. Access to this information will be password protected. Permission will be given to his supervisor to view the data if required during the study. I can withdraw at any time without negative consequences.

Sincerely,

Signature: ___________________________________
Date: _____________________________
Appendix C: First Interview Questions

Initial Interview: Demographic and Practice Description

1) How long have you been in practice?

2) Describe your practice experience and locations? (ie. Locum, associate, own practice, etc.)

3) Describe your patient population. (ie. White/blue collar, education level, ethnicity and language, etc.)

Patient Education Issues during Initial Years of Practice

All of the questions in this section will relate to your first two years of practice. Please think back to that time period when you are responding.

1) What role did patient education play in your practice at this time?

2) In what situations did you use or introduce patient education with your patients? (ie. Informed consent process, treatment choice and case management decisions, compliance with your treatment plan, prevention, etc.)

3) How did you typically use patient education in each of the areas you identified? What teaching or instructional strategies did you use? Would you please give an example of each from your early years of practice?

4) How did you, at that time, perceive your own role related to patient education?

5) Recalling your first two years of practice, please relate a story or describe a situation in which you thought that patient education was a key component of the case outcome.
6) Why do you think that patient education played such an important role in this case?

7) In the first two years of your practice, what barriers did you perceive, or experience, that interfered with effective patient education? (ie. Patient literacy/language, your expertise, time allocation, patient attitude, etc.)

8) How important did you believe, at that time, patient education was in your practice? Why did you believe this?

9) Did you feel that patient education was more important with some diagnoses as opposed to others? If so, please identify these conditions and explain why you believe this.

10) Did you find that there were some patients with whom patient education was more effective than with others? If so, what qualities or characteristics influenced the effectiveness of your patient education?

11) During the first two years of your practice, please relate a situation in which you found patient education to be difficult or challenging for you. What was it about this situation that made it so?

12) Would you please tell me about a situation in which you felt very confident as a patient educator? What was it about this situation that made you confident?

13) Are there any other comments or stories, related to patient education in your first two years of practice that you would like to share?
Appendix D: Second Interview Questions

Patient Education Issues in Recent Years of Practice

All of the questions in this section will relate to your last two or three years of practice. Please refer to this time period when you are responding.

1) What role does patient education play in your current practice?

2) In what situations do you now use or introduce patient education with your patients? (ie. Informed consent process, treatment choice and case management decisions, compliance with your treatment plan, prevention, etc.)

3) How do you typically use patient education in each of the areas you identified? What teaching or instructional strategies do you use now? Would you please give an example of each from your current practice?

4) How do you now perceive your own role related to patient education?

5) Please relate a story or describe a situation from your last couple of years of practice in which you thought that patient education was a key component of the case outcome.

6) Why do you think that patient education played such an important role in this case?

7) In your present practice, what barriers do you perceive, or experience, that interfere with effective patient education? (ie. Patient literacy/language, your expertise, time allocation, patient attitude, etc.)

8) How important do you believe patient education is in your practice? Why do you believe this?

9) Do you feel that patient education is more important with some diagnoses as opposed to others? If so, please identify these conditions and explain why you believe this.
10) Did you find that there are some patients with whom patient education is more effective than with others? If so, what qualities or characteristics influence the effectiveness of your patient education?

11) From your current practice, please relate a situation in which you found patient education to be difficult or challenging for you. What was it about this situation that made it so?

12) Would you please tell me about a situation in which you felt very confident as a patient educator? What was it about this situation that made you confident?

13) Are there any other comments or stories, related to patient education in your last few years of practice that you would like to share?

Changes in Perception and Use of Patient Education

1) Do you now feel differently about patient education in your practice than you did during the first few years?

2) Do you feel that your role as a patient educator has changed, or do you perceive your role differently?

3) Do you now use more or less patient education time in your practice than you used in your first few years? Why do you think this is so?

4) Do you feel that patient education is more or less challenging now as opposed to during your early years of practice? Why do you think this is so?

5) Are you more, or less confident as a patient educator than you were during your first two years of practice?

6) Are there any other comments or ideas related to the changes in how you perceive or use patient education that you would like to add?
Appendix E: Glossary of Terms

Adjustment: A chiropractor treating a patient may mobilize or move the bones of a joint and this motion often produces an audible and palpable “popping” sound. The sound is from the sudden release of nitrogen gas within the joint. This procedure is also referred to as a manipulation. The forces applied to the joint are usually manual.

Associateship: A business arrangement usually between two (or more) health care professionals. An associate works in a practice operated by another HCP, but has his/her own patients. Often, the associateship contract allows for a splitting of the fees collected by the associate HCP. A portion goes to the practice owner to cover overhead, rental of space, etc., and the associate keeps the remainder as income. Newly graduated chiropractors often enter into associateship arrangements since they allow the new doctor to generate revenue and learn how a practice operates without having to make a substantial financial outlay to open a new practice.

Chiropractic: A field of health care that centres on the diagnosis and treatment of various conditions including orthopaedic problems and vertebral subluxations. In Ontario, and in most of Canada, doctors of chiropractic are regulated by provincial regulatory colleges. Chiropractors do have the professional right to diagnose specific conditions, order, take and read x-rays, and treat using manual techniques and other physical modalities. They do not prescribe any drugs. (Usage note: Chiropractic is both a noun and an adjective. Those who practice are called both doctors of chiropractic as well as chiropractors.)

Chiropractic College: In Canada, those studying to become doctors of chiropractic attend a chiropractic college to earn their DC credential. Colleges offer an intensive program of study usually spanning four academic years. Both theory and practical sessions are included. Until very recently, the DC credential was not a degree in Canada, but this has now changed. Most US-based chiropractic colleges follow similar curricula and award degrees.

Informed Consent: Refers to the process of having a patient consent to examination and/or treatment by a health care professional. In Ontario, for regulated health care professionals, obtaining informed consent is required. It is the duty of the HCP to inform the patient about the risks, benefits, and alternatives of any procedure to be done. Practitioners must also answer any
questions posed by the patient. Some health practitioners prefer written consent while others use signed documents.

**Locum:** This refers to a doctor or other HCP filling in for or taking the place of a doctor/HCP who is temporarily away from his/her practice. Locum positions can last from a few days to several months. Newly graduated doctors often begin their practice in locum positions so they can generate much needed revenue and earn how practices are run.

**Manipulation:** A chiropractor often moves the bones of a joint and this motion often produces an audible and palpable “popping” sound. The sound is from the sudden release of nitrogen gas within the joint. This procedure is also referred to as a adjustment. The forces applied to the joint are usually manual.

**Orthopaedic:** This refers to an area of health care concerned with problems, diagnosis, and treatment of the musculo-skeletal system. There are some health care professionals that specialize in orthopaedic conditions. Some of these include orthopaedic surgeons, chiropractors, athletic therapists, massage therapists, and some physical therapists.

**Subluxation (Chiropractic):** This term refers to a dysfunction of a joint, particularly a spinal joint. The dysfunction can be physical and either result from structural and/or functional causes. The profession of chiropractic is concerned, in part, with the finding and removing these subluxations through the use of physical treatment such as manipulation or adjustment of the vertebrae. Some chiropractors believe that subluxations are the cause of health problems. (Usage note: For orthopaedic surgeons, subluxation refers to a joint that is partially, but not completely dislocated.)

**Vertebrae:** The bones of the spine collectively are called the vertebrae. The singular form is vertebra. In humans, the vertebrae are divided into cervical (neck), thoracic (chest), lumbar (low back) classifications.