

**THE WEBER HEALTH EDUCATION MODEL:  
HEALTH CARE PROVIDER-PATIENT INTERACTIONS**

**LORELEI DIANE WEBER**  
001011347

A Project Submitted to  
the Faculty of Education of  
the University of Lethbridge  
in partial fulfillment of the  
Requirements of the Degree

**MASTER OF EDUCATION**

**FACULTY OF EDUCATION**

Lethbridge, Alberta

May 2004

## Dedication

I dedicate this project to my daughter.

## Acknowledgments

I would like to thank my family for their love, shared history, laughter and the big talks.

I owe a special thanks to Dr. Leah Fowler and Dr. Karran Thorpe for their generous support.

A special acknowledgment is required to my patients who have had patience enough to teach me.

## Abstract

This qualitative project introduces and explores the creation of a new health education model, which emerged from a personal narrative inquiry. Using research literature and studying four patient interactions through narrative inquiry and analysis, I created a communication process to allow a deeper connection between health care providers and patients. The Weber Health Education Model provides and describes a seven-step communication structure for these health care provider-patient encounters. In the second phase of my research, I tested this model in a clinical situation and interviewed five health care providers to explore their perceptions within the context of their daily practices, asking the research question “Does the Weber Health Education Model allow for meaningful contact between health care provider and patient?” It was found that research participants were able to provide an answer which was distilled to one statement: Despite initial hesitation, health care providers found using the Weber Health Education Model to be an effective tool for meaningful connections within encounters. In particular, patients had a wide variety of expectations and found that asking about expectations was the key to a deeper understanding of an individual’s true concern with a specific health problem. It is recommended on the basis of this project that further research in this area would contribute to knowledge about the use of the Weber Health Education Model.

## Table of Contents

Dedication.....	iii
Acknowledgements.....	iv
Abstract.....	v
Table of Contents .....	vi
Overview.....	1
Chapter One: The Genesis of the Weber Health Education Model: Client Stories.....	4
Introduction.....	4
Client Story #1 “A Latté on the Way to the Farm” ...	5
Client Story #2 “Get Out of My House” .....	11
Client Story #3 “Going to the Coffee Shop”.....	16
Client Story #4 “Seeing the Light”.....	21
Chapter Two: Health Education.....	24
Introduction.....	24
A Discussion on Definitions.....	24
Health .....	25
Patient.....	26
Health Care Professionals.....	26
Health Education.....	27
A Call for New Groupings within the Health Education paradigm.....	28
Personal Health Education.....	29
History of the Profession of Health Educator.....	31

Theoretical Base for the Weber Model .....	34
Humanism.....	34
Adult Learning Principles.....	35
Orem’s Self-Care Theory.....	38
Client-Centred Therapy.....	39
Kalamazoo Consensus Statement.....	40
Whitehead.....	41
Five Trends in Health Education Literature .....	42
Shared Decision Making.....	42
Empowerment and Advocacy.....	47
Holistic Care.....	50
Pressure on Providers for Accountability.....	52
Chronic Care Pressures.....	55
Four Conclusions and a Call to Action.....	56
Chapter Three: The Creation of the Model.....	58
Foundation of the Weber Model.....	58
The Weber Health Education Model Diagram.....	60
Explanation of the Diagram.....	61
The Weber Health Education Model.....	62
Problem Statement.....	63
Expectation Viewed.....	64
Data Collection.....	66

Confirm Expectation .....	67
Health Education.....	68
Contractual Agreement.....	70
Evaluation.....	71
 Chapter Four: Research Methods.....	 73
Introduction.....	73
Problem Statement.....	73
Research Participants.....	74
Ethical Considerations.....	75
Assumptions.....	76
Limitations.....	78
Data Collection and Analysis.....	79
Researcher as Instrument.....	80
Summary of Research Methodology.....	81
 Chapter Five: Narrative Analysis of Client Stories.....	 82
Introduction.....	82
Explanation of Narrative Analysis.....	82
Analysis of “A Latté on the Way to the Farm”.....	84
Analysis of “Get Out of My House”.....	89
Analysis of “Going to the Coffee Shop.....	95
Analysis of “Seeing the Light”.....	100
Distilling the Message.....	104

Chapter Six: Results and Discussion of Research.....	106
Introduction.....	106
Major Themes.....	106
Expectations.....	106
Fear.....	108
Time.....	110
Key Findings Overall.....	111
Summary.....	111
Chapter Seven: Future Research Possibilities and Conclusion.....	112
References.....	117
Appendices.....	127
Appendix A Consent Form.....	127
Appendix B Interview Questions.....	128

## THE WEBER HEALTH EDUCATION MODEL: HEALTH CARE PROVIDER-PATIENT INTERACTIONS

The Ottawa Charter for Health Promotion states “health is seen as a resource for daily living and health promotion is the process of enabling people to increase their control over, and to improve, their health” (World Health Organization, 1986, p. 1). Health care professionals (HCPs) have sought to assist people with that control and improvement of their health through personal adult health education; this action has become a cornerstone of the practice of most modern HCPs. On a daily basis, physicians, nurses, physiotherapists, pharmacists and other health providers, educate clients regarding numerous health topics. In order to connect with their patients and educate them on health issues, HCPs look for appropriate methods, processes and models on which to base that practice. However, I have experienced difficulty in finding an approach which allowed authenticity and a genuine, meaningful connection within an educational encounter. In viewing the literature on personal health education and health care provider-patient interactions (HCP-patient interactions), therefore, it was not surprising to me to find that relatively little literature exists on the topic of personal adult health education. Even fewer approaches and tools can be found for personal adult health education practices.

Several patients gave me insights that a deeper and more meaningful connection within a health education encounter was possible, thus I saw a need for a new communication method to assist with that process. Consequently, I created a communication model in response to my concerns with that deeper connection and in response to clients who expressed frustration and even anger after encounters with HCPs.

Within my personal nursing practice, I created and used a communication tool; a specific series of steps I used when interacting with my patients. For this project, I questioned the origin of the seven-step communication model that I had crafted and was using regularly in my own nursing practice. In order to understand this question I reflected upon myself and a period of my personal and professional history that I found especially difficult.

“Conditions for creativity are to be puzzled; to concentrate; to accept conflict and tension; the willingness to be born everyday (courage and faith); to feel a sense of self” (Fromm, 1959, p. 44). I found narrative analysis to fit this review. As I evaluated my own history through stories and subsequent narrative analysis, I began to see a pattern of communication emerge that appeared to have positive outcomes for both client and myself as health care practitioner. The seven steps that emerged from that narrative analysis became a communication tool entitled the Weber Health Education Model (the Weber Model).

Chapter one of this research project starts with four client stories; offered to show the emergence of the model from my practice. In chapter two, a literature review of health education occurs in order to give background on the subject. This chapter includes definitions of terminology, a history of health education as a profession, the theoretical bases of the Weber Model, as well as a discussion on the five trends in health care affecting health educators. As a result of the five emerging trends in health care, four conclusions emerge, with a specific call for action due to those trends. Chapter three provides a description of this model and its seven step approach to personal health education encounters. Chapter four reviews the research methods used in this project. Chapter five contains a narrative analysis of each story, thus allowing for a fuller

examination of the origins of the model. This thematic analysis of the stories allows for a fuller understanding of the encounters that led to the creation of the Weber Model.

However, this project acknowledges that the development of this communication model beyond the personal level is also important. Initial research was completed with five health providers in order to broaden the scope of this model beyond my private use. The qualitative research sought the perception of the use of this model by the five practitioners with three clients during the period of one week. Therefore, chapter six outlines the results of the research conducted with a discussion of outcomes. Chapter seven calls for future research possibilities within this seven-step communication model and provides a conclusion for this project.

As health care changes in this new millennium, it is important for HCPs to seek strategies and techniques which allow for more accurate and deeper communication with their clients. As society has changed toward client empowerment, clients too are seeking a way to interact with HCPs for true connections within health care. In response to the call for a deeper connection, the Weber Health Education Model was created. This research was completed to ask and answer the major research question “Does the Weber Health Education Model allow for meaningful contact between health care provider and patient”?

## Chapter One: The Genesis of the Model: Client Stories

The Weber Health Education Model has its origins in clinical encounters with clients while I was nursing in a northern Canadian community. Potter (1996) states “narrative analysis is an analytical technique that seeks to fit messages into a pattern of storytelling” (p. 139). The following interactions with clients were recorded in story format in order that I might review time periods in my professional life that taught me much about myself and my profession in a form that allowed more dispassionate discovery of the messages. These stories were written and analyzed in order that I could then begin to uncover the genesis of the Weber Model. They are told from my point of view and I acknowledge this openly as the same story told from the patient’s point of view could be very different from my remembrances. It is acknowledged that “many a researcher would like to tell the whole story but of course cannot; the whole story exceeds anyone’s knowing, anyone’s telling” (Stake, 1998, p. 96). Names and some details have been changed in order to ensure the anonymity of the clients involved. I believe these stories are archetypical of many HCPs experiences with clients who are dissatisfied and HCPs who are searching to understand how to better communications. I wrote these stories to heal myself of the lingering feelings which still occur when I think of these people. However, as I reviewed these stories a new picture emerged that began to change those feelings. The narrative analysis of these stories occurs later in this project in chapter five.

*Client story #1 A Latté on the Way to the Farm*

“Hi Lori, how are you today?”

“Hi Bill, I’m good, how are you?”

“Great, great- you want your usual?” Bill had seen me enough to know that I loved my lattés.

“Sure, thanks. How’s business?”

“A little slow right now, but it should pick up in a couple of hours for the after-work crowd.” Bill was working on the cappuccino machine, looking a little exasperated at it.

“I love coming in here, the coffee aroma is absolutely wonderful,” I sniffed in appreciation of the rich earthy odor of coffee beans.

“You know I don’t notice it anymore, once you work in a coffee house it just becomes part of the everyday... Hey, it is going to take me a few minutes to do up your latté, I am just fixing the machine, are you okay with waiting?”

“Sure Bill, no problem.”

I went over and sat down at one of the tables. In my opinion, good chairs are one of the most important items in a coffee house. Bill was one of the few coffee shop owners who had somehow picked the most comfortable chairs. I wished I had time to sit and relax in them more often, but I just came in once a week for my latté. I was off to see the Weiss family who lived about 30 kilometers outside of town. Despite the fact that one of our rules was that our clients must live within city limits, Mr. Weiss had somehow received permission to have Home Care Nurses come to his farm to look after his leg ulcers. I didn’t mind the drive; I was able to use the government jeep for the treacherous drive and

I always picked up a latté for the trip.

I watched Bill fiddle with the cappuccino machinery and tried not to be obvious in my staring. It's not that I thought anything could ever develop between Bill and me. Bill had everything; he was young, good looking, smart and really, really nice. He would never look twice at someone like me. I just enjoyed being near him in that coffee shop. I was sorry that he finished making my latté and I had to get into the jeep for the long drive out to see Mr. Weiss.

On the way to the farm, I thought about a blunder I had made. I had been trying to make friends with Nicole, the other home care nurse, and I had made the mistake of telling her about my weekly coffee trip before going out to the Weiss's Farm. Her reaction shocked me. She said that I shouldn't get a coffee for the trip, as the roads were so bad, I should have two hands on the wheel. She said I shouldn't take chances with the drive, that it would cause too many problems for too many people if I were to crash on the way out there. She went on and on about taking responsibility and taking care, so that other people wouldn't be inconvenienced if I were to have an accident. I should have responded to her diatribe in some way I was too surprised and shocked to say anything at all. She had taken a small bit of information and twisted it in a weird way. She didn't ask any questions, she just assumed I would not know how to be responsible for my own life. She had never asked anything about my personal life, so how could she speak about anything to do with me? I could only be thankful that I hadn't trusted her and told her about my crush on Bill because I realized after that conversation that I didn't want her to know anything about me. She didn't know or care about me or the fact that the latté, in some small way, relieved my loneliness at being in this northern community without any friends or family. She didn't know me at all.

By the time I had finished drinking the latté, the treacherous drive was complete, and I was at the farm. Mr. Weiss came stomping out of the hot house to greet me. His crutches were encrusted in mud and his clothes looked ragged and a little dirty. It was sad that his clothes and the state of the farm now matched. But he always had a smile for me.

“Ja {yes}, come into the house... wie gehts {how are you}?”

“Hi, Mr. Weiss, it is good to see you, I’m good, und Sie {and you}?” We had a little ritual each time I visited. Mr. Weiss always asked my how I was in German, and he chuckled every time he greeted me as he knew he exhausted my small amount of German with the few words I used in return.

“So, did you remember to take a pain pill today?” He only grunted in response to my question. He never took pain medication before the dressing change to his ulcer. He didn’t believe in pills. But I always asked, because it was part of the doctor’s instructions and, therefore, part of the nursing protocol made up in response to those doctor’s orders.

“Hello, Mrs. Weiss, how are you? Hello Richard, staying warm today?” I greeted Mrs. Weiss and their son Richard as I entered the house. They were always present in the house when I came to see Mr. Weiss and deal with his ulcers. The first few times I wondered why they would bother to watch the torturous procedure of removing Mr. Weiss’s leg dressings, watch me examine the ulcers, watch as the purulent discharge was cleaned away, then re-dress the ulcers. But for whatever reason, they stayed, they chatted with me, and they talked to Mr. Weiss while he endured the painful routine. Despite the pain he was in from his sores, Mr. Weiss was always pleasant and never indicated how hard life must be for him. He had told me that after immigrating to Canada, he found this farm 30 kilometers outside of Clarendon. He liked the relative isolation and had a dream of a peaceful farm life during the wartime strife in his life before Canada. One could still see the remnants of what must have been a magnificent farm.

Life had been hard for the past few years. Mrs. Weiss had endured two below-knee leg amputations. She used a wheelchair to get around in the house; it had become her whole world. Her movements on the farms were limited; only if the ground was frozen or if Richard had time to lay down planks over the mud could she go from the house to the hothouse with her wheelchair. The only other place she could visit outside of the farm

was the doctor's office once a month with the help of the handicapped taxi/bus. Because they were out of city limits, it was expensive for even the one ride and the family was not rich. Their son Richard was in his fifties, he was unmarried and had looked after his parents and helped on the farm all of his life. He never said much to me, he just talked a bit with his parents while I worked on his father's dressings.

"Well, Mr. Weiss, look at that" I pointed at his calves. "That new medication we started to use last month is beginning to heal those ulcers. It only took me 30 minutes to do the dressing today. That's half the time that it took before we started this medication. Now, remember I told you that the nursing care plan we made for you says you need to rest your feet at least 15 minutes every hour. It is really important to do that now. I think your legs would be healed up in another two weeks if we keep using this new medication and you rest your legs as directed."

"Na, I told you, I cannot. Richard needs help with the farm; we have so much to do. I cannot."

"Well, please try to put them up throughout the day, Mr. Weiss. It would be great to get your legs healed then you wouldn't have to put up with us nurses coming all the time." All three looked at me silently and then Mrs. Weiss moved her wheelchair over to the kitchen and asked if I would like some sugar cookies.

The next week when I went to the coffee house, Bill wasn't there. A young woman served me my latté but it just wasn't the same. When I drove out to the farm, I was taken aback to find an ambulance at the house. Mrs. Weiss had apparently just had a stroke and the ambulance attendants were just placing her into the ambulance. Richard was going to drive his father into town behind the ambulance. Mr. Weiss told me he would have his leg ulcers looked after at the hospital, after they knew what was happening to his wife.

Three weeks later, I went to get my latté.

“Hi, Bill, could I get my usual?”

“Sure, Lori, how are you?”

“I’m okay; I just wanted you to know that I am moving down south at the end of the month, so this is probably my last latté at your shop. After the pneumonia I had earlier in the year, I decided I wanted to be closer to my family. I have been lonely up here without any family or friends, but I wanted you to know that I really appreciated your friendliness to me week after week.”

“Oh, Lori, I’m sorry to hear that, you always seemed so friendly and cheerful when you were in here, I thought you must have lots of friends, I didn’t know.”

“No, that’s okay Bill, I didn’t tell anyone how hard things have been. Anyway, best of everything in the future, hope all goes well for you and thank you....”

I drove out to the Weiss farm. Upon arriving, Mr. Weiss said to me “Ja, let’s do the dressing out here in the hothouse, it is warmer. Wie gehts?”

“I’m okay Mr. Weiss, und Sie?” We smiled at each other but my smile quickly vanished and I said slowly, “It was a nice funeral service for Mrs. Weiss; the priest said some lovely things about her.”

“Ja, he didn’t know her, but it was gut, {was good}” he paused, “She liked you.”

“Thank you, Mr. Weiss, I liked her too.”

“Ja. She always wanted you to stay longer, she was lonely. Not many people came out to visit anymore. She never liked watching you fix my legs, but she knew if she stayed, then

I wouldn't swear because of the pain. So, she stayed every time for me. I miss her."

"Yes." We sat for a few minutes without talking, without moving, just looking at each other. The moment passed when he took out his handkerchief and blew his nose.

"Well, Mr. Weiss, your legs are healed. I guess sitting beside Mathilda's bedside for those two weeks and the extra dressings that the hospital staff did for you helped to heal those sores. Also I wanted to say goodbye, you know that I have been thinking about moving south. I will be leaving at the end of the month. I really appreciated getting to know you and Mrs. Weiss and Richard."

"Nein, Lori, it was our pleasure to have you here with us every week. I didn't really care about my legs; I only did that for Mathilda. Before you came to do the dressings, the sheets were always so messy. Mathilda couldn't do laundry anymore so I wanted nurses to come out and do the dressings. So she had less laundry to do and she liked seeing you nurses. She was very lonely these past few years."

"Oh, Mr. Weiss, I didn't know."

"Ja, no one asked."

*Story #2 Get Out of My House*

Three months into my new job and I already hated the position that I worked so hard to get. After graduating from University with my Bachelor of Nursing degree, I wanted to get away from hospital work and get into community health nursing. However, finding jobs in the medical field was tough in the mid 1990s. I sent out 60 resumes and applications after graduation and gained a community health nursing job with the 59th application. I agreed to take the job before I looked on the map to find out where the town was. I was committing at least two years of my life to this place. But I could never read maps properly. I thought Clarendon was 100 kilometres distance east of Prince George (it is actually about 700 km northeast of Prince George). Northern distances were already a problem, and I had not even arrived there yet....

I knew within two months that I intensely disliked living 'up north.' My phone bills were high. I didn't like the isolation and didn't like being told "this isn't isolated; we have highways and an airport. If you want real isolation, go up north of here." Everything was different than what I had known in my 15 years working as a nurse in a hospital setting. There were new unwritten, unspoken rules about being a home care nurse and being in someone's home that I didn't understand and had no one to ask.

Actually, I knew that particular day was going to be terrible right from report that morning. We had a supervisor who was suppose to give report but Richard prided himself on not ever getting involved in anything to do with the office. So Nicole, the other home care nurse, gave report. I had two clients to see that morning and Nicole's tone of voice indicated that I had better not screw up with either client. I could never understand why she used that tone of voice though, what did it matter? Our supervisor didn't care about what went on. No one, not even the most incompetent nurse, ever got fired.

Administrators were too scared of losing anyone who was willing to work up north. In reaction to the lack of support I felt from my supervisor and co-workers, I told myself that I didn't care that I felt isolated in the office; the only people I cared about were my

patients.

“So, Bruce Light is a new client. Dr. Smythe sent a referral to us. Mr. Light has diabetes and was recently discharged from the hospital after a diabetic coma. His blood sugar on admission was 30 mmol/dl and he had the usual treatment. He did not want to stay and was discharged within 24 hours. Dr. Smythe wants him to have full diabetic education in order to avoid future hospital admissions. You have done diabetic teaching before, haven’t you?” After my reassurances that I had taught diabetic care before, Nicole sniffed and said, “Well, you may want to bring this workbook with you, this is how WE teach it here. It should only take you 10 minutes to drive to his place, then about an hour for teaching and then 10 minutes to get to your other client this morning. Your second client is Ruby Waters. She is a 32-year-old woman diagnosed with inoperable brain tumors. She just came back from Vancouver where she had been given chemo and radiation therapy. Dr. Smythe wants her to have palliative care. So, after receiving the doctor’s order, I wrote out the nursing care plan yesterday. We want her to know about pain control, ask her to begin to plan funeral arrangements, make sure she has made a will and has a guardian for her children. She needs to be realistic about things like this and if we don’t remind her about these practicalities she may leave a legal mess behind. Well, just read the care plan and follow it. You have worked with palliative care patients before, haven’t you?”

“Yes, I spent two years working on a palliative care ward.”

“Well, good, you should know what you are doing then.”

Well, Nicole was wrong about a few things. It took me an hour to find Mr. Light and ten minutes for him to order me from his house. There were seven houses without house numbers on the street that I had been given as Mr. Light’s address. At many of the houses people bailed out of windows and doors when they saw the white government jeep coming down their street. The first few times that had happened to me when I moved to Clarendon, I was extremely puzzled. Finally, someone told me that social workers had

the same government vehicles as the home care nurses. The people who left quickly did so in order that social services didn't cause problems for the supposedly lone occupant. However, because none of the houses on this particular street had house numbers, I had to knock on each one. At the sixth house, the man pointed at a grove of trees and said, "he lives there." I had not seen a house, nor could I see a driveway. However, I left the jeep on the side of the road and hiked into the grove of trees. Indeed, a tiny shack was hidden in the trees. When I knocked, a booming voice told me to come in. Inside, Mr. Light was sitting in the only chair in the small, filthy place.

"Well, hello girlie!" After a brief introduction and discussion of nurse services he asked "Want a coffee?"

I looked around at the smelly dishes and the filth and gave a quick "No, thank you!" He just laughed at me and went on talking. "I'd ask you to sit down but you don't look like you'd want to sit on the floor." He was right, I didn't want to sit on the floor! He snickered at the look on my face as I examined a moving rodent near my foot. Mr. Light was drunk and he admitted to me that he had been drunk before going into the hospital and he had left the hospital because he was 'getting the shakes' and needed a drink. I told him the doctor had ordered diabetic teaching and he gave a booming laugh. "No bloody way, what do I care about diabetes? As long as I can keep walking, I'm okay. I can still get to the liquor store. I don't give a shit what he wants me to do; I'll live my life the way I want to live my life. I don't need you, go away." I found myself gulping in the fresh air as I hiked back to the jeep. Yes, I told myself, I knew how to teach diabetic care, but I didn't know how to approach someone who didn't want to learn.

So, I drove to Ruby's house. I was hoping this visit would go better. The house was in a nice, middle-class neighborhood. Children's toys littered the front lawn and the entryway. Mr. Waters opened the door; I introduced myself and showed my credentials. He said that he was happy that I was there, as Ruby had been 'a bit down' since her return from Vancouver after completing radiation and chemotherapy. I went upstairs and saw the kids happily playing in one of the rooms. I was just sighing a little bit of relief that things

would be okay when I caught sight of Ruby.

It is not polite to discuss a person's looks; we all have been taught that as children. But in order to describe my first shock at that visit, there was no getting around the fact that Ruby was, well, ugly. Ruby was well over 250 pounds. She had very short, unevenly cut, black stubby hair with some bald patches. She had a moon shaped face from high doses of strong anti-inflammatory medication. The medications had also caused her to develop a large hump on her back. The right side of her face was misshapen and she drooled from the corner of her mouth. She had no expression on her face and generally looked defeated by life.

My shock and discomfort at her looks led me to try to chit-chat for awhile. I needed time to collect myself and begin to figure out in which order I would discuss each of Nicole's nursing care plans for Ruby. She picked up a picture sitting on the side board and looked at it for a moment. She handed it to me and I looked at the beautiful woman in the photograph. The woman was slim, vivacious and beautiful. She had red hair and a red dress that should have looked bad with red hair, but on this woman looked amazingly good. The woman was laughing and had a look of joy and vivacity on her face. I smiled as I handed it back to Ruby and said, "This woman looks happy".

"That's me" she said. "This was at an office party about a month before I started getting sick and they found the tumours. I looked beautiful, didn't I? I really miss my red hair. My nickname is Ruby because of my hair colour; I really miss my hair. It grew back like this..." She hit the side of her head with the black balding patches with one hand. I did not know how to respond and was profoundly uncomfortable with the situation. I didn't know what to say about the picture; I was shocked that the woman in the picture could also be the woman sitting in front of me.

I literally didn't know what to do, but instead of taking a moment to reflect, I decided I better do my job regarding her nursing care plan. I interrupted her. "Well, it must be hard because life changes everything doesn't it? Now, can we talk about some of the things

that your doctor has said that you need to know.”

Ruby asked wearily “What does she think I need?”

“She asked me to talk to you about several issues. There are support mechanisms available to you right now.”

Mr. Waters interrupted with “that would be great, it has been hard with the children...”

She then interrupted him and stated, “No, it hasn’t been hard, things have been just fine. Every thing will be okay now that I’m home.”

I blundered in with, “Well, there are various helps available for child care. It might be important to have help in place for the time that you can’t...”

“What are you saying?” Ruby asked in a tense voice.

Ignoring my discomfort and trying to stay on target with the directions from the nursing care plan, I continued on “Well, realistically, have you thought about the care of your children after your death...?” I trailed off and an unearthly silence took hold. Then suddenly Ruby stood up and looked at me with venom in her eyes.

She yelled loudly, “How dare you come here and... how dare you! Get out, get out, get out of my house and never come back. Get out.” Ruby was shrieking wildly by then. I sat on the chair embarrassed and scared. I just looked at Ruby who looked like she wanted to hit me. I turned to the husband and said in a small voice, “I’m sorry” which I doubt could be heard over Ruby’s continued shrieks for me to leave. I left the house.

I drove back to the office wondering what I would tell Nicole on report the next morning.

### *Story #3 Going to the Coffee Shop*

I always felt a certain tension before I went into a home to assist people with their home health care needs. Part of the tension was an uncertainty of what was going to happen in that home. This tension always caused me to pause before each home visit, take a deep breath and tell myself “Listen before you speak.” I don’t know if I always followed my own advice, but I tried.

Mr. Moore was 62 years old. His physician had contacted the Home Care Nursing office with orders that Mr. Moore was to have teaching regarding his pain medications, in order that his chest pain from his terminal lung cancer would be minimized. I could feel my inner panic rise as I thought of a client named Ruby, whom I had encountered several months previously. The initial order there was for palliative care as well. My subsequent behaviour in that home led to a sense of personal and professional humiliation, which I could not elude. I often thought of Ruby and secretly worried that a similar event would happen again and again because I still didn’t know how to fix things. I felt doomed to keep repeating the same interaction over and over.

Mr. Moore was tall, very thin and very short of breath. His son Larry hovered over him and cast frantic undecipherable glances in my direction. I could feel the high tension in the home but had no idea how to interpret the glances or what the source of tension in that home might be. I did know that my own anxiety level rose just in being in the dark house. I kept looking around trying to ascertain if the surroundings were the problem or the tension from the two men was affecting my feelings. The curtains to the windows were closed and there were few lights. I made the mistake of sitting in the closest chair in the dark living room and by the shocked response from both men, decided quickly that I must have sat in the wrong chair. I stood and said, “This other chair looks more comfortable, excuse me while I change chairs.” Mr. Moore immediately sat down in the chair I had vacated. Larry said quietly, “It is his favorite chair, very comfortable for him”.

“Dad came to live with me five years ago,” Larry explained, “we get along really well but

since he's gotten sick, things have been tough. I don't want to leave Dad alone, and I get worried about him when I am at work."

"Larry, don't fuss, I'm fine. He calls me too much during the day, I'm fine." Then Mr. Moore turned to me and said irritably, "I don't know why my doctor ordered you nurses, I don't need help."

I stated, "It looks like you are having a little trouble with some shortness of breath?"

"It isn't so bad."

I asked, "Would it be helpful to have oxygen in the home, just in case you need it in the future?"

"Nope" was the prompt response.

I tried again. "Your doctor mentioned he would like you to start taking morphine pills for pain.... Have you started taking those pills?"

"Nope."

I didn't quite know how to respond. "Would you like to talk about that?"

"Nope."

I tried a change of subject, "How are you two managing with the cooking?"

Larry leapt in with, "I do the cooking, that's okay. Dad doesn't eat much anymore; he just wants soup and soft foods and my appetite isn't so great right now either."

After that brief bit of information they both stopped talking and looked at me. I sat

perched on a chair taking time to try to decide how to deal with two men who weren't giving me much to go on. There was a very long awkward pause. Finally, I ventured forth with, "Is there anything that I can help you with?"

"Nope" was the quick response from Mr. Moore. There was another very long pause. Visions of Ruby ordering me from her house were dancing in my head. I wanted to cry. I couldn't figure out why I was in this profession, I didn't seem to be doing any good. The quiet lull continued. I had a choice; I could take his refusal at face value and leave or try somehow to connect with him.

I took a deep breath "Well, Mr. Moore, I hear you two tell me that you don't need my services. But I am here right now, is there anything; anything at all that you can think of that I could assist you with?"

"Nope."

"Okay, well then, it was nice to have met...."

"Well, there is one thing, but I don't think you could help me, aah, forget it..."

"No, I don't mind Mr. Moore, what are you thinking of?"

"Well, I really miss going to the coffee shop to see the boys. We go every.... I mean I used to go to the coffee shop every morning at ten and since I got sick, well, I've been missing the boys. Larry can't take me, he's at work....I'd sort of like to go."

"Oh, coffee shop....." My mind was a total blank. Going to a coffee shop.... I tried to figure out what the problems would be in getting Mr. Moore to the coffee shop to see his friends. "Ummm, transportation..... How could we get you there? Would a taxi do?"

"Nope, we don't really have the money for taxis."

“Okay, well, you could access the low cost taxi/bus for handicapped people. You could take that, right?”

“Well, I don’t know how to arrange that,” he admitted slowly.

“That’s okay, Mr. Moore, I do know how to arrange that, that’s not a problem. But...” I cleared my throat in nervousness, “but what might be a problem is your breathing.” He looked at me sharply and didn’t say anything. “Maybe, I could arrange for a small portable oxygen tank. You could take that with you and if your breathing gets a bit rough you could have that on hand.”

“Well, I don’t think I need it but you are the nurse, if you want me to bring it along, I guess I could do that.” Mr. Moore sat back in his chair, suddenly looking tired and worn out.

“Okay” I responded. “I’ll go back to the office and call the Handicap Bus and also arrange for the oxygen tank to be dropped off, hopefully tomorrow. Is that okay?”

“Sure.”

“And you promise to actually take the oxygen with you?”

“Sure” was his laconic reply. As I left the house that day, I felt defeated. I had a task of initiating and teaching this man about his eventual death and particularly ensuring proper pain medication and instead I arranged a handicapped taxi. Out of all the important things this man had to face as he died of lung cancer, how could this task be an essential health care issue? My assessments of his needs were so different than his stated request of arranging transportation. Mr. Moore needed oxygen on a constant basis, not just at the coffee shop; he needed pain medication and the tension in the home needed to be addressed by a counselor or specialist in that area. I couldn’t believe that instead of

dealing with crucial matters, I was arranging a ride to a coffee shop. It seemed so trivial to me.

When I saw Mr. Moore a week later, he was weaker. He was not a talkative man but he managed to tell me that he was “back with the boys” that week and while he didn’t say it with words, he looked happy about his coffee time. He didn’t say thank you or say what the importance of the coffee shop was in his life. He only mentioned that the pain was worse. After another long awkward pause where I scrambled mentally to try to figure out what this exactly meant, I ventured forth with, “Maybe we could talk about your pain medication, that way you might be able to enjoy the time with your friends a bit more.” He said, “Well, okay,” and we began talking about the relative merits of morphine tablets versus morphine liquid for pain. He mentioned he was only taking it because it meant he could go for coffee ‘with the boys.’

I didn’t see Mr. Moore for another two weeks; the other nurses had visited instead of me. When I arrived there, Larry told me that his dad was able to “go to the coffee shop for another week after my last visit.” I gave a neutral response but I still did not understand the importance of this within Mr. Moore’s life. I will never know as Mr. Moore was no longer sitting in his favorite comfortable chair in the living room, he lay in his bedroom in the back of the house. He had been relatively pain free during the past two weeks because of his liquid morphine. He died that day during my visit.

*Story #4 Seeing the Light*

“Hi, Mr. Light, it is Lori Weber, the home care nurse. May I come in?”

“Sure, come on in girlie. Hey, I remember you, you were here before.”

“Yes, I had a short visit with you several months ago.” I looked around the kitchen area; he still didn’t have another chair, nor had he changed his housekeeping habits. I looked at him with a smile and relaxed. “I can see things haven’t changed in terms of your housekeeping since my last visit. Do you mind if I park my butt here?” I took some dishes off the low counter and sat on the counter. He offered me a cup of coffee and, to my surprise, it actually tasted quite good. As I sipped, I asked “How are you doing since that first visit?”

“Yeah, well, I know that damn doctor of mine sent you again. I told him, I don’t need any nurses telling me what to do. I’m doing okay.”

“He asked me to see you again about your diabetes. You’ve been in the hospital again?” I already knew he had a short-stay visit but wanted to chat with him for a few minutes and see what he would say about his health problems.

“Yup, but not for high blood sugars, it’s my damn toe.” He sighed as he looked down at the offending part.

I looked down at my papers in some confusion, as the hospital papers indicated that Mr. Light had been admitted with a diabetic coma due to high blood sugars again and made no mention of a problem with his toe. “So you are telling me that your blood sugars aren’t a problem?”

He laughed, “Nope, my blood sugars aren’t a problem. That damn doctor told me to write down my blood sugars and they are fine.”

I was a little surprised as he hadn't struck me as the type of person who would be organized enough, or even willing, to do blood sugars on a regular basis. "Oh, did you test your blood sugar this morning? What is your blood sugar today?"

He snorted, "He told me to write them down, he didn't say to test them. I just write down a number. So you see honey, I don't need you, you can high tail it out of here again."

I took a minute to digest his unique manner of responding to his doctor's request and then said "I don't mind leaving if you want me to Mr. Light, I was just wondering if I might be able to help you with that toe. Do you mind if I take a look at it?" To my surprise he agreed and took off three layers of smelly socks in order to show me the body part. He must have been in pain, because the toe was inflamed, enlarged and seeping purulent drainage from around the raised nail. "Well, no wonder your toe is bothering you; that must be quite painful. How do you think I might be able to help you with this?"

"Honey, go see that damn doctor of mine and get some cream or something for this damn toe. I'd really appreciate that."

"Mr. Light, I'll call your doctor today and let him know about this problem. I'll talk to him about ordering the cream and I'll visit you tomorrow. Looking after your toe means the nurses may have to visit you once or twice a week to help you put on the cream. I will warn you right now though that we might talk to you about some things you that you might not like."

"Like what?" he demanded.

"Well, often foot problems develop because of high blood sugars. We can talk about why those blood sugars cause sores like this next time I visit you. This type of sore can also happen because the toenails are in need of special care from a foot doctor and we might talk about arranging an appointment with a podiatrist. Sometimes this happens because

you aren't able to bend anymore to clean really well between your toes and under your toenails when you are having your baths."

He laughed his booming laugh again. "Honey, what baths? Well, you come visit me a few times, it won't hurt. Don't tell me to get rid of my booze, cuz I won't, but otherwise you can visit."

"Okay, it's a deal."

I liked Mr. Light and especially enjoyed his big laugh and amusing way of looking at life. Over time he did let the nurses do some diabetic teaching with him and he did agree to contract housekeeping assistance. He didn't appear to ever lie outright to me, but I was always careful how I worded requests. Despite his ongoing alcohol abuse, he was never physically or verbally abusive to the nurses or housekeeping help. If any request was worded so that it would help his toe, he would grumble a bit, but usually allowed us to arrange assistance for him. He admitted that due to "your nagging" he changed some of his dietary habits. He told me he used to buy an inexpensive package of ten hamburgers and eat them for breakfast, lunch and supper until they ran out. He began eating better because, as he said "Now the house and dishes are clean, I want to cook again." He was actually a good cook and treated us nurses to the occasional savoury treat. His toe healed without becoming gangrenous or requiring surgical amputation, which can frequently occur in diabetic foot sores. He was discharged from home care nursing after six weeks, but continued with contracted housekeeping help.

## Chapter Two: Health Education

Health education is a broad term encompassing many definitions, ideas and roles. It can be seen as both a profession and a discipline. Within the view of profession, health education can refer to the education of health care professionals, or it can refer to the education of those professionals who teach individuals, groups and communities regarding health issues. As a discipline, health education can refer to many practices, models, policies, agendas and beliefs. It is important, therefore, in any research for definitions to be made explicit. Every author has a view from which ideas are generated and must share them with readers in order to clearly communicate the author's true intent. In chapter two of this project definitions, as recognized from my perspective, will be outlined followed by a brief history of the profession of health educator. This historical view of health educator as a profession is important in order to understand why relatively little literature exists that clearly defines and differentiates health education. Further in the chapter, the theoretical base of the Weber Model is reviewed and the five trends which affect health education practice are discussed. The chapter ends with four conclusions made regarding the pressures from the five trends and a call to action.

### *A Discussion on Definitions*

Health care providers can easily misunderstand each other if assumptions are made about language. Medical terminology can be confusing; various words are used to describe one term. For example, in health education there are multiple words used to describe that one phrase; health education, patient education, primary health care, and

health promotion can be used synonymously. Therefore, a review of terminology is important to ensure clear communication and mutual understanding of definitions used in this project. Until HCPs can clarify their own medical terminology and language, it will be difficult to identify relevant issues. This dilemma is pointed out in Raphael's (2000) discussion on the call for clear health promotion terminology which will allow health promoters to "identify relevant determinants of health, and then evaluate the effectiveness of these chosen activities" (p. 355). Definitions lay the cornerstone for understanding what concepts I, as writer, am applying to the Weber Model. In order to provide clarity to my chosen focus of personal health education a fuller discussion on my concepts is required. As a result, a definition of the terms health, patient, health care professional, and health education will be given from my conceptual understanding.

*Health.* I am in agreement with the World Health Organization's (WHO) definition of health. The term health, according to the WHO, is a "seen as a resource for everyday life, not the objective of living" (WHO, 1986, p. 1). When health is seen as a resource rather than a goal or target, there is less rigidity in forcing health into one mold that should fit all people. There is more fluidity to an individual's ideas of what will supply them with their source of vitality for their own life. As a result of that definition, the act of health promotion by HCPs becomes a "process of enabling people to increase control over and improve their health" (WHO, 1986, p. 1). In my view, the emphasis in health assistance should be on the words *process* and *assistance*. Emphasis on these words allows HCPs to understand their role as secondary in the process of the individual's increasing control over their own life and lifestyle. The pressure for HCPs is to find a respectful process that allows them to give that type of intimate assistance when

requested by the individual.

*Patient.* There is much debate on the proper terminology for the requestor of assistance. Until a new word is coined or a definitive word is used, I will use the word patient to identify the person requesting medical assistance. However, for the purposes of this research project the terms client, patient, resident and/or person requesting medical assistance can be used interchangeably. From my point of view, the term patient is neutral in terms of power relationships; as any word can be used in a paternalistic way depending on the intent of its user. My intent with the word patient is merely to point out that there is a difference between that person who is requesting assistance and the person who is giving that assistance. In the holistic sense of health care encounters, of course, these barriers fall away and the learner and the teacher lines are blurred. However, until new terminology is created and has become common in the health care lexicon, the words patient and client will be used interchangeably during the discussion of the Weber Model.

*Health care professionals.* In this project, health care professional and health care provider can be used interchangeably. I tend to use the term health care professionals (shortened to HCPs) for the plural usage, with a singular professional designated as provider. As every health care professional or provider is also a health educator in this Model, all three terms can also be used interchangeably. These three terms have been chosen to describe those persons who have a professional mandate to provide health care and health education to those labeled patients. Health care professionals include such persons as medical and alternative physicians, certified or registered nurses, dentists, optometrists, registered nurse practitioners, social workers, psychologists, physiotherapists, pharmacists and chiropractors. This listing is not meant to be inclusive

of all professional health care providers and other health care professionals may be added to the list. In general, most health providers are duly licensed by a professional body and are qualified in some manner to provide health education to clients. Throughout this paper, the term health care professional is used deliberately as a term inclusive of all professionals seeking to give professional and high quality health care to patients. I have deliberately chosen a more inclusive term to describe the provider of care in the Weber Model, as the need for a clear communication model is inherent for any kind of health care professional working with individuals in their health education. Further, inclusion of all types of HCPs within this project allows for professional respect extended to all types of health educators and offers a professional acknowledgment that all HCPs are seeking excellence in their care of patients. If I include only one type of professional, such as nurse, it might be understood that only nurses require a new communication model and that somehow other HCPs have accomplished what nurses have not. While I have excluded professionals outside of the health care field in the Weber Model, there is a possibility that this model may also be used outside the realm of medicine, such as education. However the possible uses in other professional bodies and situations will not be addressed in this project and further research could occur at a future date in regards to use outside the role of HCPs.

*Health education.* WHO (1998) defined health education as an act comprised of “consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving knowledge, and developing life skills which are conducive to individual and community health” (p. 4). Educational interventions, therefore, are meant to assist people with their health issues.

To me, this definition, also embraces the need for intentionally-created models and tools that have been constructed to assist HCPs with the process. This idea of working together to build consciously-constructed methods and practices to aid patients should underlie the entire professions of doctors, nurses, pharmacists, chiropractors, physiotherapists and others. Health care is based on the idea of a health care provider spending time with an individual (then labeled patient or client) in order to educate that person on a health topic and hopefully change that patient's health behaviors in the future. It is also my concern that HCPs still experience confusion in finding more consciously-constructed education practices which have been shown to assist people to improve their health.

*A call for new groupings within the health education paradigm.* One barrier to the conscious construction of health practices may be the difficulty in gaining a clear understanding of the terminology. The term 'health education' is currently used to describe one all-encompassing idea and there is no division or groupings within the words 'health education.' In my view, there are at least three natural groupings that occur within the health education field when used in regards to patient education. I call for a clear separation of each of these three categories. First, personal health education describes the HCP-patient interaction. Second, small group health education requires a different set of communication and education practices from personal health interactions. Third, a larger category of community or large scale population health (also sometimes called health promotion or community development) also exists. Of the three categories, the most well documented processes are those from the community health perspective. Currently, however, as no clear delineation exist within the term health education; there is also no differentiation of methods, groupings or skill sets needed for various types of

health education. One example of this lack of differentiation is contained in Shuster, Ross, Shagat and Johnson's (2001) work where the term community health education is described as involving "the active participation of individuals, groups or communities in identifying their own health issues and developing and implementing strategies to increase their ability to organize and improve their own health" (p. 18). Unfortunately, this definition does not make any separation of the strategies needed to assist HCPs in dealing with the three disparate categories. This lack of division in defining terms contributes to the confusion inherent in communication efforts among HCPs, in regards to one-on-one encounters.

In the paradigm shift I am suggesting, the clear division of these three categories assists HCPs in practices, techniques, communication models that best suit the audience with whom they are interacting. It is my belief if HCPs are to be more effective and efficient in their patient encounters, health educators need to more clearly delineate these three types of health education. The division may help in the provision of clearer methods, processes, strategic and definitions for each type of health education. When HCPs are dealing with individuals, small groups or with large-scale community health education efforts, each grouping requires different tools and strategies. For the purposes of this project, therefore, it is important to note that I do differentiate between these three categories within health education and call for educational processes which connect with the dissimilar types of education.

*Personal health education.* The Weber Health Education Model is contained in the first category of personal health education and provides a strategy for connecting within that HCP-patient encounter. Personal health education is used to indicate one person

requesting medical assistance interacting with one health care provider. These personal and intimate interactions are the focus of the daily practice of many HCPs and require HCPs to have a high level of expertise in interpersonal skills. Yet, processes, models and techniques for HCPs within these contacts are not greatly researched. The focus of this project will be this type personal health education, not group or community health education practice which I believe require a different set of health education processes, models and techniques. Words similar to personal health education in the literature include health care provider-patient interaction, personal health promotion, client-centered care, and individualized care. Radwin and Alster (2002) found that the paradigm of individualized care involves “acknowledgement by the nurses of the unique features of the patient and the patient’s situation, recognition of the patient as a member of a family and a community, and the willingness of nurses to listen and respond to the concerns of patients.” (pp. 54-55)

Despite the lack of clear divisions and confusing wording, it is recognized that the role of educating and communicating takes place within any type of HCP and patient interaction. “Health education is a fundamental component of the health care system” (Bedworth & Bedworth, 1978, p. 64). Regardless of this knowledge, most health education appears to be conducted unconsciously by HCPs. Practitioners may be basing their communication styles and routines founded on their past schooling, which may now be outdated or inappropriate for current health care issues. Professionals may not be responding appropriately to or even recognizing current trends in health care. Practitioners may not have fully examined their own personal lives and learning history which impacts their ability to teach others. Certainly, because of the lack of

differentiation in the teaching of health education practices to practitioners, HCPs may not fully understand the concepts which make up personal health education interactions. Further, the literature has not yet fully actualized the ideal of providing a variety of excellent tools and methods for HCPs to provide health education to patients.

### *History of the Profession of Health Educator*

The North American idea of health education emerged during the building of the western medical scientific field in the 1800s. In the 1950s, one organization was created in the United States to assist with leadership in health education. The mission of the Society for Public Health Education (SOPHE), founded in 1950, is to provide leadership to the profession of health education and health promotion; to contribute to the health of all people through advances in health education theory and research; to aid in excellence in health education practice; and to aid the promotion of public policies conducive to health (SOPHE, 2004). However, since the 1970s, a concerted effort began to discuss health education as an academic discipline and profession in its own right (Schima et al, 1996, p. 292). In the 1970s, two organizations were created to build on SOPHE's mission. The United States showed strong leadership in creating the National Commission on Health Education Credentialing (in order to assist with professional development in the credentialing of health educators) and the American Association for Health Education (AAHE). The AAHE serves health educators and other professionals who promote the health of all people. AAHE (2004) encourages, supports, and assists health professionals concerned with health promotion through education and other systematic strategies.

Canada has been a leader in large scale health promotion. Lalonde (1974) called for the Canadian government to advance the idea of health promotion and education with a call for “a health promotion strategy aimed at informing, influencing and assisting both individuals and organizations” (p. 66). The essential WHO (1986) work called the *Ottawa Charter for Health Promotion* is still used by Canada to guide health promotion practices. Health education or promotion is defined as:

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment (WHO, 1986, p. 1).

Health Canada has created several reports and studies on the state of health care within Canada and has created plans to optimize the health of Canadians. In 1999, *Toward a Healthy Future: Second Report on the Health of Canadians* was released jointly by the Federal, Provincial and Territorial Ministers of Health. Each chapter in this document contains highlights of the health promotion findings and a discussion of the implications of the findings for policy, practice and research. Topics include health status, socioeconomic environment, healthy child and youth development, physical environment, personal health practices, health services and biology and genetic endowment (Health Canada, 1999). The Population Health section of the federal government focuses on health promotion in the larger context of communities and populations; however, it does not focus on gathering information or providing structure to HCP-patient health education process.

Changes have been slow within the Canadian political and medical systems. The Canadian government released the Health Accord of 2003 which “promised to realize

Romanow's recommendations for the establishment of a national health council, a national home care program. . . [but] none of the commitments of the 2003 Health Accord have been realized within the agreed upon time" (Sullivan & Flood, 2004, p. 359). Further federal and provincial financial issues, new federal leadership and media pressure on public health issues (such as SARS, West Nile virus and Avian Flu) have delayed focus on expanding Canada's growth in the area of health care, education policy changes and health reform. In Canada, while the federal government directs health care, provincial governments and regional authorities also have governing bodies for health concerns. These multiple layers of governmental involvement in health care can lead to a scattered approach to changes and, unfortunately, there is currently no central federal agency or organization that assists people, groups and organizations in terms of building the concept and practices of health education.

Hawks (2004) sees the problems within health education as caused by the fact that health education is "a stepchild of the medical and public health professions" (p. 11) and believes that health education needs to be seen as a key act by all HCPs. Cohesive action is then needed by all HCPs to promote a unified front on the complex issues surrounding professional health education practices, research and literature. Again, in my view, the key stumbling block to understanding the need for policy and research into health education is the lack of clear definition of the three categories of health education and the need to see all HCPs as health educators. Most government agencies here in Canada refer only to large scale community and public health issues, and do not focus on small group education or personal health education.

Some individual professional groups and educational institutions are working on

creating new health education methods and expanding the literature base for health education in the new millennium. However, a concerted effort is required within the relevant academic disciplines. The differences between personal, group and community health education must be acknowledged before curriculum-building to support this new view can occur. Changes would then occur to health education literature, research, models for the various types of educational practices and new teaching methods for new professionals.

### *Theoretical Basis for the Weber Model*

A theoretical base should underpin every new model. Connections with work others have accomplished in the field help to strengthen any model. In terms of health education communication models, there is an admitted lack of literature on the subject. Whitehead (2001b) calls for authors to write papers “which seek to redress this imbalance by putting forward the case for such a model, developing it, and demonstrating how it can be incorporated into the practice setting” (p. 417). The Weber Model was created after I began to understand such theories and theorists as the Humanistic Theory (Pender, 1982), Adult Learning Principles (Knowles, 1984), Orem’s (1991) Self-Care Model and Dean Whitehead’s (2001a & 2001b) work on health promotion. These theoretical frameworks greatly impacted my view on health education. While this list of theorists does not exhaust the list of work in this field, these four areas directed my thoughts while creating the Weber Model.

*Humanism.* I began to read about a humanistic approach to understanding people and their perception of their experiences. “Humanism recognizes the importance of the inner experience of human beings and their personal goals, feelings, beliefs, attitudes, and values. In discussing the determinants of health behaviour within a humanistic context, perception emerges as a key concept” (Pender, 1982, p. 4). A person experiences an event

but in humanistic thought the meaning given to that event is more important than the event itself. The interactions with the patient are dependent on the understanding of the health service personnel to the cultural and personal perceptions, attitudes and values of that person. Whitman, Graham, Gleit and Boyd (1992) discuss the humanist perspective at some length because it is one of three major perspectives on learning theory. "Learning is viewed as a function of the whole person . . . there is a focus on self and interpersonal awareness in personal development, as well as creative problem solving and effective information-processing capability" (Whitman, Graham Gleit and Boyd, 1992, p. 69). Choices, personal autonomy, freedom, self-actualization, inter-relationships, and self-direction are all key words in the humanistic approach to health education. The client becomes the control agent. Patient decisions may or may not conform to the practitioner's view of the issue however; the patient has the ultimate responsibility for their life choices.

The basis of using the humanist approach with the Weber model is to incorporate a sense of the patient's view into the interactions with the health educator. The problem statement only encapsulates a simple statement of the issue under discussion by health care provider and patient. It is going a step beyond to probing patient's underlying needs around that problem that I believe is key to a greater degree of understanding of the whole person. I believe it is important to understand the attitudes, feelings, experiences and values given that problem by a patient. HCPs do not provide health education and knowledge to an empty, passive vessel; each client is unique and with an understanding of that individuality, a true rich connection between the HCPs and patients may be gained. HCPs can become facilitators and partners in sharing knowledge. This humanistic stance is the foundation for understanding and using the Weber Health Education Model.

*Adult learning principles.* There is a call for this type of tool towards adult individuals using adult learning principles. Davis and Chesbro (2003) state "incorporating the patient's perceptions of the problem and using teaching methods and

tools targeted specifically to adult learners can have a positive impact on the effectiveness of the intervention” (p. 106). As the Weber Model is meant to be used for adult health education, adult learning principles are also an important theoretical component. Malcolm Knowles (1984) classic work on adult learning, where he called the principles of adult learning “andragogy,” was used as part of the building blocks of the Weber Model. His work is ubiquitous; almost every textbook on patient education and teaching discusses Knowles andragogical approaches. For example, Babcock and Miller (1994) use M. Knowles comparison of pedagogy and andragogy in their textbook *Client Education*. Andragogy is defined as learning related to a learner’s need to know, rooted in self-direction and evolving life roles of the client, as well as life-centred and motivated by internal mechanisms and life goals of client (p. 98).

There are major differences in the approaches used between adult (andragogical) and pedagogical (child) education. Historically, the pedagogical approach to learning, with teacher-established direction and knowledge, (with learning that was based on the approval of the teacher) was the commonly used approach in health education. Pedagogy is now often discussed in terms of an adult teacher with a child student. While this approach is becoming less acceptable due to a culture of empowerment and shared decision-making between two adults, it is still considered a useful tool within child education. However, when this teacher-child mentality is used in health education settings, a patient who does not take on the teacher-established goals (or gain the approval of the health educator) is often labeled non-compliant and problematic. The label of non-compliance, in my view, has less to do with the patient and more to do with HCPs using a pedagogical paradigm instead of an andragogical paradigm. When using the adult learning approach, non-compliance becomes obsolete. HCPs may be threatened by using the andragogical approach to adult learning because it can be seen to erode the power base of the teacher. However, the Weber Model allows HCPs to use a communication tool that is based on andragogy, but, hopefully provides a less threatening manner in

which to engage in patient-directed and patient-centred care focusing on the patient's need to know in their everyday life.

Humanistic theory and adult learning principles combine to create a useful theoretical base when dealing with people who have their own concept of what is important in their lives; and every patient with whom I have spoken with has his or her own concept of what is important in their lives. If HCPs could find a method of tapping into that self-perception, the entire encounter between HCPs and patients changes. I believe that through education of HCPs with new communication tools and a paradigm shift, patients can be seen as real people who are "motivated to learn information for which they understand the purpose and see practical applications" (DeYoung, 2003, p. 23). This change in power base is fundamental to the belief in the self-determination ability of individuals. Nordgren and Fridlund's (2001) discuss the need for patients to have self-determination in their health care. The need for participation and empowerment of patients is discussed, as well as the fact that few studies have been undertaken to reinforce the idea of self-determination of client's within nursing care. The author's call for "a kind of partnership, where the health care professionals contribute medical and technical information, where the patient contributes personal, emotional and subjective information, and where both are regarded as equally valuable in the decision process may be considered necessary to be able to realize patient's right of self-determination" (p. 124). Humanism and andragogy can merge to form a new view on adult education. Glanz, Rimer and Lewis's (2002) echo this perspective by commenting "understanding the principles of adult education is necessary but not sufficient to meet this challenge. Designing education that changes practitioner and client behaviour, and changes systems, requires understanding the theories that have shaped research and produced effective practice" (p. 64). I began to see the need a relationship between adult education principles and humanism. I began to explore the design of a model that would merge these theoretical musings with everyday practical realities.

*Orem's self-care theory.* One particular nursing theorist is important in the formation of my views on personal health education. I realized that Orem's (1991) Self-Care Deficit theory was a strong fit to my new health education practice. Dorothea Orem's (1991) theory on nursing "assumes that nursing is a response of human groups to one recurring type of incapacity for action to which human beings are subject, namely, the incapacity to care for oneself or one's dependents when action is limited because of health state or health care needs of the care recipient" (p. 73). Orem believed that mature people try to maintain their life and their capacity to look after themselves. When a deficit exists and persons are unable to care for themselves, professionals could assist in temporarily assisting that care or educating those persons so that they will be able to help themselves again. Orem's theories are used in many nursing texts on health teaching. Whitman, et al. (1992) is one example of a text which discusses Orem's theory and explains the three key areas of Orem's self-care deficit theory. First, universal self-care exists, with a person wanting to maintain the integrity of structure, function and well-being. Second, persons sometime have deviations in their ability to maintain that integrity (self-care deficits). Third, "the nursing role is to help the patient/client decrease his dependency by encouraging self-care activities" (p. 73). Using Orem's theory, the persons we label as patients have deficits in their health which they cannot fill themselves, the role of HCPs is to aid patients in recovering self-care (even if the level of self-care is different from the time before the illness).

The health educator's role becomes neither a parent nor a filler of that deficit, but a facilitator or educator regarding that deficit. The goal is to partner with the patient to fill the self-care gap. Health care providers sometimes do fill a role of providing health care such as surgery or physical care, but within health education the goal should always be to provide patients with the ability to care for self to the best of their abilities. The removal of a cancerous tumour is the provision of health care in order that the patient may return to health. However, every step along the way during that time period of surgery (from

initial contact with a HCP regarding symptoms, to referrals, to surgery, to aftercare) should be viewed as, and include, an opportunity for HCPs to also provide education to return that patient to the fullest sense of health possible. Even if the outcome does not lead clients to a former sense of health, the opportunity is there for HCPs to assist patients with a new understanding of their health status and assisting them in learning a new sense of self.

*Client-centred therapy.* Other professions have looked at humanistic theory for their models of interactions and theories. Client-centred therapy has been in existence with psychotherapists since the 1970s. It is based on Carl Roger's (Rogers & Wood, 1974) work in the setting of primary care, and specifically family practice. Patient-centered concepts incorporate six components. The first component is the physician's exploration of both the patients' disease and four dimensions of the illness experience including: their feelings about being ill, their ideas about what is wrong with them, the impact of the problem on their daily functioning, and their expectations of what should be done. The second component is the physician's understanding of the whole person. The third component is the patient and physician finding common ground regarding management. In the fourth component the physician incorporates prevention and health promotion into the visit. The fifth component is the enhancement of the patient-physician relationship. Finally, the sixth component requires that patient-centered practice be realistic (pp. 213-214).

In transposing client-centred therapy from psychotherapy to health care, there is a natural fit. Being patient-centered does not mean that HCPs abdicate control to patients, but rather that they find common ground in understanding the patients and more fully respond to their unique needs. Corey (1977) describes this notion of client-centred therapy as a "specialized branch of humanistic therapy that highlights the experiencing of a client and his or her subjective and phenomenological world. The therapist functions mainly as a facilitator of personal growth" (p. 55) in helping the client solve his/her own

problems. It is hard to understand why these ideas have not transferred to health education.

It is also interesting to note that the idea of client-centred care has also been researched in the educational setting. The term used for client-centred care in education is 'differentiation.' This term is being examined in the newest education literature; differentiated teaching or learning is individualistic and personal. It creates a climate where people are valued and responsible, as well as self-directed in their learning. It is remarkable that psychotherapy and education have begun to use the concepts of client-centred care. Hopefully health educators can also begin to see the need for this type of approach to facilitating patient learning.

*Kalamazoo Consensus Statement.* These three theoretical frameworks (humanism, adult learning and Orem's self-care theory) were formative in my search for a new approach to personal adult health education. I began to search for existing, workable, and realistic models to aid in my understanding of the process of health education. In that literature I found the Kalamazoo Consensus Statement (1999). I was pleased to find validation for the Weber Model through this document, which evolved out of health care providers emphasizing the importance of communication in medical practice. In 1999, leaders of medical education attended a conference and outlined what they believed to be the essential elements of physician-patient communication. These seven tasks include: building the doctor-patient relationship, opening the discussion, gathering information, understanding the patient perspective, sharing information, reaching agreement on problems and plans and providing closure.

While I had created the Weber Health Education Model before reading this statement, I was struck by the similarities but wondered why the listing of essential communication elements has not translated into daily use by practitioners. I found the first element frustrating as a health care professional as the directive to 'build a relationship' does not give any method of action in order to achieve this nebulous idea.

Further, unless direct steps are made explicit in a model, the idea of ‘understanding the patient perspective’ is not as clear as ‘ask the client their expectation of this health care encounter.’ I set up the Weber Model to be seven clear, practical steps/actions which allow a professional to gain information without directing the professional that in doing the step they must have a relationship or even fully understand the client perspective. I do not suppose it is realistic to ask HCPs to have this goal for every patient encounter.

However, with seven practical steps within this model, practitioners have an opportunity to gain the information which will clarify needs, uncover hidden agendas, and allow them to have a deeper, more truthful and direct encounter.

*Whitehead.* Regarding models for health education, there has been some work in the area of health promotion by Dean Whitehead (2001a, 2001b) who supports a need for practical prototypes for HCP-patient interactions. He built a body of work with his articles “The Nature of Health Promotion in Acute and Community Settings” (Whitehead, 1999), “A Stage Planning Programme Model for Health Education/Health Promotion Practice” (Whitehead, 2001b), “A Social Cognitive Model for Health Education and Health Promotion” (Whitehead, 2001a) and “Action Research in Health Promotion” (Whitehead, Takey, & Smith, 2003). The need for further research on models for health promotion is evident. Whitehead’s work addresses the lack of communication models in health education; however, Whitehead’s model uses a different theoretical base and different method than the Weber Health Education Model; His work closely resembles mine in the call for models but the Weber Model uses a different theoretical base and explores the practical steps needed to deepen insights of client need within a HCP-patient interaction. Whitehead (2001a) admits that his theoretical base of social cognitive models is “no more descriptions of how a process might work, rather than how something does work” (p. 419). The theoretical base of the Weber Model has been examined but a view of emerging societal trends that greatly affect how we conduct our health care and education is also important.

### *Five Trends in Health Education Literature*

Within current literature on health education five major trends are noted that affect health educators. These issues are important to review because HCPs can find themselves pressured to incorporate these trends into their practice but may not be given tools to actually respond to these ideas. Finding a tool or model incorporating these elements is difficult. The Weber Health Education Model may help to answer this call. The trends to be discussed include:

- shared decision-making,
- empowerment/advocacy,
- holistic care,
- pressure on providers for accountability, and,
- chronic care pressures.

Each of these trends has begun to affect the everyday life of HCPs in North America. It is imperative to have a deeper understanding of the trends which have such a powerful, yet hidden impact on health educators.

*Shared Decision Making.* Shared decision making has become part of our mainstream cultural expectation. “Shared decision making involves an exchange of ideas between patient and physician and collaboration in the decision itself. Shared decision making in its fullest sense occurs only when real choice exists” (Whitney, McGuire & McCullough, 2004, p. 55). Allowing patient choices emerged from a medical system in which paternalism was (and unfortunately in some cases still is) rampant. As people began to ask for choices, previously-held power bases began to crumble. I personally do not agree with Rockefeller (1999) regarding “the concept of consumer coproduction;

where citizens effectively fill a larger share of their own health care needs - - is now deeply imbedded in systems of care” (p. 54). I believe that it is not yet deeply embedded, that the health care system is currently in a state of change where pockets of paternalistic HCPs deliver services next to HCPs who are attempting to incorporate patient choice into their practice. There is also a section of patients who still do not understand a patient role that includes full partnership or active participation. However, overall there is an emerging cultural pressure to bring full patient participation within HCP-patient interactions.

The concept of patient choice originates from doctrine of informed consent in English and US law. Informed consent strengthens as the power relationship shifts from paternalistic views between doctor and patient, to the rise in individualism in the latter part of the 20th century. However, informed consent is not shared decision making between HCPs and patients. The giving of information from HCPs to patients only imparts facts; it is the mutual process of collaboration between HCPs and patients that brings facts beyond simple consent, to a point where true interaction occurs and choices are created.

Respecting patient autonomy and seeing patients as partners in healthcare decision making are high on the current healthcare agenda. This is a significant change from the stance that has historically permeated healthcare provision... Greater respect for patient autonomy may also have become a necessity in a society in which deference is no longer unquestioningly given to medical staff. (Hewlitt-Taylor, 2003, p. 1323)

Partnership agreements and mutual respect are becoming key words within the medical field. “Issues of empowerment, collaboration and partnerships are central to the creation of a healthier society” (Whitehead, 1999, p. 467). Furthermore, Whitehead

(1999) calls for new approaches to health promotion. New models and new techniques are called for based on well-documented evidence and a variety of research on partnerships and mutual decision making. In the current literature and culture, paternalism is becoming increasingly unacceptable. It may be time for health educators to look to our educational counterparts for mutual support regarding educational processes. In the arena of shared decision making, it appears as if HCPs are well behind our education counterparts in school systems. Educational sources have long been examining the stake holder's rights within the evaluation process (examples Cousins & Leithwood 1986 and Morris, 2002). Therefore, HCPs can learn from the knowledge base created by another discipline regarding the subject of shared decision making.

There are also negative aspects to shared decision making. Sobel (2004) discusses the idea of patient autonomy in an article in the *U.S. News and World Report*, with a critique that ethical dilemmas are caused by asking a physician to be non-judgmental in the face of patient demands for involvement and patient autonomy in sometimes perplexing ethical dilemmas for HCPs. Furthermore, when dealing with problems surrounding shared decision making, "many perceive the patient-physician interaction as stubbornly limited, with the physician often providing scanty information and offering minimal decisional authority to patients" (Whitney et al., 2004, p. 54). In order to combat these negative views of shared decision making, it must be emphasized that the role of HCPs necessitates they be an educator of high quality, evidence-based health information, as well as accurate assessor and high-level diagnostician of presenting problems. Respect for patient preferences must be inherent along with honest communication regarding patient choices which may conflict with the HCPs own

view/choice. The sharing of good quality evidenced-based information should occur in an intimate interaction that also acknowledges legal, moral and ethical boundaries.

There are further complications beyond moral and ethical dilemmas. People are using computer technology to create more access to biomedical literature for patients. Patients are coming to their physicians with rudimentary (and in some cases advanced) knowledge of disease processes and even self-diagnosis. This situation has challenged the paternalistic view of some HCPs that a client does not need information beyond what HCPs can provide. It may be difficult for HCPs to accept that clients have sought information that may be different from their own diagnosis. Indeed, to further cause problems in regards to information giving, Coulter, Entwistle and Gilbert (1999) suggest that HCPs themselves may “lack knowledge of treatment options and their effects” (p. 318). It may be difficult for HCPs to acknowledge that patients may have had more time to research their illness than the busy professional who may have to say ‘I don’t know.’

HCPs may need to find new ways to communicate regarding the diagnosis and medical information sought by computer-literate patients. This access to knowledge can be seen as a positive change leading to less paternalism within health care interactions. However, HCPs must also understand that technology may also lead to a widening of a gap between those who have access to information and those patients who are not medically literate. It is important to remember that not all clients have access to medical literature through computers, and even if access was attained, limited reading skills, even in North America, would mean many individuals would remain medically illiterate. Communication styles of HCPs must acknowledge the varying degree of medical and educational literacy of individuals.

While access to health care literature has challenged HCPs to change communication styles, there is also the issue of the demand created by accessing medical and health literature. Questions are posed, such as, will users “become more dissatisfied if they are not given access to services to which they thought they were entitled” (Mitchell, 1997, p. 1306)? In other words, if patients are given full information regarding an illness or diagnosis, will patients also demand diagnostic and treatment services that may not be available at the time of their choosing? Will they demand services that the medical system cannot provide due to financial feasibility? Can the health care system afford the pressure that would be created by fully informing a patient of all options? Would a patient agree with the rationing notion of the statement in Maeseneer et al. (2003) that “clinical decisions to improve quality of patients' care must be made with a good knowledge of the disease (medical evidence), but at the same time they must take into account patient-specific aspects of medical care (contextual evidence) and efficiency, equity, and rationing (policy evidence)” (p. 1316). Patients are currently challenging professionals regarding the judgments on use of facilities, diagnostic equipment and services.

As well, it is important to remember that the health interaction is not shared decision making if only the patient is making the choice. In this case of one-sided decision making by the patient, HCPs become superfluous and the idea of partnership is lost. Conversely, if a patient participates as a full partner within the decision-making process, the question is whether or not they will also take the responsibility for that choice and accept consequences? This question has been discussed in the past and has been used as an argument for paternalism. Some HCPs still believe that a patient is not capable of making

decisions in partnership and believe that patients are incapable of living with the outcome if they do make a decision that is different from their HCPs. More research is needed on patient perceptions of responsibility within health care decision making and the idea of partnership in shared decision making. As well, the emergence of empowerment and advocacy as societal trends were blended into discussions on emerged decision making.

*Empowerment and advocacy.* Empowerment is closely related to advocacy as well as shared decision making, in that all three exist both as part of a HCP-patient interaction as well as an outcome. Lightfoot (2003) discusses the historical view that HCPs treat and cure patients only if the patients do what they are told to do by the practitioner within an obedience/hierarchy situation. Another definition discusses the importance of mutuality in HCP-patient interactions.

Empowering relationships between clients and health care professionals are characterized by mutuality, advocacy, and the accrual of adequate knowledge, skills, and capacity to promote clients' awareness and active participation in their own health care, with self-empowerment leading to better informed approaches to decision making and self-management. (Dontje et al., 2004, p 66)

While some aspects of the above definition are useful in understanding empowerment, the term 'better' can be problematic. Judgments as to what makes one approach 'better' than the other should be avoided in any empowerment definition. Bartle, Couchonnal, Canda, and Staker (2002), provide a clear definition when they write about a child development program where "empowerment became viewed as a collaborative effort in which staff and families engaged in activities and relationships to actualize strengths and mobilize community resources" (p. 39). Advocacy and empowerment must be seen as closely related, in that HCPs advocating on behalf of their clients also provides for the empowerment of the client. In the above definition, the term actualizing strengths is

neutral, allowing for dialogue between HCPs and patients regarding what strengths exist and what action can be taken to mobilize patient or community. I agree with this definition of empowerment because it links the ideas of shared decision making and collaboration in an effort to create synergy through mutual interactions and this definition reminds us that changes that take place because HCP-patient interactions have consequences for a larger community setting.

It is ironic that advocacy and empowerment are used as key words within many health education situations, yet there is very little research on these concepts. Galer-Unti, Miller and Tappe (2004) examined ten years of peer-reviewed articles on advocacy. These authors call for an increase in research on advocacy as they found relatively small amounts of literature on the subject. They point out that advocacy research needed as it is commonly held as a key theme for HCPs. For example, advocacy was one of the six key focal points discussed as important to health care professionals at the Health Education in the 21st Century meeting held in 1995. Galer-Unti, Miller and Tappe (2004) argue that more information is needed on the inter relationships between advocacy and health education. More articles on advocacy have been emerging in the late 1990s but these authors contend that research is lacking in identifying important advocacy issues pertaining to health education.

Returning to the idea that empowerment is flawed due to inherent judgments involved in the process, there is a concern that the term empowerment has been corrupted. "Ideally empowerment prevents paternalism. In practice, however, empowerment equals paternalism" (Powers, 2003, p. 229). This problematic situation is caused by the issue of who judges whether or not a patient has become empowered.

Predetermined goals are set by HCPs for measuring success, but too often, patients may not be aware of, or involved in the establishment of, those criteria. Empowerment used incorrectly becomes a coercive strategy. Empowerment should not be seen as an act done to another person, Powers goes on to explain that “true empowerment may result in choices that professionals do not condone” (p. 233). HCPs can fear non-mutual decision making, they may fear failing to be seen to properly inform or assist the patient, or they may fear being blamed later for the patient’s decision, especially if patients come to regret their choice.

Empowerment and advocacy are also linked to social justice. Falk-Rafael (2001) makes that connection in a discussion on the Alma Ata Declaration of 1977, which introduced the term primary health care through its conference and resulting documents. Health and social justice emerged as intertwined issues. Empowerment must be based on “the Freirean concept of conscientizacao, the premise that the process of increased awareness and concomitant action or praxis is liberating” (p. 13). While health promotion emerged out of those empowerment discussions and health promotion became part of all public health agencies in Canada, the idea of education as a liberating force is not in our mainstream thought patterns. Health education is generally understood to mean giving power and control to people but more work is needed to translate that concept into the true liberating action of patients. Power struggles emerge as both patients and HCPs cope with the fear engendered by the idea of social justice, empowerment and social action. The idea of empowerment and advocacy is to enable the whole person to *become and take action* (emphasis added). It may cause some HCPs to be fearful of that action; it is often impossible to predict in what direction that liberating force or action may go.

Shared decision making can be multi-faceted with connections to other social trends; holistic care emerges as an intertwined issue that has changed health care.

*Holistic Care.* Start with the Spirit.  
Ever in Transition.  
Integrate the Knowledge.  
Consider the Roles.  
Heal the Whole Person.  
Right where he is.  
(Lusk & Decker, 2001, p. 81)

Holistic care appears to be the newest of trends within health education and health care. However, Thornton and Gold (1999) point out that Hippocrates, the father of modern medicine, was both physician and priest and Florence Nightingale, founder of modern nursing, was both scientist and mystic. Holistic care involves awareness of patients as a whole unit, without separating the dimensions (such as physical, mental emotional and spiritual elements) of that person. The definition of holistic care has been described as a value and a foundation and an action. "Holistic care entails looking at the entire individual from a bio-psycho-social-spiritual perspective. It means understanding the connection between the mind, body, and spirit and respecting individuals cultural and spiritual perspectives" (Dontje et al., 2004, p. 66). A salient concept in holistic health care is that HCPs bring their authentic self to a participative interaction with another human being. That interaction requires a thoughtful process of reflection that leads to harmony and balance with oneself and the world. Holistic health sees the client as a whole person; shared experience (or interaction) is the focus, with authentic use of self

being the goal of both the HCPs and patients. “The goal, therefore, is to be in the moment and listen as well as communicate effectively. With a healing interaction, the end point is to preserve the relationship despite possible difficulties and conflict” (Giroux, 2003, p. 398). The objective of holistic care is not perfection but the broadening of possible actions through that therapeutic relationship.

Interestingly, while I believe holistic concepts are totally suited to personal health education (HCP-patient interactions), some argue that no two people exist in isolation. It is not the intention of the Weber Model to state that personal health education is the only method of health education. I suggest that small groups and community education are important components within health education, but the focus of this project is personal interactions. However, I do agree that a therapeutic moment may only occur between two people, but the effects of that interaction permeate all the people around the patient and the health care provider. I also concur with Dontje et al. (2004) that “holistic care cannot be provided in isolation. Rather, it requires NPs [HCPs] to use a team approach and to understand the support systems and resources available within clinic settings as well as within communities” (p. 66). A person never exists in isolation but has connections to many people in their circle of influence. Milner (2003) in her article on incorporating holism into nursing practice also makes the point that it is important to create a network of people to further support client healing needs (p. 5).

New models of health education and health care are being sought from the holistic viewpoint. Lusk and Decker (2001), for example, look at a new model for nursing education regarding patient’s lives and look at a person within four transition phases. Instead of the usual division of the five dimensions of health (social, physical, emotional,

intellectual and spiritual), these authors look at life's evolutionary phases as methods to assess and view clients. The four phases are situation transitions, health-illness transitions, developmental transitions and organizational transitions (p. 81). These new ways of viewing people are central to providing alternative approaches to understanding clients in order to enhance their health.

While holistic health care can be seen to be in opposition to monetary concerns within health, this issue is being addressed by Hawks (2004), for instance, who discusses the need for holistic health education models and wonders if holistic health education can be measured in ways understood in this monetary driven society. Alternatively, Donnelly (2003) embraces issues of money and nursing shortages as the leverage needed to promote holistic models. This pressure for accountability due to financial constraint is a reality within health care and needs to be addressed by any health education model.

*Pressure on Providers for Accountability.* Financial aspects of health care have been an especially strong pressure point. Limited resource bases have affected the North American medical systems. Davis and Chesbro (2003), in discussing rehabilitation disciplines, frankly admit "the health care climate now demands greater results with fewer available resources so that rehabilitation professional must be creative, flexible and diversified to maximize their effectiveness" (p. 107). The authors recommend integrating health promotion, education and adult education principles in order to create a more responsive environment to the needs of patients. They argue that the ability to motivate patients to be part of their own care and decision-making will lead to patient satisfaction with their health care. Patient satisfaction, in turn, positively impacts the bottom line of finances. However, while some think the pressure on the health care system will produce

positive change, others voice the worry that limited financial resources will affect quality of care adversely.

The administrative techniques and financial incentives that health care organizations employ to influence physicians' behavior may reduce costs and improve quality as intended (although evidence at this time is scant). However, they may have a negative impact on patients' perceptions of their physicians and on physician and patient satisfaction, both of which ultimately affect quality of care. (Blumenthal, 1996, p.170)

The need for research-based evidence of medical care has permeated western medicine. Calls for accountability and evaluation by patients are seen in such research as Crowe, O'Malley and Gordon's work (2001) in New Zealand, where client feedback was tracked as part of the qualitative data sought by the researchers. As a result of the research that sought client viewpoints as part of their data, mental health care evolved into partnerships between HCPs and patients. As well, problematic power issues between HCPs and patients were discussed openly with paternalism giving way to communication and empowerment.

Yet HCP-patient interactions, as the cornerstone of health care practice, have not been fully studied. Proof of health education's effectiveness as an integral change agent to a patient's health is lacking. It is difficult to read criticisms such as Whitehead's (2001a) comment regarding health education within the nursing realm. He states that despite the calls to "make health education a familiar and recognized part of nursing practice. . . nurses have been and continue to be ineffective and inconsistent health education practitioners" (p. 417). HCPs must be able to show proof that they are improving quality of care and quality of life of patients through their health education and health care practices. Further Rimer, Glanz and Rasband (2001) also challenge us by stating "the right evidence in health education and health behavior is often a challenge"

(p. 231). A model with a built-in method of evaluation is called for.

Any evaluation has accountability issues and it is important to view some basic questions pertaining to that responsibility. Questions include: who is accountable, to whom are we accountable, and for what are we accountable? All HCPs are accountable for their professional actions. However, insurance companies, hospitals, employers, patients, and government also play a role in accountability; each providing pressures of various types on HCPs. HCPs also have pressures from their local community, regulatory bodies of professional organizations, their employers and their local health authority. Yet, Beckham (1997) points out that multiple and vague stakeholders (such as accountability to a community) are problematic as some entities within that community may demand more money, care or attention. He asks “shouldn’t the organization be accountable [only] to the patient?” (Beckham, 1997, p. 34). When HCPs can answer the question of to whom we are accountable, we can begin to find methods of communicating responses for accountability to those parties. HCPs can then answer the call of Webster and Cowart (1999) for accountability which is outcome focused and research based. In order to understand how to answer a call for outcome focused accountability, Allen (2000) divides the characteristics of accountability into four areas: fiscal responsibility, process issues, programme issues and priority issues. Accountability can be discussed using any of these four areas, and it must be made explicit in any conversation which arena of accountability is of priority to each party involved.

As health educators are increasingly being called upon to provide relevant statistical data and professional accountability for actions, there is a need to demonstrate the efficacy of health education through sound quantitative and qualitative research. From the

work in the 1970s groundwork has been laid to have health education grounded in theory, within an appropriate pedagogy, within an understanding of the social context of health.

*Chronic Care Pressures.* Lightfoot (2003) criticizes the health care systems in place and states “the majority of today’s health care expenditures are spent on chronic health problems that are not cured” (p. 3). As the Canadian population ages, chronic care needs will dramatically increase, with resulting pressure on the Western medical paradigm. This pressure is already occurring in physician clinics, hospitals and the public health realms, as we review statistics on wait time for care and the growing statistics on chronic health concerns. New methods of approaching and communicating with patients with these chronic needs are needed. As Rosenberg and Moore (1997) note in their discussion on the growing elderly population in Canada “the sheer growth in absolute number of elderly people, especially those 75 and over, will present a major challenge to the people responsible for providing health care” (p. 1032). Clear communication models and new evaluation methods are needed in order to deal with the Canadian aging population. The pressure on HCPs will increase as chronic care issues burden the health care system.

Some may criticize that the Weber Model is not useful in an acute care setting, yet I would argue that although it is true that within acute care, fast action is required by HCPs for situations such as anaphylactic reactions or heart attacks, the entire health care system requires a constant emphasis on health education within acute care as well as chronic care. In the previous example, without health education following that patient’s allergic reaction, that health crisis will be doomed to repeat itself, if health education is not a key component of follow-up care of that patient. Without health education by all HCPs, the

same self-care crisis will re-occur, draining the medical system financially and in others ways. Health education cannot be seen as a luxury that is only done when a health care professional 'has time.' Health education must be seen as a pivotal role in acute care, and certainly must be a key element within chronic medical care. In one large research study on persons with chronic health problems in five countries, special note is made of HCP-patient communication.

For patients with ongoing care needs, making care more patient-centred by involving patients in care decisions and clearly communicating treatment goals have the potential for improving care. Yet in the survey at least half the respondents reported that their regular physician does not ask for their ideas or opinions about treatment and care. Sizable proportions of respondents said that their physicians do not make clear the specific goals for treatment. (Blendon, Schoen, DesRoches, Osborn, & Zapert, 2003, pp. 114-115)

The authors call for a patient-centred approach, allowing for humanistic care and clear goal setting for each encounter.

#### *Four Conclusions and a Call to Action*

The trends discussed in this paper have been presented with both a positive and also a critical view. Some trends have been seen as paradoxical, such as holistic care in relation to monetary accountability, while some are shown to be complementary (shared decision making and empowerment). In this overview of current trends, certain patterns have emerged. First, there is a conviction that interactions between HCPs and patients are the core element of health care. The moment of interaction we label 'health education' (or HCP-patient interaction) can be a powerful force in that life, those two lives and even society. Important trends affecting those interactions include the pressure on HCPs to empower patients, to provide opportunity for shared decision making, and the pressure to go beyond a basic encounter to a deeper convergence, called holistic health care. Second,

societal trends (e.g. aging populations, chronic care pressures, holistic trends, and shared decision making) hold exciting possibilities and compel change to the provision of health care, but a critical perspective is also required to balance those trends with ethical, sound health care. Third, power issues are involved in every trend and there is a call for HCPs to breakdown the old barriers of paternalism and form new partnerships with patients. The fourth conclusion regarding societal trends introduces the idea that pressure exists to provide evidence that HCPs involvement makes a difference in patient's health. HCPs can look to both qualitative and quantitative data to provide this needed proof and need to produce evidence that satisfies a variety of stakeholders. Innovative methods of showing validity of health education are important in this financially accountable world.

From these four conclusions, a call to action is made. "Here the task is to build a platform of mutual accountability that reveals the true interdependence of all those working in the service and the respective roles of all in better serving patient and public" (Dewar, 2000, p. 38). Those shared moments between HCPs and patients ought to be described in a health education/communication model that emphasizes the patient as a whole person, allows for interaction within the encounter between both people, imparts information and allows for patient participation in learning, provides advocacy and intercession with mutually agreed upon actions and decisions, with an accountability for those decisions built into the model. It is not enough to call for such action, but a model for practical, daily and ongoing use must be attached to those calls. In calling for action in this regard, I created the Weber Health Education Model.

## Chapter Three: The Creation of the Model

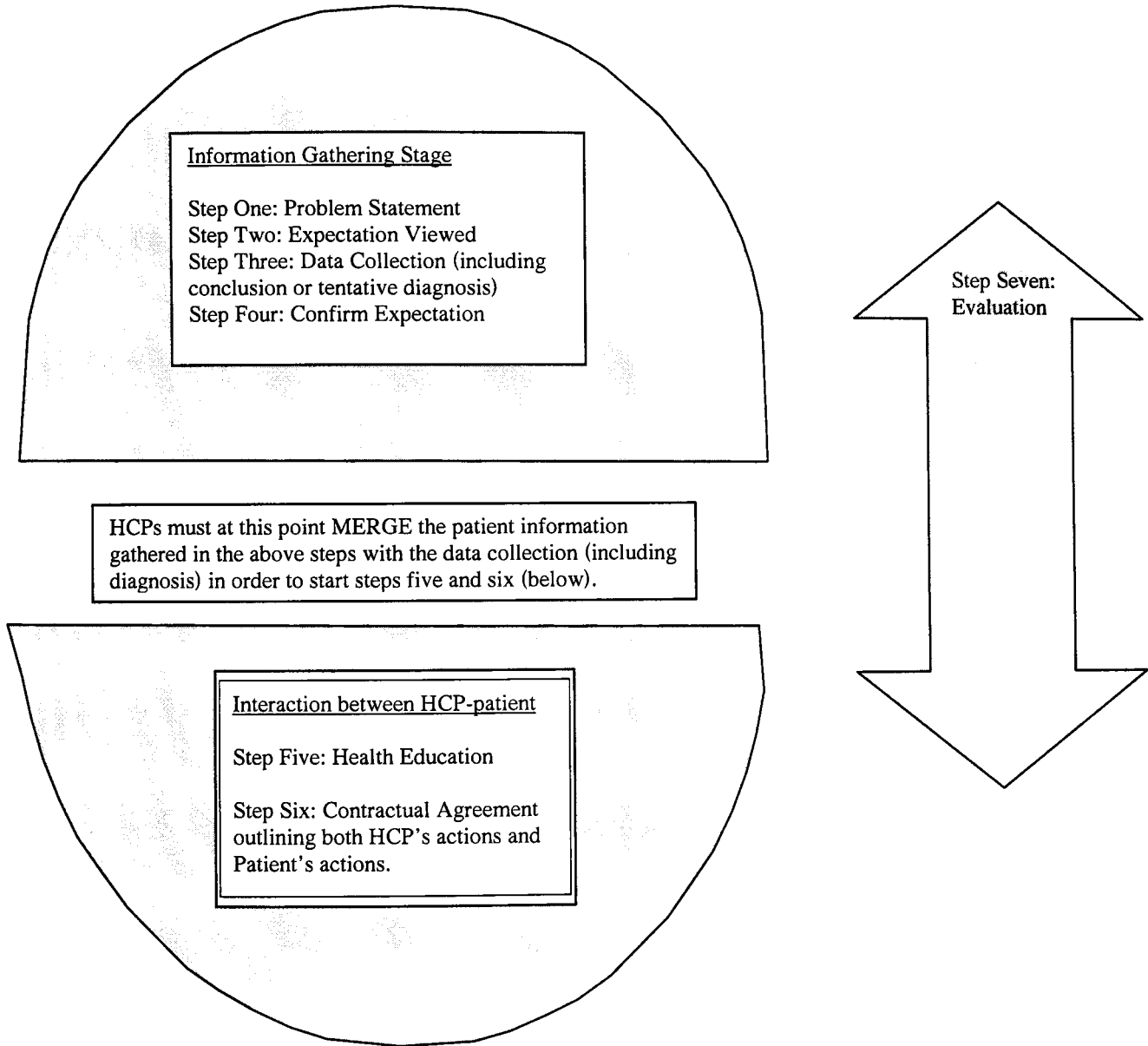
In order to the reader to fully understand the Weber Health Education Model, this chapter will initially describe the historical foundation of the model. A diagram of the model will be introduced, along with a full explanation of the seven steps involved in the HCP-patient interaction using the Weber Model. A full understanding of the seven steps of the Weber Model is critical to its usage by the reader.

### *Foundation of the Weber Model*

Working for two years in a northern Canadian community completely changed my view of patient education. I encountered nurse-patient situations in the North that I perceived as either great failures or problematic at the time. It was embarrassing to admit, even to myself, how little I knew about a deep and true connection with patients, even after ten years of nursing. Years later, while taking my Master's of Education degree at the University of Lethbridge, I encountered a Professor who challenged me to write and examine personal stories of failure, in order to seek out the lessons they held. The sometimes painful process of self-examination was central to the construction of a new communication model of personal health education. I began to reflect on the personal experiences and patient encounters in that northern community. I wrote stories showing the most important encounters. Through the intentional self-review and narrative analysis of the stories, I began to build a method of interacting that I believed allowed for more meaningful connections. The commonalities emerging from those stories were examined. It became my belief that personal health education is the cornerstone of all HCPs daily

interactions and that interaction can allow HCPs and patients to connect in a meaningful manner; allowing a partnership to develop. This partnership permits the health care provider to acknowledge him/her self as a whole person, as well as acknowledging the person who is labeled patient as a whole entity. Gallant, Beaulieu and Carnevale (2002) describe this type of process as “contemporary contextualization, the nurse [HCP] moves from being an expert care provider to being a partner with the client in order to improve the client’s capabilities” (p. 149). The patient’s view and expectation is the important element; the patient holds the key to the door which allows the HCP to connect through education in order to facilitate change. The Weber Health Educational Model began to emerge.

*The Weber Health Education Model Diagram*



*Explanation of the diagram.* In the above diagrammatical description of the Weber Health Education Model, the first four steps are the upper half of the circle, labeled information gathering. This half-circle representation includes gathering the problem statement, viewing the patient expectation, collecting data from a variety of sources and confirming the patient expectation, need or goal. In the bottom half of the circle is step five and step six; the process of health education and the resulting contractual agreement completes the circle. However, between the two halves of the circle is the most difficult process to describe. Some HCPs instinctively are aware how to bind the first half of the process with the second half. This is an inner process where HCPs take the information from the first four steps and merge or combine that information to form a manner of approaching the client. If a client expectation, need or goal can be met, this inner process may be a simple matter of combining the HCPs tentative diagnosis or conclusion with that client need and start a discussion to validate that for the client. This process becomes slightly more difficult when the client's goal is different than the HCPs conclusion of what the health goal should be. I firmly believe that even when not fulfilling the patient expectation, the acknowledgement of that expectation during the education process is the key to a positive connection between HCPs and patients. The step of evaluation is separated from the first six steps as it occurs at a time period after the first six steps. Evaluation of the contractual agreement can occur at the next appointment between health care provider and patient, or through indirect means (such as phone calls, or some type of confirmation of patient following the contracted regime or protocol). It is important to note that in general, the seven steps are meant to be sequential in nature. A fuller explanation of the model follows.

### *The Weber Health Education Model*

The Weber Model consists of two people interacting (one HCP and one client), with the following seven consecutive steps used in that encounter:

1.     The Problem Statement: Asking the patient the problem or circumstances which led to his/her asking for an appointment/health education encounter.
2.     The Expectation Viewed: Asking the patient his/her expectation of the outcome to the interaction/encounter.
3.     Data Collection: Assembling the data regarding the problem and expectation from a variety of sources. This step concludes with HCPs making a conclusion or a tentative diagnosis in regards to the medical situation.
4.     Confirm Expectation: Returning to the ideas initially voiced by the client, in order to confirm the voiced need, desire, and expectation of outcome from that patient's perspective.
5.     Health Education: Merging the patient information gathered from the first four steps with the conclusion or tentative diagnosis made by the Health Care providers. Health education, teaching, explanations, information and instruction can be given at this point in the process. HCPs may or may not be able to meet the expectation as voiced by their patients, but the expectation is always addressed and validated.
6.     Contractual Agreement: Provision of a verbal or written of actions of both HCPs and patients in dealing with the problem statement.
7.     Evaluation: A review of the verbal or written contract from the first visit, a step which occurs at a later date or on the second visit.

*Problem Statement.* For most HCPs, the problem statement is a first and obvious step at the start of any interaction. However, while this activity sounds as if it were a basic, common sense step in any health encounter, Ford, Schofield and Hope (2003) point out that:

In order to formulate a research question and obtain the correct evidence-based information, it is essential for the doctor to elicit the patient's reason for attendance. Research conducted in the early 1980s reminds us that doctors tend to interrupt patients after their opening statement so that patients fail to disclose significant facts related to their problem." (p. 590)

If this initial step of asking the patient the problem which led to their coming to the appointment (and allowing time for client to answer) is not made, the entire encounter may go awry. HCPs must ask and then listen to the response. The question should never be "how are you today"; the question should be "What brought you to see me today?" Also, it should never be assumed that what a patient told a receptionist is the actual problem statement. It is a requirement that HCPs ask each patient specifically his/her problem; this question starts the interaction. Further, this step begins the active involvement of the client in the intervention process. Dennison and Golaszewski (2002) name this point as the first of their "principles common to improvement of health behaviour" (p. 23).

Even though the model uses a problem statement as a starting point within a HCP-patient interaction, it is my belief that HCPs must never see an appointment as dealing with a problem; it must be seen as an appointment with a person (labeled client or patient) who has a health care need. If HCPs believe they are dealing with a 'problem' rather than a person, then the process becomes impersonal and will not be authentic or truly effective for that client.

*The Expectation Viewed.* In the Weber Model, the step of asking patients their goal, need or expectation is the most important component of a health education encounter. At this time, it appears that once a problem statement has been elicited, most practitioners immediately begin to gather data about that problem. While the problem statement is the first step that addresses the issue of what brought the patient to a health care provider, asking expectations addresses what they are hoping to emerge from that encounter. Humanism is the theoretical basis for the inclusion of asking the clients perception and expectation of the encounter. Pender (1982) explains that “Humanism recognizes the importance of the inner experience of human beings and their personal goals, feelings, beliefs, attitudes and values. In discussing the determinants of health behavior within a humanistic context, perception emerges as a key concept” (p. 4). It is important to the usage of the Weber Model to take the step of asking the client’s expectation of the health education encounter. Reviewing client expectations merges the humanistic viewpoint (of including the meaning of the event according to the person experiencing it), with adult learning principles. These adult learning principles include learning related to learner’s need to know, learning that is self-directed and life-centred, as well as learning motivated by internal mechanisms and life goals of clients (Babcock & Miller, 1994, p. 98). Therefore, in order to provide health education that suits the goals and life of the individual (patient), the meaning given the problem must be elicited.

According to Davis and Chesbros (2003) “incorporating the patient’s perception of the problem and using teaching methods and tools targeted specifically to adult learners can have a positive impact on the effectiveness of the intervention” (p. 106). Why is the step of asking the expectation of the encounter important? From using this encounter in

many patient visits, I have found the problem statement does not encompass the real needs and desires of the patient. For example, a patient may be asking for a visit due to heel pain, but their expectation of the visit to a health care provider may be the cure of that heel pain before the marathon they plan to run in one week. This expectation is a totally different outcome from the one given by a person with heel pain who has an expectation that it be cured so he or she can go back to working long shifts on his or her feet, or the patient who expects the doctor to ensure his or her heel pain is not a cancerous growth.

At this point, HCPs need only ask patients about their expectations of this encounter. While this request can cause some initial wording difficulties for HCPs, there are questions that can help them to elicit expectations. Some examples of questions to aid HCPs are:

- “What do you expect from this encounter?”
- “What do you hope will occur because of this visit?”
- “How do you believe we can work on that issue during this appointment?”
- “So you have XXX problem today, what do you want to have happen as a result of this appointment today?”
- “So you have XXX problem, what are you wanting to happen during this visit?”
- “How do you believe we can be partners in working on this issue?”
- “How do you think I can help you with this problem?”
- “Is there anything specific you needed or wanted today in regards to this problem?”
- “Do you have any specific needs or expectations regarding this problem during this appointment?”
- “What are your personal hopes or goals for this appointment?”
- “How can I assist you with that today?”

*Data Collection.* For most HCPs, the step of data collection has been well taught in their individual educational programs. The various ways of gathering data should include both subjective and objective systematic methods of collecting information and evaluating patients and their symptoms. Interviewing techniques are important in health assessment as HCPs try to elicit the physical, mental, social, intellectual and spiritual aspects of health of individuals. Other HCPs view various social, economic, religious, language and cultural factors related to health. Health assessment skills are an integral part of any HCPs schooling and are a daily, if not constant, need within their practice. For example, physical techniques for inspection, palpation, percussion, auscultation, and positioning are learned in basic professional programs of any health care practitioner. Knowledge of anatomy and physiology, obtaining appropriate health histories, physical examinations, and summaries of information should be part of the assessment process. Critical thinking is needed in order to provide a complete head-to-toe examination that incorporates the previously delineated components of assessment.

It is not the purpose of the Weber Model to teach the methods of gathering information from clients. It is assumed that all HCPs have the professional expertise, or growing expertise, in the area of patient assessment. The purpose of gathering information by health care providers is to form a conclusion, tentative diagnosis, diagnosis, medical opinion or health care opinion. After gathering information, all practitioners come to some conclusion to support a diagnosis. Health education serves the purpose of intertwining the diagnosis (found during this information gathering stage) with the expectation of the client. But before this intertwining (health education) can commence, the HCP must review the expectation with the client.

*Confirm Expectation.* Through the collection of data, most HCPs come to a conclusion regarding a possible diagnosis. Before rushing into ordering tests or any other step, the expectation of the client must be revisited. The confirmation of the expectation validates the patient's stated need. It must be understood by HCPs that the expectation and even the problem statement can change dramatically through the course of an appointment, as trust develops or a patient gathers courage to discuss a deeper issue. Therefore it is important that HCPs review the previously stated expectation with a simple question such as "So, if I understand correctly, your problem is heel pain and you would like this healed for a marathon you wish to run next week?" While this requirement sounds simple, it is a very important step. This affirmation of a previous statement provides the verification of the client's real desire in this health care appointment; it also provides important validation to the patient that their health care provider is listening to them as a individual.

At this point, a client has a few options. First, the patient may simply confirm the statement. Second, the patient may decide to elaborate on their problem statement or expectation. This is valuable information that can be added to the data HCPs have already gathered. Third, patients may change their problem statement at this point. If this occurs, HCPs must decide whether or not to start anew and return to the first steps of the model or continue dealing with the first issue. If the new problem statement is decided upon, the Weber Model is started from the beginning and a new session of data collection begins at that point. If two or more problem statements are made, HCPs can ask which problem has priority for this visit and deal with the client's stated priority issue during this appointment.

A patient may not always be able to respond to questions regarding their expectations. If patients cannot articulate their needs in regards to a problem, HCPs can continue with the encounter based on the problem statement, but must be willing to hear the quiet voices of inarticulate patients which may occur later in the encounter. With all patients, however, the step of confirming the expectation is important to the step of health education.

*Health Education.* In the Weber Health Education Model, HCPs are asked to understand the concept that health education is an integral component of any HCP-patient encounter. In my experience, HCPs too often leap from their conclusion or diagnosis immediately to directives to the patient on how that provider wishes the patient to deal with that diagnosis (e.g. diagnostic testing, medication regime, exercise treatment etc). According to Kemm (2003), health education “is the component of health promotion designed to achieve learning related to health or illness. While often described by other names, an educational element features in nearly all health promotion activities” (p. 106). Health education is a facilitation of learning. “Learning is a change in behaviour and involves a process of transforming new knowledge, insights, skills and values into new behaviour” (Siminerio, 1999, p. 153). Teaching according to this writer provides guidance to facilitate learning. If HCPs do not include the step of health education, then knowledge is not being imparted and behaviour change is unlikely to occur. “Effective health education efforts require incorporation of teaching-learning processes and behavioural strategies to encourage individuals to make voluntary adaptations conducive to health” (Siminerio, 1999, p. 153).

In order to achieve health education, the patient’s stated expectation and the HCPs

diagnosis merges in a conversation that explores and mingles the two domains. HCPs must understand that this step does not mean that they must fulfill each and every expectation of the client. This step provides an opportunity to bridge the client's expectation of the encounter with HCPs assessment and health care opinion. The resulting conversation should be directed by HCPs to include the client expectation but not necessarily fulfilling them. To go back to the example of heel pain, if a health care provider diagnoses plantar fasciitis, then the resulting health education deals with the explanation of the diagnosis, and how the expectation of running in the marathon the next week may not be possible given that particular diagnosis. When the client is given the opportunity to understand why the marathon may not be possible next week, but with proper care, may be possible in three or four months, the client may begin to process the information given and may even make the changes suggested by the HCP (as his or her expectation has been validated as important even if not fulfilled at this time). In shared decision making, the health care provider and patient can then make plans on when the next marathon could be run (instead of next week), however, the patient may also make a unilateral decision to run the marathon in one week anyway and refuse the health care provider's advice. However, the patient may have gained valuable information to minimize the problem and deal with the diagnosis, despite the ultimate decision. The health education step provides a manner in which the HCP can educate and provide information while validating the client, even if a specific goal, need or expectation may not be met during the appointment.

Once HCPs take time to ask both the problem and the expectation, the step of providing health education should streamline the time together. There is a clear focus of

an issue under discussion, with an understanding between both health care provider and patient as to the issue and the meaning given to that issue by the client. Health education must be emphasized as an important step in all HCP-patient encounters as ultimately, it is the key to a change in the health care behaviour of individual patients.

*Contractual Agreement.* In the Weber Model, the encounter concludes with a verbal and written statement of what each person commits to doing for dealing with the problem issue or diagnosis. It outlines the shared decision making that results from the health education discussion. This step occurs either verbally or in writing, and outlines the steps the HCP and the patient will take in dealing with the problem. Contracting can be seen as a guideline for agreed-upon behaviours and actions of each person involved. Examples of such statements can be “My diagnosis is that you have plantar fasciitis of your heel, I am willing to write a prescription for an anti-inflammatory medication, and a script for orthotic inserts for your shoes. Are you willing to take that anti-inflammatory medication every day for ten days, use the orthotic shoe inserts, try to stay off your feet as much as possible for two weeks and see me in three weeks?”

A patient may agree to the contract or may disagree. If a patient refuses a verbal agreement, HCPs should try to elicit what they would agree to do regarding the problem. In an atmosphere where a client feels validated, he or she may be more willing to communicate whether or not they will attempt to follow health care instructions in this initial encounter. However, the terms compliance and non-compliance are not used in the Weber Model. Those words imply power of HCPs over patients, with the patients not following the plan prescribed or stipulated by HCPs. Unfortunately in this decade, one still hears of the success of a health encounter to be based solely on whether or not the

patient followed through on the instructions of HCPs. While the following quote describes a nursing realm, it encapsulates a new way of thinking about partnerships, rather than a power-based health care interaction.

The paradigm shift that has been proposed in this article is for a patient-centred model in which communication between patient and nurse needs to change to give greater importance to the patient point of view. This new model not only shifts power and authority towards patients, but implies an advocacy role for nursing. It requires that nurses listen to patients and accept them as experts in their own lives and their health choices, and then convey the rationality of patient decision-making to other health care practitioners. As patient advocates, nurses need to abdicate complete monopoly over the knowledge base and incorporate aspects of patients' life experiences into the health care arena. In particular, they must acknowledge the importance of patients' self-knowledge" (Russell, Daly, Hughes & Hoog, 2003, p. 287)

It is acknowledged that a conclusion to the interaction must be made, and be made in a way that roles and expectations are explicitly laid out. HCPs also have a legal mandate to chart the encounter and their evaluation of that encounter, therefore, a contract is a method of concluding the encounter as well as recording the shared decision making which occurred during that session. A formal contract clearly outlines the expectations of both persons within the health care encounters and leads to fewer misunderstandings and complaints about unclear instructions following that encounter.

In the current paper charting systems, contracts will need to be discussed verbally between HCPs and patients. It may also be possible for HCPs to write a quick contract of both parties involvement on paper. However, in a technologically advancing health care practice, it may be possible to have a computer in each education/examination room. Before the patient leaves the office, it will be possible in a computer-literate world for HCPs to type the contract between the two parties and have the patient receive a copy before leaving. In this manner, clear agreements can be made at each appointment.

*Evaluation.* "The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed" (Jung, 1984, p. 54). Evaluating

that transformation is an important issue within health education. In regards to accountability in health care, this evaluative step in the Weber Model provides an easy way of noting whether or not the initial meeting produced tangible results; providing a method of evaluation that can assist the HCP to provide 'proof' that a HCP-patient encounter was helpful, empowering or educational.

The contractual agreement ends the initial encounter; however, the step of evaluation in the Weber Model occurs some time after the first meeting or at the second meeting. For example, a nurse may phone a client to find out if they are feeling better and can ask if the oxygen arranged for the client is easing the shortness of breath. If the client is using the oxygen that was contracted in the encounter then an evaluation can be made of that encounter. If the client reports he or she is using the oxygen, but the shortness of breath is still causing problems, then the nurse can do a follow-up visit to assess the continuing health problem. The nurse would initiate the Weber Model again, in order to obtain further information about the problem statement of the shortness of breath. If the client reports they are not using the oxygen, as agreed in the contract, then the Weber Model should be used again to try to understand the client's perceptions, needs and issues. The contractual agreement becomes an evaluation tool to the initial HCP-patient encounter.

While the evaluation may show that the initial encounter did not lead to both parties fulfilling the contract, this outcome should not mean that the contract be considered a failure, nor should the patient be labeled non-compliance. The evaluation of the initial contract should lead to a fuller discussion on the patient's issues and the reasons for not following through on the contractual agreements. The 'why' of not following through provides excellent information for HCPs in dealing with the client's health problems. For example, "I did not take the medications as they caused unacceptable side effects." If a patient is not following through on a contractual agreement, HCPs can implement the Weber Model to find out what the client's needs and expectations are in a new encounter.

## Chapter Four: Research Methods

This research is a qualitative, phenomenological exploration and descriptive study of the lived human experience of HCP-patient interactions. The major research question is “Does the Weber Health Education Model allow for meaningful contact between health care provider and patient?” The purpose of this research is to explore and describe perceptions of diverse health care providers in the usage of the Weber Model and discern whether or not the Weber Health Education Model is an effective and efficient method of providing meaningful contact between patients and HCPs. Research takes this model to a clinical context beyond my own personal practice (i.e. nursing) to a greater variety of HCP-patient interactions. Five health care providers offered insights for the purpose of establishing an initial benchmark for this Model, and provided guidelines for future research opportunities and education planning regarding the Weber Health Education Model. Two physicians, one chiropractor, one massage therapist and one physiotherapist were asked to use this model on three patients each during the course of one week. Research participants were drawn from health care providers in a Southern Alberta Health Clinic.

*Problem Statement.* The problem statement in the form of a research question is “Does the Weber Health Education Model allow for meaningful contact between health care provider and patient?” The research will initiate a view of the Weber Health Education Model, add to the body of health education research and identify further areas of needed research. Practically, it expands the scientific knowledge base of health education, qualitative research and health care provider-patient interactions. It aids in the understanding of a new communication tool or model as part of HCPs daily interactions

with patients. It provides a Canadian perspective that should be able to cross borders of country and language with further research. As stated in the previous chapter on selected literature, there is little research into this type of model. Despite the excellent work of Dean Whitehead (2001a, 2001b), the Kalamazoo Consensus Statement (1999) and client-centred psychotherapy techniques, a model has not been created that translates easily into the daily practice of HCPs. A model or practical tool is needed for daily health care practice if these individuals are to be effective in their work. The framework provided by humanism, Orem's (1991) self-care deficit theory and adult learning principles are the theoretical underpinnings of the Weber Model. From those theories comes a patient-centred health education model that aids in communication. The goal of that communication is to ultimately fulfill the self-care deficits identified by patients to their HCPs.

*Research Participants.* A variety of health care professionals were sought to be participants in this research. The initial sample of subjects included seven participants but timelines did not permit a nurse and a dietician to participate. Two physicians, one chiropractor, one massage therapist and one physiotherapist used the model and provided written consents and taped interviews. These five research participants were drawn from one Southern Alberta Health Clinic; subjects were selected purposively to provide diversity in responses. The subjects were asked to be honest in their responses and the possibility of attempting to please this writer was discussed openly in order to avoid any tendency to respond to provide 'socially acceptable' responses. Further within that initial discussion, the need to provide a variety of information that may include both positive and negative responses to the model was discussed.

*Ethical Considerations.* Robley (1995) states that qualitative research should follow “the principles of human dignity, autonomy, privacy, confidentiality, anonymity and safety (p. 46). Human dignity was accommodated by selecting health care providers purposively and seeking their participation using free and informed consent guidelines, with the right to refuse initially or at any point in the research until the taped interviews were completed. Polit and Hungler (1999) suggest that:

anonymity occurs when even the researcher cannot link a participant with the information for that person. . . [and] a promise of confidentiality to participants is a pledge that any information that the participant provides will not be publicly reported in a manner that identifies the participant or made accessible to parties other than those involved in the research. (p. 139)

However, it is recognized that the participants in qualitative research are ‘known’ to the researcher. Thus, it is essential to accommodate anonymity through careful attention to data obtained from participants. For example, informed consent forms are stored separately from data, data are given code numbers or pseudonyms, all data are stored in a filing cabinet where only the researcher has access to that data. To achieve the principle of confidentiality, every effort was taken to ensure that participants cannot be identified through what is reported in as outcomes by this research. Therefore, the name of the health clinic and any identifying information of the research participants will not be made public. It was a voluntary process for research subjects; no form of coercion or inducement was used. These research subjects were sought after consent from the Human Subject Ethics Committee of the University of Lethbridge and the supervisor of the clinic was granted. The research participants (the health care providers) were taught the use of the Weber Health Education Model after consent was received both verbally and in writing. Patients were not the subject of this research and therefore their consent was not

sought. It is important to realize that patients would receive medical care and attention from these providers whether or not the Weber model was utilized. Patient names or identifying features of patients were not used. Privacy of the health care providers was upheld and names or identifying features will not be used in this project. Submitted material was and is anonymous and consent forms, as well as interview material, has and will be kept separate from the project itself. Consent forms and tapes will be stored for five years in a filing cabinet in my home and then destroyed. Information from research participants will be aggregate (not divided by practice type) to allow for greater confidentiality. The anticipated use of the research findings were explained to each research participant. The anticipated use of this research for my Master's of Education project and dissemination to the University of Lethbridge library, journal articles, presentations and other publications were mentioned in the consent letter (see Appendix A).

*Assumptions.* As in any research, some important assumptions exist within this project. Most importantly, it is my assumption that the model that was, and is, useful within my individual practice will be useful for other clients and HCPs. Limited, informal work has been done in my workplace regarding the use of the Weber Model, however, I believe more research is needed in a variety of settings to ensure this Model would be useful to all health care providers in a wide range of situations. For example, more action research could be accomplished to show its possible impact in my own or other workplaces. This type of research is important to show actual impact within workplace setting (i.e. Alberta Teacher's Association, 2001). The research accomplished for this project was completed in order to provide a formal assessment of the use of the Weber

Health Education Model beyond my personal experience to enhance its use by a variety of HCPs. Insights gained from those research participants assist in evaluating the usefulness of the Weber Model and suggest future research possibilities for the Model.

It is also assumed that HCPs are not deliberately using a humanist-based protocol as part of their daily personal health education encounters. There are very few communication models on which to base one-on-one health education; therefore, the assumption that no deliberate protocol is used by practitioners could be assessed in this project as well as future research. Some practitioners may be using a consciously constructed communication tool, while others may be unconsciously using a previously learned model. Research results on the Weber Model will be skewed if HCPs participate in research on communication models where it is assumed they do not use a protocol, when in fact, they may already casually use some sort of protocol within their daily practice. Indeed, within my professional circle, I have seen one physician, in particular, use the problem statement and expectation review routinely as part of his practice. I have discussed this practice with him and he states “I only do what works.” Anecdotally, clients have told me “he listens to me” and “he’s not perfect but he helped me understand my problem.” How HCPs are taught to interact with their clients and what type of protocol they have used either formally or informally could be a question for further research.

Another assumption is that humanist-based approaches are positive in nature. However, depending on the outcome of the interaction between client and HCPs, the encounter may not yield positive results. It is interesting to note that “partnerships tend to be portrayed as having overwhelmingly positive consequences. Intuitively, the word

partnership suggests positive sentiments but the potential for conflict between partners, managing such conflict and the positive and negative consequences of conflict in a partnership is largely ignored” (Gallant et al., 2002, p. 155). It must be remembered that both clients and HCPs are people and subject to misunderstandings and miscommunication. Further, it must be reiterated that the Weber Health Education Model does not mean that the client expectation will always be met. The point of using this Model is that the expectations are used as a starting point for the discussion. The health education component combines the expectations of clients with the expert opinion of HCPs. HCPs do not have to fulfill each expectation; it is simply important to use the expectation as a way of connecting with each client. The assumption that validation of client expectations is enough (rather than actual fulfillment) could be addressed in further quantitative research on the Weber Model, in order to find out more fully what exactly patient’s require from their HCPs in order to achieve ‘satisfaction’ in a HCP-patient interaction. Research on this assumption would be appropriate for satisfaction surveys using Likert scales to quantitatively understand patient satisfaction; or, further work with other quantitative methods may also be appropriate. Focus groups may also prove to be a rich source of data about patient satisfaction. Indeed, any research to see the patient or HCP perspective of the Weber Model would be useful.

*Limitations.* The limitations include the small number of participants from one area of Canada. Future research could expand participants to include health care providers from a variety of geographical settings across Canada, North America or the world. This research was limited to one cultural group but further research into a variety of cultural and geographic settings could provide rich insights into diversity of the use of

the Weber Model. This research was also conducted in the qualitative research paradigm but could also lend itself to further research in the quantitative research realm. Indeed, The Weber Model could be researched in both the qualitative and quantitative realms in a variety of countries, cultures and with a variety of professionals. This research limited itself to research participants because of my assumption that they are the educator (i.e. therefore the change agent or facilitator) within HCP-patient encounters. However, patient views of the Weber Model and its usage in their health care encounters would also prove worthy of further research.

I did not explore patient information with the research participants. This may prove to be a limitation as the patients chosen may or may not have been homologous. The lack of exploration of patient types may be problematic. The research results may be skewed if clients are chosen who have the following problems:

- mental health difficulties that do not allow a basis in reality,
- head injuries,
- mental health disorders that do not allow for an exchange of truthful information,
- pediatric population,
- brain disorders (such as Alzheimer's Disease or dementias),
- and patients with English as a second language or language difficulties.

However, each of these limitations may also afford an opportunity for future research which will be discussed in chapter seven.

*Data Collection and Analysis.* During the course of one week of professional practice, five health care providers were asked to use this Model on a minimum of three patients. Data were gathered by asking participants to respond to questions verbally in

face-to-face private interviews with the researcher within the week following usage of the model. A 20 minute, semi-structured taped interview was conducted with each health care professional. Dialogue centered on the perception and subjective view of the usage of the Weber Model. Broad based and open-ended questions with prompts and follow-up questions were utilized (see Appendix B) with freedom to explore together a verbal description of the perceived response to the Weber Model. Probing into meanings and clarification of statements occurred. The taped interviews were repeatedly content analyzed and major themes extracted. The data were analyzed using qualitative content analysis to identify key phrases, themes, and concepts used to gain insight into the use of the Weber Model.

*Researcher as Instrument.* In phenomenological research, the researcher asks questions and is subjectively and actively engaged with the research participants during the data collection process. Researchers can probe responses, ask questions and pursue ideas that emerge from the discussion. It is impossible “to engage in qualitative research without constant awareness of ourselves as research instrument . . . our knowledge, skills and dispositions as educators will shape the biases we bring to research” (Evans, 1998, p. 247). In the research I conducted, I acknowledge that I was an integral part of the process and played a part in guiding and directing the discussions. While all research participants answered the basic questions asked by the researcher, the interview was often conversational in tone. The interview was also open to any topics regarding the Weber Model that the research participants found important to discuss. This approach allowed researcher and research participants to be very frank and open about their perceptions of the Weber Model.

### *Summary of Research Methodology*

In summary, this researcher sought insights into the usefulness of the Weber Model by interpreting the descriptions and meanings offered by the HCPs, labeled research participants. A qualitative, phenomenological design afforded an appropriate design with which to commence this exploratory, descriptive research. A semi-structured interview schedule was developed to explore the perceptions of the five HCPs. Specifically, the interview schedule accommodated the perceptions of the use of the Model, the perceptions of the Model as a tool of practice, as well as the perceptions of client response to the Model. Perceptions of each of the seven steps in the Model were sought, as well as any recommendations on the use for continuance of the tool for their own practice or the practice of other HCPs. The five HCPs willingly volunteered to participate in this research. During the interviews, they spoke freely and enthusiastically about their experiences in using the Weber Model. Moreover, the HCPs offered patient insights into the refinement of this Model. Data analysis occurred throughout the data collection process and in-depth analysis occurred when all the data were collected. A systematic approach to content analysis supported the process of identifying the key themes. A further discussion of these themes occurs in chapter six of this project.

## Chapter Five: Narrative Analysis of Client Stories

The data analysis of this research project is presented in two sections. In this chapter, narrative analysis of client stories is an integral component of the research. Stories themselves do not contain the step beyond of creating a mutual understanding between writer and reader. “But stories themselves are not enough. We need analysis of stories to make narrative research an authentic mode of educational inquiry” (L. Fowler, personal communication, September 18, 2003). It is essential to understand how the four stories contained in Chapter One were integral to the creation of the Weber Health Education Model. Subsequently, in Chapter Six, the qualitative research conducted on the model will be discussed.

### *Explanation of Narrative Analysis*

Each story was analyzed using Dr. Leah Fowler’s (2002) *Seven Gates of Narrative Analysis in Education Research* (the seven gates were later renamed fields). I chose Dr. Fowler’s work because I agree with her own reflection that stories allow the writer a safe way of reflecting on problematic issues. The process of narrative analysis “continues to teach me a great deal, as I examine difficulty in the safer form of story, so that I can then take the knowledge back into my own being” (Fowler, 2002, p. 12). In narrative research, a story must be analyzed in order for the writer to ensure the writer and the reader have a mutual understanding of the interpretation. Dr. Fowler’s seven fields allow an intelligent and consecutive unfolding of the thought processes of the author of any narrative. Dr. Fowler describes recognition in her work of “at least seven, significant, interconnected,

recursive, interpretive gates, of narrative analysis that could be useful to researchers in education using stories, counter-narratives, narrative interviews or critical incidents in their qualitative work” (Fowler, 2002, p. 11). Her work on narrative analysis provides a good fit to the critical appraisal needed to enhance the stories that had guided my creation of the Weber Model. The stories and the analysis helped to create a new communication tool for clinical practice

Briefly, Dr. Fowler’s seven fields are: (a) Naive storying reflects the elemental story; (b) Psychological re/construction includes affect and emotions; (c) Psychotherapeutic ethics encompassing ethics and morality; (d) Narrative craft reviews elements of convention, structure, and craft and writing contained in the story; (e) Hermeneutic philosophy reflects what is uncovered and revealed, the messages of deeper meaning; (f) Curriculum pedagogy includes what the story text offers in terms of insightful implications for teachers, for teaching, and all the contingent, contextual relational networks in teaching and learning; and, (g) Poetics of teaching suggests a conscious review of beauty, truth, justice, wisdom, art, and meaning in the story. These seven fields allow for a deeper analysis of each story and allow the writer of the stories, as well as the reader, to uncover the underlying issues beyond the storytelling. Beyond telling the basic story, this step of analysis is important because it allows for a communication of the knowledge that was gained through the incident. This analysis allows for a translation of the story from simple storytelling into more complex educational and professional lessons.

*Analysis of Story #1 "A Latté on the Way to the Farm."* Using Fowler's (2002)

seven fields of narrative analysis, the story will be reviewed and unfolded (i.e. beyond what is presented in Chapter One). In looking at the first field of naive storytelling, there is a fairly simple plot of a nurse visiting a family on a farm outside of a northern town. On the way, she stops for coffee each week before setting out on the visit. There are the characters of Lori, the nurse; Nicole, a second nurse; Bill, the coffee shop owner; Mr. and Mrs. Weiss and their son Richard Weiss. The point of view is from Lori, the nurse. The visit to the coffee shop each week is interwoven with Lori's visit to the family requiring medical care.

In the second field of psychological reconstruction, one looks at the emotions in the story. It is a story told in order that connections and disconnections are viewed. Within this story there is sadness and sorrow at the death of a character and sadness over loneliness expressed by several of the characters. There is a sense of almost everything deteriorating within the Weiss family this includes the farm, ulcers, health and relationship. In Lori's realm there is internal loneliness and a sense of severance from her support systems. The entire story exhibits an experience of isolation, as well as a severance of relationships through relocation, lack of mobility and death. There is a sense of loss that permeates the entire story. However, there is also tenderness in familial relationships where connections have been made and remain intact. There is caring expressed between the members of the Weiss family toward each other. These connections appear to be based on communication of real issues within those relationships. However, Lori's inability to communicate her feelings to Bill does not allow for any deepening of a friendship or relationship. Caring is expressed by Bill in a

personal way only after real communication occurred.

There are underlying emotions of fear and worry in the story. Mr. Weiss is worried about Richard and his wife. Mrs. Weiss is worried about Mr. Weiss, while Richard was quietly trying to take care of both his parents and the farm. Lori's fear of connecting to Bill is obvious, but her fear of connecting to both her clients and community is also present. Her method of connecting to her patients is through established nursing care plans rather than intimate interactions. Her attempt at intimate connection with her fellow nurse was not successful, even after honest communication on Lori's part. However, her relationship with Bill was impersonal when she did not communicate her true needs or desires and only deepened after she communicated authentic feelings.

In the third field of psychotherapeutic ethics, we are called to look at the work that is being done in the story regarding ethics and morality. In the story entitled "A Latté on the Way to the Farm," the work that is required is honest connections through honest communication. We cannot know what is really going on in someone's life unless we ask and there is a willingness to share. As well, no person can expect others to have inner knowledge of his or her life without honest sharing; each person is challenged to communicate the truth of situations early in relationships. A disconnect happens when no one asks and no one tells.

Narrative craft is the fourth field. The story has a duality through expression of Lori's view of her impressions of the coffee house and the Weiss family farm. Some of what she is experiencing while visiting the family on the farm is also being experienced in her visits to the coffee shop (e.g. lack of full communication, unspoken needs and desires, and loneliness issues). Each section of the story fits together to show a picture of

disconnect until honest communications occur. The story allows for a study of the personal and the professional coinciding in this nurse's life. Thus what Lori is learning in her personal life is being mirrored in her professional life as well. There are repetitious images of deterioration and loss, with an emphasis on the importance of interconnections and communication between people.

Hermeneutic philosophy is the fifth field and looks at the deeper meaning. Is the nurse there to heal ulcers, or to heal herself, or to connect and understand with people? What would be considered a triumph in this medical case? On the surface, the healing of Mr. Weiss's leg ulcers is accomplished and should be considered a success. However, from Mr. Weiss's point of view, that healing came with a high price. The ulcers healed because he was off his feet, by the bedside of his dying wife. Also, with the healing of Mr. Weiss's ulcers, he is now left with fewer people and fewer connections in his life, and more isolation. Will this situation cause more stress on Richard, the caregiver? What was the true purpose of the nurse's visit? With so many HCPs involved in the Weiss family, why did no one uncover the Weiss's true needs? Their needs were mainly of a social nature; connections needed during a time of deteriorating health and lifestyle, as well as assistance with laundry and medical issues that went beyond the medical need of Mr. Weiss's legs. Was the purpose of the nurse's visiting to heal the ulcer or provide social connections? Ultimately, no one asked why both Mr. and Mrs. Weiss had severe leg ulcers (hers resulted in bilateral leg amputations). No health care provider received information about the true needs and desires from the client's perspective because no one asked.

Was the real purpose of nurses visiting the farm the only way the Weiss's had of

connecting to the outside world? Mr. Weiss explained why Mrs. Weiss attended his ulcer care, why did Richard come into the house each time? Did Richard feel about Lori the way she felt about Bill? Did she not see others trying to connect to her? The latté was a metaphor for Lori's form of connecting socially within a self-perceived isolated environment. Further, there is the small glimpse of the workplace situation that adds to the idea of Lori's isolation as well. Some readers could look at this story and see a medical triumph (i.e. the healing of the ulcer), others could perceive this story is only about isolation, death and failure, or this story could be seen as a triumph of people finally coming together in honest communication and really connecting with each other for the first time.

Curriculum pedagogy is the sixth field and helps us understand insights into our profession. The narrator points out that the stated medical goal of healing Mr. Weiss's ulcers was not this patient's own goal or expectation. The patient only cared that his wife could not do laundry anymore and his ulcers caused too much soiling of the sheets, which caused her extra work when she was already unable to cope with her deteriorating physical condition. She probably could not even reach into the washer while in her wheelchair. The reality of their daily life was not explored as having meaning in the HCP's view. This position was shown in the fact that not one person had asked the patient or the family the real expectation of the visiting nurses. The doctor ordered ulcer care; the nurses came for the stated medical care after writing a nursing care plan from the doctor's order and never asked about the daily difficulties of their patient's life. No one asked the patient anything beyond an assumed problem. The lesson was learned and the Weber Health Education Model addresses the need to connect with patients at their

point of need/expectation. Further, there was a tension between Lori's own needs and the needs of her clients. She did not know if she could bring herself to her nursing, and found out in the end that bringing herself as a whole person is the most important lesson.

The poetics of teaching is the final field that provides us with a way of bringing forward beauty, truth, justice, wisdom, art or meaning. Speaking personally, I realized that for months I, as the nurse, had missed the mark; I didn't know the real reason they wanted visits. I deeply regret that I missed the chance to connect more deeply with the Weiss family before Mrs. Weiss died. I never called Mrs. Weiss by her first name during her life. I now ask my clients to call me by my first name and ask for the same permission to call them by their first name. I believe that it helps to initiate honest communication through the breaking down of formal address.

I also sometimes wonder what would have happened if I would had been honest with Bill earlier about how lonely I was and asked for friendship earlier. However, despite the sense of sadness over missed opportunities, I choose to dwell on the tenderness and beauty that occurs when two people connect. Between Bill and myself, there was a small connection when I actually told him the truth about how important those short visits were. There was amazing beauty in the conversation between Mr. Weiss and myself. There was an understanding between two people and out of that came the seeds of ideas to help others. Essentially, I would be a changed person from the experience of knowing that family. Within that conversation lay seeds of thought, which would later bring me to understand that all patients have a stated problem and a need or desire to move beyond that problem statement.

*Analysis of Story #2 "Get out of My House."* Using Fowler's (2002) Seven Fields of Narrative Analysis, the story "Get out of My House" will be examined. Firstly, in naive storytelling, the basic plot and information is described. This story has a nurse-narrator named Lori who provides three vignettes. There are a total of six people mentioned within the story. The first vignette gives the reader a small view of the workplace where the narrator finds herself. The second and third vignettes reveal two client encounters that ultimately end in the nurse being ordered from each person's home. It is an examination of failures in connecting with co-worker and patients within the narrator's workplace and nursing role.

Second, psychological reconstruction provides us with the emotional context of the story. The feelings of isolation, sadness, fear, disconnection, failure to communicate occur within each vignette. The cognitive work is to try and see beyond the negative emotions that each vignette offers. What are the connections between the three individuals? How does each person's isolation affect his or her life within this snapshot of one day? Connections between individuals can occur. Why did they not occur during this day? Other questions emerge such as: How does a person exist as a healthy individual within a toxic workplace? How does one struggle to maintain a sense of knowledge of the world when everything that is known is collapsing? Each character had problems with isolation. The narrator-nurse had previous knowledge within a nursing career that became ineffectual in a new setting that lacked connections and in which she perceived herself to be isolated. Ruby's world was also collapsing with her health crisis and she was struggling to maintain a sense of self when all that was previously known was changing. Mr. Light was isolated as well; it appeared that he was avoiding life

through substance abuse and a hermit existence.

Not stated outright in the story, but nonetheless present, was the fear of negative physical changes. This fear was a huge part of this interaction, hidden from view. Ruby caught the narrator at a vulnerable time in Lori's personal life. Lori had just been for tests that showed a tumor and was waiting for confirmation on whether it was benign or cancerous. Lori's own fears about cancer, physical changes and health crisis were occurring at the same time she met Ruby. Instead of making the connection that this personal situation would add to her own feelings with Ruby, Lori tried to continue without acknowledging her own self. Instead of recognizing the verbal and non-verbal clues that Ruby was not ready to talk about her palliative care situation, the nurse blundered on talking about care of her children after her death. Why was the nurse-narrator so blind and seemingly uncaring toward Ruby? Lori's own discomfort and personal fears were not acknowledged (even to herself) and, instead of acknowledging discomfort, Lori decided to try and hide behind a professional façade. Further, the nurse-narrator thought she was obliged to achieve a specific goal during the visit, as directed by her colleague. This single-mindedness also caused Lori to be blind to the many clues that Ruby was not ready to speak about palliative care. It is not that Lori needed to tell the client her thoughts or concerns, but in using a medical professional wall, she did not listen to the client at all. Lori did not ask Ruby her wishes or needs and did not even confirm Ruby's perception of her own illness. Lori's discomfort with Mr. Light was perhaps due in large measure to the surroundings (i.e. a filthy small house) or perhaps a feeling of danger due to substance abuse and lack of safety inherent in visiting people in their homes. A complete disconnect between nurse and patient occurred in both vignettes.

A third field is psychotherapeutic ethics where the potential for harm is discussed. The potential for harm in Lori's actions toward her two clients were great, as was some potential harm to herself from angry clients. Instead of just yelling at her and ordering her from their homes, physical harm could have resulted from both clients. In not dealing with a client's true needs and expectations, HCPs can become the object of anger experienced and expressed by clients. Patients perceive they are not heard; frustration and anger develop. Beyond the obvious emotional outbreaks by patients, there can also be a barrier to communication that may never be recoverable between HCPs and their patients. In this situation Lori was never allowed back into that client's house.

There is a call for Lori to work on acknowledging her own personal feelings when dealing with clients. Harm can result if she does not acknowledge that she is an intrinsic part of this encounter. She can assist in helping clients verbalize their needs and expectations or she can attempt to retain power and try to control the person to comply with a particular nursing care plan, which was made without patient input by a total stranger. Harm results if her focus is on medical orders and medical knowledge, rather than focusing on the human being. In each case, she was given clues by her patients that were ignored as she stubbornly continued on an unswerving, medically-driven, rather than patient focused, path. Clear words were spoken by both clients that gave her information of their true needs and expectations, which she ignored. Anger then resulted from both clients because of the forcing of medical issues, which were not the focus of their lives at that moment.

The ethical problem of power within medical relationships is important. Paternalism, which exists as part of the HCP-patient interactions, can cause HCPs to assume patients

will want health care services from only a narrow, preconceived view (i.e. the way the provider has been taught a patient requires health care). This perception or approach represents a typical failure within a health care provider and client relationship. Every patient's expectation of the HCP-patient interaction is completely different. While these stories all exist within the patient's home, it is acknowledged that most HCPs would not be privileged to see a person in their home environment. That is unfortunate as patients can be more forthcoming about their needs when they are in their own home environment. This examination of power issues is important as patients may be less open about their feelings and true selves when in an unfamiliar office environment. Further, clients may not be able to conceal problem areas within their natural environment that they may have been able to hide in a meeting in an office setting. HCPs must learn to ask clients their true expectations and use their observation skills as well. If an answer regarding expectations is not forthcoming from a patient, HCPs can ask again later in the encounter or in another encounter.

Narrative craft provides the fourth field for information. Here again there is one narrator telling three vignettes within the story. The three stories do not seem to be connected at first except for the purposes of describing a typical day within the role of a community health nurse. The story is held by the timeline of the day; starting with the morning's report and ending with Lori wondering what she will say on the next day's report.

Hermeneutic philosophy is examined in the fifth field. What is being revealed and what is being concealed within this story? The biggest reason for the creation of this story was for the narrator to begin to examine the series of events from a distance (in terms of

time) perspective. The actual telling of this story is the biggest challenge, as the act of revealing one's difficulties and self-perceived failures can be dangerous to one's sense of self and dangerous in being vulnerable to other people and situation. The revealing of these self-perceived failures allowed for a better understanding of events and needs of patients. In each vignette, information is given from the clients that could have been proven valuable had the nurse decided to pursue the patient's statements. For example, when Mr. Light said he needed to keep walking (no automobile), Lori could have asked whether he was having any problems walking, or alternatively, given him a business card and ask him to call if and when he did have anything he needed from the community nurse program. When Ruby stated she missed her hair, the nurse could have discussed the Cancer Program that assists women with wigs, make-up and spa care. When Ruby mentioned wanting everything to be normal, the nurse could have asked what normal had been and assist with any of those issues (before pursuing an area Ruby was not able to talk about at that time).

Curriculum pedagogy is brought forward in the sixth gate. Here, the personal is removed and lessons learned regarding the encounters is highlighted. From Ruby and Mr. Light, the narrator learned that patients have a right not to participate in their medical care. In their home setting, they are freer to tell someone they are not interested and order them to get out. It is unlikely in an office setting, where power structures are in place for HCPs, that a patient could or would tell that health care provider to leave. However, patients may just walk out the office door and become a non-compliant patient. In an office setting, patients would psychologically try to remove HCPs from their consciousness. This method of dealing with HCPs often results in patient's 'forgetting' a

health care directive or results in denial that a conversation between HCP-patient occurred in a certain way. Certainly, patients can choose not to follow through on issues that are not part of their needs or wants. When this occurs, HCPs have often labelled the patient 'non-compliant' and many believe there is no method of connecting with that patient, once so labeled.

The clear need to address expectations as part of any encounter became evident. Each patient encountered gave clues to the HCP on his or her true needs. In subtle ways, clients appeared to want to inform the HCP of the problem and their needs or expectations. I asked myself: Could the client's view be used by HCPs as a connecting point within an encounter?

Finally, poetics of teaching is examined. I have to speak of this field on a personal level. I have trouble seeing the beauty in this encounter. I continually regret the pain I caused Ruby by my lack of understanding of her life. Personally speaking, it would be easy to conceal this entire story as it does not put me (as a nurse and as a person) in the greatest light. In truth, I still cannot bear to think of the story from Ruby's perspective; it would be heartbreaking for me to write this story from her point of view. At the point of greatest need from her perspective, she encountered an arrogant, unfeeling and uncaring health care provider. Her struggle, her pain and her grief at the changes in her life were all ignored I just wanted to do what other HCPs had ordered and demanded. Perhaps it was the easy route for me to ignore patients as real people and focus on the known medical and health care protocols. This position allowed me to feel competent at a time when I lacked that feeling. Perhaps I was scared of being confronted by the unknown and was not prepared to actually listen to what the client really needed or wanted. Perhaps my

approach stems from my preparation as a professional nurse and the teachings of following orders. Perhaps my uncertainty in being in a new position in a northern community, as well as the desire to please my co-worker, caused me to react in a certain manner. No matter the reason, I felt a crushing sense of guilt and failure.

If I put myself in Ruby's situation, I would have ordered that health care professional out of my home as well. There is a certain justice or satisfaction that she was able to show her anger openly. She was able to get angry; her flat affect was lifted momentarily. I see myself as trying too hard to follow protocol and to do well in a job that I felt was tenuous and without support. In these stories, I see myself searching to relieve my own loneliness through patient contact. Yet, ironically, I could not see my own client's loneliness and need for connect at that time. I could not break out of my medical protocols; fear kept me from really communicating with patients. Contemplating this encounter and the process of re-framing it helped to alleviate the sense of guilt that I felt in retrospect. Perhaps the only beauty I can understand is that over time, and through remembering, I was challenged to change. Out of these situations, I began to reflect; that reflection led to a creation of something that aided me to become a better person and nurse and may also help others in their attempt to connect with their patients.

*Analysis of Story #3 "Going to the Coffee Shop."* Using Fowler's (2002) Seven Fields of Narrative Analysis, the story "Going to the Coffee Shop" will be examined. Firstly, in naive storytelling, there are three characters in this story. The plot is a series of three visits that a nurse made to the home of Mr. Moore and his son Larry, in which Mr. Moore is dying of cancer. The nurse has been told to provide pain education and management and instead is asked to arrange for a ride to the coffee shop by Mr. Moore.

Second, the field of psychological reconstruction helps us understand emotions and cognition within the story. Again, the emotions are seemingly negative in nature. Mr. Moore and his son Larry were not able to voice their problems and the nurse never did say to them that she felt something was wrong and ask for their input on the problems. Lori did not pursue the psychosocial problems in the home. For example, she did not know that one technique would have been to interview the two men separately in order to allow each to discuss issues without fear of hurting the other's feelings.

Fear as a theme is evident, in Larry, Mr. Moore and the nurse. Less evident is the unknown doctor's hidden fear of a painful death for the client (leading to a referral to home care for pain control issues). The patient's perception of the fear of a painful death is not explored. There also appears to be sadness at impending life changes, as well as sadness in health problems, which have led to a disruption in the house. There is honest inquiry on the part of the narrator to find a connection point, but the narrator is also living with uncertainty and bafflement over the tension and the request for assistance. There is an attempt by the nurse to honestly find out what the client really needs and a willingness to let go of prescribed medical orders. A sense of calmness is not yet present in the nurse-narrator over the process of trying to connect with the client. There is a tension between trying to connect and not understanding the connection.

Third, psychotherapeutic ethics can be discussed. HCP-patient interactions can be reviewed as relevant to issues of ethics and morality. Palliative care scenarios have many ethical dilemmas. Was it right for the nurse not to explore the cause of the tension in that house? Was something happening that should have been investigated? Ethically, medical assistance to ensure pain medication at time of someone's death is always open for

debate. Would Mr. Moore have lived longer without pain medication? Yet, would he have had quality of life in that remaining time without pain medication? Our culture and society give great emphasis on issues such as pain control during palliative care; there are a great many messages embedded in this story about our cultural response to death, pain control and palliative care.

Again missing from this story is a full understanding of the two men's view on whether or not the nurse's actions were useful. While it appeared that the nurse's actions were supportive and positive in nature, Mr. Moore did not express himself before his death, therefore, it will never truly be known if the nurse's actions in this household were actually positive from his view. His son could possibly shed some light on the subject, but his story is not present to aid in a full understanding. Many people could review this story and state the nurse was negligent in the lack of exploration of psychosocial issues. Did the nurse really assess the entire situation correctly or was she just looking for something to do to make herself feel useful? There are many unanswered questions as there often are in HCP-patient interactions.

Narrative craft provides the fourth field for information. This story is the third of four stories. The story that unfolds is simpler in nature and talks about fewer people than the initial two stories. It is more straightforward with fewer details to take one's attention away from the description of the encounter. This story discusses the duality of Lori's thoughts versus action, but no longer has three concerns (personal, professional workplace and patient issues) colliding at one time. There is some maturity from the scattered thinking of the first two stories and an honest intention to see the client as a person. The story is held within the three visits to the home, ending in the death of the

patient.

The issue of having a coffee is again present in this story. What is the meaning of 'coffee' in our culture? It appears to be an *act of connecting* within these stories, a form of inviting or declining an invitation to interact. It is interesting to note that in the first story, the latté was Lori's personal way of trying to connect, and the Weiss's also offered her refreshments. In the second story, Mr. Light offered her a coffee and she refused. Ruby did not offer coffee at all, perhaps due to physical fatigue or perhaps due to her lack of wanting anyone around at that time. She wanted normalcy, not a nurse visiting her. Perhaps the nurse could have thought to invite Ruby for a cup of coffee (and arrange child care for that time), which would have provided Ruby with a sense of normalcy in the midst of chaos. Mr. Moore wanted to connect with his friends in a 'normal' manner during a time when his body was losing its life to cancer. It may have been his way of showing the cancer had not taken away his connections to the people about whom he had cared and with whom he wanted to spent time.

Hermeneutic philosophy is examined in the fifth field. Lori is more thoughtful in this story and more willing to explore silence within the encounter. The patient is offered choices, but nothing is demanded of the client. More questions are asked by the nurse; unfortunately, they are not open-ended in nature. The deeper meaning of living with uncertainty of one's actions is brought forward. There is questioning of action, but less regret and shame voiced by the narrator. A connection is made between the major characters, but it is tenuous and less than full communication. A secondary element that is shown in this third story is that Lori, the nurse-narrator, no longer depends on a fellow nurse in the office for guidelines or verbal task-giving.

Curriculum pedagogy is brought forward in the sixth field. In reliving the story of Mr. Moore, lessons have been learned in how to connect with clients. Asking more open-ended questions is important, as is being honest with one's assessment and talking openly about what one sees and does not see (or understand). It is important to be thoughtful and take time to respond authentically but still professionally. Being more flexible is important, especially as the client's desire, expectation or need may be very different from what is expected by HCPs. Verbalizing problem statements and expectations were hard for Mr. Moore; allowances needed to be made to allow him the time to state his true need. HCPs cannot force clients into medical actions, they can only learn to connect and provide information.

Lastly, poetics of teaching is examined. Mr. Moore was able to see his friends again. While the narrator did not realize at the time, this provision may have been a warm and wonderful gift for him in his final days. Mr. Moore had approximately ten more visits with friends than he would have had without a few minutes of the nurse's time to arrange the transportation needed. While this activity may not have impacted the nurse, it certainly meant a lot to Mr. Moore. Even without vocalizing his feelings, it was obvious that it meant a lot to him. Mr. Moore had been previously unwilling to take the oxygen tank and the pain medication, but did so in order to have those ten visits. Those visits with friends may have made a difference in relieving the tension between father and son, as the son didn't have to worry about his father during those mornings. Mr. Moore was able to get support from his friends of long-standing. He did not appear to be a man who communicated easily with people. His time with friends with whom he was able to communicate may have meant more to him than the narrator will ever know. It may be

that the beauty was in those moments for Mr. Moore.

*Analysis of Story #4 "Seeing the Light."* Using Fowler's (2002) Seven Fields of Narrative Analysis the story "Seeing the Light" will be examined. First, in naive storytelling, there are two characters in this story. There is a nurse/narrator and the patient, Mr. Light. It is a story of a return visit between that nurse and the client. The initial visit is told in Story #2, which resulted in Mr. Light ordering the nurse from his home. Story #4 is an accounting of a second interaction between the two people and a follow-up beyond that initial negative encounter.

Second, psychological reconstruction discusses affect and emotions. As the fourth story within this series, a calmer affect is present in the encounter. There is no distress, nor are there overt behavioural issues such as yelling or ordering of any person. While Mr. Light has colorful language, it is essentially a civil conversation between two people. These two people quietly engage in a conversation that addresses both the doctor's request (to which the patient communicated a refusal) and the patient's request (regarding the toe). Matters that cannot be changed at that moment (such as the conditions of the household) are recognized and acknowledged but not judged. Respect of the patient's willingness to refuse medical assistance is evident. In this story, the client communicates his needs and as a result choices are provided to the patient by the health care provider.

Third, psychotherapeutic ethics affords an interesting time with examining this story. What is success? Mr. Light's alcoholism was not addressed; his diabetic education needs were not completed. Eating fewer hamburgers is not a goal in the diabetic educational handbook. Mr. Light told the nurse in the first encounter that he needed to walk, the nurse missed that cue then and even in the second visit. She did not connect that Mr. Light

needed to be able to walk out from his house (no driveway meant no car) and buy groceries, as well as liquor. Indeed, that may be the irony. The intervention on his toe could be seen as controversial. Medical intervention with his toe cannot be proven to be effective; it can be argued that the toe may have healed on its own. Furthermore, assisting him to heal his toe meant that he was able to walk to get his liquor. Ethically, which is of paramount importance? Would it have been better to try to address the alcoholism, the state of the house, the toe problem, or the filth in the house? There are no easy answers with looking at the ethics of this situation. If the ultimate goal was fewer hospital admissions, Mr. Light never did agree to official diabetic teaching and was never compliant with traditional medical care. Was the encounter a success and by whose measurement is something a success or failure?

Narrative craft provides the fourth field in the provision of information. This story is the shortest and simplest story of the four. The story is distilled down to two people interacting. There is less conflict between the personal and professional roles in the nurse. The patient still has the same issues as his introduction in story #2, but they are viewed, and addressed, differently by the nurse. The simple nature of the story, as compared to the previous three, points to the admission by the nurse that personal and professional self are not separate. When HCPs admit this realization, there is the opportunity to be oneself while assisting the patient. Truthfulness emerges as acceptable within the encounter. The nurse admitted to Mr. Light that she remembered him and his house from the first visit and that his housekeeping was still similar to the last visit. In admitting this fact, it can then be dealt with in a straightforward manner, such as cleaning off the counter in order to find a place to sit. If HCPs could make simple acknowledgements of the truth from

their own point of view, without judgments on that patient, perhaps encounters would prove more meaningful.

Hermeneutic philosophy is examined in the fifth field. What other interpretations could be given in this story? In reviewing the story, the question is asked: How does one evaluate outcomes in this scenario? Questions are raised about the outcomes. Was there avoidance on the part of the nurse in dealing with the harder issues in Mr. Light's life? Should the HCP have insisted the patient follow a nursing care plan or a diabetic teaching plan? If the nurse had insisted on following her protocol, he would probably have ordered her out of his home again. But does this encounter reflect a failure on the part of the nurse because she did not insist on a known accepted medical path? Were the nurse's actions just a nuisance to Mr. Light? Did Mr. Light appreciate what was done? Did he perceive that he asked for help with his toe and received help for his toe? Perhaps the fact that he was not hospitalized for diabetic comas during the time he received home care nurses and housekeeping help into his home was a positive outcome. In light of the fact that there was a verbal contract (HCP would contact the doctor and get a cream for his toe and the client would accept home care nurses coming to examine and care for his toe), perhaps this achievement could be used as a tool for judging success. The idea of developing a mutually agreed upon contract by both the health care professional and patient began to emerge as a useful tool and was developed as part of the Weber Health Education Model.

Curriculum pedagogy is brought forward in the sixth field. Lessons learned from this encounter led to the understanding that connections occur when HCPs uses the technique of asking the patient his or her needs and expectations. When patients are able to let their HCPs know the needs and expectations, a meaningful connection is possible. This

connection can also be tracked by use of a mutually agreed upon contract between HCPs and patients.

Finally, poetics of teaching is examined. There is beauty in a man who isolates himself (with alcoholism and a hermit-like life) who actually allows people to visit and help him. There was beauty in seeing the encounter unfold in a constructive and beneficial manner. The excess worry and concerns were stripped away to allow an unfolding of a seemingly simple, yet highly meaningful, encounter. This relationship or encounter fulfilled the needs of both HCP and client. There was a beauty and splendor to the whole event.

On a personal level, this story of Mr. Light was my breakthrough moment. It was the time when I felt authentic in my dealings with a client. I believed the separation between my personal self and my professional self did not exist in this encounter. I was wholly engaged in the encounter as an authentic person, wholly integrated as a personal and professional person. I am not an obsessive housekeeper in my personal life and I personally didn't mind clearing and then sitting on the counter. I realized my reaction the first visit was judgmental; I thought that he should have cleaned up as he knew a nurse was coming. I had power and control issues in that first meeting that resulted in his reaction of ordering me from his home. In the second visit, I had less pride and less judgment of his life choices and behaviour. I took the offer of the coffee. I merely wanted to know how I could help him where he was at that moment in his life. As a result, I believe that Mr. Light took the chance to tell me what he was really concerned about at that moment. Even with the many ethical questions around what the 'correct' actions were in that home, I believe that the partnership that developed, through the seemingly

simple act of asking Mr. Light his need, ultimately aided him in changing his health and his life. I created the first few steps of the Weber Model; metaphorically I 'saw the light.'

### *Distilling the Message*

As I analyzed these four stories from my nursing career, I found the messages from those stories greatly impacted my nursing and personal life. The stories provided insights on the evolution that occurred in my nursing practice in several patient encounters. However, if "narrative research (like most research) is conducted with the ultimate intention of improving our perception and understanding. . . suggesting ways we can enrich it, then it is part of a larger moral endeavour, one that leads towards action" (O'Dea, 1994, p. 170). I have analyzed the narratives and now call for action on the principles found in those stories. Importantly, I learned that I must meet clients using their point of need and their expectations as the starting point for a genuine exchange. I began to see that starting with this humanistic connection led to more intimate communications. When I could acknowledge that my personal self always intersects with my professional self, I could be realistic and honest in my interactions. When I was honest (but not hurtful) in my communications, it allowed my patients to do the same. Health issues were addressed on the foundation of that trust and respect. I began to learn that HCPs *who see a real person and is a real person*, has the potential to participate in authentic, genuine, holistic and constructive interactions with their patients. Individuals (labeled clients or patients) with a health care need, who have been given an opportunity to communicate their real needs and expectations (authenticity), then have an opportunity to participate in and learn from the health education process.

Further, I learned that differences exist between HCPs assumptions about what the health care needs are for clients, and what clients perceive as their own needs. The process of asking clients about their problem, as well as their desires or their expectations of the health care encounter was a starting point. Beyond that, a data collection phase was a natural part of the encounter. Following problem statement, needs assessment and data collection (which includes HCPs conclusion or tentative diagnosis), patient education could begin to occur. Health education could be intertwined around the expectation of the patient, (e.g., bringing diabetic teaching into a discussion regarding foot care) with the diagnosis of the health care provider. Then, the client expectations can be met by the professional or alternately (if expectations cannot be met) the expectations can be used as part of the educational encounter to validate the client's needs without necessarily fulfilling them. The expectation becomes the key to educating the client on either why their stated goal is not possible or what alternatives may exist. Even if not met, the expectation provides a validation of the person and a way of connecting within the health education component of the visit.

As well, verbal or written contracting between both parties provided a basis for evaluation of these encounters. The action resulting from these stories and their analysis was a new communication model that I began to use in my daily nursing practice for several years. As client satisfaction appeared to grow whenever I used this tool, I slowly began to teach this communication model informally to my colleagues. Ultimately, I decided to use this project as a concrete means to take this model outside the personal realm into an academic and research environment.

## Chapter Six: Results of the Research

The five research participants were enthusiastic in their responses but also appeared honest in their critical evaluation of the Weber Model. From the qualitative research conducted, three major themes emerged and are reviewed here. The tapes from the research subjects were reviewed and analyzed. This data was analyzed using qualitative content analysis to identify major themes, key phrases, and concepts used to gain insight into the use of the Weber Model. There were several common themes to all practitioners. This chapter outlines the three major themes and discusses the key findings overall with a summary of the research.

### *Major Themes*

Major themes emerge from qualitative content analysis. The tapes were listened to repeatedly and content analysis was employed with discerning themes within the content of the taped interviews. With the review of the semi-structured taped interviews, three major themes emerged. Expectations, fear, and time were the three topics repeatedly brought forward by the research participants.

*Expectations.* While all seven steps of the Weber Model were discussed, it was the expectation step which brought out the most discussion from each research participant. Each health care provider mentioned of their surprise at the variety and differing expectations that each client brought to the encounter. The patient's agenda "was so different than what I expected" and "it changed the manner of the appointment". Some HCPs discussed the idea that in their daily practice before using this Model, they had started to assume what the patient might want from the initial problem statement without ever asking to ensure accuracy of that assumption. The typical statement was "I

thought if they have this problem, then they must want XXX.” All discussed that in the past they made some kind of assumption about what needed in regards to a patient’s problem statement, but found out that their assumption was usually not correct, according to the patient once a patient was directly asked. All HCPs found to their surprise the avoidance of those assumptions became important as the patient responded to questioning with widely disparate expectations and needs. HCPs conceded that if they continue to assume, without asking for the patient’s true expectation, they noted that it felt like the appointment “was going around in circles”.

All practitioners stated they regularly used some aspects of the Weber Model during their daily practice but not in a step by step manner as set forth by the Model. When asked further, the majority of practitioners stated the two step they did not typically used included mutual contracts nor did they ask or confirm patient expectations. Problem statements were used routinely, as was health education and evaluation.

The step of asking and receiving the patient expectation appeared to change the encounter in subtle, and not so subtle, ways. Some stated that it subtly allowed the discussion to be tailored and stream lined. In knowing what the patient wanted from the encounter, the discussions, in some cases, were stream lined to deal with the issues. One participant mentioned that when the client was asked about expectations “it helped in working together to achieve goals.” In more than one case, the change was not subtle. Participants mentioned that they were often surprised at what the patient wanted and actually had problems reconciling the problem with the expectation and diagnosis. They noted this was not always a negative event, because in their knowing the patient expectation, the way of approaching the problem changed completely. The difference

between a HCPs expectations of patient's agendas and the actual patient stated expectation or agenda was at times so disparate that several HCPs expressed a sense of difficulty in overcoming the sense of surprise or shock at the difference.

In other discussions on expectations, research participants made mention that some patients could not express their expectation or goal on initially being asked. Some patients were initially uncomfortable or unable to answer questions regarding their expectations, goals or agendas. Some HCPs expressed frustration over the vagueness of some clients in verbalizing what the real expectation or need brought them to see the health care provider. HCPs concluded, however, that given some time and a degree of patience, almost all patients were able to verbalize their expectation later in the encounter.

One practitioner was able to see a client twice the week of the research and was able to complete the final step of the Weber Model, the evaluation of the verbal contract that was done previously that week. In the circumstance, the practitioner mentioned that the evaluation step helped the review of the past visit and helped tailor the discussion and brought focus to the next encounter.

In the end, participants stated that the Weber Model was useful in deepening the connection made with patients during the encounters. They used terminology like "deeper", "more connected", "partnership" and "meaningful." Almost all participants mentioned their surprise that this was possible during encounters that they would otherwise have seen as routine.

*Fear.* Fear was a theme mentioned by some HCPs. This was not a surprising finding, as changing the status quo always brings in an element of fear. However, the

depth of this theme was surprising to me. For example, there was some fear involved for the practitioner in asking expectations, as it was stated that the fear originated from the HCPs perception that it could diminish their sense of “what is right for the patient”. One research participant stated that a the HCP must have a strong sense of competence and firm belief in diagnosis in order to use this model where there may be some challenge to their diagnosis. Concern was expressed that in allowing the patient a voice in their own expectation, that the patient may think they are correct regarding their diagnosis, without the medical knowledge that a practitioner has to confirm the disease or illness process. Further concerns were that the patient’s expectations could sway a practitioner to stray from their real diagnosis in order to “make patient’s happy”. Fear was again mentioned in telling patients the truth- that some expectations cannot be met. Fear was also a component mentioned in the difference in styles; the styles mentioned were being “upfront” versus “concealing”.

From the patient perspective, one practitioner stated that patients may not want to tell their HCP’s about their expectations, as patients may fear the health care provider’s response if they (the patient) look too demanding too quickly in the interaction. One practitioner feared that patients may not voice their true expectation as the patient may have fear in stating that expectation. The example used by the research participant to explain this was the idea that the fear of procedures may make the patient too scared to voice a need for blood work or certain medical tests.

One practitioner wondered how many patients he/she had seen in the past but had never really understood or had real knowledge of inner concerns and needs. This practitioner mentioned that because he/she had tried this model, it would be hard to go

back to not asking the expectations. This practitioner and others mentioned that they were left wondering and fearing how many patients had been disappointed and frustrated with the practitioner and “have been lost” through not asking expectation.

*Time.* The time element caused some interesting differences between research subjects. Even before using the model, several HCPs stated that they had deep concerns regarding time element with using the model. These HCPs anticipated that in all cases the Weber Model would take more time in the appointment or encounter, when in fact they admitted later that the time element varied with the client’s ability to verbalize expectation. Essentially, two groups developed, each having differing opinions on the time element after using the model. Two HCPs stated that the Weber Model required more time to conduct the appointment while two HCPs stated that the Weber Model focused discussions and time was not wasted on extraneous issues ( and one participant stated it depended on the client). However, one of the HCPs (in the first group) who stated the model took extra time also mentioned that the extra time was taken in order to allow the patient time to verbalize an expectation. The second group of HCPs believed the model saved them from giving extra information that was not of concern to the patient.

It appears that some clients were able to verbalize their expectations very quickly and this appeared to open communication between HCP and patient early and provide ease of transfer between steps. The patient unable to verbalize a response to the expectation question or clients with multiple disparate issues tended to slow the use of the Weber Model and the appointment time. All practitioners conceded an initial discomfort with the wording of the model and the usage of a new method of interacting with patients and this

may have caused extra time.

### *Key Findings Overall*

All participants were generally positive about the Model and stated they may use it in the future. In regards to approaching clients, all participants mentioned that the Weber Model gave them much cause for thought about how to approach patients. One mentioned they did not know a new model or tool was possible within the narrow confines of a daily HCP-patient encounter. Research participants also described the interactions as more meaningful and providing a higher level of connection between themselves and their patients. However, to state these key findings more succinctly: Despite some hesitation, HCPs found patients had a wide variety of expectations and found that asking expectations was the key to a deeper understanding of an individual's true concern with a specific health problem.

### *Summary*

To begin this project the research question asked was "Does the Weber Health Education Model allow for meaningful contact between health care provider and patient?" The response to the question is "yes," the research participants validated the idea that the Weber Health Education Model does allow for meaningful contact between HCPs and patients, with the key to changing the depth of the encounter is the step of asking and confirming the patient expectation of the encounter, within the seven step process. This research project provided validation of the use of the Weber Model in daily HCP-patient interactions.

## Chapter Seven: Future Research and Conclusion

It was gratifying to hear all the research participants state that the Weber model was useful to health care practice and they may use aspects of it in the future. However, with the positive and negative observations, there are many areas for further research. A new model has been created but where does it go from here? There are many areas of research which may prove worthwhile with the Weber Model.

Within the qualitative realm; there are many options to exploring this model. “Although building and maintaining relationships with clients is at the heart of nursing practice, few studies have explored nurse-patient interactions and how these interactions influence the outcome of care” (Spiers & Caron, 2003, p.1033). Exploring the experience and perceptions of being a patient, the experience of being a health care provider, and the experience of communication within a health encounter could be one of many options. Research would be useful that would assist in answering the questions “Will patients be content with a validation of their expectation with an health education encounter?” or “Does the encounter need to fill the patient’s expectations before they call that encounter successful?”

Discovering, through narrative research, the stories of clients and their interactions with HCPs (as well as HCPs narratives of clients) could be exciting work. It would be interesting to explore the positive and the negative themes in these narratives. A qualitative case study could prove interesting, if done on a HCP who admits to already using some elements of the model, in order to gain a fuller view of that health care provider, how they gained the same view as the Weber Model and whether some elements of the Weber model are useful in isolation from all seven steps. A review of

teaching methods within health education of practitioners would be interesting. What are the similarities and differences in how HCPS are taught to conduct health education? A review of teaching practices within the schools of various health care providers would give important background information to the variation in HCPs methods of interacting with patients.

A form of focus group where HCPs and clients could talk about the visits together would be ground-breaking research. Action research in a workplace or clinic could also be another venue for research with a project on changing patient satisfaction levels. Linking financial aspects of the use of the Weber Model to actual practice would be useful in this day and age of financial constraints. It is also important to take this model into the public domain through knowledge dissemination to get more feedback on this communication tool.

This Model also lends itself well to quantitative research views. Research using Likert scales regarding satisfaction levels within a HCP who uses the model in comparison with a Likert scale regarding satisfaction with a HCP who does not use the model would provide interesting data. Focus groups could then occur with clients or HCPs to give valuable data on HCP-patient interactions and what is considered a positive or negative appointment from each. The model could be explored in each of the different types of health care provider's roles, to give information on its usefulness toward each group. The model could be explored in realms other than medical, such as the education or business sectors. The model is currently set for personal health education which is one on one, but the exploration of its use in small groups or a community-wide setting could also yield useful information. There are numerous possibilities in the qualitative and

quantitative research arenas, as this Model has the potential for application in diverse settings by various disciplines.

As previously mentioned research could occur with a variety of patients who may have such health problems as mental health difficulties, head injuries, and brain disorders. It is interesting to note that any limitations within the research are actually areas that could host further research. For example, patients who do not speak English well or have language difficulties may need this communication model. The cultural issues that lead to a wholly different set of expectations in this group of patients may require a high degree of inter-connectedness between provider and client. The health care expectations and needs of a person from outside the western culture may be quite disparate from what a western-oriented health care provider initially understands. Therefore, further research is needed to see if HCPs could find the Weber Model useful in meeting the needs of persons who may have culturally-diverse expectations.

Another example of limitations that can be viewed as future research opportunities include clients with brain disorders or brain injuries who may not be cognitively functioning at a high level. It initially appears that the use of the Weber Model is limited with brain disordered clients, but exploration of the point where people can no longer participate with their own decision-making would be useful. Certainly, the use of the Weber Model with the families of brain disordered clients would be another source of valuable resource; this would bring the Model out of personal health education into exploration of its use in small group health education. The same could be said of the use of the Weber Model within the pediatric population. Younger clients may not be able to fully participate in questions regarding their own care: however, it would be interesting to

conduct research into understanding at which age the Weber Model moves from being inappropriate to appropriate. This population would also afford an opportunity to apply the model in a group format (i.e. HCPs, child and parent or parents, as well as siblings and other relatives). Again, while limitations may occur in the pediatric population, further research into the use this model with the parents of those pediatric patients may be useful. Hopefully, I can be part of bringing this Model to others, in order to be part of the process of providing excellence in collaborative communication between HCPs and patients.

### *Conclusion*

Within this project I have sought to answer the research question “Does the Weber Health Education Model allow for meaningful contact between health care provider and patient?” This project was created to show the development of ideas gained from narrative analysis of stories of several patients encountered while nursing in the Canadian north into the creation of a model used by HCPs to assist in their patient interactions. Those four stories, once interpreted through narrative analysis, provided the basis for a seven-step model known as the Weber Health Education Model. Research was conducted to allow for health care practitioners to use the Weber Model in their professional practice and share their perceptions with me. The outcome of that research assisted with a greater understanding of HCP-patient interactions and generated the following statement and a call for more research: Despite initial hesitation, health care providers found using the Weber Health Education Model to be an effective tool for meaningful connections within encounters. In particular, patients had a wide variety of expectations and found

that asking about expectations was the key to a deeper understanding of an individual's true concern with a specific health problem. This project was an initial step in searching for meaningful connections between HCPs and patients. It is my hope that the research called for in this project will allow for greater contributions in this use of this Model and meaningful communications. While the following, from Rilke (1987), talks about love, it could easily refer to the intimate interactions between HCPs and patients.

The most difficult task that has been given to us . . . the work for which all other work is merely preparation . . . Love does not at first mean merging, surrendering, and uniting with another person. . . Rather it is a high inducement for the individual to ripen, to become something in himself, to become world, to become world in himself for another's sake. (p. 235)

## Reference List

- AAHE. (2004). *Mission, vision and guiding principles*. American Academy of Health Education. Retrieved April 13, 2004 from [www.aahe.org](http://www.aahe.org)
- Alberta Teacher's Association. (2001). *Action research: Facilitation and Implementation*. Edmonton, AB, Canada. ATA.
- Allen, P. (2000). Accountability for clinical governance: Developing collective responsibility for quality in primary care. *British Medical Journal*, 321(7261), 608-611. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Babcock, D., & Miller, M. (1994). *Client education: Theory and practice*. St. Louis: Mosby.
- Bartle, E., Couchonnal, G., Canda, E., & Staker, M. (2002). Empowerment as a dynamically developing concept for practice: Lessons learned from organizational ethnography. *Social Work*, 47(1), 32-43. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Bedworth, D., & Bedworth, A. (1978). *Health education: A process for human effectiveness*. NY: Harper and Row.
- Beckham, J. (1997). The accountability crisis in health care. *The Healthcare Forum Journal*, 40(4), 34-38. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>

- Blendon, R., Schoen, C., DesRoches, C., Osborn, R., & Zapert, K. (2003). Common concerns amid diverse systems: Health care experiences in five countries. *Health Affairs*, 22(3), 106-121. Retrieved June 20, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Blumenthal, D. (1996). Effect of market reform on doctors and their patients. *Health Affairs*, 15(2), 170-185. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Corey, G. (1977). *Theory and practice of counseling and psychotherapy*. Belmont, CA: Wadsworth Publishing Company.
- Coulter, A., Entwistle, V., & Gilbert, D. (1999). Sharing decisions with patients: Is the information good enough? *British Medical Journal*, 318(7179), 318-322. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Cousins, J., & Leithwood, K. (1986). Current empirical research on evaluation utilization. *Review of Educational Research*, 56(3), 56-62. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Crowe, M., O'Malley, J., & Gordon, S. (2001). Meeting the needs of consumers in the community: A working partnership in New Zealand. *Journal of Advanced Nursing*, 35(10), 88-96.
- Davis, L., & Chesbro, S. (2003). Integrating health promotion, patient education, and adult education principles with the older adult: A perspective for rehabilitation professionals. *Journal of Allied Health*, 32(2), 106-109.

- Dennison, D., & Golaszewski, T. (2002). The activated health education model: Refinement and implications for school health education. *Journal of School Health*, 72(1), 23-27. Retrieved November 16, 2003 from <http://0-proquest.umi.com/darius.uleth.ca>
- Dewar, S. (2000). Collaborating for quality: The need to strengthen accountability. *Journal of Interprofessional Care*, 14(1), 31-38. Retrieved March 31, 2004 from <http://0-proquest.umi.com.darius.uleth.ca>
- DeYoung, S. (2003). *Teaching strategies for nurse educators*. Upper Saddle River, NJ: Prentice Hall.
- Donnelly, G. (2003). Integrate holistic care one patient at a time. *Holistic Nursing Practice*, 17(2), 117. Retrieved March 31, 2004 from <http://0-proquest.umi.com.darius.uleth.ca>
- Dontje, K., Corser, W., Kreulen, G., & Teitelman, A. (2004). A unique set of interactions: The MSU sustained partnership model of nurse practitioner primary care. *Journal of the American Academy of Nurse Practitioners*, 16 (2), 63-70.
- Evans, J. (1998). Changing the lens: A position paper on the value of qualitative research methodology as a mode of inquiry in the education of the deaf. *American Annals of the Deaf*, 143(3), 246-254. Retrieved March 31, 2004 from <http://0-proquest.umi.com.darius.uleth.ca>
- Falk-Rafael, A. (2001). Empowerment as a process of evolving consciousness: A model of empowered caring. *Advances in Nursing Science*, 24(1), 1-16. Retrieved March 31, 2004 from <http://0-proquest.umi.com.darius.uleth.ca>

- Ford, S., Schofield, T., & Hope, T. (2003). What are the ingredients for a successful evidence-based patient choice consultation: A qualitative study. *Social Science and Medicine*, 56(3), 589-602.
- Fowler, L. (2002). A curriculum of difficulty and "The Anger of our Miss Marple": The story and the commentary. *Language and Literacy*, 3(2), 1-21. Retrieved May 1, 2004 from <http://educ.queensu.ca/~landl/archives/vol32papers/fowler.htm>
- Fromm, E. (1959). The creative attitude. In H. Anderson (Ed.), *Creativity and its Cultivation*. (pp, 44-54), NY: Harper & Row.
- Galer-Unti, R., Miller, S., & Tappe, M. (2004). A content analysis of CNHEO journal for policy and advocacy articles 1991-2000. *American Journal of Health Education*, 35(1), 30-37. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Gallant, M., Beaulieu, M., & Carnevale, F. (2002). Partnership: An analysis of the concept within the nurse-client relationship. *Journal of Advanced Nursing*, 40(2), 149-157.
- Giroux, J. (2003). Healing interactions. *Urologic Nursing*, 23(6), 398, 413. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Glanz, K., Rimer, B., & Lewis, F. (Eds). (2002). *Health behaviour and health education theory research and practice*. San Francisco: Jossey- Bass.
- Hawks, S. (2004). Spiritual wellness, holistic health, and the practice of health education. *American Journal of Health Education*, 35(1), 11-16. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>

- Health Canada. (1999). *Toward a healthy future: Second report on the health of Canadians*. Ottawa, Ontario, Canada: Health Canada.
- Hewlitt-Taylor, J. (2003). Issues involved in promoting patient autonomy in health care. *British Journal of Nursing*, 12(22), 1323-1330. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Jung, C. (1984). *Jung extracts: Psychology and western religion*. Princeton, NJ: Princeton University International Finance.
- Kalamazoo Consensus Statement. (1999). Essential elements of communication in medical encounters: The Kalamazoo consensus statement. *Academic Medicine*, 76(40), 390-393. Retrieved May 13, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Kemm, J. (2003). Health education: A case for resuscitation. *Public Health*, 117(2), 106-112.
- Knowles, M. (1984). *Andragogy in action*. San Francisco: Jossey-Bass.
- Lalonde, M. (1974). *A new perspective on the health of Canadians*. Ottawa, Ontario, Canada: Government of Canada. Retrieved June 30, 2004 from <http://www.hc-sc.gc.ca/hppb/phdd/pdf/perspective.pdf>
- Lightfoot, C. (2003). Discovering the experts. *Canadian Journal of Dietetic Practice and Research*, 64(2), 3. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Lusk, M., & Decker, I. (2001). Moving toward a model for nursing education and practice. *Nursing and Health Care Perspectives*, 22(2), 81-87. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>

- Maeseneer, J., van Driel, M., Green, L. & van Weel, J. (2003). The need for research in primary care. *The Lancet*, 362(9392), 1314-1319. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Milner, J. (2003). Compassionate nursing care with meaning: Incorporating holism into nursing practice. *Chart*, 100(6), 4-6. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Mitchell, P. (1997). Shared decision-making poses problems for UK. *The Lancet*, 349(9061), 1306. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Morris, D. (2002). The inclusion of stakeholders in evaluation: Benefits and drawbacks. *Canadian Journal of Program Evaluation*, 17(2), 49-58. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Nordgren, S., & Fridlunds, B. (2001). Patients' perceptions of self-determination as expressed in the context of care. *Journal of Advanced Nursing*, 35(1), 117-125. Retrieved March 31, 2004 from <http://www.ncbi.nlm.nih.gov>
- O'Dea, J. (1994). Pursuing truth in narrative research. *Journal of Philosophy of Education*, 28(2), 161-171.
- Orem, D. (1991). *Concepts of practice*. St. Louis, MI: Mosby Yearbook.
- Pender, N. (1982). *Health promotion in nursing practice*. Norwalk, CT: Appleton-Century-Crofts.
- Polit, D., & Hungler, B. (1999). *Nursing research Principles and methods (6<sup>th</sup> ed.)*. Philadelphia: Lippincott.

- Potter, W. (1996). *An analysis of thinking and research about qualitative methods*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Powers, P. (2003). Empowerment as treatment and role of health professionals. *Advances in Nursing Science*, 26(3), 227-237. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Radwin, L., & Alster, K. (2002). Individualized nursing care: An empirically generated definition. *International Nursing Review*, 49(1), 54-63.
- Raphael, D. (2000). The question of evidence in health promotion. *Health Promotion International*, 15(4), 355-367.
- Rilke, R.M. (1987). *Letters to a young poet*. NY: Random House.
- Rimer, B., Glanz, K., & Rasband, G. (2001). Searching for evidence about health education and health behaviour interventions. *Health Education and Behaviour*, 28(2), 231-248. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Robley, L. (1995). The ethics of qualitative nursing research. *Journal of Professional Nursing*, 11(1), 45-48.
- Rockefeller, R. (1999). Informed shared decision-making: Is this the future of health care? *Health Forum Journal*, 42(3), 54-56. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Rogers, C., & Wood, J. (1974). Client-centred theory: Carl Rogers. In A. Burton (Ed.). *Operational theories of personality*. NY: Brunner/Mazel.

- Rosenberg, M., & Moore, E. (1997). The health of Canada's elderly population: Current status and future implications. *Canadian Medical Association Journal*, 157(8), 1025-1032. Retrieved June 20, 2004 from <http://proquest.umi.com.darius.uleth.ca>
- Russell, S., Daly, J., Hughes, E., & Hoog, C. (2003). Nurses and 'difficult' patients: Negotiating non-compliance. *Journal of Advanced Nursing*, 43(3), 281-287.
- Schima, M., Ames, E., Nolte, A., Allensworth, D. et al. (1996). The health education profession in the 21st century: Setting the stage. *Journal of School Health*, 66(8), 291-299. Retrieved March 31, 2004 from <http://0-proquest.umi.com.darius.uleth.ca>
- Shuster, S., Ross, S., Shagat, R., & Johnson J. (2001). Using community development approaches. *Canadian Nurse*, 97(6), 19-22.
- Siminerio, L. (1999). Defining the role of the health education specialist in the United States. *Diabetes Spectrum*, 12(3), 152-157. Retrieved March 31, 2004 from <http://0proquest.umi.com.darius.uleth.ca>
- Sobel, R. (2004, January 19). Health, right and wrong? *US News and World Report*, 136(2), 65. Retrieved March 31, 2004 from <http://0proquest.umi.com.darius.uleth.ca>
- SOPHE. (2004). *About SOPHE*. Society for Public Health Education. Retrieved April 13, 2004 from [www.sophe.org](http://www.sophe.org)
- Spiers, J., & Caron, C. (2003). Patients and nurses negotiated home care interactions within six interpersonal contexts. *Evidence-Based Nursing*, 6(3), 1. Retrieved November 16, 2003 from <http://o-proquest.umi.com.darius.uleth.ca>

- Stake, R. (1998). Case studies. In N. Denzel (Ed.). *Strategies of Qualitative Inquiry*. Sage: Thousand Oaks, CA
- Sullivan, T., & Flood, C. (2004). Cretien's prescription for medicare: A green poultice in lieu of accountability. *Canadian Medical Association*, 170(3), 359-360. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Thornton, L., & Gold, J. (1999). Integrating holism into health care for the new millennium. *Surgical Services Management*, 5(12), 41-44. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Webster, J., & Cowart, P. (1999). An innovative professional nursing practice model. *Nursing Administration Quarterly*, 23(3), 11-16. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>
- Whitehead, D. (1999). The nature of health promotion in acute and community settings. *British Journal of Nursing*. 8(7), 463-470.
- Whitehead, D. (2001a). A social cognitive model for health education/health promotion practice. *Journal of Advanced Nursing*, 36(3), 417-426.
- Whitehead, D. (2001b). A stage planning programme model for health education/health promotion practice. *Journal of Advanced Nursing*. 36(2), 311-321.
- Whitehead, D., Takey, A., & Smith, P. (2003). Action research in health promotion. *Health Education Journal*, 61(1), 5-22.
- Whitman, N., Graham, B., Gleit, C., & Boyd, M. (1992). *Teaching in nursing practice*. Stamford, CT: Appleton & Lange.

Whitney, S., McGuire, A., & McCullough, L. (2004). A typology of shared decision making, informed consent, and simple consent. *Annals of Internal Medicine*, 140(1), 54-59. Retrieved March 31, 2004 from <http://0-proquest.umi.com.daruis.uleth.ca>

World Health Organization. (1986). *Ottawa charter for health promotion*. Geneva: WHO.

World Health Organization. (1998). *WHO health promotion glossary*. Geneva: World Health Organization.

## Appendix A - Consent Letter

April 2004

Dear Sir or Madam

You are invited to take part in a research study. I am asking you to use the Weber Personal Health Education Model (attached) on three patients over the week of April 19-23, 2004. On the following week, I will be asking for some time to discuss with you (in a short, semi-structured taped interview) the effects of using that model in your practice. You will not be asked for patient name or information, only your perception of the interactions while using the model. The information you provide will assist in understanding how best to conduct health education encounters. I will be asking you for honest and frank responses with both positive and negative responses to the model.

Please read the following carefully and sign below if you are willing to participate in this study.

I understand that I am participating in a study about my perceptions of five health education encounters using the Weber Personal Health Education Model. I understand that I may refuse to participate in this study by informing the researcher that I am not able to participate or by simply not using the model. I also have the right to withdraw at any point until the completion of my taped interview. By agreeing to participate, I will use the model during five patient encounters during the week of April 19-23, 2004 and agree to be interviewed the following week in a brief, taped, semi-structured interview. I grant permission for the researcher to use the data so provided for the study. I understand that at no times will names of health care providers or clients will be used in the research project by the researcher. My anonymity will be respected. I understand the researcher may use the data for a Research Project and that this project may be available at a future date through the University of Lethbridge Library and used in other sources such as presentations, future research, published works, journal articles etc. The researcher has informed me that data will be kept for approximately five years in a secure filing cabinet in my home, then destroyed. I understand I can inquire about the research and that the researcher will provide me with a copy of the Project paper upon request for up to a year beyond this participation.

Any questions regarding the research study should be directed to myself or the following people at the University of Lethbridge, 4401 University Drive, Lethbridge, AB, T1K 3M4

- 1) Dr. Leah Fowler, Project Supervisor (403) 329-2457
- 2) Dr. Karran Thorpe, Committee Member (403) 329-2012
- 3) Chairperson, Human Subjects Research Committee, Dr. Thelma Gunn (403) 329-2455

Thank you      Sincerely

\_\_\_\_\_  
Lori Weber (M.Ed. Candidate) phone (403) 381-3641

I \_\_\_\_\_ consent to participate as a subject in this study.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Appendix B - Research Instruments

### Five Open-Ended Questions to Assist in Creating Structure to the Interview Process

- 1) What were your perceptions (as a Health Care Provider) of the use of the Weber Personal Health Education Model last week? (What was your perception on the use of the Model in terms of making a difference - or not- in your patient encounter or practice last week?).
- 2) What was your perception of the Weber Personal Education model as a tool of your practice? (both positive and negative perceptions sought)
- 3) What were your perceptions of client response to the Weber Personal Education model? (From your view, was the client response to its use any different from encounters not using the model)?
- 4) In terms of educating the client, what were your perceptions of the tool in
  - a) gaining insight into client desires of encounter
  - b) focussing discussions
  - c) the education process
  - d) providing commitment to dealing with the problem statement
  - e) providing closure
- 5) Would you recommend the use of the Weber Personal Health Education for other practitioners? Why or why not? Would you continue using this tool, why or why not?