What is the clinic patient learning? Is it good, or is it negative? Within the existing framework, can that learning be made more effective?

Health Education for Outpatients

By MARY LOU SKINNER, M.P.H., and MAYHEW DERRYBERRY, Ph.D.

WORKERS in hospital outpatient clinics have an unusual opportunity for health education. People who come to the clinic do so because they have a health problem. It is of real concern to them. And the clinic is where they expect to get help. What takes place in the clinic can be more meaningful educationally than academic discussions or lectures about healthful practices at times when people are not actively concerned about their health.

There is an analogy between health education and medicine. Medicine is the art of applying the basic biological sciences for the benefit of the physical health of the individual. Health education is the art of applying an equally basic body of knowledge about the ways in which people acquire information, develop attitudes, and change their behavior about health.

Health education requires diagnosis of the particular situation before methods are chosen just as medicine requires diagnosis before treatment is prescribed. However, there is a tendency for some to choose an educational method that has proved successful in a particular situation for which it was designed, on the assumption that it is generally effective in all situations. This same tendency is sometimes observed in medicine. A dietitian tells this story:

One of the older physicians on the staff had ordered an extremely high fat diet for a diabetic patient. A week or so later, diet orders with a very high fat content came down to the diet kitchen for two other diabetic patients. Thinking there must be some good reason for this deviation from the hospital's usual practice, the dietitian went up to the ward to inquire. The new intern said in surprise, "Oh, are those diets unusual? Why, I just ordered what old Dr. Brown had prescribed for the last diabetic patient he had here." As it turned out, Dr. Brown had put his patient on a ketogenic diet during the hospitalization period for a special reason. In routinely following the other physician's prescription, the intern had unknowingly prescribed diets which were not appropriate for his patient's needs.

Such a procedure would, of course, be condemned by the experienced physician who thinks about the whole organism when a patient complains about a single symptom. In good

Mrs. Skinner is health education consultant in the Public Health Service, Department of Health, Education, and Welfare, Region II, New York City. Dr. Derryberry is chief, Health Education Services, Division of General Health Services, Public Health Service. *Their joint paper was presented to the outpatient session of the Tri-State Hospital Assembly at Chicago, Ill., on March 4, 1954.*

education, too, the whole range of educational principles must be examined in order to select the best methods for a particular purpose.

How People Learn

It may be beneficial to take a look at some of the basic knowledge about how people learn before exploring ways of educating patients in clinics. Part of it will be familiar—some ideas have been recently documented by research, others are "educated hunches"—but application of the following five points is well worth all the emphasis that can be given.

First, all learning is motivated within the person, not by exterior force. Education in the real sense begins only with a problem of immediate interest to a person. The patient in the clinic has some problem of present concern to him, or he wouldn't be there. Thus, a condition favorable to learning already exists in the patient. Is maximum use made of this opportunity?

Beyond that immediate interest, people are truly motivated to do only those things which they think help achieve something they want or help cope with their own special personal problems. These goals may not be clear to the individual or to the person working with him. As a matter of fact, they are likely to be unrecognized by either. Nevertheless, they are the determining factors in what is learned in a given situation. Learning takes place more effectively when the experience has meaning for the learner, and he is able to see the full implications of the experience.

Second, learning is an active process. It occurs only through the person's own efforts. So long as he is passive toward a situation, he will learn little. Yet, how often are people "told" what to do, lectured about tuberculosis or cancer, handed leaflets about health subjects? How often does the patient's "Yes, Doctor," or "Yes, Miss" response to the information given him delude the clinician into thinking the patient is learning? Sometimes there has been real interchange of ideas, but at other times the patient's assent is simply to free himself from an undesirable situation or to prevent exposing his lack of understanding.

Third, a person selects what he sees, hears, or feels largely because of both his past and present interests or motivations, and this selection determines what he learns. Furthermore, what is learned and how it is learned differ from one person to another because each comes into a given situation with a unique background of experience and point of view.

For example, three people walk down the street past a poster announcing a chest X-ray schedule. The man who wants an X-ray will see the poster and go to the clinic. The man who thinks he has no need for an X-ray may not see the poster at all. The third person may see the poster all right but will avoid the clinic because of negative feelings about all clinics, because he is afraid of tuberculosis, because he has had a recent X-ray, or for other reasons.

The response to a simple poster arises out of complex feelings. Consider then the tangled skein of past experiences. These enhance or hinder his ability to utilize the educational opportunities in the clinic.

Fourth, behavior is seldom changed because a person has been told to do something different. He will change his behavior in a prescribed manner only when he understands what to do and when he sees the action as leading to the satisfaction of a felt need. He must want to learn the new action. He must also know clearly what action he is to take. Finally, he must see that the action will help him achieve a goal that is important to him. This characteristic of the learning process is particularly important in the outpatient clinic. How often information is given in medical terms that mean nothing to the patient! Besides that, the patient may not readily understand that the behavior advocated by the nurse or physician is related to the solution of his own health problem. He may then remain unconvinced that the procedure will cure his ailment.

It is important for the clinic staff to remember that the patient is not likely to carry out any suggested action to meet his health need which to him appears to be in conflict with his way of life. The fact that the advice is acceptable to the person giving it often blinds that person to the ways in which the information may conflict with some deeply held value of the patient. This failure to consider the personal element sometimes defeats the clinician's goal.

Fifth, the attitudes of the groups to which the patient belongs are a significant force. Most people tend to conform to the accepted standards and sanctions of family and friends. These may determine whether information is accepted or rejected and whether the person takes any action. It is often difficult to recognize many of these group influences because they may be unrealized by the patient himself. The factors which appear on the top layer often camouflage the real values held tenaciously underneath.

One expression of the way group pressures operate is through the cultural patterns of the people. These patterns are not readily discernible, and the assistance of educators and social scientists will be needed to discover the cultural medium in which a patient lives if it is to be used with insight in his education.

Current experiments with new research methods are providing additional perceptions about cultural reactions and their relation to learning. Although the full meaning of these studies is not quickly understood, and the facts are apt to be forgotten since they do not agree with prevailing concepts, it is desirable to look at some of the recent developments in the field because their significance has often been overlooked.

Stratified Attitudes

Studies on class stratification in the United States show a society made up of fairly well-defined classes (*1*). These studies agree, too, that: (*a*) each class has different values in which it believes and which it preserves, and each has different attitudes toward education; (*b*) each class tends to reject people who are in another class; and (*c*) members of each class have different ways of managing their own lives.

The class system of this country is not like that of the European countries. It is distinctly our own. Most professional people in medicine and the allied fields are drawn from the middle and upper-middle classes. Most middle-class people think that what they believe is the common belief of all right-minded, intelligent people. This attitude trips up many educational efforts. It results in annoyance and leads to the comment that people are uncooperative, stupid, hostile.

Not everyone in the United States regards infant life, health, life, or death the way this middle class does. Nor will everyone learn easily to change behaviors regarding health and medical care unless these changes are behaviors valued by the group to which he belongs. People who are in one social class do not accept easily the teaching given them by a person from a higher social class. More respect must be accorded the varying resistances of the different cultures in our society.

Most of our observations of the expressions of cultural values are empirical and tinged with unconscious prejudgments. Only a few studies which get at this kind of fact have been done in the health field. One which deserves thought was done recently at the Veterans Administration Hospital (West Kingsbridge Road) in New York City (*2*). This study attempted to pin down the effect of cultural differences in patients' responses to pain.

Among the groups selected for intensive study, the Italians and Jews were described as tending "to exaggerate" their pain. Free expression of words, sounds, and gestures is expected, accepted, and approved in both Jewish and Italian cultures. A patient from an Italian culture is more apt to be concerned with the present. If his pain is eased, he will relax and forget his sufferings and manifest a happy and joyful disposition. The Jewish patient, however, is often reluctant to accept the analgesic drug. He explains this in terms of concern about the effects of the drug on his health. He is apprehensive about the habit-forming aspects. After being relieved from pain, many Jewish patients continued to display depressed and worried behavior.

The conclusions of this phase of the study were two:

Similar reactions to pain manifested by members of different ethnocultural groups do not necessarily reflect similar attitudes to pain.

Reactive patterns similar in terms of their manifestations may have different functions and serve different purposes in various cultures.

From this, there would seem to be practical implications for education. First, there is not

a public of patients, but many groups within the total patient clientele. Also, there is no quick way to bring about changes in behavior within these different groups.

Many of the symptoms which bring people to clinics are life crises—social and emotional as well as physical. A mother concerned about a new baby, a breadwinner recovering from a heart attack, a family adjusting to the diagnosis of cancer in a member—these are real life situations. At such times, barriers to learning are lowered. However, life crises produce many anxieties, and the patient may raise barriers to learning if the approach appears to be too great a threat to his goals of personal security.

The fact of having to admit illness, for the most part, threatens the familiar image of the patient's own successful ways of meeting life. Illness calls into play unaccustomed responses. The patient is more apt to worry about the unfamiliar. He has to ask for help, and these feelings about seeking help can be charged with guilt. Staff members may share emotionally charged feelings about seeking help or dealing with illness. Their inner judgments affect the inflection of voice and physical gestures. These become cues to which the patient reacts favorably or unfavorably, raising or lowering his defenses accordingly. In fact, what the patient perceives is just as potent a force in his education as the planned instruction during a lecture or individual conference.

For an educational program to make the most of its opportunities, the clinic staff must seek more knowledge about, and be willing to accept the worth of, patients' values and knowledge. There are two kinds of educational opportunities in a clinic that may be considered against the background of educational principles— the ones you plan for and the ones you don't, or opportunities for indirect and direct education programs.

Indirect Education Programs

A thoughtful objective look at what goes on in the clinic will indicate some of the instances and situations in which unplanned education occurs. What does the patient see? What is he made to feel?

What the patient learns depends on the clinic atmosphere—its climate. An inquiry into its physical makeup is a good starting point. For example: To what extent has the staff impersonalized the hospital-clinic routine? Must the patient sit in brown and dingy corridors? Does someone explain to him what he is to expect and why; and, is he prepared to spend the time required? Is the unit aware of what the wait means to the patient; and, is the patient uncertain while he waits?

Uncertainty creates fear, and fear is apt to produce anger which, though it may be expressed in many ways, often appears as resentment or apathy. When there is vagueness about the details of therapy, it is perfectly normal for the patient to imagine the worst. He will cooperate more readily when he knows about routine matters.

A public health nurse tells about the time she was suddenly taken ill while on her vacation. The hospital physician she called urged her to come to the outpatient clinic. There she had to wait a long time, feeling more and more miserable. Finally, she was vaguely aware of a stiffy starched nurse advancing toward her and carrying a hypodermic needle. The strange nurse told her to get up on the table in the cubicle "over there." It was only because of her hospital training that the public health nurse questioned this command. As it turned out, the physician had had an emergency call. He had been sure from the patient's description of her symptoms that penicillin was indicated and had left an order for it to be given.

In this instance, it was particularly fortunate the patient spoke up—she knew she was sensitive to penicillin. But what might some other patient, not a nurse, have learned about medical practice from such vague experience, so unrelated to his own understanding of cause and effect and expectations of medical service? And what kinds of feelings would such patient transfer to the next situation? Simple thoughtfulness will reassure a patient, make him less demanding and more ready to hear the advice of the staff. It will make a positive health education experience the more likely.

The Physician's Role

The medical director can set the stage in which real education occurs, or he can defeat

the opportunity for education. Among other studies bearing this out, the Denver study of tuberculosis hospitals (*3*) shows that the organization of a hospital often does not encourage sufficiently free exchange of information between various professional services. When the barriers are down, so that there is a pooling of information concerning patients, all benefit. It is the medical director who creates the climate in which this can happen.

The position which the physician holds in the patient's regard is the rock upon which treatment succeeds or fails. If the patient is given the feeling that the physician is interested in him personally, he is able to utilize other aspects of the medical care much more adequately. This was seen in Boston in the diabetes education program sponsored by the Diabetes Field Research and Training Unit of the Public Health Service. How the physician referred the patient to the group classes made a difference in the patient's willingness to come to the classes and to accept the information given by the nurse and nutritionist throughout the 8 weeks' session.

The staff's perception of how it feels to be a patient will be increased by each member's participation in situations which parallel those experienced by the patient. There is a growing trend to plan situations for the staff in terms of the conditions in which patients find themselves so that they can better understand how it feels to be a patient. Many a hospital routine has been changed by wise physicians or nurses, after they themselves have been real life patients. It is not possible to, nor would one wish that every person could, have the experience of being a patient. Accumulated knowledge, however, attests the contribution to patient care and education of contrived experiences which develop insight.

At Boston Psychopathic Hospital, staff members are offered an opportunity to take a drug which can create in well people for approximately 24 hours the feelings which a schizophrenic patient experiences. This sensitizing experience is not possible or necessary for all of the hospital staff. But it illustrates the idea of devices by which one may become more sensitive to a patient's feelings. Staff members have also tried role-playing of "how it feels to be a patient" and are enthusiastic about the usefulness of this technique. There was a health department, too, which changed its entire procedure for handling telephone reports of communicable disease after the role-playing of "what happened on a call about a suspected diphtheria case." Another technique might be to have young medical students get the "feel" of clinic processes by going through a clinic identified only as a patient.

The Patient's Response

It saves time and makes for effective education to know the patient's opinion. After all, the patient acts on his own opinion whether it is correct or not. A simple well-planned interview with the patient usually will obtain the necessary information. When patient opinion is known, it is possible to plan an educational program which will hit the target more accurately.

Most patients realize that they are not competent to judge medical care, but they become impatient when their wishes and ideas are ignored. Their progress toward recovery and in education can be delayed by rules and procedures they do not understand and by indifferent personnel. Positive education is not apt to occur in a discontented person. Many people lose their dissatisfaction when they realize that the clinic is sufficiently interested in them to find out what their opinion is. One study of patient opinion found that most satisfied patients complained about not having the hospital schedule explained (*4*). Is this worth exploring in outpatient clinics?

The interviewers in this same poll were startled by one complaint which may have significance for outpatient clinics. Patients who were generally well satisfied did not feel that they had received enough information about how to care for themselves at home. The poll-takers concluded that "it was evidence of the failure of nurses and doctors to seize opportunities for health teaching; as well as showing a lack of interest in the patient as a person who will continue to exist and have health problems related to his illness even after he leaves the hospital. It could show, too, a lack of integrated planning with allied health agencies for followup care."

Direct Education Programs

The "diagnostic" process (*5*) of telling people things is not the most successful or satisfying way of working educationally with them—it is often dangerous, and its effect cannot be foreseen. It would seem preferable to adopt the "therapeutic" process of helping people to recognize things for themselves. However, since many shared attitudes are derived from the teacher-pupil experience of academic life, the attitude that one educates people by doing things to them is carried over into, and dominates, the educational relationships to patients. The difference in the diagnostic and therapeutic processes is between doing things "to" or "for" people and doing things "with" them. These ways of thinking affect the indirect and direct education that is done.

Printed literature, exhibits, and information racks are useful tools in an educational program, but the extent of their effectiveness depends on thoughtful planning for their use. The Veterans Administration Hospital in Rutland Heights, Mass., used to give packets of pamphlets on tuberculosis to every new tuberculosis patient admitted. They lay untouched on the bedstands. However, when racks were put in the wards where the men could make their own selections, pamphlets began to disappear, in considerable variety and number.

Another, and even more significant use of health literature, is that reported by Schwartz (*6*). The Cornell University Medical Center outpatient department in New York City started using pamphlet racks with a wide range of subject matter. Some of the staff were cynical.

Why child guidance leaflets in an adult clinic? they asked. Who on those benches requires prenatal care? A glance would show that the average age is 60. But patients waiting on outpatient benches, like people everywhere, have families. They did not discard family problems or interests at the clinic door, and the pamphlets disappeared.

The educator was still not satisfied, and another approach was tried. This time only one copy of each leaflet was made accessible. It was clearly marked "Please do not remove this booklet from the clinic. If you think a copy will help you, talk with the nurse about obtaining one." These pamphlets were mixed with copies of the *Saturday Evening Post* and other magazines. To the surprise of the clinic staff, there were 136 requests for the leaflets in the first 4 weeks. Pamphlets in hand, the patients came and asked for information. The conferences which followed brought to light all manner of problems not directly related to the patient's reason for coming to the clinic. Transfer to physicians of information important to the treatment of the individual patients was a valuable result.

Advising and planning with patients and their families on what to expect in connection with medical therapy can produce favorable educational results. The study on hospitalization of children for tonsillectomies (*7*) conducted by the Albany (N. Y.) Medical College Department of Pediatrics is an example of such anticipatory planning. Among other things, this study showed that young children resented a jab with a hypodermic needle. The child was told that the only jab he had to take was the finger prick for a hemoglobin reading. The staff found that if young Philip knew in advance that his finger would receive a slight prick, such as he gets dozens of times playing, followed by the appearance of a round bead of his own beautiful red blood, he was likely to watch without anxiety while the bead of blood rose in a little glass tube, just as he had been told it would. Mother might stand by trying to keep from shuddering, but Philip was fascinated. This is health education of real significance.

Any number of people, given the opportunity, will welcome the chance to help with the clinic's education program. It is not at all necessary for the clinic to do it alone. If mimeographed maps or guides to the clinic routine are needed, volunteers can solve the problem. If the staff is too busy to take time to talk with foreign-born folks who struggle with English, the local adult education center may be able to supply volunteers from its foreign language classes.

If time will not permit inservice education of staff, a plan used in Boston may be the solution. There, 9 hospitals and 11 official and voluntary agencies set up a committee on outpatient education to plan ways for improving educational practices. Educators are members and suggest

improvements for the staffs to try. Other services for which the hospital clinics do not have time to recruit independently are provided in other ways.

Volunteers provided the Lubbock Memorial Hospital in Lubbock, Tex., with pamphlet racks and kept them filled; they also provided transportation for the indigent. While doing this, they learned about another need and have helped the hospital develop a Negro prenatal clinic. Now, they are working on community understanding of welfare problems which affect the hospital. Thus, a double educational goal is being served. Not only are the patients in the hospital learning, but the volunteers have discovered many opportunities for effective action.

Group activities is one of the more significant methods that can be used by clinics to provide learning opportunities. This method is being tried in a wide variety of situations. Group discussions with parents in child health conferences at the Lillian Wald Health Station in New York City (*8*), group discussion with parents and families of premature babies and of children with rheumatic fever at Grace-New Haven Community Hospital, New Haven, Conn. (*9*), the group work with diabetic patients carried on in Boston by the city hospital and the Diabetes Field Research and Training Unit of the Public Health Service, and the group work with obese patients at Herrick Hospital in Berkeley, Calif., indicate some of the experiments. Group work with patients who have had coronary attacks has been proposed. Alcoholics Anonymous is working closely with some hospital clinics in group discussions with alcoholic patients. Group methods of education can be used to help parents of handicapped children learn how to work more successfully with their own children (*10*).

"Group activities" in this context does not mean classes in the traditional lecture form; it means, instead, ways of bringing people together to create situations in which they feel free to discuss their own reactions about the problems in question. They learn from each other and give support to each other. The classic study (*11*) with mothers of young infants on feeding orange juice and cod liver oil, done at the University of Iowa Hospital, brought out clearly the advantage of decision-discussion methods. In such group discussions, incorrect ideas are likely to be rejected by the group; people are strengthened by group attitudes of their peers and supported in changing or in tentative new convictions.

Leadership for this kind of group discussion is a skill. Only recently has it been taught in school. Moreover, new studies in group discussion methods are going on all the time. The clinic staff which is interested in exploring this method would be well advised to consult with local resources for help in adapting these skills to their special needs.

Another Challenge

Not many in public health or hospital administration are specialists in education methods or have the skills of social scientists. As in the medical field where general practitioners sometimes fail to recognize a symptom which a specialist would spot at once, so in the education field it is easy to miss significant opportunities for education. Social scientists can be called on for help on problems in these fields. More and more hospitals are asking educators or sociologists to observe their practices and to suggest more effective ways of working. The demand is growing for consultation and service from anthropologists, health educators, adult educators.

These different professional groups will not provide a common body of accumulated knowledge with ready-made answers. The professions are advancing together into new, experimental, and more profound ways of working with people. Although these newer methods are not so well formed or definitive as the older academic ways of teaching, they can, when wisely used, offer greater satisfaction. Imaginative people in a clinic, who take their responsibilities thoughtfully, will be challenged to find out from day to day what the patients are learning and to enhance that knowledge positively.

It is important for everyone to become more familiar with the nature of the cultures and the ways of life of others: their goals in life; their values, beliefs, traditions, customs, and taboos with respect to health and illness. More

must be known about the objectives for which people are willing to strive and conversely, more must be understood about the aspects of life which mean very little to them. These understandings are not easy to acquire. Since understanding is limited or not always possible, perhaps respect for differences is an attitude to nurture.

The only people who are really going to do anything for the patient are the persons who work with him. Not everyone is equally ready to learn about health at all times. But there are times in a lifetime when an individual is ready. One such time is when he comes to the outpatient clinic for service.

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Legal Note on Water Pollution Control

A Connecticut trial court was authorized to modify an order of the Connecticut State Water Commission by extending the time within which the defendant was required to comply with the order in the case of *State Water Commission* v. *City of Norwich*, 107A 2d 270 (Conn. 1954).

The Connecticut Supreme Court of Errors construed a State statute authorizing judicial enforcement "by appropriate decree or process" of the commission's orders covering control of water pollution as giving the trial court authority to attach to its decree such conditions as it may in its discretion find necessary for the adequate enforcement of the order. The court held that the additional time was necessary to make the decree appropriate and effective since the date set in the commission's order had expired.

Accordingly, the change in dates was held not to be a material change in the commission's order and, consequently, was a proper exercise of the broad equity powers of the trial court rather than an attempt by it to exercise administrative functions.