
Crafting a Model of Patient Education: Negotiating Meaning and Shared Clinical Reality

Purpose: The article reviews chiropractic patient education as it relates to health outcomes, public perceptions of chiropractic, and changed health behaviors and examines chiropractors' commitment to and practice of patient education. **Method:** A review of relevant literature was conducted. **Conclusion:** Most chiropractors view patient education as necessary and intuit its therapeutic value. While its practice is commonplace in clinical settings, disparity exists between patient perspectives on chiropractic's identity and practice objectives and those held by the profession itself. We can learn a great deal from this disparity. Chiropractic's commitment to patient education must be elevated to an explicitly described perspective and model that can forward links between practice, theory, and research. **Key words:** *attitude to health, chiropractic, health behavior, health education, health promotion, patient education, patient participation, physician-patient relations, program development, program evaluation*

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INTRODUCTION

Patient education is now an accepted, even expected, part of all health professionals' practice.¹⁻³ Generally defined as any set of planned activities that are designed to promote changes in patients' health behaviors or beliefs, patient education is an outgrowth of health education and has been associated with the achievement of particular treatment outcomes, patient satisfaction, and improved health status.⁴⁻⁶ Patient education and health promotion are among the fastest-growing programs in the health care arena. Still, in the midst of widespread acceptance of these programs and rapid growth in access to health information in general, dissatisfaction with medical communication continues to grow.⁷ And while health professions and providers acknowledge a lack of formal training in communication and instructional skills, professionalization of patient education through formal educational training, professional standards for communication, and protocols for patient education practice remain underdeveloped.⁸ As either consequence or causal factor, reimbursement channels—through which the value of these educational services would be demonstrated to purchasers, policy makers, the public, and practitioners—do not presently exist, thus creating a strong disincentive to develop a nonrevenue aspect of clinical practice.⁹ It is said that “reimbursement arrangements too often drive the clinical encounter, discounting the fact that *care* is a

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social and interpersonal, as well as, medical phenomenon."¹⁰ Yet it is the interpersonal dynamics of the clinical encounter that is a leading factor in patient satisfaction^{11,12} and is purported, as well, to have healing qualities of its own.¹³⁻¹⁵ Table 1 offers several examples of sources of satisfaction in chiropractic health care encounters.

Demand for better health information, explicit choice, and shared decision making originated with the public through a change in cultural consciousness about health care.¹ Sociocultural currents of the past several decades transformed the once passive or "good" patient into a savvy consumer: "The shift in perspective from medicine-as-service to medicine-as-business transforms patients into consumers of health care."¹⁰ No longer satisfied with a medical system that modeled its care on paternalistic or authoritarian relationships with unidirectional communication patterns, consumers demanded a reframing of clinical relationships with different roles for both provider and patient.^{10,16} In the wake of this demand, participatory or relational

models of care have emerged in which patients are active partners in decision making and work toward common goals.^{17,18} Table 2 identifies examples of how this consumer demand is manifesting itself. Empowered by both information and self-care activities, the responsibility for health outcomes has increasingly shifted to the patient. Patient education has been a key mediator for equalizing the health care relationship and changing the balance of power, authority, and responsibility. Symmetry or balance of power has long been a notable characteristic of the chiropractor-patient relationship and education a necessary component of clinical practice.^{12,19}

This article examines chiropractors' commitment to and practice of patient education with emphasis on objectives and outcomes, programmatic concerns, and assumptions that underlie theory and practice. Aspects of this practice are reviewed with regard to the negotiation of clinical reality, changing of health behaviors or beliefs, and public perceptions of chiropractic. The extent of practice, including its content and delivery, is assessed in light of both outcomes and preparation of students, faculty, and practitioners in skills of communication and teaching/

Table 1. Factors that influence patient satisfaction

Patients experience satisfaction when the doctor does the following:

- Attends to patient as a whole person, rather than as an isolated condition or body part (ie, spine).
- Ensures that a full discussion of a patient's concerns, priorities, and goals has taken place, and they are understood.
- Encourages questions, listens attentively, and uncovers what is not understood.
- Gives information that is understandable, explains clinical findings, and tells patient what can be expected from care.
- Seeks agreement with the patient about nature of presenting problem or concerns, health goals, management plan, and need for follow-up.
- Pays attention to feelings and responds appropriately; demonstrates empathy, generates trust and confidence, and provides support and encouragement.
- Monitors patient progress at appropriate intervals by mutually understandable and meaningful measures.
- Recognizes when a patient's situation requires extra time, even if disruptive to doctor's schedule.
- Addresses differences of opinion so together a conclusion can be reached that is acceptable to and safe for the patient.
- Collaborates with patient and empowers him or her to take active role.
- Works with patient on self-care activities, prevention, and health promotion.
- Works effectively as a member of a health care team.
- Assures that all staff respect the patient so that he or she feels acceptance and a nonjudgmental atmosphere.

Table 2. Examples of issues and actions reflecting health consumer demands

- Spiraling costs with failure to significantly improve health status
- Social movements empowering those groups experiencing gender, racial, and ethnic discrimination
- Activism demonstrated in Patients' Bill of Rights legislation (1973) and self-care and self-help movements
- Increased emphasis on informed consent and patient autonomy
- Increased dissatisfaction with medical communication and patient-doctor relationship
- Changing profile of health problems in an aging population
- Rise of consumerism, bureaucratization of medicine, technological interventions, iatrogenesis, and depersonalization of patient-provider relationship
- Increasingly litigious environment
- Administrative containment of care costs with limited choice of practitioners and rise in regulatory influence of third-party payers
- Uneven quality and access of care for different segments of population
- Inattention to sociocultural factors in disease and illness
- General lack of preventive and health-promoting care
- Rising concerns with conventional medical practices and increasing choice of holistic approaches to care
- Increased access to health information both through patient education and electronic media
- Increased attention to cost, quality, and access issues as well as to outcomes of care

learning strategies. Suggestions are made to advance the development of an explicit model that can help establish links between practice, theory, and research.

ASSUMPTIONS UNDERLYING PATIENT EDUCATION

Whether structured or informal, patient education in some form is common to chiropractic practice.^{20,21} Through this interactive process, the doctor gives meaning to the chiropractic experience. By supplying necessary information and offering explanatory models, doctors guide and develop patients' understanding of chiropractic's unique approach to health care, the role of subluxation in health and illness, and the ways in which chiropractic may meet their particular health needs.^{13,22} The document *Recommended Clinical Protocols and Guidelines for the Practice of Chiropractic*²³ defines patient education as the process of sharing information pertinent to patients' pending or continuing care. By understanding chiropractic, patients will be able to make health care decisions "based on fact and not misunderstanding."²³

While understanding is clearly an appropriate learning objective, it also is a difficult outcome to measure. This difficulty is further confounded by documentation suggesting that understanding or changes in knowledge do not necessarily lead to changes in behavior or health status.^{1,24} The assumption that understanding *does* lead to change in behavior, however, continues to drive much of health education theory and practice.²⁴ It underlies the statement in the aforementioned chiropractic guidelines that once a patient understands the benefits of care, "they will utilize these services as a preventative type measure, thus assisting in the cost containment of the overall health system."²³ Though this statement is intuitively sound for most chiropractors, or even experientially true for some and therefore tempting to make, it cannot presently be supported by data from objective studies on cost effectiveness or long-term health status.²⁵ Yet chiropractic is not alone in making assumptions such as this. Many medical practices and procedures, public health policies and programs, health services research, cognitive psychotherapy and learning theories, complementary and alternative medicine (CAM) practices, and health education programs are premised on similar assumptions.

The primary objective of health education is to change health behaviors or beliefs.^{1,3} Patient education was an innovative response in the 1970s to a growing problem with noncompliance to medical regimens.²⁶ Noncompliance was believed to be a major causative factor in spiraling health care costs. By improving compliance through delivery of information, it was thought that cost containment and a shift to patient responsibility for health outcomes would follow. However, little evidence has substantiated this belief or approach to health care manage-

ment.^{1,24} Still, patient education continues to grow and to mediate positive responses in patient satisfaction and in some health outcomes, though not necessarily through changes in health behaviors. For example, it has been suggested that the clinical encounter itself has therapeutic value and "may enhance patient efficacy expectations."⁴ Thus, patient education may serve multiple purposes in clinical practice.

PURPOSE, OBJECTIVES, AND CONTENT OF PATIENT EDUCATION

Purpose is said to shape practice, but to what extent have objectives and outcomes been specified so that the effectiveness of purpose can be assessed? While certain purposes for patient education are unique to chiropractic, most health practitioners share many of the following frequently cited objectives: giving information and helping patients to understand their health status and care options^{3,6}; empowering them to take personal responsibility and make better health decisions^{2,17}; securing informed consent^{4,9}; establishing and developing a satisfying and effective patient-doctor relationship^{8,27}; "realigning their belief system"²² or getting patient "buy-in,"¹³ changing health attitudes and beliefs^{1,26}; and improving compliance or adherence to a care management plan.^{17,24}

Particular to chiropractic are objectives for increasing patient visit average, stimulating new patient referrals, and stabilizing the practitioner's flow of patients. Though we assume that these objectives are grounded in patient benefits as well, they are, nonetheless, articulated from a practice-building perspective that is exemplified in the following statement: "If the patient truly understands the purpose and the benefits of chiropractic on his [or her] health, then he [or she] will be able to make better decisions, giving us greater practice control."²⁸ How do we know when a patient "truly understands" the purpose, and whose purpose should motivate health care decisions? Are patient education programs in chiropractic based on patient needs, or are they primarily shaped by the doctor's own objectives or needs? Or both? Is patient education fulfilling its purpose, and to what end?

Answering these questions requires explicitly stated objectives with precise meanings or statements of both content and behavior. A program begins with objectives. Like a map, objectives explicate and guide the kind of instructional strategies and assessment measures necessary to achieve and document programmatic success. Clearly stated objectives allow others to know what you are thinking and highlight the standards by which to evaluate your program.⁶ In this way, a program can be evaluated to determine its effectiveness and impact on the target audience—patients, community, and so on. Program evaluation also offers feedback to modify and improve procedure, methodology, or content.²⁶ And content should support the objectives.

CONTENT CAN BE EVALUATED IN RELATION TO PATIENT PERCEPTIONS OR SPECIFIC LEARNING OUTCOMES

Issues of content in chiropractic patient education need to be wrestled with due to the extensive variance in intraprofessional objectives.^{29,30} Having a clear definition of chiropractic's practice objectives is necessary for coherent programs of patient education. Without such clarity, content tends to vary and public perceptions continue to be confused. If most chiropractors truly believe that they offer health, wellness, and primary or preventive care, then patient education content, patients' perceptions, and health care choices should be more closely aligned to reflect these practice objectives. And while content is a critical issue, its examination is beyond the scope of this article.

PATIENT EDUCATION: TEACHING OR LEARNING?

To what extent and with what teaching/learning methodologies is patient education undertaken in chiropractic practice? Survey data from the 2000 *Job Analysis of Chiropractic*³¹ indicate that a chiropractor spends 15.3% of her or his occupational time engaged in patient education activities. This figure may be low, as much of direct patient care (a separate category in this analysis) requires ongoing communication to secure patient consent and to facilitate understanding of clinical procedures, care recommendations, and experiential outcomes. Many chiropractors, as well, offer health and lifestyle information or counseling within the context of direct patient care.^{21,23} Patient education is not a compartmentalized activity; it is integrated throughout the clinical encounter. Further data from a 6-year, multisite study on the use of chiropractic services supports a higher level of patient education activity.³² Overall, 31.4% of US patients and 17.2% of Canadian patients received education during treatment for a current episode of low back pain.³² Yet questions remain: What kind of education did they receive? And what did they learn?

A recent study³³ in South Carolina surveyed the use of CAM, patient satisfaction, and physician involvement. Chiropractic was considered as one of the "alternative therapies." While one in every five respondents had visited a chiropractor sometime during their lifetime, statistics revealed that only 1 in 12 had been under care during the previous year. Of all the purported CAM practices studied, chiropractic (with the exception of biofeedback and hypnosis) had the lowest retention or percentage of current use by previous chiropractic patients. The retention issues reflected in this utilization data suggest a need for chiropractors to examine and refine their educational strategies so that programmatic content supports explicit purposes, specific objectives, and intended outcomes of their

efforts. But it is equally important to remember that the chiropractor's objectives and outcomes for patient education will only be successful to the extent that they are compatible with the patient's interests and motivations to learn.

DISTINCTIONS BETWEEN TEACHING AND LEARNING

While patient education may satisfy multiple needs and mediate beneficial outcomes, it is, at its most fundamental level, a process of learning. Education, however, has traditionally focused on teaching rather than learning, and on outcomes rather than process.³⁴⁻³⁶ Yet education or teaching that is modeled on unidirectional patterns of information, flowing from expert/teacher to learner/student, is increasingly understood to be inadequate and unsuccessful for producing learning outcomes.³⁷ The patient as learner can no longer effectively be regarded as an empty vessel to be filled by the teacher or "font of knowledge"³⁶; the patient can no longer be regarded as a passive object of improvement.¹ "Patient" is a small part of most people's identity, and not generally the one that supplies the main frame of reference within which decisions about life are made."¹⁰

Each individual brings his or her own unique life experiences, knowledge, beliefs, values, learning styles, and voice to the clinical encounter.¹⁰ And this means that engaging an individual with educational strategies and posing appropriate learning objectives optimally require a personalized approach, in addition to whatever standardized information the patient receives.^{2,38} As Oths describes this process, there is an "initial transmission of large amounts of comprehensible information successively supplanted by personal affective dialogue."²² Yet what purpose or intent does this affective dialogue serve? Relationship-building, learning objectives, or both?

In holistic or participatory health or learning models, both provider and patient are simultaneously teacher and learner.^{15,16} This process requires dialogue, trust, and time. Learning relies on reflection on one's experience and is a process that may require facilitation.^{39,40} It is not surprising, then, that while many providers believe that both patient education and recognizing a patient's uniqueness are very important, they also admit to multiple obstacles or difficulties in actually providing such services. Time is a critical commodity for a health practitioner, and it influences both the quantity and depth of information and the delivery style used. Many chiropractic patient education programs are scripted, videotaped, or text-based with limited face-to-face time for exploring patients' unique beliefs, experiences, or needs. Chiropractic can, perhaps, be said to primarily focus on teaching tasks rather than learning tasks: "Through his [or her] instruction, the D. C. dogmatically transmits to the patients his [or her] own sense of conviction in his [or her] method."²²

Learning tasks require more involvement and initiative based on the learner's need for information or knowledge, rather than on the teacher's agenda for transferring information.⁴¹ "Dialogue is the method of choice to facilitate the construction of meaning and the identification of what is known and what needs to be discovered."³⁸ Yet chiropractors are practitioners first and only secondarily transmitters or teachers of health information. Beyond the telling and information-passing aspects of teaching, most providers are not trained as educators to identify unique learning needs in a client. According to Coulehan, "Chiropractors' academic understanding of interpersonal skills and the dynamics of healing may not be greater than that of the average physician."¹³ While the average physician is deemed underdeveloped in this domain, chiropractors are said to intuitively sense the importance of the interpersonal dynamic. But they are no more likely to explicitly discuss the "scientific value of personal care"¹³ or to acknowledge the placebo effect as a positive, mediating force in clinical care. Given these clinical and academic realities, to what extent do practitioner and patient share perceptions and meanings?

PERCEPTIONS AND CLINICAL REALITY

According to multiple researchers and repeated survey data, chiropractors view their role as primary care, primary contact, or "wellness" practitioners.^{21,42,43} Most chiropractors support practice objectives beyond that of pain relief for a limited number of musculoskeletal conditions. Despite this broad view of their health care role, approximately 95% of patients initially seek care for relief of acute musculoskeletal pain.^{44,45} Though many patients who receive the benefits of initial condition-based care decide to continue for "maintenance" purposes, can we assume that their personal objective for continued care is the same as their practitioner's? How many other patients, after initial relief care is completed, never visit a chiropractor again or only return for a subsequent episode of acute pain? While chiropractors speak of their role in subluxation correction, health promotion, prevention, or wellness—and cite many benefits related to health improvement—the public in general and other health care professionals do not share this broad view of chiropractic's practice objectives.^{46,47} Despite chiropractic's self-image as a "complete system"⁴⁸ or a "prevention-oriented wellness profession,"⁴⁹ continued disparity in perception argues for needed change in public and interprofessional communication.^{11,50} For some reason or reasons, the chiropractic message is not getting across.

From her exploratory study of patient/practitioner perceptions, Jamison⁵¹ advises that we not assume patients share our beliefs or perceptions regarding chiropractic. Perceptual differences are more the norm rather than the exception. Because

there is no objective reality "out there," the subjective experience and interpretation of reality is, to greater or lesser degrees, "in here."^{52,53} Each individual constructs the meaning of an event or experience based on a number of contextual factors—culture, gender, age, past experience, familial history, beliefs, values, and present state of mind and body as well as many others—in a process that is both taken for granted and frequently out of awareness.⁵⁴ While sharing many of the meaning schemata or cultural lenses through which we view our experience or reality, meaning and understanding are always personal and subjective.^{38,51} And the process of making meaning is an ongoing, dynamic, and negotiative process.

In health care settings this process has been referred to as "the cultural construction of clinical reality"⁵⁵ and involves a dialogical process of negotiation between the practitioner and patient²⁷ or "transactions between explanatory models."⁵⁵ It is all too common in health care practice to find disagreement, whether explicitly stated or unstated, between patients and providers on the nature of health problems, the recommended care plan, and expected outcomes.^{56,57} Transactions often involve differences and, therefore, require a willingness to continue dialogue across belief systems that may be divergent or to move forward even when complete agreement is highly unlikely.³⁸ The meaning of negotiation, however, must be broadened beyond its association with adversarial relationships or conflict: "The goal of doctor-patient negotiation is to enhance collaboration, the problem-solving process, and the health of the patient and family."²⁷ The content of this negotiation is relative to the agendas of the patient and/or practitioner. The task of negotiation is to determine where the differences are and to what extent they will affect care and productive outcomes.⁸ Patient education can be conceptualized as a transactional experience between a chiropractor and a patient during which the negotiation of clinical reality takes place on multiple issues and levels: responsibility, authority, and self-care; informed consent; and explanatory models including, but not limited to, the meaning of subluxation, health and illness, diagnosis, and care choices.

HEALTH BELIEFS AND THE NEGOTIATION OF MEANING

Patient's meanings, priorities, and goals may shift without the direct awareness or knowledge of the practitioner, particularly when therapeutic communication and the process of education and content do not remain focused, consistent, and ongoing. How many times have practitioners been caught off guard, totally surprised by a seemingly "compliant" patient who truly understood the chiropractic objective, was continuing care "for the right reasons," and then suddenly expressed an absolutely divergent point of view or dropped out of care

without warning? Without explicit knowledge of a patient's beliefs, previous experiences, and health care goals, the chiropractor can unwittingly project his or her own beliefs, values, needs, or interpretations upon the patient.¹⁰ Lack of a shared clinical reality and discrepancies in perceptions and expectations can have a negative effect on patient satisfaction, compliance, and resolution of problems.^{57,58} Providers may lack adequate communication skills or interpersonal awareness; they may fail to elicit or provide information in such a way that differences in health beliefs, values, and goals are revealed.^{38,59} "Self awareness of one's own conceptual frame or bias can avoid projection of one's own values and other assumptions onto others, thereby obscuring from view their frame of reference."¹⁰ Feeling unseen or unheard, the patient may be reluctant to express his or her needs, feelings, or concerns directly to the provider, including the decision to discontinue care. How well do we, as practitioners, understand this dynamic process of communication by which meaning is constructed or negotiated and by which relationships are developed?

Observers of chiropractic practice have highlighted the collaborative nature of the doctor-patient relationship and the therapeutic value of the communication patterns in which educational information is effectively embedded.^{19,29} It is suggested, as well, that such patterns of communication and education lead to high patient satisfaction and successful reframing of patients' health beliefs.^{13,22} This reframing or realigning of beliefs to a chiropractor's paradigm is the reason why, according to Oths, that "clinical interaction and education is [are] structured in such a way as to instill in new patients a coherent and comprehensible set of health beliefs, one that maintains a unified monocausal theory of disease etiology."²² However, if chiropractors were truly successful at realigning belief systems and achieving patient "buy-in" to a subluxation model or a "monocausal theory of disease etiology," it would be reasonable to find a greater degree of congruence between patient perceptions of chiropractic and those of the profession itself. Yet the gap between chiropractors' representations of their care or practice objectives and the patients'/publics' understanding and subsequent utilization patterns continues to exist.⁵⁰ Why does this gap or discrepancy in perception exist when chiropractors routinely educate their patients and offer explanatory models that, according to observers, conform to popular belief, are concrete and comprehensible, "appeal to both mechanistic and holistic aspects of culture,"¹³ and are easy to adopt?²²

The mechanistic explanatory model for subluxation as a "bone out of place" may be easy for a patient to adopt from within our familiar cultural paradigm, but represents only superficial learning. To truly convey the chiropractic paradigm or model of health requires more than information transfer, simple analogy, or superficial learning. Learning that

lasts—that transforms existing beliefs—requires making the patient an active participant in a dialogue about his or her beliefs that is grounded in his or her ongoing experience with chiropractic care. Before giving explanations, the chiropractor must discover what the patient knows, believes, cares about, or even fears regarding chiropractic. Addressing discrepancies in belief systems requires first acknowledging where a person is emotionally, cognitively, and experientially. Building from there, new learning must relate to what the patient already knows and does. One-size-fits-all analogies will not be effective for many learners. When pointing out differences in paradigmatic assumptions or perceptions, the chiropractor must always be sensitive to the individual patient's ability to hear or readiness to learn. Conveying the chiropractic paradigm will necessarily involve exploring the connections—or lack thereof—between a patient's existing health beliefs and goals, the content of patient education, his or her experience of chiropractic care, and the meanings the patient constructs from a multitude of contextual factors. And still perceptual differences will continue to exist.

While causative factors for disparate perceptions are complex, embedded in sociocultural contexts, and complicated by scant research on "wellness" care in chiropractic,^{25,60} we would be well advised to examine local conditions that are more amenable to our control or influence. We must look locally across our own practices, college curricula, and practice management programs for factors that daily shape meaning and clinical reality. While patient education has a presence to varying degrees in each area, it has, to date, been largely the province of for-profit practice management seminars and consulting groups. And while filling a gap in students' and practitioners' preparation for practice, the form of patient education that has been disseminated is a teacher-based model of information transfer that simultaneously became linked with the generation of care recommendations. Recognizing chiropractic students' need for developmental competence, colleges should now take the lead in examining and advancing the theory, practice, and research of patient education and the interpersonal dynamics of the clinical encounter.

OUTCOMES AND EVALUATION

If the objectives are to realign or reframe the patient's belief system on any lasting basis, to share clinical reality and meanings, or to close the gap in perceptions, then different learning strategies are required. First, reframing cannot be accomplished before a patient's beliefs are made explicit, consciously recognized, and explored.⁵⁸ Open-ended questions about health beliefs and goals for treatment should be aimed at eliciting the patient's explanatory model and discovering which differences are important to outcomes.^{8,61} Second, the patient must always be accepted and engaged in learning based on present under-

standing and current needs.⁶ Third, the kind of learning that results in lasting change, or change of another order, is transformational in nature and requires a different commitment on the part of the educator or practitioner.^{37,40}

Transformational learning is an adult learning theory and educational practice that is vitally connected to the developmental process and impacts learners so that they are recognizably different afterward.^{34,62} Subsequent learning experiences build on this change, which also can affect the way one learns. Learning is construed in terms of meaning formation and highlights critical reflection on cultural and personal meaning systems through which experience is mediated and interpreted.⁶² General cultural or meta-contexts give form to beliefs and behaviors (including those of health), both socially and personally, through underlying explanatory models or health strategies that are rooted in deeper paradigmatic givens, metaphors, and assumptions.^{58,63} While chiropractic is presently an attractive explanatory model for certain biomechanical conditions, it has not supplanted the dominance of the biomedical model and the mechanistic and reductionistic paradigm from which that model evolved. The cultural and epistemologic power or rootedness of these mental models should never be underestimated. It is these mental models that need to be subjected to dialogue and critical reflection.⁶⁴

In addition to transformational learning, other objectives and outcomes must be specified to provide a general framework for deciding what information to seek or to measure. Lorig⁶ suggests the following five basic categories for constructing outcomes for patient education:

1. Knowledge—indicating whether patients learned what you wanted them to learn
2. Behaviors—indicating adherence to or participation in a therapeutic care plan
3. Attitudes/beliefs—indicating change in beliefs and patient satisfaction as an attitudinal measure
4. Health status measures—psychological or physiologic
5. Health care utilization—statistics on practice visits, retention, rationale for patient's visit, and so on

Of these five categories, chiropractors predominantly use indicators of health care utilization to evaluate outcomes. Yet the appropriateness of these measures used singly or without establishing clear objectives and operational definitions may overemphasize or misrepresent the outcomes or causal relationships.

CONCERNS, QUESTIONS, AND RECOMMENDATIONS

Despite the importance of patient education in the delivery of health care outcomes and patient satisfaction, study of this topic is in its very early stages. Most research is descriptive and observational; little exists in chiropractic specifically,^{13,50,65} and links to theory are often lacking or tenuous.¹ Has patient

education been adequately conceptualized as a practice and skill in chiropractic and incorporated in the formal curricula of colleges? Have we evaluated our programs of patient education, based on explicit objectives and specific outcome measures? What principles, models, or theories exist to support patient education in chiropractic? What is our philosophy of education?^{66,67} Do health education or other fields that deal with education and evaluation inform that philosophy? Have we evaluated content, delivery, and assessment?

The following text presents the critical concerns and questions that remain and suggest avenues for further examination and action. First, how much actual learning or realigning of belief systems is taking place in chiropractic patient education? The interpersonal dynamic of the clinical encounter is, perhaps, the therapeutic aspect most closely associated with patient satisfaction, and the educational content may be, for all intents and purposes, beside the point. By providing care "characterized by personal involvement, concern, and supportive communication"²² and by delivering excellent clinical results with condition-based symptoms that have been ineffectively managed elsewhere, patients are more interested in and excited by the results and immediate benefits of care than they are with understanding the mechanism of the subluxation and how it works.⁴ But still there are questions.

It seems reasonable to propose that the content dealing with the chiropractic objectives of subluxation correction, health, wellness, or prevention is not being absorbed or adopted and that it would be useful to reexamine the assumption that patients are adopting chiropractic belief systems.¹³ Is it really true that "the chiropractor first manipulates a patient's belief system before manipulating his or her physical structure, providing an analogous structural realignment in both the mind and body"?²² To carry this analogy further, perhaps the chiropractor is only realigning a hypermobile segment and thus never effectively resolves the fixation or moves the set of underlying cultural assumptions. A deep appreciation for the fixedness of cultural beliefs and assumptions gives good reason to pause at the prospect or objective of transforming paradigmatic thinking or realigning belief systems.^{58,62} Yet beliefs are changeable over time, particularly when evidence repeatedly supports a new perspective,³⁹ and "because personal experience will always hold the evidential and epistemological high ground."¹⁰

Next, how bidirectional is the patient education or communication process? Despite the substantial support for a collaborative model of patient education or therapeutic communication, there are indications in actual practice settings that this process may be significantly influenced by the chiropractor and shaped by teaching/management needs rather than the learning needs or health goals of the patient. Thus, it would be prudent to beware of any patient education program that embodies any of the following: predominantly unidirectional,

subtly manipulative, or blames the victim or medical model; uses charisma, dogma, or affective dialogue to achieve compliance; assumes patients have understood or share the belief system that was disseminated in early educational efforts; or sells a one-size-fits-all educational model.

There is need for dialogue, reflection, and qualitative methodologies to reveal and develop phenomenologic descriptions from chiropractic patients, particularly those who have been under long-term care. There is virtually no lexicon or way to speak about health, though there are endless terms and descriptors of disease and illness. We face an enormous challenge in assisting our patients, as well as ourselves, to reflect on and articulate the experiential ways in which subluxation (and its correction) has both subtly and dramatically played a beneficial role in health and wellness. Phenomenologic and qualitative descriptions can do much to point us in new and fruitful research directions.^{19,29} Such data can be collected in the educational process of experiential and transformational learning. This will, however, require significant training and time. Not all practitioners can be expected to participate, but we do need more than anecdotal accounts. We must move the dialogue on health and wellness into the forefront.

There is a vital need for training in interpersonal skills, so that we move beyond our intuitive grasp of this dynamic into explicit understanding, intentional objectives, and propositional knowledge. While recognized as caring professionals, chiropractors are perceived neither as "an important health informance source,"⁵⁰ nor as skilled in patient education.^{11,49} Chiropractors' sense of the importance of the interpersonal aspects of the clinical encounter must now be translated into theory, practice, and research. Jamison gives an appropriate warning in this regard, "Practitioners who are relationship oriented need to ensure that they do not base their clinical success on tacit knowledge when they structure management plans."¹⁶

Training in educational strategies and communication skills should be incorporated into the formal chiropractic curricula and involve ample clinical training experiences for both students and faculty.⁶⁸ Collaboration with field practitioners should be sought out to advance practice and research. A critical need exists, as well, to educate and effectively train chiropractic personnel, as they can increasingly play a significant role in therapeutic communication and experiential patient education.

No well-developed model of patient education can be found in the academic literature, and this practice has not been significantly evaluated or researched. To date, very little has been done with conceptualization or evaluation of the purposes, objectives, content, delivery, reimbursement, and outcomes of patient education. Likewise, disciplines or perspectives outside of chiropractic including, but not limited to, health education and promotion, nursing theory and practice, adult learning perspectives and strategies, and program evaluation

guidelines have not informed the practice. A model must be advanced that can forward links between practice, theory, and research. While still the subject of further research, the crafting of a model for patient education should be guided by the following values and precepts: an ethic of caring, therapeutic communication that is bidirectional, empowerment, holism, collaboration and dialogue, acceptance of multiple realities, a goal of shared clinical reality and negotiated meaning, transformational learning, and the recognition of subluxation as the core concept around which chiropractic revolves.

CONCLUSION

Patient education has assumed major emphasis in health care and become an integral feature of health professionals' practice. The majority of chiropractors view patient education as a necessary clinical procedure and intuit the therapeutic value of this process. While the practice of patient education is commonplace or routine in clinical settings, a significant disparity continues to exist between patient/public perspectives on chiropractic's identity and practice objectives and the perspectives held by the profession itself. We can learn a great deal from this disparity by studying the preparation for and practice of patient education in the clinical setting. To date, very little has been done with conceptualization, theoretical modeling, and evaluation of the purposes or objectives, content, delivery, and outcomes of patient education. Moreover, teaching and instructional knowledge or theories, adult learning perspectives, and health education or program evaluation guidelines have not significantly informed the practice of patient education. It is critical to elevate chiropractic's commitment to patient education from a necessary part of clinical reality, but one with little programmatic or academic evaluation, to an explicitly described perspective and model that can forward links between practice, theory, and research. A model that incorporates the concepts of negotiated meaning and dialogue, an ethic of caring, and an objective of transformational learning has substantive and practical value for both practice and research.

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