PATIENT EDUCATION AND HEALTH LITERACY

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Structured abstract
Introduction; Patient education is a relatively new science within the field of health care. In the past it consisted mainly of the transfer of knowledge and mostly biomedically based advice. Research has shown this to not be effective and sometimes counterproductive. As health care has moved away from applying a traditional paternalistic approach of ‘doctor knows best’ to a patient-centred care approach, patient education must be tailored to meet persons’ individual needs.

Purpose; The purpose of this master paper is to increase awareness of patients’ health literacy levels. Health literacy is linked to literacy and entails people’s knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course. Many patients have low health literacy skills, and have difficulty with reading, writing, numeracy, communication, and, increasingly, the use of electronic technology, which impede access to and understanding of health care information.

Implications
Multiple professional organizations recommend using universal health literacy precautions to provide understandable and accessible information to all patients, regardless of their literacy or education levels. This includes avoiding medical jargon, breaking down information or instructions into small concrete steps, limiting the focus of a visit to three key points or tasks, and assessing for comprehension by using the teach back cycle. Printed information should be written at or below sixth-grade reading level. Visual aids can enhance patient understanding.

Keywords: patient education; biopsychosocial; health literacy; patient centred care
INTRODUCTION

Patient education is now an integral part of all physiotherapy treatment, but it has not always been that way. The professional development of patient education as a discipline and its foundation in scientific research is relatively new (Hoving et al., 2010). Until the 1960s, health care providers were the authority, responsible for the diagnosis, treatment and healing of patients. The patient was viewed as passive and was not expected to participate actively in diagnosis and treatment decisions or to ask any questions (Hoving et al., 2010). By the end of the 1960s a growing number of health care professionals, policy makers and initial patient groups began to express new opinions on patients’ right to be fully informed about their condition. Gradually more emphasis was placed on patient education in general and on individual information supply in particular. By the late 1980s patient education had become a regular part of most health care professionals’ curricula. By the mid-1990s patients’ rights to receive all information necessary to give informed consent on all diagnostic, therapeutic and research procedure were signed into law in most Western countries. As a result of this law, a flood of standardized information materials were developed for the most common diseases and medical interventions. These were frequently not developed in a systematic way, but based on what the health professionals thought was important (Hoving et al., 2010). Today, providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions (patient centeredness) is a priority (Institute of Medicine, 2001). As a consequence, patient education has shifted from just a transfer of knowledge to the co-creation of knowledge (Aujoulat et al., 2008). The evidence shows that patient-centred care improves disease outcomes and quality of life, and that it is critical in addressing racial, ethnic, and socioeconomic disparities in health care and health outcomes (Epstein et al., 2010).

Results from systematic reviews on patient education to date are disappointing. Not only are there very few studies on physiotherapy patient education, but the educational content and outcomes are poor. Yu et al. (Yu et al., 2016) conducted a systematic
review to evaluate the effectiveness of structured patient education for the management of patients with whiplash-associated disorders or neck pain and associated disorders. They reported “All structured patient education interventions included advice on activation or exercises delivered orally combined with written information or as written information alone. Overall, as a therapeutic intervention, structured patient education was equal or less effective than other conservative treatments including massage, supervised exercise, and physiotherapy. However, structured patient education may provide small benefits when combined with physiotherapy”. Straube and colleagues (Straube et al., 2016) reviewed the evidence for back schools and found a weak evidence base for the use of back schools to treat chronic low back pain. A recent systematic review and meta-analysis (Ainpradub et al., 2016) on the effect of patient education for non-specific neck pain and low back pain concluded that “Education programs were effective in treating low back pain in the intermediate-term follow-up but not in the long-term follow-up.”

The interventions included in these reviews reflect our educational history. Many “educational interventions” can be considered information giving only, such as providing a booklet or other written materials, or frontal lectures with the physiotherapist transferring mostly biomedical information.

There is, however, limited evidence that pain neurophysiology education (PNE) significantly reduces catastrophizing and increases knowledge about pain (Geneen et al., 2015) in patients with chronic musculoskeletal pain. The possible strength of PNE may be it that it aims to reconceptualize thinking about (chronic) pain and is less focused on the sending of information and more on a dialogue between provider and patient.

PURPOSE EDUCATION

What do we aim to do with our patient education? Is it just about the provision of accurate and truthful information so that individuals can become knowledgeable about their condition and make an informed choice? While this may have been ground-
breaking almost 40 years ago, nowadays most of our patients have chronic conditions and information provision is not enough. Patients increasingly must learn to manage their own condition which requires not only knowledge, but also medical or behavioural management, role management, emotional management and self-management skills (Lorig and Holman, 2003). The World Health Organization (WHO) (Guilbert, 2000) defines therapeutic patient education as education that helps patients to learn and to develop many competencies as well as to adapt behaviours leading to the improvement of health. What this means is that we should aim to increase people’s health literacy skills through patient education.

HEALTH LITERACY

Health literacy has been defined in many different ways since it was first introduced as a term and concept. One definition is: “Health literacy is linked to literacy and entails people’s knowledge, motivation and competences to access, understand, appraise and apply health information in order to make judgements and take decisions in everyday life concerning health care, disease prevention and health promotion to maintain or improve quality of life during the life course” (Sorensen et al., 2015, 2012). Another much used definition is “The personal, cognitive and social skills which determine the ability of individuals to gain access to, understand, and use information to promote and maintain good health” (Nutbeam, 2000).

People with limited health literacy most often have lower levels of education, are older adults, are migrants and depend on various forms of public transfer payments (Kickbusch et al., 2013).

Nutbeam (Nutbeam, 2000) distinguished 3 levels of health literacy:

1. Basic/functional literacy—sufficient basic skills in reading and writing to be able to function effectively in everyday situations. This means being able to read health related pamphlets, or reading the label on a pill bottle.

2. Communicative/interactive literacy—more advanced cognitive and literacy skills which, together with social skills, can be used to actively participate in everyday activities, to extract information and derive meaning from different forms of communication, and to apply new information to changing circumstances. At this level a
person can, for instance, read and interpret health information from the internet and discuss this with a physician when negotiating treatment.

3. Critical literacy—more advanced cognitive skills which, together with social skills, can be applied to critically analyse information, and to use this information to exert greater control over life events and situations. A person with critical literacy can effectively self-manage, ask for help when appropriate and make informed decisions.

Patients with critical health literacy skills are what we consider easy patients; they come on time, are prepared, can clearly articulate a specific goal for treatment and complete questionnaires without complaining. They remember information, do their homework, but they are rare in clinical practice. According to National Assessment of Adult Literacy (NAAL) only 12% of American adults fall into this category. Overall, 36% of the adult participants had basic or below basic health literacy skills (Cutilli and Bennett, 2009). The European Health Literacy Survey conducted in 2011 concluded that nearly half of Europeans have inadequate and problematic health literacy skills; 12% of all responders had inadequate health literacy skills and 35% had problematic health literacy skills (Kickbusch et al., 2013).

INSERT PIC HEALTH LITERACY IN EUROPE

This study also found that the amount of physical exercise was most consistently and strongly associated with health literacy; the higher the health literacy skills, the higher the frequency of physical exercise. Sixty percent of adults in Canada lack the capacity to obtain, understand and act upon health information and services and to make appropriate health decisions on their own (Murray et al., 2008). Equally, 60 percent of adult Australians have low individual health literacy skills (ACSQHC - Australian Commission on Safety and Quality in Health Care, 2014).

Patients with low health literacy skills have insufficient reading, writing or numeracy skills for effective functioning in the health context. They may not be able to follow the direction signs in a hospital, tell the time (thus coming late for their appointment), adequately follow directions for their care as described in written materials, such as appointment reminder cards and informational brochures, understand how to take medications, read the labels on their pots of pills and have more difficulty in managing chronic or long-term conditions on a day-to-day basis. This includes planning and
adjusting their lifestyle, making informed decisions and knowing when and how to access health care services. They also have trouble providing information about their health problems to healthcare professionals. Patients with low literacy may not realize what information health care professionals need, may lack the health vocabulary to report symptoms accurately, or may relate information in an illogical or out-of-sequence fashion (Williams et al., 2002).

**INSERT PIC SIGNS OF LOW HEALTH LITERACY**

A systematic review showed that low health literacy is consistently associated with more hospitalizations; greater use of emergency care; lower receipt of mammography screening and influenza vaccine; poorer ability to demonstrate taking medications appropriately; poorer ability to interpret labels and health messages; and, among elderly persons, poorer overall health status and higher mortality rates (Berkman et al., 2011). Many patients with reading problems are ashamed and hide their inability to read (Parikh et al., 1996). The recurring reason given by participants who said they were reluctant to ask questions or to make it known that they had not understood what was said was that they were concerned to avoid revealing to health professionals that they had literacy difficulties (Easton et al., 2013). They had concealed their low literacy in healthcare settings, for example, by saying they did not have their reading glasses; relied on a trusted person who accompanied them to consultations; saying they would read something later; or making an excuse to leave (Easton et al., 2013). Participants frequently reported difficulties in understanding what was said during consultations and they attributed these difficulties in part to the language used by clinical staff (especially physicians). Several studies have shown that health care providers often do not recognize health literacy difficulties among working age adults who can engage in spoken conversations in the dominant language (Bass et al., 2002; Kelly and Haidet, 2007; Rogers et al., 2006).

Good patient–professional interaction is essential for good outcomes (Dibbelt et al., 2010; Nijs et al., 2013; Oosterhof et al., 2014; Stewart et al., 1979). Factors associated with a high quality patient-professional interaction include the patient experience of being taken seriously, the involvement of the professional with the patient, a clear explanation of the pain, and an open interaction between patient and professional.
A health literate sensitive approach may foster an environment that promotes patient empowerment, which could ultimately lead to improved adherence to self-management strategies (Mackey et al., 2016). Although there are a number of tools that screen for limited health literacy, they are primarily used for research. Routinely screening patients for health literacy has not been shown to improve outcomes and is not recommended. Instead, multiple professional organizations recommend using universal health literacy precautions to provide understandable and accessible information to all patients, regardless of their literacy or education levels (Hersh et al., 2015).

PAIN BELIEFS
Although there is very little research on how or if low health literacy influences patient’s beliefs about their condition, it is, however, increasingly important for us as researchers and healthcare professionals to understand how the perceptions, experience and impact of having a musculoskeletal condition might influence a patient's interpretation and response to it, so that we, in turn, can respond more appropriately (Hale et al., 2007). It is not only essential to understand our patients, but also to have insight into our own beliefs. Our own beliefs influence our behaviour, such as the choice of treatment strategy or advice given to patients (Daykin and Richardson, 2004). Quantitative studies in chronic low back pain have shown that physiotherapists’ fear avoidance scores were positively correlated with increased certification of sick leave, advice to avoid return to work, and advice to avoid return to normal activity. A higher biomedical orientation score (indicating a belief that pain and disability result from a specific structural impairment, and treatment is selected to address that impairment) was associated with advice to delay return to work, advice to delay return to activity, and a belief that return to work or activity is a threat to the patient (Gardner et al., 2017). When medical investigations fail to shed light on a physical cause of pain, the mind-body dichotomy is invoked: If the cause is not in the body it must be in the mind. Explaining chronic pain in terms of psychologic factors, “the pain is in your head”, can be experienced by patients as disbelief and a denial of their pain. On the other hand, understanding and affirming patients’ stories of their pain, may aid in a shared understanding, helping to address not
only the patient’s experience of isolation but also the anger and frustration that can stem from not being taken seriously (Newton et al., 2013).

According to Leventhal’s Common Sense Model of Self-regulation of Health and Illness, people try and make sense of their symptoms which then guides their actions and emotional responses.

Leventhal and colleagues (Leventhal et al., 1997) describe five components of these illness representations: 1. Identity (what do I have?), 2. Cause (what caused it?), 3. Time line (how long will it last?), 4 Consequences (what are the short and long term consequences?) and 5. Curability / controllability (What can I or my health care providers do to influence it?). When affected by pain, a natural belief could be to interpret the pain as damage to the body. This may lead to protective behaviours towards the wounded body part (Stenberg et al., 2014). In a qualitative study in patients with acute neck and back pain the theme “fear of hurting the fragile body” was expressed to some degree by all subjects, indicating fear of further damage (Stenberg et al., 2014). This underscores the need to explain pain to all patients, not just those with chronic pain, and to provide reassurance. Beliefs about pain are developed in interaction with others and patients get information from many sources (Darlow et al., 2013). According to Darlow et al. (Darlow et al., 2013) participants experiencing acute low back pain faced considerable uncertainty and consequently sought more information and understanding. Although participants searched the Internet and looked to family and friends, health care professionals had the strongest influence upon their attitudes and beliefs. Health care professionals influenced their patients’ understanding of the source and meaning of symptoms, as well as their prognostic expectations (Darlow et al., 2013; Stenberg et al., 2014). Providers can contribute to avoidance beliefs directly by focusing on what patients should not do and indirectly by providing management advice and pathoanatomic explanations, which are interpreted as meaning the spine is vulnerable and requires protection (Darlow et al., 2013). Patients
expect an explanation for their pain and we do our best to comply. Well-meant information giving as to the cause of the patient’s pain, or why therapy might be beneficial, however, such as “you have an unstable vertebra that needs to be held in place by exercise”, “you should not go back to work with the kind of work you have”, “you’ve got a disc that's bulging out this way, if you do this McKenzie technique it will push it back in” (Darlow et al., 2013; Oosterhof et al., 2014; Stenberg et al., 2014; Synnott et al., 2015) is likely to increase patients’ fear and conviction that something is dangerously wrong with them.

In addition, the clinical practice guideline for low back pain (Delitto et al., 2012) specifically reports “Clinicians should not utilize patient education and counselling strategies that either directly or indirectly increase the perceived threat or fear associated with low back pain, such as education and counselling strategies that 1) promote extended bed-rest or 2) provide in-depth, pathoanatomical explanations for the causes of low back pain”. This is likely sound advice for all musculoskeletal pain. The fact that health care professionals can negatively influence patients’ beliefs is important, as evidence is increasing that maladaptive illness perceptions can negatively influence treatment outcomes. For instance, low recovery expectations (Iles et al., 2012), expectations that low back pain will last a long time (Campbell et al., 2013; Foster et al., 2008; Henschke et al., 2008) and believing low back pain will have serious consequences (Moss-Morris et al., 2007) have all been associated with poor outcomes.

In contrast, unambiguous activity advice can be very empowering, and appropriate reassurance and positive prognostic expectations can have a very beneficial effect. These approaches positively influence participants’ beliefs about their current and subsequent episodes of low back pain (Darlow et al., 2013; Stenberg et al., 2014). Fortunately, this approach is supported by the evidence: Patient education and counselling strategies for patients with low back pain should emphasize (1) the promotion of the understanding of the anatomical/structural strength inherent in the human spine, (2) the neuroscience that explains pain perception, (3) the overall favourable prognosis of low back pain, (4) the use of active pain coping strategies that decrease fear and catastrophizing, (5) the early resumption of normal or vocational
activities, even when still experiencing pain, and (6) the importance of improvement in activity levels, not just pain relief. (Recommendation based on moderate evidence)(Delitto et al., 2012).

THE CLINICAL IMPLICATIONS

Keep it simple / simply put

Readability is the ease with which a reader can understand a written text. It is an important attribute of written material, which can affect the reader’s ability to comprehend. Currently, the average adult reads at a grade eight level. The National Institutes of Health (NIH) suggests that patient education materials be written at a sixth to seventh grade reading level (National Institutes of Health, n.d.). However, most of the available patient education materials in medical care is written at a reading level that does not meet these standards and may be too complex for comprehension by a substantial proportion of the population (Agarwal et al., 2013; Badarudeen and Sabharwal, 2010; Eltorai et al., 2015; Ganta et al., 2014; Shah et al., 2015; Vives et al., 2009). In physical therapy research there is almost no information on the readability of physical therapy educational materials, which highlights that this a forgotten topic within the field. We were able to identify one paper on the readability of online information relating to the treatment and management of Acute Low Back Pain (Hendrick et al., 2012). The readability scores in this study indicate that a large proportion of ALBP website information may be too complex for mainstream users to understand.

The Flesch–Kincaid readability tests are tests designed to indicate how difficult a passage in English is to understand. The formula will output a number from 0 to 100 - a higher score indicates easier reading. An average document has a Flesch Reading Ease score between 6 - 70. As a rule of thumb, scores of 90-100 can be understood by an average 5th grader.

Eight and 9th grade students can understand documents with a score of 60-70; and college graduates can understand documents with a score of 0-30. There are a number of on-line tools available that can help assess the readability of texts (see, for instance, https://readable.io/text/ or http://www.readabilityformulas.com/freetests/six-readability-formulas.php). The patient information example beneath from a Patient Guide on patient
rights and responsibilities from a University hospital in the United States has a reading ease score of 44.8, which is equivalent to almost 12th grade. This is college level and rated as “difficult to read”. Most patients will not be able to comprehend this text on their rights.

**PIC HERE ON READABILITY RATING PATIENT RIGHTS**

The National Institute of Health (NIH) has provided recommendations on how to improve the readability of patient education materials (Center for Disease Control and Prevention, 2009). Key to readability is plain language; short, simple words, writing short sentences (7-14 words), and avoiding unnecessary words and jargon.

**PIC HERE ON PLAIN LANGUAGE**

Making it personal and using the patient’s experience (e.g. sore foot instead of plantar fasciitis) of the condition helps readability. Dividing the document into manageable chunks of information with clear headings and more distance between the lines also helps readability (Health Communication, n.d.). Adding pictures to written and spoken language can increase patient attention, comprehension, recall and adherence. Research suggests that pictures can help low literacy people understand relationships, provided that they understand the elements being related. Research also suggests that spoken information can, with the help of pictures, be recalled to a high degree by people with low literacy skills. This could enable people with low literacy skills to make optimum use of information spoken by health care providers (Houts et al., 2006). Katz et al. (Katz et al., 2006) in their review of pictograms in pharmacy, also recommend using simple, realistic pictures with limited content, using whole body images as reference for body parts, and minimize using abstract symbols.

**PIC SIMPLE  PICTURES OF HOW THE BODY WORKS (not sure if copyrighted)**
In communicating with patients it helps to use plain language; use present tense in short sentences with simple words or use the same words as your patients. Speak clearly, not too fast, be specific and limit the information (3-5 key points). If possible, use simple pictures and/or drawings to explain. To make sure a patient has understood the information given, the Teach Back method can be used. Teach back, also known as “show me” or “closing the loop” is a method that aims to increase people’s understanding of the information being communicated by asking them to repeat back key points of the instruction. Questions to ask are: Could you tell me what we just talked about to see if I was clear? I want to be sure that I explained everything clearly. Can you please explain it back to me so I can be sure I did? Please show me how you are going to do this at home so I know if I was clear.

Evidence from a systematic review (Ha Dinh et al., 2016) supports the use of the teach-back method in educating people with chronic disease to maximize their disease understanding and promote knowledge, adherence, self-efficacy and self-care skills.

PIC TEACH BACK CYCLE

**Challenge maladaptive beliefs**

Physical, psychological, and environmental factors may all worsen a person’s pain experience. Although we all claim to have abandoned the traditional biomedical models with a focus on pathophysiology, in physiotherapy it seems we have not completely embraced the biopsychosocial approach to understanding patient’s problems. There is a growing body of literature documenting that physiotherapists do not (fully) address psychosocial problems or patient beliefs (Roussel et al., 2016; van Wilgen et al., 2014)(Emilson et al., 2016; Synnott et al., 2015). In contrast to this reluctance of physiotherapists to discuss these factors with patients, previous research has identified that acknowledgement by a clinician of the impact of pain on a person's psychological health is considered to be very valuable by patients (Laerum et al., 2006). Although many physiotherapists may feel unprepared to address psychosocial problems, an effective plan of care must include addressing these factors hypothesized to impact the experience. The brief Illness Perceptions Questionnaire is a questionnaire with 9 items
that can be downloaded for free from http://www.uib.no/ipq and is available in many languages. Having patients complete this questionnaire and subsequently discussing their answers with them can provide insight into their beliefs and opens up the opportunity to challenge unhelpful beliefs. Of importance here is that a Socratic-style dialogue of education is preferred over ‘lecturing’ to the patient. The therapist activates the patients’ thought processes by naïvely questioning about illness perceptions and potential strategies for improving health (Siemonsma et al., 2008).

PNE, with the emphasis on changing beliefs from “pain equals damage” to a perceived need of the brain to protect body tissue (Butler and Moseley, 2013), may be helpful. The goal of PNE is for learners is to acquire functional pain literacy; to understand how pain is produced and to integrate this new understanding into their wider pain and function-related beliefs, attitudes, behaviours, treatment and lifestyle choices. (Moseley and Butler, 2015) In our experience, however, low health literate people find this difficult to understand and will respond with “that’s all very well, but my pain is real” or “I don’t understand all this brain stuff”.

Equally, Kleinman’s explanatory model (Kleinman, 1988), which is only one of the six steps in culturally informed care, can be used to assess patient beliefs. According to Kleinman (Kleinman and Benson, 2006), the one activity that even the busiest clinician should be able to find time to do, would be to routinely ask patients (and where appropriate family members) what matters most to them in the experience of illness and treatment. The clinicians can then use that crucial information in thinking through treatment decisions and negotiating with patients.

PIC EXPLANATORY MODELS APPROACH HERE

SUMMARY
We must move away from the biomedical approach and embrace the biopsychosocial approach by listening to our patients and addressing their concerns, beliefs and fears in a language they understand.

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Multiple professional organizations recommend using universal health literacy precautions to provide understandable and accessible information to all patients, regardless of their literacy or education levels. This includes avoiding medical jargon, breaking down information or instructions into small specific steps, limiting the focus of a visit to three key points or tasks, and assessing for comprehension by teaching back. Additionally, printed information should be written at or below sixth-grade reading level. Visual aids, graphs, or pictures can enhance patient understanding (Hersh et al., 2015). Finally, make sure your patients have the answer to the following “askme3” questions: 1. What their main problem is, 2. what they need to do 3. Why it is important to them (IHI and NPSF, n.d.).

HEALTH LITERACY RESOURCES

http://www.healthliteracyplace.org.uk/
https://www.nala.ie/
https://www.plainlanguage.gov/resources/checklists/checklist/
http://www.npsf.org/?page=askme3

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HEALTH LITERACY IN EUROPE

SIGNS OF LOW HEALTH LITERACY

Behaviour in the clinic

I do not complete questionnaires
I ask few (basic) questions
I often miss appointments
I am passive in treatment
I do not follow-through with home exercise / referrals to other providers
And, by the way, my head hurts too..

Reaction to written information

I have forgotten my glasses,
I’ll read this when I get home/can you read this to me?
I’ll discuss this at home with...(wife/children)
HEALTH THREAT 

ILLNESS REPRESENTATION 

COPING 

APPRAISAL 

EMOTIONAL RESPONSE 

COPING 

APPRAISAL 

EVENTHAL COMMON SENSE MODEL OF SELF REGULATION
Patient Rights and Responsibilities

We want to partner with you in providing the very best care and are committed to maintaining the rights, dignity and well-being of our pediatric and adult patients. Adult patients or, when appropriate, the patient’s representative (as allowed by state law) and parents/guardians of minors will receive information on rights and responsibilities upon admission to the hospital. This information is available to all patients in our outpatient practices as well.

The hospital does not discriminate against any individual based on race, color, religious creed, gender, gender identity or expression, genetic information, sexual orientation, age, disability, veteran or active military status, marital status, or national origin/ethnicity.

The Patient Has the Right:

• To be treated in a caring, safe and compassionate way
• To receive timely, complete and accurate information
• To know the name and specialty of those providing care
• To say "yes" or "no" to treatment as allowed by law
• To ask questions about what is happening and why
• To have things explained in their preferred language
• To make an advance directive, such as a health care proxy, for those 18 years or older
PLAIN LANGUAGE – WHAT IS IT?

• Short sentences, simple words
• Use present tense
• Use the same words as your patients
• Speak clearly, not too fast
• Limit the information (3-5 key points)
• Be concrete
• Use simple pictures, drawings
SIMPLE PICTURES OF HOW THE HUMAN BODY WORKS

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**Teach Back Cycle**

1. **Physio explains**
2. **Patient understands and remembers**
3. **Physio asks back**
4. **Physio explains adjusts info**
5. **Can you tell me in your own words?**
6. **Did I explain it well?**
7. **Offer information in “chunks”**
8. **Check understanding after each “chunk”**
9. **Make sure to complete the cycle**
10. **Use plain language**

- New concept
- What will you do at home? Why? How?
EXPLANATORY MODELS APPROACH

• What do you call this problem?
• What do you believe is the cause of this problem?
• What course do you expect it to take? How serious is it?
• What do you think this problem does inside your body?
• How does it affect your body and your mind?
• What do you most fear about this condition?
• What do you most fear about the treatment?
HIGHLIGHTS

- Many adults in the Western world have difficulty understanding health information
- Physiotherapists need to provide understandable information to all patients
- Medical jargon should be avoided and plain language be used
- Comprehension should be assessed by teaching back.
SHORT BIO

Harriët Wittink trained as a physiotherapist in the Netherlands. She then moved to the United States to pursue a master’s degree in Orthopaedic and Sports Physical Therapy. Following this she became an Orthopedic Clinical Specialist and gained her PhD at Boston University in 1998 with a thesis on “Chronic back pain, aerobic fitness, physical functioning and disability”. From 1989 – 2001 she worked in large academic hospitals in Boston as a member of interdisciplinary pain management teams. Since 2007 she is professor and chair of the Lifestyle and Health Research Group of the Utrecht University of Applied Sciences.